‘We’re All in This Together?’ The Role of Social Identity Processes in the Collective Experiencing of Trauma and Adversity by NHS Ambulance Personnel in England During the Covid-19 Pandemic.

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July 2024

Abstract

It is well known that psychological trauma and adversity are inherent to the work of emergency ambulance personnel. While there is a large research base that examines the individual impacts and risks of such exposures, little is known as to how they are experienced by ambulance personnel in their social work groups or teams, nor what the effects are when the context of adversity is prolonged.

Through qualitative inquiry, this thesis aims to understand the social psychological dynamics operating within the depths of NHS ambulance service culture, specifically exploring how these features influence the social behaviours and relationships between ambulance practitioners and their collective experiencing of trauma and emotionality. In addition, this study explores social identity and self-categorisation as influential factors in mediating these relational, psycho-emotional, and behavioural responses.

Interviewing thirty ambulance personnel over the course of the first year of the Covid-19 pandemic, this longitudinal research demonstrates how the social identity approach is highly relevant in its application to this emergency services setting. Qualitative insights show just how extensive and pervading these social psychological dynamics were in influencing the ambulance practitioners' perceptions, interpretations, and emotionality in response to adverse and traumatic situations.

This study contributes new knowledge of how, in the context of the pandemic, group memberships shaped practitioners' social and psychological worlds, especially the social psychological dynamics operating within ambulance service culture. Overall, I argue that these processes deeply influenced the interactions, relationships, and behaviours of participants, and in this way, impacted their psycho-emotional responses to collectively experienced adversity and trauma.

Author's Declaration

I declare that this thesis is a presentation of original work, and I am the sole author.
This work has not previously been presented for an award at this, or any other University.
All sources are acknowledged as references.

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Acknowledgements

The journey of undertaking a doctorate during the Covid-19 pandemic was one that was full of the unexpected and the unpredictable. It was a voyage that was turbulent and uncertain and was exceptionally challenging at times. If it wasn't for key people supporting me along this road, this thesis would not have reached its conclusion.

To everyone who has helped me in this journey, thank you.

I would like to express my sincere gratitude to my principal supervisor, Professor Leo McCann, whose unwavering support, constant enthusiasm, encouragement, and expertise made this journey possible. Indeed, his belief in my abilities has been invaluable in enabling me to grow as a social scientist and academic. Thanks also go to my second supervisor, Professor Tony Royle for his guidance, support, and for reviewing my progress.

I would also like to give my deepest appreciation to the College of Paramedics, in particular 'the Bosses' Liz Harris and Tracy Nicholls, for their invaluable support in championing my research and their understanding that it has, at times, consumed me. In addition, I'd like to thank my brother, Matthew, who cast his grammatical eye over sections of text, and my friends, who in the latter years of this study have put up with me not being around much.

Of course, none of this would have been possible without those who participated in this study. I am so grateful to you for your kindness and willingness to talk to me, sharing your stories of suffering and strength, and in giving up your time when life was chaotic, uncertain, and traumatic. It is so important for your voices to be heard, and my hope is that I have honoured your experiences here. Through your contributions, I hope that this thesis will be meaningful, that it will improve our understanding of trauma and adversity within paramedicine and will inspire positive impact upon cultural change.

This thesis is dedicated to my family, friends, and colleagues who lost their lives during the four years of this study.

Note of Caution

This thesis contains the experiences of ambulance personnel who worked at the frontline of emergency healthcare during the Covid-19 pandemic. Their narratives contain accounts that are, at times, distressing, and include discussion of death, dying, serious illness or injury. Some individuals might find these quotations difficult or traumatic to read.

Chapter 1 - Introduction

1.1 Introduction

'So, we have a novel virus with…no treatment protocols and no vaccine at this time' the physician declared.

Dr Ellis Cheever is an experienced, quietly assuming, yet decisive medic bravely leading the taskforce against the fictitious meningoencephalitis virus 1 (MEV-1); a highly contagious and lethal outbreak in the United States. 'That is correct', replied Dr Ally Hextall, the public health researcher played by Jennifer Ehle. Later, Kate Winslet in the role of Dr Erin Mears, an Epidemic Intelligence Service Officer at the Centre for Disease Control and Prevention, stated with analytical objectiveness that 'how fast it multiplies depends on a variety of factors. The incubation period, how long a person is contagious. Sometimes people can be contagious without even having symptoms…'

These quotes from the film *Contagion* (2011) captured the viewer into a dramatic yet plausible new reality of terror and uncertainty over a 'lethal airborne virus that kills within days'. In the world of Hollywood, the film industry has no shortage of captivating story lines designed to play into our imagination as an escape from reality. Certainly, this movie was gripping and fast-moving, filled with heroism and bravery particularly from medical and health professionals. It gave the perilous sense that the collective life of society can tip over in an instant - the human social impact of a contagious virus was immediate; yet, to avert catastrophe the characters drew upon multi-agency collaboration and forged a sense of 'we're all in this together' in the fight for survival by developing a vaccine and a cure.

Hollywood movies like *Contagion* speak to something important about society and its fragility, about the moral suffering and risk people can be forced to endure. In this way, the film drew us in to the power of humanity and emotionally reconnected us to what really matters – our interactions and relationships with others. Although based upon folk knowledge with its primary purpose being to entertain, it is a film that lends itself to deep questioning about how communities confront disasters and traumatic scenes, especially when they are prolonged. As one becomes immersed in this thriller, it really hits home just how vulnerable humanity is. Films of this kind, however, are obviously works of fiction. In reality, it is surprising how little we really know about how professional groups are impacted by and behave when faced by disasters of such magnitude and duration.

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At the start of 2020, the world was quickly becoming acquainted with a threatening, novel, and highly contagious virus, which would later be designated by the World Health Organisation (WHO) as SARS-CoV-2 resulting in mild to severe acute respiratory illness; initially thought to be a viral pneumonia, specified as coronavirus disease 2019 (Covid-19) (WHO, 2024).

Even as the news emerged from Wuhan, China, where this zoonotic virus was first identified, it was evident that the pathogenesis of this disease was of greater public health concern than that of two prior coronaviral contagions; severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) both of which caused mortality in a number of countries, although not in the United Kingdom (UK). Indeed, the significant human-to-human transmissibility of Covid-19 would lead to worldwide contagion, posing an 'extraordinary threat to global public health' (Hu et al, 2020, p.141). On 30th January 2020, the outbreak was declared by WHO as a 'public health emergency of international concern' and was formally designated as a pandemic on 11th March 2020 (Hu et al, 2020; WHO, 2020a).

Like SARS and MERS, patients with Covid-19 presented with symptoms such as a fever, new cough, shortness of breath, reduced blood oxygen saturations, and loss of taste/smell – although some individuals experienced no symptoms at all (European Centre for Disease Prevention and Control, 2023). More worrying was the short time frame for clinical progression in severity of illness which saw individuals deteriorate from being well to seriously ill, which on average, was found to be 10-12 days for those who required admission to intensive care (American College of Emergency Physicians, 2024). Despite attempts by countries to implement public health containment measures such as lockdowns and restrictions, the virus continued to spread internationally. What perhaps was not initially realised was the enormous loss of life that our societies would face or how this would pan out to become a prolonged health catastrophe infecting millions of people (Cascella et al, 2023; Davis et al, 2023). As we now know, it was a contagion that would profoundly impact every aspect of the lives, work, and social interactions of almost every human being. It would place overwhelming pressure upon health services, particularly hospitals and intensive care units (Appleby and Davies, 2021), but also the wider healthcare system including that of ambulance services, who provided a pivotal frontline response (Association of Ambulance Chief Executives (AACE), 2024a; National Health Service (NHS) Providers, 2024).

This thesis explores the real-time lived experiences of individuals working within NHS ambulance services in England over the first year of the coronavirus pandemic outbreak. I explore their adversity and trauma, experienced as individuals in the context of their membership of collective work groups. I also explore how organisational structures and behaviours influenced their perceptions of the pandemic and their emotional and behavioural responses as guided by in-group norms, values, and beliefs. Finally, I also explore the relevance of the ambulance practitioners' shared professional social identity, and the influence of this upon emotional and behavioural responses.

This chapter contextualises the background to my research, providing an overview of the key elements; that of working within the NHS ambulance service, pandemics as disasters, and the relevance of social psychology - social identity theory in particular - for examining this field. In addition, this chapter outlines the importance of this research and the contributions it makes to academic knowledge. This chapter concludes by outlining the study research questions, aims, and objectives. A brief overview of the methodology and findings are given. Finally, I provide detail of the theoretical framework for this research; a social identity approach, and critically examine the arguments for and against this theory in light of the prior discussed literature.

1.2 Background to the Study

This section provides a broad overview to the key themes of this thesis and introduces the reader to the current contextual factors of concern. This includes a very brief history of the ambulance service in England which is essential for understanding the cultural evolution of the technical and social worlds in which ambulance personnel reside. Important concepts such as ambulance culture and social identity are introduced, as are the influential works of key researchers, including eminent theorists of the social identity approach. From this brief overview, I draw the reader towards an understanding of how the modern-day socio-cultural context of the ambulance service has created concerning implications for the frontline workforce in respect of their psychological and emotional wellbeing – particularly when faced with the prolonged and enduring adversity resulting from the Covid-19 pandemic.

1.2.1 Contextualising the NHS Ambulance Service in England

Despite much advancement and innovation in recent years, the ambulance service features remnants of a tapestry of technical procedures, practices, and ways of doing things that is reflective of its historical past. Whilst ambulance services, as they have become known today, were integrated into the National Health Service only in 1974, prior to this, bus and coach companies were contracted by local councils to provide transportation of the sick and injured to a place of definitive treatment (Wankhade, 2017; McCann et al, 2013). Such ambulances were staffed by a driver and attendant, both of whom had little more than first-aid training. However, the Millar Report (Ministry of Health, 1966) was pivotal to improving standards of pre-hospital knowledge and care. Subsequently, the first paramedics – 'ambulancemen' with extended training - were incepted from the mid-1970's to provide 'advanced' resuscitation skills such as undertaking heart monitoring and administering drugs to people in cardiac arrest (Newton et al, 2020). As this chapter later shows, this is a far cry from today's paramedics whereby such skills are now considered

fundamental and where advanced practice comprises master's degree level qualification specialising in expert clinical skills associated with emergency, critical, and urgent care.

Modernisation of public services does not occur without policy impetus. Indeed, over the last few decades Government driven strategy has and continues to, advocate for national service improvements that are responsive to data analysis trends yet are set within a backdrop of cuts to public spending (Wankhade et al, 2015). To date, these have shown an immense shift in terms of the number of calls received by the ambulance service through the '999' system. Most recent data shows that across England, just under thirteen million calls were received by NHS ambulance services in 2023 (AACE, 2023), with monthly data highlighting that in May 2024 alone, call volume was more than 758,000 (AACE, 2024b). Perhaps of surprise is the trending nature of calls, which has seen a dramatic shift in the last few decades, away from those mostly of a life-threatening nature – which NHS England (2018) and Wankhade (2016) estimated to more recently be around 10% of the total call volume, towards a greater number of those that are 'low acuity' – such as for chronic illness, mental health conditions, soft tissue injuries, and musculoskeletal back pain (Carnicelli et al, 2023; Eaton, 2023; Austin et al, 2018).

Mapping the changing needs of society clearly required a significant paradigmatic shift in thinking as to the core business of the ambulance service (Eaton, 2023). Firstly, this resulted in the demise of services that were county-based. In 2006, ambulance trusts were restructured to strategically align and integrate with wider NHS regions thus resulting in just ten ambulance services across England (AACE, 2024c). The second change was a move away from traditional response models of transportation to hospital to a highly complex, contemporary framework that encapsulates a system of unscheduled care integrated with clinical pathways across the health service. This has represented a significant shift in ways of working in response to lower acuity calls yet allows ambulance practitioners to provide definitive treatment and refer patients to specialist teams such as community nursing services, occupational therapy, and primary care, thereby negating the need for hospital admission – which is thought to have resulted in approximately 50% of ambulance callouts resulting in patients being discharged at scene (Knowles et al, 2018; NHS England, 2018).

Digital advancements have certainly played a part in this (Nuffield Trust, 2020). However, the advent of digital forecasting models has brought with it live data capture pertaining to crew mobilisation and response times, and indeed, every part of the patient's journey in the ambulance system. Whilst this data is correlated against nationally reported performance targets, arguably, this remodelling of service delivery has led to a highly target-driven, performance-orientated organisational culture which is widely despised by ambulance crews who tend to view targets and metrics as punitive tools used to micro-manage their work and a detraction from the quality patient care they provide - which can go unnoticed by leaders (McCann, 2022).

The organisational need to achieve these government targets has ultimately impacted upon the social worlds of ambulance personnel. It has seen them being strategically re-positioned away from their base stations, meaning that during a shift they now often respond to calls outside their usual geographical region and rarely get time at their station (Clompus and Albarran, 2016). Driving increasingly lengthy distances 'on emergency' which requires high levels of concentration, is taking its toll, and the evidence suggests that this, and attending call after call with little time in-between to catch one's breath, has added to an already high-pressured and intense working environment and has been attributed to reduced morale and increased staff turnover rates (Granter et al, 2019). Indeed, a shortage of staff through attrition and sickness represents one of the most significant challenges for ambulance services today.

1.2.2 Professionalisation of the workforce

Since the late 1970s when those first 'ambulancemen' undertook their extended training, the clinical role of the paramedic has advanced almost beyond recognition. The journey to professionalisation started with the requirement to register as a paramedic (a title subsequently protected in law) with the Council of Professionals Supplementary to Medicine (CPSM) from 1999 which, after several variations, came to be known as the Health and Care Professions Council (HCPC). Around the same time, the British Paramedic Association was established as the professional body, later becoming the College of Paramedics, which now has more than 21,000 members (College of Paramedics, 2024).

To adapt and meet the rising complexity of patients' urgent and emergency healthcare needs (Department for Health, 2008; Department of Health, 2005), the scope of practice and professional accountability of paramedics has advanced significantly since the turn of the century, alongside regulated reforms to their education (Health & Care Professions Council, 2023; College of Paramedics, 2019; NHS England, 2019; Wankhade, 2016) from internal certificated, vocational training courses to graduate and post-graduate entry (HCPC, 2023; Givati et al, 2018). Indeed, the breadth of paramedicine taught within higher education degree programmes is now expansive – to prepare the clinician for the wide-ranging situations they may be called to – from assisting a birthing mother, resuscitation, treating minor injuries or illness, to responding to major trauma, a terrorist attack, rail crash, or other significant incident (Eaton, 2023; Tavares et al, 2016; Blau et al, 2012).

NHS Digital (2020) identified that in July 2020, not long after the Covid-19 pandemic outbreak was declared, 17,019 ambulance personnel and 13, 027 paramedics worked within NHS ambulance services in England (Clark et al, 2021). The Nuffield Trust (2022) reported a rise in the number of paramedics to 17,847 as of June 2022, with approximately 25,000 ambulance technicians and assistant practitioners employed. Clinicians working in the ambulance sector are not just from an ambulance professional

background, however, yet the number of professionals employed from other disciplines such as nursing and midwifery, are not yet known. Furthermore, although numerous throughout the nation, data appears not to have captured the number of unqualified staff members fulfilling the vital role of emergency care assistant.

For clarity, Appendix A provides a synopsis of the professional groups working within NHS frontline ambulance practice. In this thesis, the professional role titles of paramedic and ambulance personnel/ practitioner are used interchangeably for ease of reading.

1.2.3 Clinical practice

Modern-day ambulance clinical practice requires relative autonomy, with practitioners undertaking a wide range of clinical assessments, complex decision-making, and providing treatments without direct medical supervision. Most recently, advanced clinical practitioners' scope of practice has extended to include independent prescribing (NHS England, 2018; Tavares et al, 2016; College of Paramedics, 2015). Whilst time has seen considerable clinical progression, it remains that paramedics are yet to fill any national leadership roles (Eaton, 2023), and the medical and nursing professions continue to provide external control and governance over the 'sub-ordinate' paramedic's clinical remit and practice (McCann et al, 2013, p.754). Nevertheless, this is not to say that change is not afoot. Indeed, in recent times, some ambulance services have appointed Consultant or Chief Paramedics into their senior leadership teams, thus giving voice and high-level representation for this profession (North-West Ambulance Service NHS Trust, 2024).

Advancing the education and skills of paramedics has created opportunity for employment outside of the ambulance arena, once the only choice of employer for these clinical professionals. Prospects now include primary care (Eaton, 2023; 2018, Mahtani et al, 2018; Brown, 2017, Primary Care Workforce Commission, 2015), emergency departments, end-of-life care, and other specialist clinical response teams (Health Education England et al, 2017; AACE, 2015; Blaber and Harris, 2014). A number of paramedics also work in other environments such as the military, prisons, police custody, the oil and gas industry, and cruise ships, for example (College of Paramedics, 2018). Undeniably, this expansion of employment opportunities alongside other factors such as a lack of career development (Harris, 2019) and challenging working conditions is problematic for the ambulance service which is seeing a depletion of its more experienced clinical workforce and increasing difficulties in retaining staff (Granter et al, 2019; National Audit Office, 2017).

Furthermore, organisational pressures such as long shifts with frequent late over-runs, regular over-prioritisation of emergency calls as life-threatening, queuing outside hospital emergency departments for

hours on end, cancelled professional training due to high call demand – or organisational expectations mandating its completion in one's own time, as well as perceptions of feeling unvalued and unsupported, all impact upon employee morale, wellbeing and, ultimately, their desire to stay in the job (Mancholev and Lewis, 2021; Care Quality Commission, 2020; National Health Executive, 2017; Wankhade, 2016, Sterud et al, 2011).

1.2.4 Social cultures

Frontline NHS ambulance employees usually work in pairs; one clinician (such as paramedic, ambulance nurse, associate ambulance practitioner) with one non-clinician (emergency care assistant), sometimes with a student paramedic joining them. Crews often work from a base station or hub, which is assigned to a geographical area of an ambulance service. Although no two ambulance stations, or indeed, organisations, are exactly the same due to variations in size, resources, populations served, geography and so on (Tannenbaum, 2013), certain characteristics are predictably shared within all NHS ambulance services such as the nature, purpose, and co-ordination of the work (i.e. to provide an efficient and effective emergency health service) and order of the work (for example, through hierarchy and command, policies, and procedures).

From a socio-cultural perspective, operational ambulance staff work within an embedded organisational structure comprising social units of individuals who have shared experience of working in a frontline emergency setting. As such, shared organisational practices naturally develop through the collective realities of authentic lived experience, meanings, and processes ascribed by those who do the work, and manifests within dimensions of their behaviour and attitudes thereby creating a co-constructed culture within a group. Importantly, deconstructing and understanding these collective level processes gives insight and allows understanding and sense-making of implicit rules or norms, and 'everyday' routines. These processes include tacit assumptions, beliefs, and values, and are often out of conscious awareness yet are incredibly powerful and influential in guiding and regulating the internal social worldview of paramedicine – that is, how the usual practice of daily 'ambulance work' is experienced and done (Deal and Kennedy, 1982), how organisational activities are hierarchically ordered, and the expected behaviours around social interactions and relationships (Wankhade, 2017; Schein, 1992). In this way, culture gives communal meaning, predictability, and stability in terms of rules around those expected behaviours, and a sense of coherence to the organisational life of the group (Hogan and Coote, 2014; Tannenbaum, 2013). Furthermore, they also guide collective social identity. It can powerfully yet subtly influence and shape the actions of individual members, requiring them to adapt and 'fit in' to their salient groups (Fine and Hallett, 2014). If they do not conform however, they are potentially stigmatised and ostracised as 'out-group' which, may have considerable impact upon their self- identity, self-worth, and opportunity for support.

Despite modernisation of the context in which the work is undertaken, the culture within the ambulance service remains one that is based upon its historical past, drawing upon dominant, masculine, hegemonic discourse, that highly values stoicism, and requires tight emotional regulation such that emotional expression is contained or inauthentically enacted to conserve one's true feelings – even in the face of tragedy or adversity. Conforming to these group norms, however, can be extremely challenging and evidence suggests that the quest to hide and suppress one's emotions and distress can lead, in some cases, to profound psychological sequelae as well as intense emotionality such as shame and guilt.

1.2.5 Leadership and followership

Irrespective of impressive developments in a relatively short time frame, there has been little change of note in how leadership and followership is organised within the service. Indeed, the leaders of today, like their forefathers, are usually promoted through the ranks, and generally, the higher up they go, the longer service they have - which has given rise to the symbolic street-level notions of 'old school' to categorise these workers' social standing, yet arguably reflects operational leaders' drift away from the realities of being 'out on the road' (Wankhade, 2010) – although it is noted that this is not typical of those pursuing clinical leadership roles which still attracts active clinical practice.

The term 'forefathers' perhaps catches one's eye here, but its use is deliberate to capture the overwhelming prevalence of males holding senior leadership positions – which has been reported by numerous papers but was particularly noted within Ulrich et al's (2023) important study giving voice to female paramedics' experiences of career progression in the London Ambulance Service NHS Trust. Their findings highlighted perceptions of leadership being an 'old boys club' to which if you didn't measure up to masculinist behaviours, you were unlikely to be promoted – thus providing critical insight into how leaders and followers categorise and identify themselves and the gender dynamics at play. Indeed, most recently, news reports celebrated the first national appointment of a female into the senior role of Chief Paramedic (London Ambulance Service NHS Trust, 2024).

A top-down, hierarchical discourse within operational leadership remains prominent today and has been associated with a command-and-control authoritarian style whereby 'masculine' behaviours such as authority, self-reliance, and competitiveness have been collectively valued by those within as necessary for effective leadership (Heath et al, 2021). Whilst this approach, ubiquitous of hierarchical social groups, may result in socially co-ordinated actions and group achievements with 'getting the job done', it has been criticised for being highly controlling of the activities of ambulance personnel with excessive scrutiny over the clinical and technical aspects of their work. This led McCann (2022) to question whether paramedics truly hold the autonomy in their work that they perceive they have. Ultimately, he argued that from a

social relations perspective, such an environment makes for a culture of mistrust, bullying, and a tendency to blame and shame those at street-level (McCann, 2022); a finding confirmed in national inquiries and ambulance service cultural reviews (The National Guardians Office, 2023; Lewis, 2018; 2017). Indeed, this example highlights the importance of taking an analytical approach that places leaders and the dynamic concept of leadership and followership within the social and cultural context in which these relationships occur, as arguably, these are intertwined. However, it remains that the socio-behavioural and socio-relational elements of leader-follower dynamics in the ambulance sector is critically understudied. Yet, this is of great significance given leaders' influence over the behaviours of group members, their identity, self-esteem, and psychological welfare, thus providing support for a social identity approach to explore these notions further.

1.2.6 Psychological and emotional realities of street-level ambulance work

By the nature of their work, ambulance personnel are exposed to events that many people would find emotionally and psychologically challenging. Indeed, the profession is one that is well-recognised as being associated with poor psychological health as a result of the scenes sometimes witnessed but also as a result of accumulative stressors linked with the work (Carbajal et al, 2021). Furthermore, recently, researchers have identified that a previously uncaptured trauma exposure in these emergency responders – that relating to a violation of one's morals (such as not being able to provide timely and appropriate care for patients due to systemic issues) results in a sense of betrayal and is often perceived as perpetrated by leaders and/or organisations.

Whilst not all exposures to trauma and adversity result in psychological sequelae, the experiencing of difficult emotions such as guilt, shame, and distress are common responses. This, however, presents a problem for ambulance personnel whose social group norms, the informal rules guiding their collective behaviours, tend to favour the need to conceal one's true feelings such that in complying, they outwardly (inauthentically) retain the composure of a professional who is calm and in control. In the short term, this may appear a successful strategy and help them to deal with the distressing event. However, in the longer term, the use of emotional suppression, avoidance, and dissociation from one's feelings has links to psychological ill health, particularly that of the syndrome of burnout, and traumatic stress. Not only this, but evidence suggests that these behaviours may also have a 'ripple effect', subtly socially influencing the way that other team members interpret and experience similar situations, such that they collective appear emotionally 'hardened'; detached and unempathetic.

Nevertheless, the literature shows a tendency to only take a monodisciplinary individualistic approach to understanding and interpreting the complexities of trauma by presenting psychological reactions within a medical model and focusing upon post-event symptomology. Crucially, however, paramedics rarely face

such incidents alone and generally work as part of a close, cohesive team. Yet, how they experience adversity together, as a collective, does not appear to have been studied. In addition, many papers have, to date, either focused upon single incidents lasting no more than a few hours or an accumulative build-up of a series of stressful events. Longitudinal study of a prolonged, collective disaster such as war, flood, or a pandemic – in real time as it is happening – does not appear to have previously been undertaken within the United Kingdom, with little examination of this phenomenon internationally.

Taking a collective approach to this understanding is particularly important as, firstly, the evidence shows that drawing upon one's resources i.e. other members of one's group for support is critical in mediating responses to a distressing event especially in terms of reducing feelings of isolation. Secondly, the literature has robustly identified that having the opportunity to talk and share emotions within a psychologically safe context is associated with more positive psycho-emotional health outcomes (Pennebaker and Seagal, 1999).

1.2.7 Pandemics

In a relatively new epidemiological analysis of novel infectious disease outbreaks, Marani et al (2021) estimated that pandemics or public health emergencies of international concern (World Health Organisation, 2019) are becoming increasingly more likely, with 'a high probability of observing pandemics similar to Covid-19'. They further added that the 'probability of experiencing [a pandemic] in one's lifetime [is] currently about 38%, which may double in coming decades' (Marani et al, 2021, p.1). Nevertheless, by nature, the global spread of new pathogens is unpredictable. When they do occur, they have the potential for 'high consequence' incurring rapid human-to-human transmission leading to catastrophic mortality and morbidity – for which there is often no treatment or vaccine available, thereby posing significant threat to human populations (Department of Health & Social Care, 2020). During previous coronaviral outbreaks such as severe acute respiratory syndrome (SARS) and middle eastern respiratory syndrome (MERS), scaling up strategic preparedness and response was key to limiting this impact, particularly when individuals have limited to no immunity. This included fortification of a country's ability to identify, diagnose, and treat infected people, undertake contact tracing, epidemiological surveillance, and forecasting, and implement infection containment measures such as lockdowns and social isolation (WHO, 2020b).

While pandemics are relatively infrequent within England, modelling and preparedness plans such as those tested in 'Exercise Cygnus'; a high-level simulated exercise (Public Health England, 2017) received criticism not only for their overt centrality on pandemic influenza – thus, not accounting for other outbreak types, but also of the associated report findings which the UK Government refused to publish or disclose until legally ordered to do so. The report was stark, candidly highlighting how in response to a

'severe pandemic' (Public Health England, 2017, p.6), the United Kingdom (UK) capability to respond would be woefully insufficient. Although detailed recommendations were provided, it is reported opinion that 'lessons learned from the exercise were not implemented, which led to well-publicised problems experienced with the Government's response to the Covid-19 epidemic' (Journal of Anaesthesia Practice (2021, online) (McKee et al, 2022; Pollock and Coles, 2021).

Crucially, the exercise failed to take account of public responses to a pandemic outbreak (Public Health England, 2017) and did not seek modelling from socio-behavioural science. Arguably, in reality, such a crisis affects whole communities and presents as shared social experiences, often requiring significant behavioural change and casts widespread psychological burdens upon individuals (Byrne-Davis et al, 2022; Michie et al, 2020). In response to pandemic-mediated adversity and trauma, collective populations may confront helplessness, uncertainty, fear, loss, and grief (Van Bortel et al, 2016). Whilst this may illuminate powerful acts of solidarity, prosociality, altruism, and benevolence behaviours, thus, bringing groups a sense of 'we are all in this together', it is important to note how such circumstances also expose inequalities and social oppression.

Collective experiencing extends to those providing healthcare who face the challenges of caring for and treating those infected with a potentially lethal virus. Indeed, prior research has examined the shared experiencing of treating patients in a pandemic, capturing healthcare workers' sense of connection to one another, cohesively united in their heightened fears of infection and of the ethical challenges posed by a sense of duty to continue to undertake their role versus the risk of potential mortality to themselves and/or their loved ones. Thus, exposures to a virulent pathogen have also led to clinical personnel experiencing considerable long-term psychological difficulties including the development of post-traumatic stress disorder (PTSD), depression, and anxiety, as well as profound feelings of disconnection and isolation from family members and friends.

Less is known, however, about the social and psychological realities of ambulance staff, who are distinct from many other healthcare workers, in that they are often the first professionals to encounter patients with infectious diseases within the community. Furthermore, as Bitely et al (2019) argued, the out-of-hospital environment poses additional challenges not seen within other clinical settings – particularly around limited opportunity to decontaminate and clean equipment, their uniforms, and themselves (including handwashing) due to limited to no access to water, having to rely upon disinfectant wipes and gels, and facing demanding work pressures to 'clear' from incidents to respond to the next call – which ultimately reduces the time available for cleaning and sanitising. Thus, with the advent of the Covid-19 pandemic in England, it presented a unique opportunity to study these realities as they happened, in real time.

1.2.8 Social identity approach

Knowing that we belong to social groups provides us with a sense of knowledge and purpose about who we are, and our understanding of our place in the world in the context of a larger community of people. Indeed, social identity refers to how individuals self-conceptualise (or self-categorise) themselves on the basis of their membership of these groups, and from which their self-esteem may be derived and influenced. Social identity theory (Tajfel, 1978; Tajfel and Turner, 1979), one of the most influential social psychological frameworks for understanding intergroup relations, considers how our self-concept comes to embody group memberships and influences an individual group member's thoughts, feelings, attitudes, behaviours, and social relationships with other (in-)group members and those who are non- or out-group members. The seminal works of Tajfel and Turner (1979) highlighted how social identities become most influential when they are considered salient by the individual; that is, when they hold strong emotional ties with their membership of a group such that it becomes central to their self-concept. Whether a particular social identity become salient also depends upon social context – for example, socially identifying as a paramedic is salient whilst performing one's role whereas when at home, in the context of family, it is likely that identifying as a paramedic is far less salient.

Importantly, social identity theory highlighted two key, implicit processes associated with becoming a member of a group. The first is the pressure held within groups for all members to conform to group social norms – essentially providing direction for accepted social behaviours and beliefs, and secondly, that members view their in-group more favourably to those positioned within out-groups. Undertaking these unconscious processes serves to bolster social identity and self-esteem of in-group members, making the group more cohesive.

In terms of the workplace – which is representative of a social category (Ashforth and Mael, 1989), employees who identify more strongly with their work groups and organisation, such that this identity becomes deeply embedded within individuals' self-concept, are 'seen to embody or even reify characteristics perceived to be prototypical of its members' (Ashforth and Mael, 1989, p. 22). Resultantly, individuals assimilate the organisations characteristics, values, and goals into their own behaviours, internalise loyalty and commitment to the organisation (Coser, 1974), and are motivated to retain this sense of belonging and membership. Whilst this has been linked with positive psychological wellbeing, strong social identification can lead to intergroup bias and discrimination against non-group members, leading to exclusion. Furthermore, it can heighten pressures for in-group members to conform to social norms at all costs, resulting in internalised conflict, power imbalances, and tension, such that a toxic cultural working environment may ensure, characterised by intense mistrust and siloed mindsets

(Hennessy and West, 1999). Subsequently, it is these dynamics that can contribute towards poor psychological health of employees (Wilde, 2016).

1.3 The research 'gap': Rationale for this study

Studies focusing on the cultural and psycho-emotional worlds of paramedics through a social lens are rare, more so when this takes a social psychological approach. Yet, as this chapter and the next show, studying group processes and socio-relational dynamics from this perspective holds key significance for developing our knowledge of how such underlying forces present within an organisational context and strongly influence how ambulance personnel as group members, perceive, feel, experience, and respond to the adverse and traumatic situations they face within their work.

Whilst some studies researching ambulance populations indicate the prevalence and individual clinical outcomes in terms of psychological conditions, it remains for a study to capture the collective experiencing of such events. Furthermore, prior literature has overwhelmingly focused upon the short-lived nature of the incidents that these workers attend or discussed the accumulative or vicarious effects of distressing situations. But far less is known of the social psychological impact of prolonged exposure to adversity upon this close-knit community. The current study therefore fills a very real 'gap' in the literature.

1.4 Research aims, objectives, and research questions

Noting the limitations of quantitative research when studying the social, emotional, and relational behaviours of individuals within groups, this study develops a qualitative inquiry to this research.

To address the concerns I raised, **the aims of this thesis** are:

To understand the social psychological dynamics implicitly operating at the 'hidden' level of NHS ambulance service culture and to explore how these dynamics influence the social behaviours and relationships between ambulance practitioners, and their collective experiencing of trauma and emotionality in response to prolonged adversity.

To explore social identity and self-categorisation as processes influential in mediating the above.

The **objectives**, therefore, are:

- To understand how Covid-19 was contextualised as an adversity by ambulance populations.

- To capture paramedics' experiencing of the disruptive effects of the pandemic upon their social worlds, relationships, and social group behaviours in the workplace.

- To explore how social identity and self-categorisation influence how paramedics individually and collectively respond to adversity.

- To understand how, in this unique context for emotional experience, mediating psychological distress is likely dependent upon social and relational phenomena operating within ambulance cultures and salient in-groups.

- To investigate the role leadership and organisational social dynamics played in influencing ambulance personnel's individual and collective emotional experiences to prolonged adversity.

- To explore ambulance service culture from a relational and social psychological context.

- To highlight organisational recommendations for promoting and supporting psychosocial and emotional wellbeing in ambulance personnel both during and after a large-scale incident such as a pandemic.

The **research questions** are:

1. To what extent did organisational practices influence the social identities of ambulance personnel and their social group processes during the first year of the Covid-19 pandemic?

2. Through a social psychological lens, how did ambulance personnel respond to prolonged adversity and potential trauma experienced over the study period?

3. How did social psychological dynamics operating within the social relationships between ambulance service leaders and employees shape their interactions, emotionality, and behaviours during the pandemic?

4. How did ambulance personnel as a collective group come to be seen by wider society during the first year of the pandemic, and how did this impact their sense of self?

1.5 Thesis structure

This thesis is organised into nine chapters. This first chapter has provided background to the study, offering context and justifications for the research. The research aims, objectives, and research questions were detailed.

Chapter two critically explores literature pertaining to the socio-cultural worlds of ambulance personnel including the development of social identity through socialisation processes, and how a shared social identity helps to forge a sense of belonging and being a member of a team. Social norms relating to in-groups and the wider ambulance organisational culture are discussed and examined in terms of their influence upon individual and group members' perceptions and behaviours – particularly in the context of adverse and traumatic incidents encountered within their work. In reviewing the literature, I argue that current papers examining trauma and adversity in ambulance staff are often only considered through an individualistic lens. But there is a pressing need to understand the adversity they experience from a collective approach – especially given that these workers rarely face emergency scenes alone and are renowned for their tight-knit culture and close social bonds.

Chapter three examines the key approach referred to in this study; that of social identity – a metatheory comprising social identity theory and self-categorisation theory.

Chapter four presents the qualitative methodology used within this study. I explain the reasons for employing qualitative inquiry, utilising in depth interviewing and justify the methods used. This chapter provides an overview of the recruitment of participants and sampling process, ethical considerations, and the ethical approvals gained. Importantly, I highlight the specific challenges of attempting to undertake data collection in the midst of a virulent pandemic.

Chapter five is the first of three empirical chapters. This chapter provides rich description and detailed analytical interpretation of empirical data relating to the first phase of the study; thirty frontline ambulance personnel in England engaged in semi-structured interviews undertaken between April and May 2020, just after the declaration of the contagion as a pandemic and the commencement of the first lockdown in England.

Chapter six reports a critical exploration of the empirical data relating to the second phase of interviews which were undertaken between September and October 2020. Twenty of the original participants from phase one contributed to this stage of the study.

Chapter seven is the final empirical chapter. It details the data analysis of the third phase of interviews, encompassing the voices and lived experiences of the remaining fourteen participants who consented to partake in this study. This data was gathered towards the end of the first year of the Covid-19 pandemic in England, between January and February 2021.

Chapter eight, the discussion, draws together the key findings from this study and critically situates them within the context of current theory and literature. Here, I highlight how this research makes new and valuable contributions to knowledge.

Finally, chapter nine offers a conclusion and discusses limitations to this research study. This chapter also details recommendations for future areas of scholarly consideration as well as summarising points that may be practically applied to ambulance organisations.

This study contributes new knowledge of how, in the context of the pandemic, group memberships shaped participants' social worlds including the social psychological dynamics operating within ambulance service culture. Overall, I argue that these social processes influenced the interactions, relationships, and behaviours of participants and, in this way, impacted their emotional responses to collectively experienced adversity and trauma. Subsequently, in light of the worsening psychological health of NHS ambulance personnel, there is a real and urgent need to rethink how adversity and trauma is conceptualised within the context of the ambulance service and to revise the distinctions that have previously been made in this field.

Chapter Two – Literature Review

2.1 Introduction

The aim of this chapter is to situate the current study within the extant literature which has primarily been drawn from both the disciplines of social psychology and paramedicine.

In seeking to explore the social worlds of ambulance personnel, the reviewed literature examines multiple concepts including the construction of social identity through socialisation thereby providing these workers an occupational sense of who they are. How this process contributes towards learning the cultural rules and social norms that implicitly impact upon their collective beliefs and behaviours is also explored. The chapter briefly highlights contemporary issues facing ambulance services such as bullying and harassment and shows how the interplay between social interactions and social relationships are deeply connected with behavioural dynamics - particularly between ambulance staff and leaders, thus also providing insight into how these bonds influence how group members think, feel, and act. In this way, the literature provides important context. It allows for understanding of how the perceptions and experiences of adversity and trauma encountered by ambulance practitioners in their work, may be highly shaped by these social psychological elements and likely influences their heterogenous psycho-emotional responses. Nevertheless, the research points to an individualistic discourse underpinning these concepts. As I demonstrate, there is an advocative need for a social understanding of trauma collectively experienced by paramedics taking account that they usually attend incident scenes as crews and reside within a close-knit occupational culture. As prior studies identify, disasters and pandemics are a social context whereby this phenomenon is hugely significant.

Throughout this examination of existing studies, I highlight the 'gaps'; where the breadth of current research falls short and where unanswered questions remain. I show how this analysis has determined the key research problems upon which this study is based, and subsequently informs my study aims and objectives.

2.2 Understanding ambulance service culture through a social identity lens

Despite the clear importance of social identity theory in the context of organisational culture and leadership, there remains a paucity of research when applied to the field of paramedicine. In terms of meta-analytical interpretation of the collective-level social and relational processes within paramedicine group cultures, it is noticeable from the stark lack of literature that the research agenda for understanding the social psychological climate of ambulance work remains limited to date. Only a few specific published

works relating to this domain were identified during this literature review. There are several contending suppositions as to why this may be, namely, that traditionally, this profession has been constructed predominantly within a positivistic biomedical framework dominated by medical oversight, which has driven the development of pre-and post- qualification curricula and associated fields of research (Devenish et al, 2016; O'Meara et al, 2016; Campeau, 2009). Whilst it would be unreasonable to expect a curriculum to represent a plethora of academic disciplines, it remains that the social sciences in general have been much less studied and received little research attention when applied to the UK ambulance sector. Yet, arguably, this approach is critical to understanding the socio-cultural worlds of paramedicine.

Nevertheless, whilst no single social psychological study pertaining to social identity as applied to paramedicine appears to yet exist, it has been possible to extrapolate empirical data findings from existing studies of ambulance service populations from which elements of social identity may be drawn, including that of social categorisation and social comparison. These will now be examined.

2.3 Shared identification through self-categorisation and socialisation

Ambulance staff work within an embedded organisational structure comprising social units (such as ambulance stations or hubs) of groups of individuals who have shared experiences within a frontline emergency setting. As such, shared organisational practices have naturally developed and been shaped through the collective social realities, meanings, and social processes ascribed by those who do the work. These have manifested within dimensions of their behaviours and attitudes, thereby co-constructing culture within their group.

Importantly, prior studies highlight how deconstructing and understanding these collective micro-level processes provides insight, understanding, and sense-making of the implicit rules, norms, and 'everyday' routines that occur within ambulance service organisations. These implicit notions are often out of conscious awareness and yet, can be tremendously influential in guiding and regulating the internal social worldview of ambulance personnel; how the usual practice of daily 'ambulance work' is experienced and done, how organisational activities are hierarchically ordered, and the expected behaviours around social interactions, relationships, and emotion management, for example.

Meta-narratives pertaining to *who* ambulance personnel are and their distinguishing *modus operandi* may be assimilated through examination of the literature relating to professional socialisation processes and role identity formation. It is in striking contrast to policing (Cockroft, 2020; Charman, 2018; Loftus, 2009), that few papers have investigated how individuals embody the identity of and categorise themselves as ambulance service members (Hill and Eaton, 2023). Of the available literature, the focus almost always

appears to be upon the role identity transition of student and newly qualified paramedics into their registrant role and seemingly, research to date, has neglected to account for the socialisation and identity formation processes experienced by those entering the profession through apprenticeships and non-clinical roles such as that of emergency care assistant. Entwined within this argument, the literature is criticisable for taking overt examination of identity formation through the lens of 'knowing' and 'doing' the role of paramedic but often has failed to account for the social sense-making of 'becoming' and feeling that inner connection with 'being' a paramedic and member of the cultural group (Hill and Eaton, 2023, p.43; Eaton, 2023; O'Meara, 2011). Indeed, few studies make this conceptual link. Nevertheless, two papers are of particular importance here.

The first, by Capsey (2010), suggested that central to a paramedic's professional identity, and which is also their 'unique selling point' (p.242), is their adaptive ability to apply their clinical skills and care in often compromising and unpredictable working environments; a feature that is distinctive to these healthcare professionals. He explained that:

'…it is a measure of our skill that we know which aspects of…specialist care can appropriately be applied in a sixth floor flat, in a public house, or on a motorway' (p. 243).

This finding was previously asserted by the author of the second paper for mention here, that of Campeau (2009), who identified that the management and control of an incident scene was highly reliant upon the dynamic socio-relational processes and adaptable social activity between paramedics in their teams. Notably, Campeau's research and subsequent development of this 'space control theory of paramedic scene management' drew associations from the work of the eminent sociologist Erving Goffman (1959). Indeed, he considered via dramaturgical theory, the performative aspect of paramedic behaviours whilst 'on scene' or, as Goffman asserted, the 'front stage' region, whereby the public were noted to be the 'audience'. Campeau drew upon Goffman's symbolic notion of 'work control' to highlight that, to do their work, paramedics needed to be skilled in establishing 'space control' whilst operating in front stage regions where the emergency scene was in progress. Subsequently, Campeau's space control theory provides considerable insight into conceptualising the socio-behavioural realities of paramedic practice when attending emergency calls. This in itself is critical when considering both the professional role identities of paramedics and the socialisation process of those new into the profession. Indeed, both Campeau (2009) and Capsey (2010) argued that this notion of space control appears to be central to the formation of a paramedic's professional identity but added that paramedics have undersold this uniqueness of who they are. Nevertheless, these studies still fall short in examining the process of *how* one takes on the identity of 'becoming' and 'being' a paramedic (Eaton, 2023; Chomatowska et al, 2021). That is, experiencing the transfer of knowledge relating to the socio-behavioural and cultural elements of what it means to be and belong to their occupational group; that of the paramedic profession and the

organisation for which they work Hill and Eaton, 2023; Mausz et al, 2022; Jashapara, 2017; Lloyd-Jones, 2015).

A comprehensive paper by Devenish et al (2016) also yields valuable and salient points. The authors identified the influence of 'socialisation agents' (p.4) in formulating individuals' preconceptions of what it means to identify as a paramedic. How these workers are seen by those outside of the profession, they argued, has been heavily shaped by the media, television programmes, and film; often portraying the highly dramatic life-saving heroics of paramedics which in truth, is often far from reality (Rees et al, 2022; Charman, 2015; Wankhade and Mackway-Jones, 2015; Scott and Tracy, 2007; Tangherlini, 2000; 1998). However, it was previous life experiences, volunteering for organisations such as St John Ambulance, and the job roles held by parents; particularly when family members themselves worked within the emergency services or healthcare professions, that provided more realistic perspectives of the role and associated day-to-day practices. Ultimately, these preconceptions - including that of the heroic status portrayed on-screen, were found to shape participants' views of, and decision to train as a paramedic.

Notwithstanding, it was during clinical placements that student paramedics undertook their greatest socio-cultural learning. Although not yet accepted into ambulance culture, they were nonetheless exposed to normative, expected behaviours, values, and beliefs espoused by those operating within this context. It was in this 'hands on' environment that students began to develop a sense of self as a paramedic from the 'inside' perspective of those who do the job and have internalised this identity (Mausz et al, 2022; Johnston and Bilton, 2020).

Recognising that socialisation and social identity formation was a continual process extending from studentship through to internship, Devenish et al (2016) highlighted how this phase was not without challenge. Indeed, their paper was critical for lifting the lid on the dark side of professional socialisation and organisational culture. Their analysis revealed how social processes deeply embedded within complex relational dynamics were instrumental in determining how a sense of 'us' was crafted and how students became integrated and accepted into an established social group. However, the authors described how interns faced harsh social experiences and a critical culture of ritualistic behaviours from established paramedics that sometimes developed into perceived ostracism and stigmatisation, reflecting that they had yet to be accepted within the group or orientate towards paramedic social identity. Acceptance into the in-group had to be mercilessly proven and earned through displays of undivided loyalty (Bandura, 2002), in response to status and power and value-laden 'rites of passage' (Nippert-Eng, 2003; 1996; Scott, 2003; Van Gennep, 1960). Devenish et al (2016) provided example of this, citing how paramedics were 'tested' through their responses to time-critical activities such as how they conducted their first 'blue-light' drive, or their first attendance to a life-threatening incident whereby they were 'thrown in at the deep end' (p.7) and had to swim by themselves to stay afloat by managing a chaotic and possibly dangerous scene calmly

and delivering the patients' treatment competently and effectively (Campeau, 2009). It presents a juxtaposition of trauma and triumph, following which interns will have demonstrated their 'worth' to salient individuals and thus earned the right to consider themselves an in-group member.

This behavioural initiation process for new recruits has long-been associated with uniformed service cultures (Afzal, 2022), particularly the ambulance service (Lazarsfeld-Jenson, 2014). How an individual is accepted into a social group is crucial to the development of their identity, self-concept, and self-esteem (Hatch and Schultz, 2002; Dutton and Dukerich, 1991). Where this is a negative experience, this can have hugely detrimental psychological impact. Indeed, most recently, socialisation and cultural processes within the sector have been exposed as associated with a 'wolf pack mentality' of misogyny, bullying, and sexual harassment (The National Guardian's Office, 2023; BBC, 2019a) – thus speaking of underpinning masculinist behaviours from which these rituals take on a demonstrated power-play, 'othering' women; a similar finding from reports into fire service culture (Afzal, 2022; Gouliquer et al, 2020) and the police (Workman-Stark, 2020). Therefore, the findings from Devenish et al (2016) almost certainly remain relevant today.

2.4 Symbolic representations of organisational culture and social identity

Artefacts undoubtedly convey deeply held, socio-cultural and historical symbolic meanings, shaping contemporary cultural ideology – particularly around professional roles, social identity, and behavioural expectations. Symbolic representation of one's membership of the ambulance service is easily located in their corporate dress, denoted by the green combat-esque uniform, fluorescent jackets, badges, insignia, and epaulettes displaying signs of hierarchical rank, authority, and status (Grimell & Holmberg, 2022; Pollock, 2013; Tannenbaum, 2013). Furthermore, technical artefacts including Battenburg (yellow and green) markings on ambulances, and technology such as radios and clinical equipment provide implicit insight into the social order and social worlds of ambulance personnel. They convey detail of the axiomatic nature of the routine day-to-day work (Robinson & Baum, 2020; Tangherlini, 2000), but equally project information to both the inner and outside worlds about how these routines are performed, who performs them, and the expertise required to use them (Caudle et al, 2019) - thus these artefacts have been associated with the projection of particular worldviews and socially constructed meanings to signify 'paramedics', 'ambulance service', and even 'heroes'.

Associated with organisational artefacts as a means of articulating symbolic cultural meanings including norms and ideologies, is the esoterical language shared amongst and understood by those within the ambulance service frontline setting (Steen et al, 1997). Commonly referred to as 'jargon' or 'slang' (Hogan and Coote, 2014), Wankhade (2017) made a valid point in highlighting the influence of historical parlance

present in contemporary ambulance culture that arguably conveys nostalgic recognition of a shared past that continues to unwittingly shape in-group members' ontological realities, their worldviews, and socio-relational behaviours (Robinson & Baum, 2020). Nowhere is this more apparent than when considering everyday terms such as the 'manning' (meaning those rostered on shift within a twenty-four hour period), and 'third manning' (signifying individuals who are supernumerary in being crewed on an ambulance vehicle). Boyle (2005; 2001) is probably the best-known researcher whose work is relevant to review against these gendered, colloquial expressions. She, no doubt, would argue that such terminology is reflective of not only a long-standing hegemonic masculine culture but also of presiding masculinist patriarchies within the leadership (Manolchev and Lewis, 2021). Indeed, despite the almost equitable physical gender split within the ambulance service workforce (Wankhade, 2017), the social reality of contemporary culture is still very much represented in terms of a historical masculine framework of interpretation, raising important questions as to the continuing dominance of masculinity within hierarchy and power status (Workman-Stark, 2020).

Application of Hatch and Schultz's (2002) work examining identity processes within organisational settings, offers brief insight into how cultural language symbolic of organisational culture connects individuals to a sense of 'we-ness', a collective social identity of togetherness and a 'socially constructed sense of belonging' (p.1002). However, as the next section identifies, it remains that far too little attention has been paid to this complex social psychological dynamic within prior examination of ambulance culture. Ultimately this discussion holds scholarly relevance to the current study as to the inherent communication of underlying assumptions, values, attitudes, gender, power, and equality that subtly infiltrates and influences the social psychological behaviours of ambulance personnel within their workplaces.

2.5 Group processes: A social comparison of 'us' versus 'them'

Prior research has highlighted societal discourse that paramedicine is often typically viewed as 'dirty work' (Hughes, 1951) that carries heightened risk. Thus, it is perhaps unsurprising that given the daily exposure to pathogens, threats, and dangerous situations (Halpern, 2012a; McFarlane & Bookless, 2001), ambulance personnel, as 'dirty workers' (Hughes, 1962), have been found to hold a strong, closed in-group identity, whereby at the core, is a deep sense of camaraderie and social cohesion that is highly valued by these frontline workers (McCann, 2022; Soleimani et al, 2019; Corman, 2017; Nirel et al, 2008). These organisational behaviours create a sense of heightened self-esteem, pride, and positive self-concept grounded within their salient roles, that facilitate strong cultural ties. Although not explicit in ambulance-related study findings, researchers from policing have looked at this more closely. Workman-Stark's (2020) results, for example, indicated that officers who shared social identification with colleagues

experienced a strong sense of belonging and trust, creating an emotional attachment to each other and with their policing organisation. Similar findings were also reported by Filstad (2022), Cockroft (2020), and Charman (2018).

We gain a sense of how social attachment and pro-socialness between group members facilitates bonded social relationships (Leiter et al, 2015; Bandura, 2002; Bowlby, 1969) through empirical research that showed how the highly prevalent, shared practice of storytelling within paramedicine has been associated with a deeply uniting 'tribal' commitment between colleagues and their organisation, separating them from 'others' outside of the profession (Regehr et al, 2002; Tangherlini, 2000; 1998). Being united in service was not only captured by these authors, but also in the later study by Lazarsfeld-Jensen (2014), who highlighted the omnipresence of normative beliefs depicting paramedics' stoical dedication to their socio-occupational groups and employing organisation.

It could be suggested that this high-level commitment is an embodiment of the prototypical attributes that encapsulates paramedics' self-concept and social identity. However, as yet, this link, nor the dynamics influencing paramedics' emotional attachment to their salient group have not been expressed within published papers. Neither have any parallels been drawn in respect of ambulance practitioners often strong social identification with the wider ambulance 'green family'; a contemporary, colloquial social construct symbolising one's membership of the service. Arguably, developing a sense of group members as 'family' indicates significant social bonding whereby individuals feel deeply connected – not only to each other but also to their collective group such that they feel a sense of fused 'one-ness' – whereby their personal ('I') and social ('we') identities both remain salient but the boundaries between become blurred (Buhrmester and Swann, 2015). Indeed, there has been little consideration of how these intragroup dynamics might serve to bolster in-group cohesion and self-esteem (giving a powerful sense of 'us').

What may be derived from the literature is that having impermeable socio-cultural boundaries such as those seen within the ambulance service, can create insularity, so that internal, seemingly unique, cultural ideologies, assumptions, beliefs, and importantly, members' true social identities, are protected or hidden from outsider 'threats' that may question and raise uncertainty around these orthodox cultural practices and behaviours (Ashforth and Kreiner, 1999; Palmer, 1983). Indeed, there is a plethora of evidence that demonstrates what happens when aspects of organisational culture serve to conceal deeply hidden cultural meanings and discriminatory agendas such as power inequalities, that otherwise might serve to heighten the boundary that divides 'us' from 'them'. In perhaps its simplest form, atypical working hours associated with shift work have been identified as impeding the social relations that paramedics have with those outside of the job (Anderson, 2019; Kirby, 2016) thus further increasing in-group solidarity and insularity, such that ambulance staff tend to end up drawing support and socialising only with each other.

The non-diversity within the workforce only adds to this (Rudman et al, 2022; Health and Care Professions Council, 2021). However, it is the next issue that is particularly interesting.

Examination of the literature revealed how, at a deeply implicit level, ambulance services, outwardly associated with morally 'good work' have, in the past, sought to preserve this positive conceptualisation in their social relations with wider society by, in effect, concealing psychological distress felt by workers such that it was not recognised or acknowledged. Rather, the more favourable ideology of mental toughness and beliefs such as 'we can deal with anything' have been externally projected – thus becoming valued aspects of paramedics' identity and arguably, are symbolically connected to the 'dirty work' associated with the role (McCann and Granter, 2019; Ashforth and Kreiner, 1999). Subsequently, it is possible to draw links with these beliefs and cultural behaviours said to test or affirm an individual's hardiness – similar to the rites of passage which in effect, represents earning a 'badge of honour' as discussed earlier. The literature certainty points to these exclusivist and sometimes dysfunctional behaviours as arguably serving to further disconnect the in-group culture of ambulance personnel from that of society. In doing so, however, this may lead to perceived collective injustices, and behaviours such as stigma, discrimination, and/or harassment.

Unequivocally, recent independent cultural reviews of ambulance services within England (Melia, 2024; The National Guardians Office, 2023; Lewis, 2018; Lewis, 2017) have exposed its once tightly hidden culture, opening it up to intense and, arguably, much needed scrutiny (Hatch and Schultz, 2002). It is clear that damning findings have identified internal cultures of silencing, cover-ups (NHS England, 2022a; Sunday Times, 2022) and blame towards others except the organisation itself (McCann and Granter, 2019; House of Commons Committee of Public Accounts, 2017; van der Gaag et al, 2017). Worryingly, the reports also identified that employees held insidious fears of 'speaking up' about issues or concerns, feeling that to do so was unsafe and 'would not achieve anything' other than reprisal and making life very difficult for them, which could have lasting consequences (McCann and Granter, 2019).

The ambulance services are not alone in this high-level cultural exposure, with similar reviews having been documented in other sectors of the NHS and emergency services (Casey of Blackstock, 2023; Afzal, 2022). Nevertheless, a strong theme arising from this collective of reports indicates how tight social relationships within the workplace were identified as a barrier to speaking out due to worries that individuals held around being disloyal to their team or that raising concerns would be detrimental to the social structures of their group. Indeed, the reports highlight passive acceptance and disempowerment amongst staff of 'that's the way it is around here' (The National Guardians Office, 2023, p.25). As McCann and Granter (2019) argued, it is '…these cultural elements [that] are often cited as powerful influences that make these occupations resistant to change' (p. 223).

In addition, the media have reported negative practices and abuse of power within the ambulance service, uncovering extreme behaviours including bullying (Care Quality Commission, 2022a), sexual harassment (Venables & Spencer, 2024; Care Quality Commission, 2022b; Lewis, 2018; Lewis, 2017), misogyny, and discrimination, as well as the employment of neoliberalist management practices used to enforce the micro-management of performance targets and hierarchical regulation of workers' behaviours and self-identity (Manolchev and Lewis, 2021; Telford and Briggs, 2021; BBC News, 2019a; NHS Staff Survey, 2019; NHS Employers, 2018; Evening Standard, 2015). Subsequently, individuals enduring such pressured everyday working conditions are pushed to the very limits of their 'normal or optimal functioning' (Jenner, 2007, p.26); the psychological and emotional impacts of which will be examined later in this chapter.

2.6 Social relationships between leaders and followers

What is unquestionably evident from the investigations and reviews into ambulance culture is not only the uncovering of the systemic issues noted above, but the critical nature and influence of management and leadership in determining the pervading behavioural dynamics that seem so clearly foundational to the development of a negative social environment. Examining this further, McCann (2022) drew attention to the powerful 'command and control mentality' (p.94) traditionally held amongst ambulance leaders, and indicative of a hierarchical, authoritarian, top-down presence. Indeed, his sociological research provides important insights into the quaternity of command, control, leadership, and management that has long been associated with the uniformed services (Wankhade, 2010). In particular, McCann (2022) highlighted that, despite arguments from those within the service as to the necessity for this approach especially in the context of complex incidents, it is one that has been criticised in post-disaster reports, exposing examples of how, in the overwhelm of an incident, standards and procedures have hindered aspects of decision-making and communications, leading to confusion (Saunders, 2022; Greater London Authority, 2006). Nevertheless, it is an approach that has its place in providing ordered structure (McCann and Granter, 2019) and remains deeply embedded within ambulance service culture and continues to exert day-to-day organisational control over subordinates operating at street level.

Throughout several of their scholarly works, McCann and colleagues (e.g. McCann, 2022; McCann and Granter, 2019) make their argument that, despite their perceived professional autonomy, ambulance personnel are highly controlled; a point also made by Seim (2020) and Corman (2017). Illustrating this dichotomy, frontline workers were identified as having a level of discretion as to the technical aspects of their work, particularly when out 'on the road' or on night shifts - when management levels were reduced. However, this was held in complete contrast to the oppressive and extensive use of the systems of 'New Public Management'; organisational and managerial means of 'monitoring…crew performance' through

such methods as 'big brother' data tracking devices on ambulance vehicles and other managerial and accounting metrics (McCann and Granter, 2019, p. 220). It was through these hierarchical and regulatory 'formal control systems' (Hogan and Coote, 2014, p.1611) that ambulance staff face scrutiny over the specifics of their work such as time taken to mobilise to an incident or to clear from hospital and are held to account against government directed targets and standards. It is in this way, McCann (2022) argued, that their professional autonomy was challenged, and Lawn et al (2020) highlighted how such demands, particularly over a prolonged period of time, significantly contribute to heightened levels of stress and increased sickness absence.

Whilst much of this surveillance is undertaken by managers remotely through computer software, the authors noted that at times of increased demand, local supervisors would often form an active presence at hospital departments in order to 'chase' and expedite crews to 'clear' for the next call. Interpreting these scenarios, McCann et al (2013) drew upon moral narratives indicative of a low trust culture within which were embedded fears of reprisals and of making mistakes, particularly in terms of patient care. This is in a context of little managerial or organisational support and a snap-decision tendency to blame and shame staff, heightening mistrust. Critically, however, McCann and Granter (2019) acknowledged that their earlier (2013) paper was perhaps 'overly pessimistic' (p.218) in its interpretation of street-level issues. This is not to say, of course, that the findings of their analyses are to be disregarded. Certainly, their reflections were concurrent with those identified at a similar time by other academics (Corman, 2017; Wankhade, 2017). Furthermore, it could be argued that this pessimism was perhaps reflective of something much deeper – a sense of unconsciously developed solidarity between the researchers and their participants, for whom pessimism is understood to be an established collective belief (Regehr and Bober, 2005). Nevertheless, it could be said that McCann et al (2013) placed much emphasis on frontline workers' experiences of leadership with less focus upon leaders' experiencing of undertaking their role; a point transparently identified within their data collection methods and justified in terms of leaders' reflective input on the organisational context rather than their personal experience. In his 2022 publication, however, McCann discussed how 'some local line managers were excellent and took a compassionate and supportive approach' (p.157); a finding that may have reflected the 'significant strides that the paramedic profession has made in recent years' (McCann and Granter, 2019, p216).

Despite this challenge, McCann et al's (2013) observations provide important insight into the social order and value given to the work of ambulance staff by managers and the powerful relational dynamics and social influence of cultural norms associated with an 'obsessive' performance target culture, of 'treating the clock and not the patient' (Wankhade, 2017, p.136). Indeed, this dehumanising but dominant organisational norm is arguably, one of complete juxtaposition to the assumptive beliefs and professional values regarding the centrality of patient care, held within the street-level culture of frontline staff (Nirel et al, 2008). Subsequently, it was recognised that this dichotomy has led to further tensions and disconnect

between staff and management and presents a source of bitter frustration (McCann and Granter, 2019). This corporate dissonance is especially the case when managers are seen to place the need to achieve targets above patient care and crew welfare (McCann, 2022; Montminy et al, 2021). Even today, it seems fair to say that ambulance services continue to struggle to find a compromising balance between how to meet performance targets in a climate of increasing demand for services versus the social realities of paramedics who hold quality patient care close to their core and is key to their professional social identity.

Although studies examining ambulance service leadership have been conducted by only a handful of other authors, they have tended to focus on clinical leadership (Johnson et al, 2018), or the wider systemic issues associated with macro-level aspects of leadership and performance delivery (Montminy et al, 2021; Taylor and Armitage, 2012; O'Meara et al, 2010; Taylor, 2010). Whilst informative, these studies are not really relevant here. Importantly, the exploratory analytical focus taken by the sociological and organisational scholars of ambulance work (such as Seim, 2020, McCann et al, 2018, Corman, 2017, and Wankhade, 2010) clearly places leaders and leadership within the social and cultural context; an element in stark contrast to much of the wider literature that classically conceptualises leadership from the perspective of personality traits, leadership styles and skills (Hou et al, 2021), and/or characterisations that Haslam and Reicher (2016) argue are 'constrained by an *individual* metatheory' (p.22). Yet, it is of great significance to understand leadership as a dynamic and influential process situated in the presence of others such as group members, as promoted by social identity theory (Hou et al, 2021), rather than existing as an inherent 'thing' that an individual is in possession of. Indeed, Mercer et al (2018) in their qualitative study of 29 emergency medical services paramedics from Canada, found that 'leadership extends beyond the 'figureheads' at the top' and rather, is a shared 'relational process' (p.17). This perspective was also noted by Johnson et al (2018) in their social constructionist interpretations of leadership development in paramedic organisations. If this is considered true, then questions could be asked of how the social practices of leaders and followers merge in synthesis to co-produce, in social relationship, the dynamic phenomenon of leadership. Furthermore, how do leader-follower social relationships influence in-group behavioural responses in creating and maintaining what is often a toxic culture, and why do followers tolerate and continue to conform to harmful, yet unspoken rules despite their juxtaposition to the more progressive, clinical value system held within and by street-level groups of ambulance personnel? To answer these questions, we need to look deeper within; to the (often subliminal) cognitive-behavioural dynamics pervading within these social relationships.

Leader positioning is an important consideration here to understand how leaders and followers conceptualise themselves as such, and in relation to each other, as group members (Hou et al, 2021). However, this detail is scarce in the ambulance literature and is yet to be explored in any depth. The only empirical findings identified refer to the presence of self in relation to others within hierarchical rank structures. Nevertheless, this is a crucial point and may also lead us to gaining some understanding of

how normative behaviours become reinforced through hierarchical structures and processes, and subsequently, become deeply embedded into everyday practice. McCann's work is, again, pivotal here.

Indeed, his studies, and that of others, illustrate the historically deep divide that exists between leaders, in their 'ivory towers' (Wankhade and Mackway-Jones, 2015, p.74) and followers – those with their 'boots on the ground' (McCann and Granter, 2019, p.223). In line with this, the socially constructed perceptions of how ambulance staff see their leaders, rarely provides positive insight, although as previously noted, McCann (2022) identified how some were seen to be more supportive. Nevertheless, leaders were mostly viewed through adjective terms of 'remote', 'unapproachable', 'indifferent' and 'dismissive', and having a 'bullying style', further 'othering' them from the workers' in-group (McCann, 2022, p.157). 'Old school' was a term that featured heavily and was symbolically used to categorise and identify those leaders who were experienced and of long service, who had worked their way up through the ranks (Wankhade, 2010) yet had lost touch with the modernity of clinical paramedicine and the realities of being 'out on the road'. Linked with this notion, Ulrich et al's (2015) study of the perspectives of female paramedics towards career progression, importantly drew attention to the historic but equally prevailing masculinist nature of those holding senior leadership positions within the ambulance service. Their qualitative survey of 94 women employed by London Ambulance Service NHS Trust revealed perceptions of an 'old boys club', alluding to beliefs that promotions were non-transparent and selectively biased to those who fitted a masculinist identity; a finding also referred to by McCann (2022). Furthermore, in response, Ulrich et al found that 'women perceived themselves as having to behave in a certain way to be considered a confident leader' and 'the term 'alpha female' was used' (2015, p.233). Indeed, their paper critically highlights gender inequalities and misogyny prevalent within ambulance culture and leadership.

Interestingly, ambulance leaders' views of their staff is an area of research that is yet to be overtly examined but arguably, raises important considerations when exploring the behavioural dynamics of these social relationships, especially given leaders' significant influence on the development of group norms, beliefs, social identity, workers' self-esteem, and psychological welfare (Hou et al, 2021; Tajfel and Turner, 1979). Furthermore, we still really don't know a great deal about how ambulance leaders self-conceptualise themselves as such, nor their phenomenological experiencing of being a leader within this field, or their prototypicality as a group member crafting a sense of 'one of us' and 'we-ness'; a shared social identity that brings the group together as one (Steffens et al, 2014). After all, leaders do not operate in isolation and are members of the (salient) group that they lead (Van Knippenberg and Hogg, 2003).

What we do know, however, is that the empirical evidence captures the dark side of leadership, exposing deep-rooted attitudes and harmful behaviours that exist within ambulance culture and leader-follower social relations. Indeed, McCann (2022) described the relational space as being encapsulated in strain, conflict, fear, and mistrust with disagreements particularly when staff and patient needs have seemingly

been disregarded and/or neglected to meet targets; perhaps symbolically echoing at a deeper level, feelings of abandonment in favour of the self-interests of the leader or organisation – although this, and more specifically, group-based emotions, are not explored within the work of McCann and that of other sociological and organisational scholars. There remains scope to explore questions around the attachment bond between leaders and followers, and the subsequent impact upon their social identities and group behavioural processes. These are points that are yet to be investigated.

Although there appear to be no published academic studies that directly address the micro-elements of leadership toxicity within the ambulance sector, additional empirical evidence from McCann and Granter (2019) has relevance for this study in highlighting how social relations taking a more transactional nature, can conceal abuse of managerial authority including coercion and bullying, micromanagement and enforcement which required conformity and obedience from followers - the toxic dangers of which are starkly apparent in the aforementioned cultural reviews. Arguably, this approach gives indication that individuals can become excluded and 'outed' from group membership and subsequently can experience a sense of inequitability and injustice. Indeed, we know from these reviews that, due to a fear of rejection, isolation, and retaliation, group members fail to speak out and whistle-blow perceived organisational and leader wrong-doing, but the literature has yet to fully examine the relational dynamics between ambulance leaders and followers in this context. Examining these dynamics between leaders and followers is crucial to understanding how social influence (such as (non)conformity to rules and norms) emerges within this context and when applied to a crisis situation such as a pandemic when members face impending threat. Furthermore, it will provide valuable insights into how, through a social identity approach, social behaviours and group norms can lead on the one hand, to enhanced social belonging and feelings of connection, but, on the other hand, they can also lead to toxic outcomes. Equally, they can be harnessed to bring about behavioural and cultural change.

2.7 Social processes in the context of psycho-emotional regulation

The inert social processes subtly operating at a sub-conscious level that implicitly guide and influence collective behaviours, values, and beliefs, otherwise referred to as 'social norms' (Neville et al, 2021), have been evidenced in various guises throughout this literature review. This includes discussions around the normative behaviours of giving total commitment and undivided loyalty to ones work team including ones employing organisation (Coser, 1974). While this was illustrated in terms of the socialisation processes experienced by newly qualified paramedics into frontline ambulance service culture, other examples have drawn upon the overt mismatch between managerial emphasis upon behavioural norms that support the need to achieve performance targets at all costs, in contrast to the perspectives of street-level staff members who tend to resent this and hold opposing norms within their sub-cultures.

The prior subsection emphasised the centrality of leaders in influencing social processes and the inherent development of assumptions, social norms, values, and attitudes that are prevalent within the day-to-day life of their social and professional group cultures. Nevertheless, leaders are not the only contributors to these developments. Rather, there is growing empirical evidence to suggest that this phenomenon is far more intersubjective, and the meaningfulness of norms is also collectively dependent on the salience of one's social identity, in-group, and the social context relevant to the individual (Rathbone et al, 2023; Neville et al, 2021).

Although supporting literature from the ambulance sector remains limited, there is a wealth of evidence demonstrating that the norms associated with people's salient occupational groups have a major role in shaping their identities, collective worldviews and thoughts, feelings, behaviours including social relationships, and beliefs (Jetten et al, 2020; Heracleous, 2001; Hatch, 1993). Through application of social identity theory, we know that this is likely to be reflected in their shared social identity and, as such, it has been recognised that those who strongly socially identify with their eminent group, are more likely to internalise these shared norms into their understanding of 'who we are' and 'what we do', further enhancing a sense of belonging to their group and a shared sense of 'us' (Rathbone et al, 2023, p. 1357; Davidson et al, 2021; Drury et al, 2019; Reicher et al, 2010). Thus, these social norms become a part of a person's self-concept and behavioural responses without conscious awareness – a point that was indirectly articulated by Palmer (1983) in his early ethnographical work examining the occupational behaviour of paramedics and emergency medical technicians (EMT's) in the United States. Palmer (1983, p.170) described how 'EMT's become hooked on the work of providing emergency medical care' such that he coined the phrase 'trauma junkies', symbolically indicating how collective beliefs influenced their social behaviours and identity of who they are and what it means to be an EMT. On this, it has been argued that whilst examination of social norms and assumptions are essential to understanding organisational culture, they may be so engrained within the unconscious forces of a group and within individuals' behaviours, that they can be difficult to ascertain or articulate (Schein, 1985). However, as previously alluded to, there is good evidence to suggest that they may be uncovered through qualitative analysis of narratives, traditions, esoterical language and via social interactions.

Of significance to the current doctoral study is an area of inquiry for which there is only limited current interest from paramedical researchers; that is, the part social norms play in socially influencing how group members collectively and individually manage their emotions and emotional responses. In their seminal works, Glaser and Strauss (1968) recognised that doctors and hospital workers, in facing challenging medical situations, had to manage their emotions to enable them to do their job. In particular, they highlighted the collective emotional regulation practices that hospital teams engaged in to help them cope with strong affective responses experienced by team members after the unexpected or sudden death of

patients. More recently, there have been comparable questions asked of those working within the ambulance sector particularly when faced with tragic and traumatic events, although this scholarly analysis has tended to be a consequential finding from related areas of research. Thus, it is fair to say, the picture of our understanding of this phenomenon in paramedical populations is, at present, far from comprehensive.

Synthesis and analysis of the extant literature reveals the real complexities around the conceptual understandings of emotional regulation. Indeed, it is clear that most of the authors commenting on this phenomenon have taken the stance of focusing on how social norms imposed by an employing organisation influence the way that individuals regulate their emotions whilst undertaking their work. That is, how the normative behavioural rules established and enforced by the ambulance service shape the prototypical behaviours and beliefs of their staff such that, in their duty, they are required to maintain a level of composure and are self-controlled, not letting 'themselves become overwhelmed by their feelings, regardless of the situation, the state of the patient, or the empathy that they may feel' (Henckes and Nurok, 2015, p. 1029). Indeed, in this body of literature (Biss, 2023; Hayes and Corrie, 2020; Williams, 2013; Blau et al, 2012; Filstad, 2010; Boyle, 2005), focus is given to individuals' tolerance of burdening emotions in conforming to their organisations' 'feeling rules'; shared norms that prescriptively, socially influence what is considered by the in-group to be an appropriate emotional display in a given context – assuming, of course, that individuals are able to feel emotions and have the understanding to know when these rules come into play (Hochschild, 1979). Furthermore, these papers examine the strategies a paramedic skilfully develops and utilises to manage their emotionality within (Williams, 2013; Filstad, 2010; Boyle, 2005), drawing comparisons with Hochschild's (1983) seminal works on 'emotional labour' including her sociological concepts of surface and deep acting as emotional regulation and emotional display strategies. Indeed, the research has identified that paramedics modify their inner feelings and/or their outer emotional expressions to meet social normative expectations in a given work-related context or situation where to show one's authentic emotions would be deemed inappropriate (Vishkin and Tamir, 2023).

From this perspective, individuals are regarded as central to this professional emotion work. Thus, in an important consideration for the current research study, it could be argued that by individuals holding the responsibility for managing their emotions in order to conform to the presiding normative expectations of their employer, organisations have, in effect, systematically structured, imposed, and influenced the ways in which paramedics manage their emotional experiences (Henderson and Borry, 2023; Korczynski, 2003). Crucially, gaining a deeper understanding of these processes would provide valuable insight into how the social dynamics of organisational culture and organisational norms impact the behaviours and emotional responses of paramedics during and following exposure to distressing and adverse events whilst undertaking their role. This is vital, as it is known that those who are positively able to regulate

their acute feelings of emotional distress, are less likely to feel the lasting impact or develop more serious psychological consequences such as post-traumatic stress reactions (Halpern et al, 2012a).

This sociological positioning can be strengthened through the argument that organisational social norms are not only enacted by individuals operating alone. Rather, the ways in which a person's emotions and behaviours are regulated, can also be understood to be highly influenced by collective social norms operating within local ambulance teams. This has also received little prior study. Taking this approach provides some understanding of how emotionality is collectively negotiated and regulated within paramedics' close-knit teams (Henckes and Nurok, 2015). Furthermore, this extends to how these norms influence the strategic and novel ways in which paramedics actively regulate their arousal and cognitions that form emotional responses, both individually and between group members (Grandey, 2000), so that they can 'maintain their emotional balance' (Henckes and Nurok, 2015, p.1024). Although not articulated within the published paramedical literature, this perspective is undoubtedly underpinned by assumptions that emotions are socially constructed, and thus, are open to social influence both within and outside of an individuals' salient group and their employing organisation. How paramedics themselves have socially constructed emotionality, however, will be revealed as the literature is explored.

In one of the most recent papers examining emotion work within paramedic teams, Henckes and Nurok (2015) reflecting on fieldwork undertaken by Nurok (2007), importantly promoted the view of social norms as a fluid entity in guiding in-group rules around emotional regulation. Indeed, they make an important point in highlighting the relevance of changing social contexts as a key dynamic in how emotions are framed and interpreted (von Scheve, 2012), and the subsequent responses that are collectively enacted by members. Although it is a limitation that no specific example is given by the authors, their findings go some way to explaining how emotions can be collectively perceived and responded to differently, depending upon the circumstances being faced. Going a stage further, Shuman (2013) articulated that 'emotional regulation leads to the creation of social situations where individuals choose to behave towards others in specific ways because they seek to experience or not experience anticipated emotions' (p.1). This is a critical finding that is not only very relevant to the current study, but also highlights how 'social contexts regulate emotions by arousing emotions and by determining the goals of emotional regulation' (Shurman, 2013, p.1).

For ambulance personnel, ultimately emotional regulation appears to be governed by a powerful socio-cultural context, historically situated within a masculine paradigm, and driven by strong hegemonic beliefs that unconsciously pervade cognitions and perceptions (De Soir, 2003; Regehr et al, 2002). Scholarly works within this field have captured such ideologies endemic within ambulance culture the world over. Beliefs such as 'we can deal with anything, all of the time' and correspondingly, 'to seek support is a weakness' have been associated with social norms that collectively engender the denial, suppression and

avoidance of felt emotions, and determine that in-group members should outwardly display emotional neutrality or detachment, thus giving the stoic appearance of being calm, composed, and in control (Williams, 2013; Regehr and Bober, 2005; Steen et al, 1997); characteristics that, as previously noted, are expected of ambulance workers who deal with the sometimes distressing and chaotic scenes of emergencies (Avraham et al, 2014; Hegg-Deloye et al, 2014; Blau et al, 2012).

Whilst the role of social norms in guiding emotional regulation and associated behaviours is highlighted here, it is also useful to apply Glaser and Strauss' (1968) earlier findings to enhance our understanding of this phenomenon further, beyond that captured within the current paramedic literature. Their work demonstrated that, when faced with dying patients, healthcare workers often perceived difficult emotions such as distress and upset as a potential source of threat to their integrity as a professional, arguably placing them at risk of being exposed to others as vulnerable. Their research, whilst ground-breaking, has however, been criticised for its lack of depth of understanding as to the micro-complexities of emotion management (Timmermans, 1994). Drawing upon social identity theory here, is therefore helpful for suggesting that this fear may be connected to perceived implications to one's social identity, self-esteem and self-concept, and be viewed as a character weakness or flaw by other group members - arguably destabilising their sense of fit with and positioning within their salient group – as showing strong emotions associated with distress or anger, for example, is not what 'we' do (Henckes and Nurok, 2015; Oyserman, 2007). Thus, in defence, groups are motivated to develop collective norms guiding members to behave in a socially appropriate manner, by requiring them to suppress their authentic distressing emotions and present themselves in a dissociated, detached way, such that retains their outward behavioural composure.

Certainly, studies of ambulance personnel suggest that on the one hand, group members adhere to such norms because it offers positive opportunity to prove their prototypicality to other in-group members, and to 'seek and receive approval' from them (Rathbone et al, 2019, p.1349) - thus strengthening their self-esteem (Steen et al, 1997), their embeddedness within, and bond to the group – their sense of 'we'-ness (Henckes and Nurok, 2015) and validating their shared social identity. Yet, enacting their identities in this way appeared to have considerable social and psychological costs as Glaser and Strauss (1968) articulated. Indeed, in their large scale study of emergency services personnel exposed to trauma, Regehr and Bober (2005) highlighted the evocation of emotional-behavioural inhibition, stating that, in order to act like an in-group member 'individuals frequently disguise their emotions for fear of revealing personal 'flaws' or not measuring up to some image of toughness' (p.95); a highly treasured aspect of paramedics' shared social identity as also referred to by Avraham et al (2014). Regehr and Bober (2005) further added that to show emotions or to seek psychological help was equated with an image of 'incompetence, dependence, and [being] inferior to others [in their team]' (p.97) and a loss of control; a conclusion also noted by other researchers (Jenner, 2007; Steen et al, 1997). This was deemed especially troublesome for

male paramedics for whom these norms appeared to be more concerning (De Soir, 2003). Lawrence (2011) explained how normative behaviours within paramedic circles have ultimately led to assumptive beliefs that deny explicit 'emotional dialogue' (p.8) such that, members who strongly identify with their group may be at risk of losing their ability to recognise or articulate their emotions (alexithymia) and ask for support (Wojciechowska et al, 2023; Asadi et al, 2021; Halpern et al, 2012b). Resultantly, social in-group norms dictated that felt emotional distress should be contained (or suppressed) within and/or managed through the use of dark humour, joking, and 'buddy talking' (Steen et al, 1997, p.6), although, this too, was boundaried by socio-behavioural rules as to its appropriate contextual use (for example, humour is not used after calls to children or those patients at the end of life) (Clompus and Albarran, 2016; Charman, 2013; Williams, 2012; Scott, 2007).

Whilst the use of humour may seemingly take the pressure off in the heat of the moment and provide some relief (Lancaster and Phillips, 2021; Sliter et al, 2013; Rowe and Regehr, 2010), the empirical evidence also tells us that emotional regulation through suppression is wholly problematic in the longer term especially when faced with an incident that is deeply distressing and/or invokes feelings of vulnerability (Avraham et al, 2014) as these unexpressed feelings do not simply disappear (Williams, 2013). Yet, this example does provide some evidence to show, firstly, how, as a result of collective emotional regulation, social situations can become psycho-emotionally transformed, and secondly, how individuals may self-regulate their emotions to fit collective norms - but this is subsequently influenced through relationship with others, their feelings and behaviours (Schuman, 2013). Indeed, this raises a deeply significant point for consideration; how are emotions held within the socio-relational space between ambulance personnel if they are not to be expressed?

It appears that the only paper providing any insight into this quandary, is again provided by Henckes and Nurok (2015) who examined social and emotional relationality between crew mates on scene at incidents. They identified that if a colleague struggles to contain and conceal their emerging emotions, the remaining team members strategically worked together using similar techniques utilised in managing patients' emotions, in attempts to support the person to regulate their emotional response in line with social norms depicting the required emotions for the social context. Henckes and Nurok (2015) argued that there is good reason for this 'emotional teamwork', as not only do these strategies serve to preserve the emotional stability and relational nature of the group, but 'the strong emotions of a team member can sometimes be contagious, and they often constitute a threat to the team's sentimental order' (p.1029). Nevertheless, the authors note that this in-group defining prosocial attribute of supporting and, in essence, 'having each other's' [emotional] backs' - to enable crew members to achieve valued group goals of composure and calmness - strongly cements the social bonds that connect them together.

Unfortunately, our understanding of how social norms constructed by ambulance personnel influences their self- and collective regulation of felt emotions and their emotional-behavioural responses has not moved much beyond that documented here. In fact, this social psychological phenomenon has failed to be examined further. Although these papers make a start in opening up the knowledge base, they are now mostly somewhat dated, and perhaps are no longer a true reflection of today's ambulance sector which has seen rapid changes in recent years – such as the emergence of graduate paramedics, changes in ambulance work to reflect more unplanned primary care rather than traditional life-threatening emergencies, a changing gender composition with females now representing almost half of the workforce (NHS England, 2021), plus the entry of a small number of overseas trained paramedics. Arguably, the literature has failed to keep pace with these developments and thus, it leaves many unanswered questions.

We still really don't know the extent to which social norms operating within ambulance cultures influence the emotionality experienced by these workers. Nor do we know anything further about the relational context of how social norms contribute to and influence the constitution and preservation of one's sense of self and social identity as a paramedic. Neither is there a detailed understanding of the impact of emotional regulation on the social bonds held between ambulance personnel, or of the fluidity of these social psychological dynamics when placed within differing social contexts and social relationships with others. Understanding these nuances in more depth through a social identity approach would be immensely valuable in enhancing our insight into how these cultures unconsciously, very subtly, steer and greatly influence a paramedic's everyday thoughts, feelings and behaviours, and then, how these underlying forces impenetrate their emotionality when faced with exceptionally challenging situations such as highly distressing and traumatic scenes encountered through their work.

2.8 Social psychological impact of adversity

The above leads us to ask of the literature what is known from both an individual and collective perspective, about the social and psychological impact of regulating one's emotions in accordance with in-group norms, particularly when these emotions are distressing or strongly felt, such as in response to adverse or traumatic situations encountered through one's work as a paramedic. However, to examine these points, we firstly need to establish the conceptualisations associated with adversity and traumatic situations, and the emotional experiences, such as distress, that may be encountered by ambulance personnel as a result.

2.8.1 Conceptualisations of trauma and adversity from paramedic and social identity perspectives

'Trauma' is a conceptualisation that is highly topical and relevant across many contexts and scenarios. It is a phenomenon certainly not limited to emergency responders, nevertheless, trends in the academic study of this population have increased in recent years. Whilst the concept may be understood from multiple disciplinary perspectives, certain similarities across all fields means that it is possible to broadly define trauma as the experiencing of a distressing event that is 'extreme or intense' such that it causes disruption to a person's life, overwhelming their ability to cope (UK Trauma Council, 2024). The experiencing of a traumatic event can sometimes lead to lasting psychological sequelae, yet it concurrently presents a possibility for growth and transformation. In contrast, 'adversity', for which the structure of this experience appears to have barely been captured within academic literature, could be said to provide conceptualised meaning to the existential disorientation and reorientation faced in response to the more universal human experience of difficult or unpleasant situations, such as bullying at work, loss and grief, or experiencing violence, through which individuals experience difficult emotions not limited to emotional distress (Jackson et al, 2007).

As this section will show, understandings of trauma and adversity within paramedical literature is still scarce, and arguably, provides only a limited view of the complexity of trauma, primarily from a monodisciplinary clinical approach. Thus, it is a concept that when applied to this field, has scope for interpretation and negotiation of meaning.

In attempts to define 'trauma' in the context of paramedicine, the literature has primarily sought focus from defining what constitutes a 'traumatic incident'; that is, the particular 'type' of emergency incidents felt to be typically representational of those provoking psychologized reactions within frontline workers. MacNab et al (2003) for example, referred to such calls as those that are 'a disturbing event that is well outside the range of usual human experience' (p.367). Yet, the simplicity of this definition is open to many challenges, notwithstanding that paramedics' work experiences in attending accidents, injuries, and life-threatening events, are generally outside that of 'usual' human experience. Furthermore, whilst this conceptualisation draws inferences with that of the American Psychiatric Association's (2022) clinical definitions of trauma, it does not account for the influence of socio-cultural factors such as the emergency services response or the prior emotional experiences of the responder.

More recently, a retrospective study of 223 emergency medical technicians and paramedics in Canada was undertaken by Halpern et al (2012b). In their analysis of participants' self-identification of a 'troubling incident' and their subsequent self-reported reactions to attending these emergency calls, the authors identified fourteen incident characteristics that were strongly associated with emotional sequelae and thus, were categorised by the authors as 'critical incidents'. Interestingly, rather than focusing on specific types

of events (such as major fires, murders, or transport collisions) as prior researchers have, the characteristics identified by these researchers notably go one layer deeper, providing insight into how the participants subjectively perceived and made sense of emergency calls, conceptualising traumatic incidents as those where they felt 'factors were beyond my control', 'I felt helpless' and/or 'the situation was dangerous for me or another paramedic' (p.9), with the latter, arguably, representing a fear of potential threat to one's (or one's colleagues') life.

In being retrospective, Halpern et al's study is critisable for its potential for participant recall bias. Furthermore, it was completed with participants only employed by one emergency medical service. Therefore, it is not clear from these results alone if these elements are truly reflective of a held understanding of traumatic situations amongst ambulance personnel more generally. Although there appear to be no British studies determining the meaning of 'trauma' within paramedical settings, an abundance of more general national and international academic literature on psychological stress in ambulance responders suggests this to be relatively accurate (McCann, 2022; Clompus and Albarran, 2016; Henckes and Nurok, 2015).

In contrast, Behnke et al's (2019) embodiment of emotionality into their understanding of trauma and adversity, devised from studying their German emergency medical services population, highlighted the significance of developing an emotional and empathic connection with patients. Indeed, this bond deeply challenged ambulance responders' usual ways of coping by maintaining emotional distance from patients; findings that are consistent with both recent and prior research (McCann, 2022; Ludick and Figley, 2017; Avraham et al, 2014; Halpern et al, 2009; Jonsson and Segesten, 2004; 2003; Regehr et al, 2002). Behnke et al's emphasis on emotionality taps into a socio-relational conceptualisation of trauma; highlighting how, through relationship with patients and others, paramedics may feel deeply affected (Regehr et al, 2002). This includes vulnerable patients who are lonely and isolated from family and friends, children or adults at the end-of-life who are surrounded by their grieving families, or perhaps an individual living in squalid conditions or who cannot afford food or heating, and who don't have support around them.

What is interesting here is that whilst there are some structural differences between German and English ambulance services, essentially the nature of the clinical work is similar (Dittmar, 2021). Certainly, clinical paramedicine does expose these workers to high-stakes activities that are generally outside of most people's everyday experiences (such as shootings, stabbings, road collisions, and incidents where they fear for their safety (McCann, 2022)). Halpern et al (2012b) identified that paramedics' subjective perceptions of the event as being one in which they felt their own life or someone else's was at risk from a threat, or if they found the incident to be particularly horrifying, was also central to the event being experienced as traumatic – which also draws parallels with a contemporary definition of trauma (American Psychiatric Association, 2022). However, more often than not, in England, it is the lesser acuity calls that more

frequently present these emotionally challenging social circumstances. In this respect, Behnke et al (2019) bring to the fore, the knowledge that it perhaps is the salience, meaning, and emotionality associated with an incident that has far more emphasis in provoking an affective or potentially traumatic response in ambulance personnel, rather than this determination being made in respect of the nature or cause of an incident alone (Charuvastra and Cloitre, 2008; Jenner, 2007; Bounds, 2006).

Undoubtedly, this literature captures the essence of adversity in the context of paramedicine. However, it is not without empirical shortcomings. Indeed, to establish the grounding of these studies and their conceptualisations of trauma and adversity, it is necessary to consider the assumptive underpinnings and epistemological positioning elucidated within these texts. Three key points for consideration arose from the literature.

The first refers to the generally held consensus reflected within psychological discourse that recognises how exposure to adversity and/or trauma may be experienced directly (such as a responder facing threats to their safety) or indirectly, through vicarious (or secondary) means – such as witnessing the suffering of another person (Muldoon et al, 2021; Lawn et al, 2020).

Secondly, the authors show alignment with modern-day conceptualisations highlighting that whilst emotional distress may result from a single exposure to an event felt to be traumatic, equally, this sequelae may also result from the accumulation of 'frequent and repeated confrontation with a multitude of complex and emotionally challenging situations' (p.2) that ambulance (and other emergency responders) experience in the course of their duties (Hansen et al, 2022; Lawn et al, 2020; Gayton and Lovell, 2011; McFarlane and Bryant, 2007; Beaton, 2006). Thus, in contrast to early research in the field (Mitchell and Bray, 1990; Mitchell and Everly, 1996), these contemporary papers acknowledge the chronic, repetitious exposure to everyday organisational stresses and potentially traumatic situations as an inherent facet of ambulance work.

Although not explicated by the authors, there is a sense that these distress-provoking events are generally of short duration – reflecting the normative daily life encounters of paramedics attending emergency calls that last a few hours. However, one phenomenon that has yet to be considered, at least within Western contexts, is that of prolonged exposure to potentially traumatic situations as might be collectively experienced by paramedics facing the same threat such as a disastrous event of war, drought, long-term loss of infrastructure, or a pandemic that may last several years. Indeed, even the most recent research pertaining to the Covid-19 pandemic (of which there are few papers) examine the impacts upon ambulance personnel from over a short period during the first wave of the contagion (Barrett et al, 2024; Rees et al, 2021), or retrospectively (Carbajal et al, 2022). Certainly, there does not appear to be any

longitudinal UK studies of a year or more, investigating the impacts of prolonged trauma and adversity upon paramedics.

In addition, it must be emphasised that, of the available literature, almost all seem to consider the impacts of trauma and adversity retrospectively – that is, data collection is based upon individuals' memories of the event(s) or their post-trauma symptomology. Indeed, this criticism is perhaps reflective of the methodological challenges of mobilising a real-time research study in response to a spontaneously occurring traumatic event – unless of course, that event was sustained rather than short-lived.

A final but crucial critique is with regards the ontological positioning of trauma within paramedical research. It is clearly evident that these papers conceptualise adversity as an inherently individualistic experience - reflecting the neoliberal, dominant discourse situated within clinical psychology (Haslam and Reicher, 2006); a discipline associated with a positivist, reductionist paradigm that understands human traumatic experiences through fear-based pathological dysfunction. Indeed, this ideology has flooded the literature documenting paramedics' psychological post-traumatic stress responses (Petrie et al, 2018) arguably generating a dependency upon specialist practitioners to 'cure' through 'treatments' and 'interventions'. Taking a fear-based approach, however, does not account for post-traumatic growth responses purported by positive psychological theorists; that is, developing a deep sense of meaning, enhanced social connections, and personal growth following a distressing experience (Muldoon et al, 2019; Joseph, 2013; Joseph and Linley, 2008).

An individualistic approach to trauma may be criticised of its failure to recognise and acknowledge the relevance of the social and cultural context in which the event(s) occur, and the social space in which an individual attempts to process their experiences thereafter. Indeed, attracting a broader framework arguably enables us to take a compelling approach to understand how trauma emerges in the collective context of others, within social relationships (Woodhouse et al, 2018). Certainly, the American Psychiatric Association (2022), in detailing the risks for developing PTSD, situates three out of four categories of trauma in a socio-relational context – including occupational exposure to a traumatic event, and witnessing trauma to others (Muldoon et al, 2021). However, this context is rarely accounted for within paramedical literature. Indeed, whilst an early study of Swedish ambulance personnel by Jonsson and Segesten (2003) identified how the relational space between a crew and their patients was the medium through which trauma was vicariously experienced, what the literature does not tell us is how adverse and traumatic events may be collectively experienced in the social relationships between ambulance personnel – perhaps those two, three, or more crews that attend an incident together, and the ripple effect this has upon their wider group and upon their collective identity and esteem. As the next sub-sections reveal, in this way, trauma may compromise in-group social relationships and cohesion, which may cause fractures within the team. Yet, equally, it may enhance a sense of belonging and camaraderie.

To summarise this section, the above discussions have highlighted that how trauma is conceptualised and defined has a critical bearing on our capacity to understand human distress and how it is researched.

2.8.2 The influence of group processes upon the experiencing of adversity

With this in mind, the social identity approach is arguably well-placed as a useful meta-theoretical framework for understanding how experiences of emotional distress and traumatic responses are situated within social relationships, collective beliefs, behaviours, and group life (Muldoon et al, 2021). How people categorise themselves in terms of a particular social identity notably aligns them with an in-group approved framework (such as norms and values) which, through conformity, influences how they collectively perceive, interpret, and make sense of situations that are potentially traumatic, in so much as they are evaluated in light of their membership of a salient group rather than as their individual selves (Canto and Vallejo-Martin, 2021; Berman, 2016).

Although this is not directly evidenced within ambulance-related empirical literature, the previous discussions of emotionality highlighted earlier in this chapter align well for illustrating how the often historically situated socio-cultural symbols and cognitive representations such as beliefs that shape group members shared social identity, may strongly influence how ambulance staff collectively comprehend and subsequently form depersonalised attitudes and behaviours in response to adversity (Berman, 2016; Turner et al, 1987; Tajfel and Turner, 1979). An exemplar here, is the reference to 'we can deal with anything' (Steen et al, 1997) and '*man* up and get on with it'; assumptive, gendered beliefs which depict the (toxic masculinised) mental 'strength' of those who hold the shared identity of a paramedic. Moreover, these shared beliefs appear to powerfully communicate to those who categorise themselves as in-group members how they should appraise, interpret, and make sense of potentially distressing events, and how they should behave in response (Muldoon et al, 2019) – that is, in the interests of the group they should not openly show emotional distress, although there are exceptions to this (such as paediatric resuscitation calls) as previously highlighted.

With these beliefs also comes the implicit evaluation of oneself in light of this identity – such that if one cannot measure up and 'hold it all together', will team members view them as weak, and will this disrupt their sense of belonging and place within the group? Indeed, Halpern et al (2009) suggested from their qualitative study of sixty self-selected ambulance workers and managers that such beliefs made it difficult for these employees to acknowledge their felt distress; a finding also corroborated by Bounds (2006) who added that resultingly, paramedics often 'deny the impact of their work on their wellbeing' (p.126) in essence to conceal their distress or difficult emotions. In addition, this also led to a fear of stigmatisation by other in-group members, reported in their later study (Halpern et al, 2009) as, 'the stigma is so firmly entrenched in the culture that it remains unrecognised and unchallenged' (p.145). Certainly, the literature

is awash with references highlighting the mental health stigma persisting within this culture, albeit its prevalence is now less than in previous years (Hazell et al, 2021; MacKinnon et al, 2020; Mind, 2019). Subsequently, these in-group attitudes were identified as impacting upon paramedics' behavioural capacity to access supports, leaving them feeling disconnected from colleagues. Thus, it is clear from the literature that stigma threatens group members' ability to authentically share their emotions, which likely reduces their ability to connect with others, leading them towards isolation and to have less access to key social supports (Muldoon, 2020). As a result, the suppression and avoidance of emotions by paramedics has been correlated with increased experiencing of negative psychological and emotional sequelae (Halpern et al, 2012b). The social identity approach could be key to providing greater understanding of the underpinning socio-behavioural dynamics at play here, thus contributing further to our knowledge of how group memberships shape and influence paramedics' responses to traumatic distress.

2.8.3 Influence of workplace social relationships in navigating distressing experiences

Theorists assert that social psychological processes and relationships eminent within groups can effectively structure individual and collective responses to traumatic, distressing and/or emotionally difficult situations (Muldoon et al, 2019). In applying this to the field of paramedicine, Donnelly et al (2016) who surveyed 269 primary and advanced care paramedics in an ambulance service in Canada, highlighted the significance of social bonds between ambulance peers and managers, and their corresponding social support as a mediator against traumatic sequelae and distress. Furthermore, Halpern and colleagues (2012b) revealed how 82% of 190 Canadian paramedics surveyed within their study reached out to a colleague or supervisor after a distressing call. Prati and Pietrantoni's (2010) meta-analytical review of thirty-seven studies also detailed how social dynamics among ambulance workers fostered shared meaningfulness, thus reducing anxiety and distress. This was illustrated through their example whereby how, after a challenging incident, the social relationship between peers and managers became a space for solidarity and reassurance; that the team member had done all they could for a patient. This sense of collective experiencing appeared to enable paramedics to feel understood and supported their self-esteem, and as Jonsson and Segesten (2003) identified, this was critical especially when crew members were left with uncertainty and existential questioning such as 'could I have done anything differently?' (p.218) which were often pre-emptive of feelings of guilt and shame.

These examples provide an important but very limited contribution supportive of the accumulating social psychological evidence that intragroup social relationships can foster protective conditions against adversity and promote group motivated emotional regulation. Indeed, when one's shared social identity is salient, researchers argue that it 'provides a basis for group members to receive and benefit from social support' (Woodhouse et al, 2018, p.38). Furthermore, shared experiencing has also been found to be vital to enhancing social connectivity within pre-established relationships and is linked with a strengthened

sense of collective efficacy, sense of belonging, and solidarity among in-group members (Muldoon, 2020; Muldoon et al, 2019; Schmidt and Muldoon, 2015; Haslam and Reicher, 2006). Despite this increasing knowledge base focusing on the protective nature of socio-relational dynamics in adverse contexts, it is still yet to be considered in any depth within emergency ambulance personnel populations; a close-knit occupational group who are well-recognised as being at risk of exposure to traumatic and distressing scenes (Petrie et al, 2018; Donnelly et al, 2016; Mishra et al, 2010). Resultantly, this leaves many unanswered questions as to how this plays out within paramedicine cultures. Taking a social identity approach may further bridge this knowledge gap, providing much-needed depth of understanding to this phenomenon by adding valuable insight, elucidating the importance and bearing of social group bonds in protectively contributing towards the affective responses of in-group members when faced with adversity.

In counterbalance to the above discussion, the literature also highlights that adversity can equally compromise a person's sense of belonging to a salient group, thereby rocking social relationships and challenging their shared social identity. Certainly, Muldoon et al (2021) advocated that group memberships can shape more negative responses to traumatic situations, particularly if individuals do not feel, or are not treated as, part of the salient in-group. Whilst this has, in part, been discussed in terms of the stigmatising and ostracizing effects of some collectively held beliefs and social norms prevalent within ambulance culture, a systematic review conducted by Lawn et al (2020) provides additional relational context. In this study of thirty-nine papers published between 2000 – 2018, they identify how post-incident distress and stress 'profoundly [negatively] influenced' (p.7) the interactions that ambulance personnel had with peers, citing behavioural responses including social withdrawal and a loss of compassion such that 'difficult feelings' and 'negative emotions' (p.7) were projected onto those around them.

Whilst no single study has yet examined this context from a social identity approach, application of theorists' prior notions are useful in highlighting consistencies between Lawn et al's (2020) findings and those argued by social identity researchers. Indeed, these scholars add further understanding as to how the destabilising and disruptive nature of adversity hurls in-group social relations into disarray, thereby challenging individuals' sense of belonging and their subsequent ability to access support from others in their group (Muldoon et al, 2019; Charuvastra and Cloitre, 2008). Certainly, this is highlighted by Lawn et al (2020), and they further note how this process led paramedics to unconsciously create distance between themselves and the negative emotionality that they were feeling. Although this strategy could be deemed as dysfunctional for managing difficult emotions, it offered a way of lessening their felt distress. Indeed, as previously noted, emotional distancing as well as suppression and dissociative techniques have been highlighted in a number of other publications exploring the coping strategies used by these workers. In the long-term, such responses are associated with negative psycho-emotional outcomes (Pietkiewicz et al, 2023; Arble and Arnetz, 2017; Mishra et al, 2010). While Lawn et al's contemporary and comprehensive

paper is well-conducted, critically, it tells us little more as to the socio-cultural dynamics that may be underpinning these tactics. We are left wondering if and how these responses are mediated by factors such as assumptive norms, cultural beliefs, and values (Berman, 2016).

Further building on the argument that social psychological processes may play a vital and critical role in how paramedics manage adversity, it must be acknowledged that the literature discussed thus far, has, in line with a social identity approach, only considered the social embeddedness and interconnectedness among paramedics residing in social groups in terms of their collective and relational bonds. Critically, however, in studying these close relationships, there is arguably a necessity to acknowledge the interpersonal ties held between ambulance personnel and their individual team members, thus drawing upon a personalised aspect of the 'social self' (Brewer and Gardner, 1996).

Examining relational connectedness raises complex questions regarding an individual's personal capacity to form close social bonds with salient others. Although this leads more into the psychological study of individual differences, which is not the focus of this thesis, this concept raises an important consideration that connects with the points discussed in the last sub-sections and provides some understanding of the manifestation of distress operating at the social level.

Of relevance to this research study is the academic finding that some individuals may find it more difficult than others to form social bonds with group members, particularly if, in the context of that relationship they experience personal feelings of mistrust and hold perceptions of a lack of psychological safety. Notably, research has identified that this can subsequently impact their ability to seek and accept help and support when facing challenging or adverse situations and can promote difficulties in regulating one's emotions (emotional dysregulation).

In one of the only published papers exploring this phenomenon within ambulance populations, Halpern et al (2012a) established that following exposure to adversity, paramedics who had the most difficulty engaging in and maintaining close social relationships with team members were those categorised as having a fearful-avoidant attachment style; a particular cognitive-behavioural approach to relationships that is marked by the turbulency of high anxiety and high avoidance such that people wish to have social connections yet also fear people getting too close (Bowlby, 1969). Halpern et al's (2012a) research further identified that ambulance personnel exhibiting this particular way of relating to others, tended to socially withdraw (avoid others) following an emotionally provoking incident, and also experienced emotional dysregulation in the form of high levels of anxiety, further impacting their ability to socially connect. In addition, paramedics holding this attachment style tended to perceive that managers would not be supportive, thus despite their desire to receive support, they were hesitant to reach out or accept it when it was offered. Subsequently, these participants encountered more prominent and prolonged emotional

and psychological distress including burnout and PTSD. Critically, Halpern et al (2012a) warned that the articulation of negative suppositions about inadequate support from managers and/or their employing organisation, may, in some cases, actually be indicative of expressions of emotional distress. Thus, they provide an important, challenging argument, that contributes to widening our knowledge and understanding of what may appear as the incessant, cynical outlook on managers typically held by street-level workers (McCann, 2022). Similar contextual findings have also been reported from studies of police officers (Gray and Rydon-Grange, 2019; Waing et al, 2010), firefighters (Leonard et al, 2023; Landen and Wang, 2010), and nurses (Hawkins et al, 2007).

Whilst Halpern et al's study does not provide analysis of the prevalence of ambulance staff who have fearful-avoidant attachment styles, Miller (1995) estimated that it may be commonplace. Although it is noted that this research is now dated, it appears to be the only reference providing this detail. If this estimation is true, then this concept may have important bearing on the implicit social, relational and behavioural dynamics operating within the emotional cultures of ambulance services, especially when these workers are faced with adverse and emotionally challenging incidents.

2.8.4 Impact of adversity upon paramedics' social meaning systems and collective worldviews

Over the last decade, contemporary studies have reflected substantial scholarly interest in respect of the moral dimensions of adversity. Certainly, there is growing evidence that the experiencing of profound human vulnerability, as is often witnessed by ambulance personnel, may not only evoke intense emotionality in response (Newman et al, 1997), but also impact the collectively held basic assumptions and beliefs that provide groups and individuals with social systems of meaning. Subsequently, this informs their worldviews, thereby shaping their 'outlook on life' (Mifsud and Sammut, 2023, p.1) and perceptions of 'us' and self. Empirical research has further highlighted that shared beliefs and embodied worldviews form cognitive representations for how we construct and organise our thoughts to provide us with an interpretation and understanding of our socially constructed reality and where we see our place in the social world around us (Newman et al, 1997). This also draws upon behavioural elements, as beliefs and worldviews are said to guide our individual and collective actions including those relating to our morality, to help us 'navigate the world around us' (Mifsud and Sammut, 2023, p.2), and arguably conform to the moral code determined by, and in relationship with our salient in-groups (Cahill et al, 2023).

This literature is highly relevant to this doctoral study, particularly from the perspective that in the face of adversity, individuals intuitively rely upon their beliefs and worldviews to mitigate the distress felt from the uncertainty that these situations often give rise to. However, given the 'ontological assault' (Crossley, 2000) that profound adversity can have, Berman (2016) noted that it can lead individuals to reappraise

and re-evaluate their most basic assumptions (such as the world is a safe, predictable, and benevolent place), and often, these understandings about themselves (including perceptions of their self-worth) and understandings of their social world, are fundamentally disrupted (Park et al, 2012; Janoff-Bulman, 1992; Horowitz, 1986). Indeed, there is much evidence to suggest that this violation of social meaning systems adds to the experiencing of post-traumatic stress responses including intrusive thoughts and feelings, of which the risk increases with greater exposure to these kind of events (Litz et al, 2009). Eminent researcher Janoff-Bulman (1992), theorised that this is because individuals, in their efforts to make sense of adversity, face challenge in assimilating information about the event into prior held worldviews that have since been 'shattered'. In essence, they no longer have the structured belief system in which to interpret the new and overwhelming information created by the traumatic situation – it is essentially incompatible and irreconcilable with previous ways of understanding the world. Thus, in referring to the example above, adversity may challenge deeply held beliefs such that the world is no longer seen as a safe, predictable, or benevolent place, and instead, is replaced with perceptions that the world is unsafe, it is unpredictable, and bad.

This understanding appears to be especially important in its application to the field of paramedicine and can be applied to incidences where, in 'high stakes' situations, institutional and similar constraints contradict or violate one's moral beliefs, not so much as to the world being unsafe, but in this instance, about what is morally right (Murray et al, 2018). The leading early researcher examining this phenomenon in nursing, Jameton (1984), argued that if one's moral beliefs are transgressed in this way, it 'makes it nearly impossible to pursue the right course of action' (p.6), causing a sense of injustice; that the world is, in some way, not fair. Murray (2019) asserted that such events include the 'witnessing [of] human suffering' or failure to 'prevent outcomes', exampled through the ambulance-relevant, entrenched belief 'that life can and should be preserved by appropriate and timely medical intervention' (p.424). Cahill et al (2023) argued, however, that this sense of injustice may also come from individuals' perpetrating the act themselves (for example, making life/death decisions in multi-casualty incidents), which ultimately may violate the collectively held medical principle of 'do no harm'.

Critically, through their empirical studies, researchers have uncovered how being exposed to such events and being unable to reconcile or assimilate them within one's belief system can lead to self-critical feelings, notably the moral emotions of guilt and shame, which often converge with sustained anger and disgust (Testoni et al, 2022; Giner-Sorolla and Espinosa, 2011). It is known that these feelings are associated with internalised dilemmas around self and collective moral worth and esteem and may impact upon ones social status within a group setting (Litz et al, 2009). Such a definition fits the contemporary construct of 'moral injury' as coined by the distinguished psychiatrist and scholar, Shay (2014), who emphasised it, not as a clinical or pathological concept as some more recent scholars have professed (Jinkerson, 2016), but as a natural, subjective response to a 'socially inflicted wound of betrayal' (Hollis et

al, 2022, p. 85). It is this sense of betrayal that arguably, deeply impacts social relationships in terms of shattering one's assumptions that other people are trustworthy (Roth and Newman, 1991) and that the world is a benevolent, just place. Furthermore, unresolved guilt and shame challenge the inherent assumption that 'the self is worthy' (Janoff-Bulman, 1992) therefore disrupting individuals' social needs for belonging and cohesion, such that they can become isolated (Cahill et al, 2023; Murray, 2019).

On this basis, examining the concept of moral injury as applied to paramedicine appears that it would be very helpful as a means to capturing the experiences of those individuals who do not encounter post-traumatic distress per se, but legitimise the narratives of those who are 'troubled' by what they have witnessed in their work (Murray et al, 2018, p. 591). Certainly, in recent years, it has gained prominence within the study of other healthcare professionals, presumably due to the linked impact upon patient care. Despite this, however, it is frustrating that there is still very little research investigating the effects of adversity and/or challenging events on the moral belief systems held by ambulance personnel.

In one of the few original studies including a cohort of paramedics, Smith-MacDonald et al's (2021) grounded theoretical research supported the relevance of the concept of moral injury to the work of emergency services employees. Furthermore, they confirmed, in alignment with Shay's conceptualisations, that the inability to do what is 'right' was key to an event being felt as morally injurious; a finding also supported by Rodrigues et al (2023). This extended into feelings of helplessness at not being able to meet the needs of some members of the public especially those who called for assistance often but where systemic pressures acted as a barrier – such as where health and social care services were stretched. Chronic exposure to these events reportedly led the participants to feel 'disillusioned', 'frustrated', and 'hopeless' (p.13) which perhaps is reflective of their perceived injustice at the situation versus the way it 'should' be and a sense of betrayal by those who could make changes to the system. Smith-MacDonald et al argued that in the case of emergency services personnel, if moral feelings were left unresolved, participants attempted to manage their emotions through regulatory techniques such as avoidance and numbing, or 'moral compromising' (p.10); attempting to put 'cognitive and emotional space between themselves and their original moral imperative' (p.10). However, they noted that these can lead to psychological sequelae, with the latter associated with a violation in moral integrity.

Unpacking this further, Smith-MacDonald et al provide brief insight into the underpinnings of this concept, noting how morally violating acts can deeply undermine the authenticity and social coherence of one's life, and compels individuals to act incongruently against their moral code, thus resulting in existential disarray. This has been linked to social detachment in the form of depersonalisation, emotional exhaustion, and correspondingly, the psychological syndrome of burnout (Kroger, 2020). Whilst this provides only a snapshot into a highly complex construct, their proposition appears well-nested within

contemporary assumptions positing a human's in-driven need to pursue genuine concordance between their moral selves and their behaviours (Cahill et al, 2023).

Nevertheless, the author's examination of this dynamic stops short of uncovering how morally transgressive acts perpetrated by employing organisations may affect the social identity of emergency responders and their culture constructed upon shared social norms (Muldoon et al, 2021). Whilst we do not yet have a comprehensive understanding of how this is implicated within the ambulance service, some insight on this may be gleaned from papers reporting findings from other healthcare professionals, and indeed, brief detail may be teased from a few other published studies of paramedics.

In keeping with Shay's (2014) original definition of moral injury, it is clear from the literature that the influence of leaders, the holders of legitimate authority, were often perceived as the perpetrators in the betrayal of trust, especially in the context of working conditions. Indeed, one of the most insightful examples supporting this supposition comes from a study of NHS staff working at the height of the Covid-19 pandemic, in which French et al (2022) noted a sense of felt abandonment; a lack of care, support, and protection shown by leaders to the staff, thus fuelling perceptions from the staff that they were 'disposable or replaceable' (p.517). Certainly, comparisons may be drawn here to the earlier findings from McCann (2022) who reported how ambulance staff frequently felt like they were no more than a number to their employer or just a 'bum on a seat' – yet the organisation still demanded their dedication and loyalty – drawing connections with Coser's (1974, p.4) conceptual analogy of 'greedy institutions' in recognition of those organisations who make 'total claims on their members' and 'seek exclusive and undivided loyalty'. In addition, Rodrigues et al (2023) in their study of 38 public safety personnel (of whom 24 were paramedics) elaborated further, drawing attention to the transgressive nature of frequently unmet basic needs such as not getting a meal break or being denied permission to use the bathroom as operational demands were of more vested importance to managers than the personal needs of staff – thus, in the eyes of the workers, represented a violation of doing what is 'right' by them.

On this note, even prior to, and despite the Covid-19 pandemic, the limited data suggests that healthcare workers and emergency personnel including ambulance staff are vulnerable to potentially morally injurious events experienced through their work. At the start of this doctoral study, empirical evidence situated in the context of a pandemic appeared not to have been undertaken, and therefore was an unknown as to how such transgressive acts would be experienced by these workers when faced with a serious risk of disease exposure. However, as we now know from the empirics conducted since, the pandemic served to heighten medical professionals' exposure to moral transgressions associated with a lack of resources, lack of personal protective equipment, clear guidance, or adapted clinical practices, for example. Nonetheless, whilst the literature contributes knowledge as to the clinical psychological

ramifications of these experiences upon employees, it remains a failing of the research that the social psychological aspects have yet to be considered at depth.

Although not commenting directly on the impact upon the social identity of these groups of workers, French et al (2022) draw inference to the dehumanising nature of these moral imperatives and capture the insult upon the workers' self-esteem in terms of their questionable worth to their organisation such that this betrayal led them to feel devalued. Undoubtedly, this draws parallels with the shattering of the basic assumption that the self is worthy (Janoff-Bulman, 1992), but also has untold social implications for the status of the workers' in-group. A social identity approach would question how negative esteem plays out amongst the behaviours of salient others in maintaining and protecting their shared social identity. Indeed, this framework is particularly well-suited to understanding the way that moral transgressions by organisations, leaders, and managers influences how individuals who are part of a salient group think and feel about themselves and others (such as leaders), and the implications this has in terms of their social context such as group normative behaviours and attitudes, and their social relationships as, arguably, it is through relationship that the possibility for betrayal is built.

This perspective ultimately, opens up exciting opportunities for examining the complex ways that social relationships and social psychological contexts affect and influence the heterogeneity of ambulance staff responses to adversity, and their prospects for subsequent recovery.

2.9 The social psychological impacts of pandemics upon ambulance personnel

Exploration of the literature so far has provided insight into how the role of social identity and group processes including social relationships and behavioural norms have become integrated into the narrative of the everyday work life of ambulance personnel. Furthermore, exploration of these socio-cultural practices has provided an arguably methodical, although undisputedly unexplored framework through which to examine the complexities of human experiences that relate to adversity encountered by paramedical populations in the context of their work. Indeed, social context here is critical, as the literature upon this topic is impenetrated with underlying assumptions positioning adversity through an individualistic lens (Brooks et al, 2019; Naushad et al, 2019), or at best, vaguely appreciates the ripple effect of ambulance crews' experiencing of such events, extending across their salient in-group memberships (for example, impacting all those connected with a particular ambulance station or a geographical 'divisional' area). Whilst the research indicates that these events can cause great psychological disruption to paramedics' personal lives, rarely do these incidents also impact the entire community or society in which they work and reside. However, this becomes apparent in the face of a large-scale disaster or pandemic, whereby the breadth of numbers of those affected is extremely wide.

Although exceptionally infrequent and uncommon, at least, in the Western world, adverse major events give rise to significant disruptions to the social realities of daily life, unprecedented uncertainty, chaos, and often present as a threat to life (Naushad et al, 2019). Certainly, pandemics or public health emergencies of international concern (World Health Organisation, 2019) indicative of the metapopulational spread of an emergent, novel, life-threatening pathogen are one example of this (Singer et al, 2021). Prior examples as previously noted include SARS and H1N1 'swine' influenza, although for both of these contagions, the mortality rate was relatively low (Hine, 2010).

These kinds of large-scale emergencies present shared social experiences that have significant effects upon whole communities and societies over a prolonged period (Muldoon, 2024a). As they confront helplessness, loss, grief, and uncertainty between them (Alessi et al, 2021), it presents a case for understanding the adverse impact as a collective phenomenon (Sanchez-Gomez et al, 2021; Brooks et al, 2016). Indeed, in providing emergency healthcare under these conditions, commonality of shared adversity leads responders and healthcare workers to develop collective meaning-making about such a novel event and to construct new social norms reflecting changes in practice. Whilst much enquiry has focused on the shared experiencing of treating patients in challenging scenarios, the social realities for this population also extended to emotionally connecting to one another through a heightened fear of infection, of developing symptoms, and of potential mortality of self or loved ones. Sanchez-Gomez et al's (2021) study findings for example, are consistent with much of the research reporting upon the impact of Covid-19 that highlighted a generally held, intense fear of contracting the virus. Kaubisch et al (2022) posited how intense emotionality could potentially be associated with severe psychological outcomes across communities; thereby framing this as a collective trauma (although whether it may be labelled as a trauma at all, continues to be hotly contested amongst scholars, see North, 2021).

Although this may be true for healthcare workers on the whole, the social reality of ambulance personnel in their distinctness at being one of the first professionals to encounter patients with infectious diseases whilst in the community (Ebben et al, 2023; Watt et al, 2010), has been less explored. Adding support for the relevancy of profession-specific literature, Bitely et al (2019) argued how the out-of-hospital environment poses sources of risk for emergency medical staff not encountered by healthcare professionals working in other clinical environments. Citing the example of challenges to handwashing and cleaning of equipment when in the field, they emphasised how access to water is limited and juxtaposed this against the demands and pressures of the work and lack of cleaning time which ultimately heightens risk of exposure and transmission for these personnel. Indeed, Thomas et al (2017) drew attention to the risk of prevalence of infections incurred by ambulance staff particularly in the case of the SARS outbreak where in Toronto alone, seven emergency medical technicians were diagnosed, and one lost their life to this illness. Furthermore, countless others faced quarantine (Smith et al, 2009).

In one of the very few papers originating within the UK, Rees et al (2021) undertook a grounded theoretical exploration of nineteen Welsh paramedics' experiences of caring for patients during the first six months of the Covid-19 pandemic (March to November 2020). Whilst this comprehensive paper predominantly focused on the technical aspects of the work, the findings bear relevance here. Demonstrating parity with Sanchez-Gomez et al's (2021) results, Rees et al captured paramedics expressed fear at contracting the illness and passing it on to their family, particularly if those family members were clinically vulnerable to infections. Behavioural outcomes were reported in terms of participants avoiding their own family members and, when on scene, they placed distance between themselves and their patients, which was also symbolically addressed through the wearing of personal protective equipment. In their work, Alessi et al (2021) drew moral inferences, likening fear to a sense of potential violation of one's safety and security, and in terms of distancing and avoiding others, they pointed to violations to one's basic needs for connection and physical contact, leading to profound feelings of disconnection and isolation (Carbajal et al, 2021) – both of which, they argued, are at the core of complex trauma. Indeed, Rees et al (2021) commented on the conflictual incongruence of balancing ones role with protecting family, such that this observation also provides insight into the strain that the work of paramedics and their intense emotionality was having upon their social relationships.

A similar finding was reported by Smith et al (2018) who considered the ethical challenges posed with 'duty and risk' (p.191), highlighting how emergency responders involved in the September 11th terrorist attacks were faced with the impending dilemma of doing their job knowing that they may die. Their paper also cast light on the 2014 - 2016 Ebola outbreak in Africa, whereby healthcare practitioners encountered the same plight in weighing up their duty to treat infectious patients in the context of having insufficient access to personal protective equipment. In this epidemic, the case rate of Ebola was subsequently found to be 42 times greater in healthcare professionals compared with members of the public, leaving questions as to organisations' expectations of their staff to provide 'high stakes' care without addressing their safety needs (Smith et al, 2009). Synthesising this literature with that from the field of moral injury, would ultimately suggest that employees who feel compelled to work in these scenarios may existentially question their worth and meaningfulness to their organisation. In perceiving that they are not adequately taken care of or protected, they are also at risk of experiencing a deep sense of betrayal (Muldoon, 2024b) and abandonment by their organisation, whom they have often devoted much of themselves to. Indeed, this opens up further questions around mistrust in the relationship between individuals and their management, especially given that Smith et al (2009) reported a collectively held belief amongst paramedics that, during a disaster, information provided to them by their organisation would likely be 'incorrect or misleading' (p.25) such that in their quest for accuracy (and arguably reassurance), they sought comparisons from information provided by other 'trusted' organisations. Indeed, as Muldoon

(2024b) concluded, 'trust is particularly important in situations where there is a high degree of uncertainty and where people feel they are vulnerable' (p.14).

Examining this point further, Alessi et al (2021) warned how those 'already dealing with [pre-pandemic] psychological impacts of trauma...' (p.81) may feel overwhelmed, challenging basic assumptions including one's perceptions of trust in how things should be. This arguably links with perceptions of safety, as prior adversity could have negatively impacted ones sense of stability, leading to individuals bracing against further incidences of uncertainty (Muldoon, 2024b). Thus, as Alessi et al (2021) intimated, these individuals '…may struggle to gauge realistic risk of contagion, even while maintaining social distance, intensifying an already activated fear response' (p.81). This is of particular relevance to paramedic populations for whom, even prior to Covid-19, were well-evidenced to be at risk of poor mental health including post-traumatic stress disorder (Carbajal et al, 2021). These findings, however, only capture the psychological outcomes for paramedics from incidents of relatively short duration. The nature of a pandemic, however, is a prolonged adversity, sometimes lasting a few years or more. Thus, it is quite possible that in this scenario, these paramedics are at even greater risk of distress and psychological injury, and, as Maunder et al (2008) highlighted from their study of Canadian healthcare professionals active in service during the SARS outbreak, this may well be a concern into the longer term – although this has yet to be established.

Rees et al's (2021) analysis also provided powerful insight into the stark social realties faced during the first six months of the pandemic – how every aspect of paramedics' work was disrupted, and how the structure and order of clinical processes and procedures was thrown into disarray, requiring the ability to quickly adapt to new behaviours and possibly, changing social norms. This point raises important considerations as to the role ambulance organisations played in terms of providing collective order and a level of stability over the work on the one hand and, on the other, the socio-cultural influence upon the development of new shared intersubjective meanings about this emergent virus and the new ways tasks needed to be achieved. Although Rees et al recognise the imperative nature of organisations in establishing patterns of social and clinical practice for determining the way things are done, their analysis here leaves room for exploration of how group processes were collectively embodied into this, particularly in terms of conformity to new practices (Thomas et al, 2017), and how these processes subsequently influenced paramedics' thinking about the contagion. Indeed, Abrams et al (2021) argued the necessity of going one layer deeper to explore salient group level processes viewed to be pervasive in guiding and influencing decisions about such procedures and allocation of resources, but also, how this understanding ultimately plays a key role in framing group members' collective perceptions and meanings of the situation, thus determining how they define themselves (Muldoon, 2024b) and navigate their social world amidst change and uncertainty. Again, it is this level of detail that has yet to be examined within the context of English ambulance services.

Nevertheless, through paramedics' narratives, Rees et al (2021) opens our mind further to this possibility by highlighting the solidarity behaviours felt by ambulance crews during the coronavirus pandemic. Although only given a brief mention, this important insight illustrates the sense of unitedness of 'we are all in this together' in the campaign against the viral threat. Indeed, this is a finding that resonates with many other studies of group populations experiencing major disasters such as a pandemic (Drury, 2023; The British Psychological Society, 2023; Drury et al, 2008). This understanding is vitally important as the collectiveness embedded within this conceptualisation sits in juxtaposition with that of the individualistic discourse that remains so prevalent within the academic literature informing our knowledge of this field. The role of solidarity amongst ambulance personnel in such circumstances remains a rather elusive concept.

Rees et al (2021) provide a glimpse into the socio-relational bonding and interdependence held between crews and their organisation, in their committed attempts to share a common cause. Yet, there is real opportunity here to expand on this much further, to explore how this collective cohesiveness reflects a socio-relational link between group members giving an identifying sense of 'we' rather than 'I', and, as Albert et al (2022) added, how these dynamics, based upon shared beliefs and normative practices, are essential, as solidarity ultimately may be viewed as the 'co-responsibility of each person for the moral wellbeing of all others' (p.330). This said, the work of Carbajal et al (2021) who drew upon the framework of attachment theory, remind us that solidarity is unlikely to be a blanket sense of feeling among all members of a salient group. Rather, the functioning of social relationships and social bonds between members is dependent upon individuals' ways of relating to one another, and this 'can be negatively impacted by the traumatic and challenging experiences [paramedics] face during their work' (p.785). This is an important consideration that is not always accounted for within the literature exploring this phenomenon.

Chapter Summary

This chapter has provided detailed examination of the extant literature pertaining to the social psychological group processes and culture inherent within the ambulance service. Moreover, this review has pinpointed what is currently known about these dynamics through a social identity theoretical approach, particularly when applied to the context of collective adversity and trauma such as that experienced by ambulance personnel during a pandemic. Nevertheless, the study of relevant literature revealed significant openings for new research as prior empirics are considerably lacking in this field. Indeed, it raises many concerns that formulate this study.

My first concern is that there is a real need to understand the social psychological dynamics – particularly that of social identity and self-categorisation - operating at the 'hidden' level of ambulance culture. Secondly, there is an urgent need to explore the socio-relational processes manifesting between leaders and followers, with a focus on how they play out in the context of high stress and highly changeable situations such as the Covid-19 pandemic. Finally, this literature review has led me to ask, 'how do paramedics individually and collectively experience and manage their psycho-emotional responses to adversity – especially when that adversity is prolonged?'.

Deeper examination of these influential and subtly acting processes will provide valuable insight into how they influence and impact upon the worldviews, psycho-emotional, and behavioural responses of ambulance personnel. By understanding this to a far greater depth than is currently known, I will make an original contribution to academic knowledge that potentially may be applied towards changing the course of psychological ill health amongst this frontline population.

The next section sets out the methodology and methods utilised to gather data in order to answer these questions.

Chapter 3 –Theoretical Framework

3.1 Introduction

The prior chapter examined the extant research previously published by academics in respect of the socio-relational worlds operating within ambulance service environments. It also evidenced how limited scholarly attention has been given to understanding this field through a social psychological lens; in particular, via the metatheoretical social identity approach. There is clearly a real and current need for developing an understanding of the inherent processes subtly yet powerfully influencing the social, psychological, emotional, behavioural and relational dynamics within, and between ambulance personnel and their teams. Thus, the chapter concluded by arguing that applying this approach will contribute new knowledge to our understanding of the phenomena explored by the research questions of this study.

The purpose of this chapter is to provide further consideration of the social identity approach and its constituent social identity and self-categorisation theories; the theoretical analytical framework upon which this doctoral study is firmly grounded. In doing so, this chapter will highlight the core concepts and assumptions associated with these theories, provide theoretical critical examination, and justify why this approach, rather than others, is so relevant here.

3.2 Theoretical approaches to social identity

The perception of self and social identity has long been focal to the disciplines of sociology, psychology, political sciences and anthropology. However, trends in the theoretical understanding of this concept have been subject to much philosophical debate, with Pozarlik (2013) arguing that whilst social identity is 'an existential imperative of the human condition' it is '…too complex, too dynamic to be captured within a single theoretical paradigm' (p.77). This sits in contrast to Brewer (2001) who noted divisiveness amongst theorists, with social identity '…integrally embedded in separate theoretical structures and literatures with little or no cross-citation or mutual influence' (p.115). Indeed, this challenge was certainly noted when undertaking a scoping review, particularly of sociological and psychological frameworks which were deemed most relevant to this study's aims and objectives.

Although a number of theories were considered, two key approaches were pinpointed as central to conceptualising understanding of social identity and group processes and were deduced to be potentially appropriate frameworks within which to site this research. From a sociological perspective, these theories were those of symbolic interactionism incorporating identity theory. From a social psychological

perspective, I draw upon the social identity approach – comprising social identity theory and self-categorisation theory. These will now be critically discussed.

3.2.1 Sociological theoretical frameworks of social identity

As an analytical framework, symbolic interactionism offers a distinct theoretical approach for examining the social construction of identity within the context of contemporary society (Blumer, 1969). In this view, sense of self - one's identity - is valued as a dynamic and evolving social construct, consistently being redefined through symbolic meanings associated with norms and behavioural patterns that constitute social order and interactions, aided by the use of symbols such as language (Hall, 1996). Pozarlik (2013) further added that it is through the 'subjective construction of meanings related to self-understanding' that one defines the 'self through relation to the other' (p.78); thus, illustrating an underpinning assumption, which infers that our sense of meaning, and definitions of self and our social identities are derived from our interactions with others (Vryan et al, 2003). Consequently, symbolic interactionism understands people to be 'active agents' (Scott, 2015, p.5) in the continuous shaping and conceptual reformulation of 'self' and 'social identity' through micro-level social interactions including judgements of others and personal reflection (Erikson, 1959).

Whilst this analytical framework would support the epistemological development of knowledge relevant to providing insight into how ambulance workers' social identity is constructed through various social processes including group norms, the underpinning focal emphasis on understanding human experience through objects and symbols such as language (Garfinkel, 1967) was felt to be at the expense of not comprehensively analysing the socio-relational processes operating between individuals, in different social contexts. Furthermore, it is an approach that has been widely criticised for its failure to account for dynamics operating beyond the micro-level (such as power or institutional influences) and thus would not take cognizance of any effects of ambulance organisational culture upon group processes, for example. Scott (2015) also highlighted criticism that symbolic interactionism, in determining individuals' appraisals of social situations, is too cognitive-focused. Subsequently, I would further argue that this view does not provide sufficient conceptual capture of emotionality nor embodiment – which is not consistent with the aims and objectives of the current study for which social psychological exploration of emotionality is at its core.

In addition, the philosophical tradition central to this theoretical approach, that of pragmatism, presents an ontology recognising that human's meaningful actions and interactions take place within a subjective social reality that is in constant change (Kelly and Cordeiro, 2020) and epistemologically, offers a conceptualisation that knowledge can only be acquired through prior actions which then can be used to problem solve and enact change (Dewey, 1931). Thus, from this perspective, actions precede theory and

knowledge. Indeed, Blumer (1969, p.71) argued that 'the essence of society lies in an ongoing process of action – not in a posited structure of relations' adding that 'without action, any structure of relations between people is meaningless'. This philosophical approach is, however, one that sits in contrast to that suited to this study - which is more aligned to an epistemology that accounts for knowledge being developed upon the basis of beliefs, values, and lived experiences rather than solely through actions.

Based upon the tenets of symbolic interactionism, identity theory (Stryker, 1968) focuses on how 'individuals experientially construct a sense of self through the enactment of social roles' (Mausz et al, 2022, p.2) shining a light on understanding the behaviours individuals enact through those roles when the role is salient to them. From this perspective, a role is 'a relational position within society to which there are…behavioural expectations and norms including various attitudes, values, and beliefs' (Mausz et al, 2022, p.2). These theories posit that through social interactions related to one's social status or position, particular identities will develop, and their construction will lead to role-playing behaviours that are influenced by supporting social structures such as norms (Stryker, 1980). Identity theory determines that the social self is developed in the context of society and assumes that a person may hold multiple identities given the various roles and social contexts one may find themselves in - a concept not dissimilar from psychological theories of identity. However, Hogg et al (1995, p.256) expressed that from this view, the self is not seen as an 'autonomous psychological entity' but rather, is co-constructed within social structures – thereby aligning with sociological principles.

This theory, whilst helpful for providing examination of our societal fit, could, in the context of this current study, yield understanding of the impact of role identity upon the behaviours of paramedics. Nevertheless, it is a theory criticisable for its lack of understanding of how an individual internalises a particular identity and how this process may impact upon themselves and others with whom they interact. Indeed, theorists of this approach transparently recognise that the underpinning cognitive process are not the focus of understanding here (Hogg et al, 1995). Thus, I am of the opinion that the application of identity theory to this research would leave a fundamental gap and would not enable a contribution to knowledge that unpacks and gives depth of understanding to how social identities link to social behaviours (such as conforming to norms, for example). Furthermore, whilst identity theory is underpinned by assumptions that identities are sensitive to role changes, Stryker (1980) assumed that these were fairly stable and, as such, less attention is placed upon the dynamic influence of changeable social contexts and group memberships (Hogg et al, 1995) – both of which are arguably very relevant to the social spaces within which ambulance personnel operate. In contrast, identity viewed through a social psychological lens places less emphasis upon prescribed social roles (Desrochers et al, 2004). Rather, it considers the agency of an individual in cognitively embracing social membership of groups that are deemed by them to be valuable and meaningful, and how this provides individuals with a sense of who they are.

In critically considering identity through various theoretical frameworks, it is evident that a social psychological approach is optimal in its fit to the aims, objectives, and research questions posed by this study. Indeed, as the next section implies, the social identity approach offers its value in terms of its capacity for explaining and generating new understanding of how group memberships have a collective influence upon the subtle social dynamics connected with social behaviours and identity formation and maintenance. Overall, it is this theory that I consider to be most applicable to exploring the collective social group context encompassing the work-life worlds of ambulance personnel when faced with a prolonged adversity and potentially psychologically traumatic situations. The next sub-section provides a critical review of the social identity approach to provide a balanced consideration of its advantages and limitations.

3.2.2 The social identity approach

The social identity approach, which resides within the discipline of social psychology, comprises both social identity theory and self-categorisation theory (Tajfel, 1972; Tajfel and Turner, 1979). It is a metatheory of intergroup relations that 'seeks to understand the distinct contribution that group life makes to people's psychology and behaviour' (Davidson et al, 2021, p.2) for which its efficacy has been widely established within the empirical literature, particularly in terms of examining organisational phenomena. Nevertheless, whilst this theoretical framework is held in high regard in terms of its eminent contributions of knowledge to intergroup relations, it does feature some possible shortcomings in light of this doctoral study. This section will provide the reader with the underpinnings of both of these theories and a critical review, contextualised with reference to eminent scholars of this approach.

Social identification reflects the notion that people perceive and interpret a sense of who they are, their understanding of their place in the world, and their ways of relating to others, through their social worlds – that is, how they are viewed by, and how they perceive others and the groups around them (Tajfel and Turner, 1979). The purpose of the social identity approach is to provide a theoretical framework to elucidate how people see and understand themselves in the context of being members of groups, and the relational influence intergroup dynamics have upon the individual – in terms of the way they think (such as their perceptions, beliefs, and interpretations), feel and experience their emotions, and behave or interact in response to prescribed norms, collective values and beliefs, for example (Rathbone et al, 2023; Jetten et al, 2017).

The main proponent of social identity theory, Henri Tajfel (1972), defined social identity as 'the individuals knowledge that (s)he belongs to certain social groups together with some emotional and value significance for (her)him of this group membership' (p.31). Thus, according to this theoretical

perspective, our sense of who we are; our self-concept, is understood to be a complex and dynamic construct that is assimilated and shaped in relation to one's 'multiple personal and social identities' and group memberships, which 'ebb and flow' in terms of their salience and are 'influenced by perceptions and experiences of context or situation' (Pegg et al, 2018, p.50). In this way, our sense of self, through social interactions and relationships with others, develops from and becomes intertwined with the beliefs a person holds about themselves and others (Baumeister, 1999; Hogg and Abrams, 1988). Indeed, there seems to be widespread acceptance that identity is socially influenced (Korte, 2007). Tajfel (1972) made the distinction, however, that social identity is in contrast to that of personal identity, which Jetten et al (2020) described as 'the persons sense of their own individuality' (p.13), although arguably, the two are interlinked (Tajfel and Turner, 2001).

3.2.3 Gaining a sense of 'who we are' and 'what we do' (our social identity) through social categorisation and social comparison

Importantly, Tajfel's (1970) classic 'minimal group studies' highlighted how, when, and why we come to see ourselves as being psychologically connected to others, how we collectively come together and feel a part of a social group and define ourselves as such, and how we establish our sense of social world positioning through comparing our group against that of others. Whilst his study was experimental and thus may be criticised for its application to real-life, Tajfel (1970) demonstrated that even in the most trivial and meaningless of circumstances, or the most minimal of conditions, individuals hold a natural tendency to categorise themselves into social groups on the basis of perceived shared characteristics extrapolated into a shared social identity. In this experiment, sixty-four teenage boys were randomly and meaninglessly categorised into groups, following which the boys were asked to allocate rewards to anonymised members of those groups. Typically, they discriminated (or maximised difference) against those boys assigned to the 'other' groups, thereby favouring those within their own group.

Despite its ethical limitations (as participants were not informed of the true reasons for the study, therefore, leaving questions as to the validity of their consent) and criticisms regarding the generalisability of the findings given the homogeneity of the sample (Moghaddam and Stringer, 2001), this study is noteworthy for its contributions to Tajfel's subsequent development of social identity theory of social behaviour. The findings informed his assertion that how we see ourselves (our self-concept) and our beliefs about our worth and abilities (our self-esteem) are influenced by the social categories we assign ourselves to and the social groups to which we belong. Thus, Tajfel and Turner (1979) argued that in categorising oneself as a member of a particular group, i.e. viewing oneself as holding similar characteristics to others in the group and forming a shared social identity which becomes integral to their self-concept, leads to intergroup processes of social comparison between one's own group in contrast to other groups (Oakes et al, 1994). This results in perceptions of positive distinctiveness, that is, naturally

favouring one's group ('us') over another ('them') against whom biases are held. It was this systemic notion explaining this phenomenon that they coined 'self-categorisation theory' (Turner et al, 1987; Tajfel and Turner, 1979).

Indeed, categorising oneself as part of a group invariably means that a person defines themselves collectively through the subjective pronouns of 'we' and 'us' rather than individually via 'me' and 'I', leading to depersonalisation of the self as a person takes on the shared characteristics, or prototypical identity of the group (Reicher et al, 1995; Abrams and Hogg, 1988). Subsequently, this is reflected in the interactions and connectedness that develops between the individual and those group members with whom the social identity is shared. Tajfel and Turner (1979) further added that our sense of who 'we' are more often comes from knowing who we are not – distinguishing 'us' – those who are similar to us and hold shared characteristics, from 'them' – those who are dissimilar, and do not hold shared characteristics. Certainly, it is an underpinning assumption of self-categorisation theory that this difference is key, and of importance, is that intergroup differences must be greater than any intragroup differences to enable the categorisation process to occur.

An often-cited example is that of football supporters who feel a shared connection with a club with whom they identify, seeing themselves as distinctly different from (and better than) fans who support the 'other' clubs. Similarly, the same may be applied to ambulance personnel from a particular station or divisional area, or indeed, a specific ambulance service or the paramedic profession. As members of these occupational groups, they too take on a sense of 'we' and, as the prior reviewed literature alluded, when this is strongly felt, they are shown to internalise beliefs that make categorical distinctions between 'us' and outsiders ('them'). This was particularly the case in discussions of the closed culture that serves to keep out intrusions and threats from non-group members.

Whilst illustrations such as these provide some support for self-categorisation theory, a weakness of Tajfel and Turner's (1979) work is that it did not examine the driving force as to why individuals naturally undertake this process (Demirden, 2021). Hogg and Abrams (1993) suggested that this motivation may come from a desire to reduce internal feelings of uncertainty - cognisant of a potentially impending threat, by seeking out others similar to themselves with whom they may forge a connection with. This is an interesting proposition, which essentially suggests that by increasing a sense of similarity between oneself and other members of the group through a process of self-categorisation and depersonalisation, it reduces uncomfortable feelings of uncertainty and provides a sense of safety and controllability (Grupe and Nitschke, 2013). Certainly, there is evidence supporting this notion from studies of individuals' social behaviours following adversity and disasters. From this research it was identified that people tend to spontaneously make connections with those whom they share similar characteristics or similar experiences, coming together on this categorical basis to prosocially support one another, particularly if

that group is marginalised. Indeed, being part of a group, no matter the context, not only provides 'group members with shared definitions of situations' (Davidson et al, 2021, p.2) but also unites people in terms of a shared common purpose (Haslam et al, 2009). In the case of adversity, trauma, or disaster, this could mean saving lives and increasing a sense of togetherness, allyship, solidarity, and control (Tekin et al, 2021; Drury, 2012).

3.2.4 Salience of social context, social history, and social influence

As noted, the social identity approach advocates that individuals hold their own personal identity and also a multitude of social identities dependent upon the social groups they belong to. For example, a person may be a member of an ambulance team, yet also a supporter of a football club, and a parent in the family setting. Determining the relevance (salience) of a particular social identity upon which to define (or categorise) oneself is contextually dependent (Turner, 1999). Indeed, as was determined by Tajfel (1970) in his minimal group paradigm studies, social identity theory posits that an individual's cognitive positioning of oneself as a member of a specific group is highly dependent upon the salience of that group and meaningfulness of the social context to that person at a given time (Tajfel, 1982). Thus, in the example above, one's identity as a supporter of a football club would likely be highly salient if the club was playing a match, but not so in the context of performing ambulance work, when in this instance, being an ambulance practitioner, is likely of greater salience. Indeed, as Davidson et al (2021) pointed out, in an organisational setting, a person may hold various social identities, for which each can 'become salient in different contexts' – providing the example that 'a paramedic can define herself as a member of a particular team, as a member of a particular profession, or as an emergency worker' (p.3). Haslam and Turner (1992) referred to this salience of social identity and social context as the 'social fit'. As Demirden (2021) argued, however, this theoretical approach assumes that 'all groups are psychologically comparable for their members in relation to the social identity process' (p.50) and does not consider the influence of social functions upon identity processes that contribute to making them salient. Indeed, he referred to the works of Deaux et al (1995) who proposed that groups operate with differing identity dynamics, highlighting that some groups provide members with a sense of high status, whilst, in contrast, others provide a sense of safety and security. Thus, Demirden contested that salience of identity is not born of context alone and meaningful social functioning is arguably a key mediator in this process also.

Unpacking these social processes further, Oakes et al (1994) proposed that, equally, an individual's determination of whether a social situation presents as salient for group identification or not, is also dependent upon social history and social influence. They argued that social history acknowledges the relevance of past memories that a person has in terms of membership of prior groups that are relevant to the current context (for example, recalling one's experiences of being part of a hospital team prior to working for the ambulance service). Social influence was succinctly summed up by Jetten et al (2020,

p.18) as 'the way we define ourselves is also shaped by the way that others, particularly other group members, encourage us to define ourselves'. From this statement, it may be understood that influence may be attributed to social pressures exerted by other group members, for example (Turner, 1991). This is key to note because social identity theory highlights that when a person categorises themselves as similar to others and subsequently their social identity aligned with a particular group is salient, then the social pressures evident within group dynamics will likely result in a person changing their thoughts, feelings, and behaviours to conform with those shared by other members of that group. If, however, in the presence of these social pressures, an individual's personal identity (rather than their social identity) is salient (so, there is no social fit) they are prone to rejecting such pressures and are unlikely to change their attitudes and behaviours to conform with those of the group. Consequently, social identity theory acknowledges that the strength of one's identification with a group, the salience of the social situation, and their subsequent behavioural changes to conform with group norms or rules, is actually highly contextualised.

3.2.5 Social comparison and positive distinctiveness

As noted, Tajfel's (1970) minimal group paradigm studies highlighted two fundamental theoretical principles central to social identity theory; social comparison and positive distinctiveness. In establishing their sense of social world positioning, Tajfel (1970) drew upon Festinger's (1954) social comparison theory to argue that members of social groups innately seek comparisons between their group and that of other relevant groups, to increase their sense of interconnection and belonging (Haslam et al, 2022), thus elevating positive evaluation of themselves such that they work better together (Drury et al, 2009). This is based upon members' categorisations of other people who share similar or dissimilar characteristics.

In the process of making comparisons to others, an individual integrates the shared sense of identity held amongst in-group members and unconsciously embeds it into their own self-concept, thereby depersonalising the personal aspects of their own self-identity. This process culminates in perceiving oneself as unified with individuals who are socially similar; a process termed 'group identification'. This dynamic is seemingly motivated by an innate need to establish a social identity that is positively distinct from that of other groups – referred to as 'out-groups' (Tajfel and Turner, 1979).

Social identity theory asserts that this bias, or positive distinctiveness, towards one's in-group, which tend to be held in more favourable terms by individual members ('we' are better than or different from 'them') is motivated by the assumptive need to develop and preserve individuals' positive social identity, particularly a positive sense of self-esteem within the group setting (known as the 'self-esteem hypothesis'). This serves to further enhance one's connection and sense of belonging to the group (Abrams and Hogg, 1988; Tajfel and Turner, 1979). If, however, a group fails to positively support a

member's social identity, this may result in an individual leaving the group to seek another that fosters positive distinction (referred to as 'social mobility'), or they may seek competition with out-groups to enhance dissimilarity, for example.

Nevertheless, this process is arguably constrained by the social reality being faced and the implication of social dynamics such as power and status (Jetten et al, 2020). Indeed, groups holding perceptions of higher status are often advantaged by way of a positive social identity held in high regard which individuals compare favourably against. This is in contrast to lower status groups who are more likely to be held in view of being inferior, and thus less attractive to individuals. As the present research study later shows, this point is an important consideration in the social context of the Covid-19 pandemic, whereby group status of ambulance personnel was highly elevated in the early months, yet subsequently was threatened and fell back to lower status more akin to that associated with 'dirty work', as seen in later months.

3.2.6 Collective behaviours and group norms

Social identities, when salient, subtly shape and guide the beliefs and behaviours of group members through group norms; that is, the adopted informal rules regulating social behaviours that are considered typical for, or expected by, the average (prototypical) member of the group (Reicher et al, 2010). Thus, group norms determine how in-group members should act in a given situation (Turner, 1991). However, this process culminates in underpinning dynamic social pressures, which implicitly influences in-group members to conform to these socially scripted behaviours and actions, indicating the way members should behave in various social situations (Asch, 1956). As Rathbone et al (2023) argued, the social identity approach is 'particularly well suited to understanding the role of group norms in shaping attitudes and behaviours because it incorporates an analysis of not only how, but importantly when, norms affect these outcomes' (p.1347).

Certainly, a wealth of empirical evidence from a variety of different contexts supports this theoretical conceptualisation linking social identity, group norms and behaviour. A key finding from such research is that the more a person identifies with their group, the more likely they are to adhere to the group's social norms, internalise collective beliefs into their sense of self, and embody the views and behaviours associated with their salient group (Pegg et al, 2018; Haslam et al, 2009; Levine and Moreland, 2004; Tajfel, 1982). Rathbone et al (2023) argued that 'the social identity approach theorizes that a person is more likely to be influenced by the norms of a particular social group when that person's social identity as a member of that group is both psychologically meaningful to their sense of self (they are a 'strong' identifier) and salient in the current context' (p. 1348). Building upon this further, Rathbone et al (2023), conducted analysis of data gathered from a longitudinal study of young people attending large events, seeking to examine the relationship between the participants social identification with their friends and

the groups' social norms around drinking behaviours. Although context and time dependent, they found that those exhibiting higher social identification with those in their friendship group were more likely to adhere to their groups' norms, which subsequently intensified their connection and sense of belonging and commitment to the group. Furthermore, in applying this concept to the workplace, Haslam et al (2009) found that employees with high social identification felt a greater level of satisfaction and pride in their work and demonstrated organisational citizenship. Moreover, individuals sharing a sense of identity are more likely to be motivated to enact co-operative behaviours for the good of the group, thereby enhancing the groups success (Davidson et al, 2021).

Whilst it may be held true that social identification is a key mediator in people's adherence to group norms, Jetten et al (1996) also highlighted that when group norms are modified by way of experimental manipulation or via natural phenomenon, this can also lead to changes to the shared social identification held by in-group members. Indeed, this normative and social identity change has been shown to subsequently alter the behaviours exhibited by individuals within that group. Postmes et al (2005) also noted this reciprocal, reinforcing relationship, postulating that in the need for social connectedness, individuals are motivated to conform to group norms to maintain their attachment to the group. However, they found that the group norms themselves also influence the strength of one's social identification with the group and, as such, further reinforces their belonging to the group and places the individual in a more positive and valued light by other in-group members – thereby bolstering their and the group's self-esteem. Nevertheless, this connection between social comparison/ differentiation and the motivational role of self-esteem has not received such positive support from other studies which have suggested a 'weak and inconsistent correlation' between the two and argued that 'it may be better seen as a by-product of discrimination rather than a direct cause or effect' (Brown, 2000, p.755/6). Arguably, this raises questions as to how these social group processes play out when in the organisational setting particularly in the face of adversity and uncertainty, and where some members of the group will be perceived of higher status than others.

Rathbone et al's (2023) work provides additional theoretical insight as to why individuals are influenced by group members to conform to social norms. Recapping on self-categorisation theory, it may be summarised that in categorising oneself as part of a group, there is the inherent tendency to assume that others in the group share characteristic similarities. Thus, an expectation occurs that individuals within the group will share similar opinions. According to this theory, this assumption extends to an understanding that the perceptions and thoughts held by other group members will, through social pressure, influence an individual member's own opinions (Asch, 1956); therefore, leading to the adoption of collective beliefs, formulating and reinforcing the group's ontological view of 'this is how we understand the world' and 'the way we do things is the right way'. Consequently, this application of the theoretical approach taps into human's intrinsic motivational need for mastery, which, according to social identity theory, may be

reconciled through one's conformity to group norms. This is especially true in high-stakes situations whereby accurate decision-making pertaining to behavioural responses is critical – further strengthening conformity by group members.

In contrast, individuals perceived to act in non-conforming ways to their group norms, challenge the status quo. Whilst this may bring positive benefits such as innovation, strengthening of values, and can bring about change, equally the literature highlights how non-conformity can destabilise and undermine the collective influence of a group, potentially compromising their beliefs and assurances that their reality is true. Such individuals are positioned as deviant and are often negatively evaluated by other in-group members in terms of their loyalty and commitment (Coser, 1974). Thus, a person whose behaviours are non-conforming may face social isolation, stigmatisation, and their social identification inferred from that group becomes undermined. This can lead to fears of victimisation and ostracization.

3.2.7 Theoretical relevance of the social identity approach to understanding the social and psychological worlds of ambulance personnel

Noting the gaps in the empirical evidence reviewed in the prior chapter combined with the principles and underpinning philosophical assumptions of the social identity approach as discussed here, I believe there is a convincing argument that supports the suitability and relevance of this framework as applied to the current research study. Indeed, the theory of social identity provides an appropriate structure through which we may enrich and deepen our understanding of the highly influential social psychological processes operating within the context of social groups and intergroup relations within emergency ambulance service teams working in the frontline setting. Furthermore, it is a lens that also holds relevance for uncovering how people view their jobs, their organisation, and the relational dynamics between employees and leaders. Therefore, I argue that the social identity approach is an important magnifying glass through which we may understand how individuals 'perceive new information, attribute cause, make meaning, and choose to...' adopt new beliefs and behaviours in the organisational context (Korte, 2007, p.177). In addition, it is both ontologically and epistemologically applicable to investigating how individuals and groups of people are impacted by and respond to adversity and potentially traumatic situations from a behavioural, emotional, psychological, and relational perspective. Certainly, it is arguable that without understanding these inert social psychological processes emanating from group memberships, we may be no further forward in developing our knowledge of the impact of collective adversity and trauma and addressing the socio-cultural dynamics that may be perpetuating poor psychological health of employees.

Undoubtedly, 'the strength of social identity as a concept comes from its deep meaning to individuals living and working in groups within organisations and from its focus on the source of that meaning

beyond the individual' (Korte, 2007, p. 177). Whilst this approach has seemingly not been applied to paramedicine previously, it is through this theoretical orientation that this study will make sense of these social realities. Ultimately, applying this framework to ambulance personnel facing the prolonged experiencing of a pandemic will bring new insight and contribute new knowledge to the understanding of this phenomenon within an English setting.

3.3 Conclusion

This chapter has explored the key theoretical approaches to social identity as recognised within the sociological and psychological literature. Following a critical discussion of these theories, justification is provided as to why a social identity approach was applied to this research study of ambulance personnel. The next chapter explores the methodology and methods used for empirical data collection and analysis, employed.

Chapter 4 - Methodology & Methods

4.1 Introduction

While the previous chapter highlighted and provided justification for the social identity theoretical approach, it was chapter two that gave insight into the limited research examining adversity and trauma, particularly prolonged exposure as experienced by ambulance practitioners. Little is known of this concept, and prior research has predominantly taken an individualistic perspective to examining this. The overall aim of this study is therefore, to understand the social psychological dynamics operating at the 'hidden' level of ambulance culture and explore how these subtleties influence social behaviours and relationships including the collective experiencing of trauma and regulation of emotions by ambulance practitioners in response to prolonged adversity.

This chapter provides contextual understanding of the methodological design of this study, highlighting its relevance for developing knowledge in this field. It identifies the philosophical underpinnings of this study, stating its epistemological (social constructionism) and ontological (relativist) positioning. Both are important for understanding the social realities of the participants and how their perceptions, beliefs, and knowledge are influenced by social psychological, cultural, and societal dynamics, as highlighted in chapter two and thought to be critically important considerations in the context of adversity and trauma. Rationale and justification are provided for the use of a qualitative methodology and the employed research method of focused ethnography as a data collection framework, drawing the reader towards its relevance in interpretivist social constructionist research. Following consideration of the detailed aspects of the research process including participant recruitment, this chapter comprises a section exploring research ethics pertinent to this study design. Finally, data analysis will be discussed prior to concluding with a chapter summary.

4.2 Philosophical underpinnings: Epistemological and ontological positioning

In chapter two, I highlighted how previous research into adversity and trauma has overwhelmingly investigated and constructed knowledge of these concepts from one that centres the experiencing and emphasises the psychological effects upon individuals; thus, in philosophical terms, presents a realist, objective existence of a social reality that aligns with a positivist paradigm. However, I argue that the complexity of these concepts cannot be limited to an individual, objective experience as adversity and trauma are socio-relational phenomena, and thus, the context of the culture(s) in which individuals reside

have a crucial role not only in how they perceive, draw meaning, make sense of, and process such events, but also how these cultures influence how others, who are collectivist members of these groups, also appraise and respond to adverse events.

Holding the assumption that cultures collectively shape individuals' cognitive and emotional processes, this study takes the position that social reality and the nature of existence is multivarious; that is, that many social realities and ways of knowing phenomena exist, some of which may be shared based upon 'context-specific' phenomena (Ormston et al, 2014, p.4). Taking Ormston et al's (2014, p.4) definition and applying it to this study provides philosophical understanding that refutes a 'social reality that exists independently from human conceptions and interpretations' as associated with positivist approaches. Rather, this research takes the fundamental ontological view that an objective, external reality of social phenomena is impossible – thus, is anti-positivist. Rather, this study accepts a relativist perspective, acknowledging that realities are complex, multivarious, multi-layered, and diverse (Berger and Luckmann, 1966).

Indeed, at the foundation of this study's research questions are implicit assumptions about the metaphysical nature of social reality which draws ontological alignment with the philosophy of relativism and derives epistemological knowledge through social constructionism – thus, accounting for how individuals, between them, construct knowledge and understanding of their social worlds through their collective perceptions, beliefs, and interpretations which together, form their worldviews (van der Walt, 2020; Crotty, 2003; Richards, 2003; Lincoln and Guba, 1985). In this way, it is understood that a single phenomenon may yield multiple interpretations arising from the subjective experiences of individuals and groups (Chen et al, 2011). Thus, interpretivist research methodologies do not seek to explore a single truth or existence, but rather, look to unearth purposeful meaning from the complexities of social phenomena socially constructed through individuals' perceptions, cultural experiences (which may be historical), and ideological positioning (Willig, 2010). Indeed, there is valid argument that great depth and richness can be gained from unpacking and examining at depth these meanings and perceptions underpinning the complexities of human experience (Leavy, 2020). Nevertheless, whilst this may allow for pluralistic perspectives and holistic insight, it is acknowledged that in their diversity, multi-intersubjective meanings may, at times, be conflictual (Appleton and King, 1997).

Taking an interpretivist position, this study firmly acknowledges a relativist ontological stance and epistemologically draws inference with social constructionism. This philosophical approach concurs with those utilised within prior disaster-focused social research whereby this tradition is well-established and well-regarded for its epistemic and subjective positioning in understanding human interactions and social processes existing in crisis situations. Indeed, relativism and social constructionism are common lexicon within the social sciences, and although not so well acquainted within the discipline of psychology (which

tends to favour realist approaches) (Masaryk and Rogers, 2024; Biggerstaff, 2012; Banister et al, 2011), this philosophical perspective is accepted within 'mainstream…psychology in the UK' (Willig and Stainton-Rogers, 2008, p.8) as a methodology for producing thick description of meanings (Denzin, 1989) and the development of theory, thereby contributing to psychological knowledge of social processes and theoretical constructs such as adversity and trauma. This approach also reflexively aligns with my (as the researcher) experiential beliefs and worldview regarding the existence of multiple socially constructed realities and the multivariate ways of knowing and understanding phenomena.

I therefore argue that this approach and its foundational assumptions are highly appropriate to the research questions and aims of exploring experiences of adversity and trauma among ambulance personnel whilst working within the novel social context of the Covid-19 pandemic. It is a relevant position for capturing insights of how knowledge and sense-making of adverse and traumatic experiences are influenced by and understood in the context of social and group processes. Furthermore, it relates well to the interpretive exploration of symbolic and social constructions such as shared meanings, cultural norms, social representations, and social relations that have developed within ambulance culture both historically and more recently in response to the changed realities associated with the pandemic. By exploring the richness and complexity of the phenomena in this way, it is possible to theorise understanding of meanings ascribed and their social context.

Within the interpretivist-constructionist paradigm, conceptual and theoretical epistemic knowledge and understanding of the social world are examined through qualitative methodology. This approach, which will be examined next, promotes an inductive process for intimately examining human behaviours, experiences, and social contexts in a way that allows for the development of conceptual and theoretical understanding (Rahman, 2017; Tuffour, 2017; Petty et al, 2012; Willig, 2010; Cresswell, 2009; Heracleous, 2001; Denzin and Lincoln, 2000; Philips, 1997; Berger and Luckmann, 1966).

4.3 Methodological approach

Taking a systematic qualitative methodological approach to inquiry, this study intended to adopt a focused ethnographical method for data collection primarily on the basis of its synchroneity with the underpinning philosophical assumptions of this study and fit with the research aims and objectives. The evolving nature of the pandemic and impact of nationwide social restrictions, however, made its application challenging. Therefore, whilst retaining the core elements and underlying assumptions of this method, in being responsive to the rapidly changing social context, the methods employed within this study underwent some adaptation, taking on the broader approach of qualitative inquiry. In the next

sections, I provide an overview and justification for the empirical use of these methods and discuss the impact of the Covid-19 pandemic upon the research design process.

4.3.1 Focused ethnography

Taken from socio-anthropological roots and underpinned by interpretivist philosophical assumptions (Hammersley, 1991), the applied research method of focused ethnography aligns to the interpretivist paradigms associated with traditional ethnographical inquiry (Rashid et al, 2019). As with established ethnographic methods, studies utilising focused ethnography connect evolving phenomena with socio-cultural processes thus generating deep exploration of individual experiences within the context of communities. Subsequently, this research process therefore allows for analysis and understanding of social meanings implicitly embedded within social interactions and relationships, and how these dynamics impact individual and group behaviours (Arnout et al, 2020; Rashid et al, 2019; Lopez-Discastillo and Belintxon, 2014). However, focused ethnography differs from traditional ethnography in a number of ways. Firstly, it examines a single phenomenon thereby advocating a 'focused field of enquiry' (Bikker et al, 2017, p.1). Based upon a literature review and the researcher's *a priori* knowledge of the field, problem-focused research questions are developed prior to the collation of data (Knoblauch, 2005). This is in stark contrast to traditional ethnography whereby researchers access the field of study without prior conceptions or formulated research questions (Wall, 2015). Nevertheless, Muecke (1994) cautioned that the close connectivity of the researcher to the research process risks exclusion of data that may be more apparent to a researcher without these links. He therefore argued that trustworthiness and transparency of the research process must be upheld. This issue will be discussed in detail in section 4.5.

Secondly, focused ethnography entails short-term methods of data collection, usually over a fixed period of time relevant to the event or phenomena being studied. Lastly, whilst observation is viewed as a key data collection method, focused ethnography does not rely upon this exclusively. Interviewing is also considered a core method for generating empirical evidence, with participants selected for their relevance to the research issue (Bikker et al, 2017; Wall, 2015; Higginbottom et al, 2013). Many critics have, however, questioned the legitimacy of 'ethnographic' studies that refrain from using observations as a primary source of data collection method (Knoblauch, 2005; Wolcott, 1999), Wall (2015, online) challenged the synonymous link between ethnography and observation which is taken for granted within many socio-anthropogenic scholarly works. She importantly highlighted that, in fact, 'it's not data collection techniques that make a study ethnographic, it is the intent of the research that legitimises the use of the label'; a point previously made by Hall et al (2012). Although the literature supporting this notion is exiguous, an earlier publication by Brewer (2004) further indicated that essentially the method of data collection is irrelevant. What is important, however, is that the technique employed provides 'access to people's social meanings and activities and involves close association and familiarity with the social

setting. This does not necessarily mean actual participation in the setting…' (p.312). Indeed, the authors clearly concur that whilst observation provides a tool that allows the researcher immersion into the social worlds of the participants, equally rich and meaningful, high-quality findings can prevail from using other methods whilst retaining the underpinning cultural intentions of ethnography (Wall, 2015; Knoblauch, 2005).

To date, traditional ethnography has rarely been conducted within the fields of social psychology or paramedicine, less so, the newer contemporary method of focused ethnography. However, its application is growing, particularly within other health, psychological, and social research disciplines, and has delivered scholarly works examining professional cultures and complex communities of staff working within hospital and clinical settings (Rashid et al, 2019). As such, it could be said that this 'increasingly popular research method' (Trundle and Phillips, 2023, p.1) forges a strengthening methodological and theoretical bridge between sociology and psychology that it well suited to the social psychological domain particularly in terms of examining the complexities of group memberships and interpersonal behaviours (Rashid et al, 2019).

4.3.2 The methodological challenges of conducting qualitative research during the Covid-19 pandemic

The evolving and uncertain nature of the Covid-19 pandemic, whilst arguably providing a unique qualitative research opportunity to 'test theories in real time and often in novel and ground-breaking ways' (Jetten et al, 2021, p.34), also posed numerous challenges to all aspects of this doctoral research process. Being responsive to this uncertainty required persistent understanding of the developing context and a flexible and adaptive approach to determining appropriate techniques for data collection and adjustment of the research design process. Three key issues are discussed here.

The first issue encountered was that of the rapid emergence of the viral contagion, quickly leading to lockdown restrictions. Whilst setting up of the study was in progress, it was a positive benefit that research pertaining to the pandemic was being fast-tracked for ethical approval by the Health Research Authority. Thus, despite having to complete the same standard application process, ethical approval for this study was granted within one week. This was pivotal in enabling me to quickly progress the research by starting real-time data collection relatively soon after the emergence of the outbreak and lockdown having been declared. Nonetheless, representative of a second issue, prior plans regarding observational fieldwork and face-to-face interviews had to be discontinued due to national restrictions (Rahman et al, 2021). Resultantly, the methods of data collection centred upon telephone interviewing (Howlett, 2022). The benefits of this method was its geographical convenience in that no face-to-face contact was required. It is recognised that this method, whilst empirically acceptable and enhances anonymity (Novick, 2008; Tausig and Freeman, 1988), has 'generally been considered inferior to face-to-face

interviews' (Drabble et al, 2016, p.2). This is due to a multitude of issues including limited telephone signal which has the potential to disrupt the flow of the interview (Carr and Worth, 2001), challenges to privacy, and environmental distractions (Opdenakker, 2006). This posed thoughtful consideration for how to best facilitate a psychologically safe environment inclusive of trust, which is particularly important in the study of vulnerable populations and where the topic of interest may be sensitive (Denzin and Lincoln, 2018). To address this issue, confidentiality and privacy were emphasised to participants prior to, and at the start of the interviews, and no major issues ensued.

On this note, the use of digital communications posed an alternative method for conducting interviews (Arnout et al, 2020). However, video interviewing was determined to be a risk to the quality of interviews and potentially could have posed significant challenges to the data-collection process (Tremblay et al, 2021). Indeed, the perceived disadvantages primarily centred upon the requirement for participants to have access to video calling and know how to use it, which at the time, few people were familiar with (Lobe et al, 2022; Narney et al, 2020). Furthermore, technical issues such as screen freeze, cameras not working and ethical questions around recording video calls were felt to be too perilous given the need to capture data within specific periods of time.

A third issue presented by the Covid-19 pandemic was that of its protracted time frame. The original design of this study was conceptualised to be short-term, with a window of three to six months for data collection, based upon a presumption that containment of the virus would have occurred, and life resumed to normality by this time. As is now known, of course, this was not the case. Upon realising in the early months of the contagion that this would be a prolonged adversity, a revision to the ethical approval was sought and permitted by the Health Research Authority to greatly extend the study to one year, to allow for maximum data collection and capture social and psychological change over this time.

4.4 Methods

This section provides brief overview of the technical aspects of research implementation such as the study setting, participant recruitment, methods of data collection, ethical considerations, and analytical interpretation.

4.4.1 Overview of methods

This research was a longitudinal study informed by the qualitative method of semi-structured interviewing. Data was collated at three phases over a one-year period which commenced shortly after the outbreak of the Covid-19 pandemic and the first lockdown implementation (23rd March 2020). The first

phase of interviewing was undertaken in April and May 2020. The second phase took place between September and October 2020, and the third data collection was undertaken during January and February 2021. Thirty ambulance service personnel from across England consented and took part in the study. However, by the third phase of interviews, this number had waned to eighteen. As will be discussed in section 4.7, data from the interviews were transcribed verbatim and subsequently analysed via thematic analysis.

4.4.2 Study setting

Following the remit of ethical approval provided by the Health Research Authority, this study was limited to recruitment of participants from NHS ambulance services in England. England was also the geographical focus of this study with a view that social restrictions were generally consistent across the country when compared to those of the devolved nations, which at times, were quite different. Nevertheless, towards the latter months of the study, there was some variation across English regions, with some areas facing more strict restrictions than others.

As noted within the literature review, the ten ambulance trusts across this country vary in terms of geography and population served. However, each provides core emergency and urgent healthcare services and operate in a similar nature. Despite the broad scope of professional employment opportunities for paramedics, the ambulance services still remain the largest employers of emergency ambulance staff. Arguably, the primary focus upon NHS ambulance services does limit this study, as it excluded those working for private ambulance companies; organisations that worked to support the frontline emergency medical response during the study period. Their exclusion here, is simple, in that the NHS ambulance services are the statutory provider of emergency medical response in England. Furthermore, the numbers of individuals working for private providers in an emergency care or practitioner role is relatively limited in comparison to the quantity employed by the NHS. Workers from other related locations such as ambulance control rooms, and volunteers such as community first responders and those volunteering for partner organisations such as the British Association for Immediate Care, were also not included for similar reasons. Military paramedics who were assigned to work within NHS ambulance services during the study period were included in this study.

4.4.3 Participant recruitment and sampling

Recruitment of participants came from two key sources. The first, was via NHS ambulance services themselves, of whom seven of the ten trusts within England agreed to act as recruitment sites, disseminating via internal communications pre-written study information and electronic consent forms to potential participants. The remaining three trusts declined due to partaking in other studies, or they did

not reply to my scoping email. The second source of recruitment was via social media promotion through both my personal accounts and also those of the seven consenting ambulance services.

These recruitment processes involved both purposive and snowball sampling. To gain the richest data to answer the research aims and questions, participant inclusion was restricted to those in a face-to-face patient-contact and/or operational response role including those who were operational managers. These modalities of sampling were practical and cost-efficient in terms of time (Etikan et al, 2016). Limitations of these techniques include researcher and sampling bias (Sharma, 2017) which are addressed later in this chapter. On this note, although the paramedic/ ambulance community within England is relatively small, I did not specifically seek to recruit those whom I knew personally. However, four of the participants were colleagues whom I had worked with previously.

In total, thirty participants consented to take part in this study and completed the first phase of interviews. Twenty-one of these interviewees further consented to participate in phase two, and finally, eighteen of the cohort consented to interviewing in phase three. Details of participant demographics are provided in the table overleaf.

To date, there has been little agreement by qualitative researchers as to how to determine an adequate sample size, and in the absence of an agreed framework, debate continues as to the best strategies to use. Boddy (2016) advised that both context and the study's employed philosophical paradigms are key (but not the only) determinants of sample size. However, guidance in terms of interpretive relativist studies, is not forthcoming. Indeed, Boddy (2016, p.430) concluded that 'in making a justification for an adopted sample size, qualitative researchers should make reference to the scope of the study and nature of the topic, the contact time to be spent on each individual…participant…and the homogeneity of the population under consideration'. With this in mind, the sample size for this study was guided by the number of individuals who had consented to participate. This was felt to be adequate given the nature of the study, the homogeneity of my sample, and the time constraints posed by this being doctoral research.

Table 1: Participant demographics

Pseudonym	Age	Job role	Length of service (years)	Phase 1 Interview	Phase 2 Interview	Phase 3 Interview
Adie	NG	Clinical Operations Manager	33	✓		
Alan	NG	Ambulance Nurse Specialist/ Emergency Care Practitioner	13	✓	✓	✓
Ava	29	Graduate Paramedic	1.5	✓	✓	✓
Dan	55	Ambulance Technician	10	✓		
Ffion	NG	Paramedic	15	✓	✓	✓
Gareth	34	Paramedic	10	✓		
Gianna	NG	Graduate Paramedic	7	✓	✓	
Greyson	22	Ambulance Technician	4	✓	✓	✓
Harper	NG	Clinical Team Educator	23	✓	✓	✓
Jeremy	NG	Emergency Care Assistant	NG	✓	✓	✓
Joel	NG	Graduate Paramedic	7	✓	✓	✓
John	32	Graduate Paramedic	5.5	✓	✓	✓
Keisha	55	Graduate Paramedic	13.5	✓	✓	✓
Liz	50	Team Leader	15	✓	✓	✓
Marcus	NG	Newly Qualified Paramedic	<1	✓		
Natalie	42	Emergency Care Assistant	2	✓	✓	✓
Nicky	29	Graduate Paramedic on a Clinical Supervisor secondment	5	✓	✓	
Ollie	NG	Divisional Manager	22	✓	✓	✓
Osian	NG	Team Leader	18	✓	✓	✓
Paul	NG	Paramedic	16	✓		

Pete	57	Emergency Care Assistant	3	✓	✓	✓
Rod	NG	Emergency Care Assistant	11	✓		
Sally	26	Ambulance Technician	5	✓	✓	
Simon	61	Ambulance Technician	11	✓	✓	✓
Sunia	34	Graduate Paramedic	8	✓		
Tomasz	NG	Clinical Supervisor/ Paramedic	16	✓		
Tony	28	Military Paramedic seconded to an ambulance service	8	✓	✓	✓
Vicky	NG	Paramedic	16	✓		✓
Willow	NG	Clinical Support Manager	15	✓	✓	✓
Wojciech	25	Newly Qualified Paramedic	1	✓		

NG = not given

This did, however, provoke thoughtful consideration of the concept of 'data saturation' (Glaser and Strauss, 1967), which in its broadest application to qualitative research, is defined as the point at which 'no new information or themes are observed in the data from the completion of additional interviews' therefore, implying justification for an adequate sample size having been attained (Boddy, 2016, p.427). Whilst its inclusion into the research process has arguably been linked with data collection validity and rigour (Morse, 2015), it nevertheless, is a notion that is not robustly articulated within the literature, with no clear guidance identified to inform a definitive answer (Guest et al, 2006; Morse, 1995). Rather, as Morse (2000) determined, there are multiple variables including the number of interviews per participant, the theoretical implications, and the study design that may influence the richness and depth of the data collated. Thus, the concept of saturation is arguably quite problematic for knowing when one has reached the 'end point' and completeness in the research. On this basis, Saunders et al (2018, p.1091) concluded that 'saturation is an ongoing, cumulative judgement that one makes, and perhaps never completes, rather than something that can be pinpointed at a specific juncture'.

With reference to sampling, a further consideration in respect of longitudinal research design is that of attrition and interruption in the continuity of interviewees participation. Loss of participants from the study was difficult to predict and enlightenment did not come from prior literature as a longitudinal study of this nature, in the context of a prolonged crisis, and with this population – or similar populations, does not appear to have previously been undertaken. Nevertheless, I anticipated that not all participants would complete all the interviews given the intensity of the workload they were facing and the significant impacts upon their lives and their families. Caruana et al (2015, p.E538) recommended that longitudinal research must have the capacity to 'withstand' the duration of the study; indicating that sample size should be enough to account for a level of attrition and incomplete interviewing. Whilst the number of participants who consented to, and completed the first interviews was such that there was good capacity for a level of attrition, the circumstances were so novel that even though participant numbers had reduced to fourteen by phase three, the capturing of their experiences was still extremely valuable and continued to generate rich data.

4.4.4 Longitudinal design

Following on from the above, the research aims, objectives, and research questions have aligned with the assumption that the experiencing of adversity and trauma is a continual, dynamic psycho-emotional process that evolves over time in response to its nature, impact, and changing social contexts and relationships. This is further compounded by repeated exposures to such psychologically challenging events. Subsequently, this was of great concern given that through their emergency work, paramedics are often exposed to distressing scenes, and scholarly predictions from the outset of the pandemic anticipated that due to the extreme exposure to patients with serious illness and death, high levels of psychological

sequalae would ensue particularly among healthcare workers (World Health Organisation, 2020c). In addition, this study sought to investigate the natural course of how social psychological group processes influenced the participants experiencing of and responses to trauma and adversity; a dynamic phenomenon that could not be captured in a single snapshot of data capture and rather, required a method that allowed for analysis over a period of time. Therefore, a longitudinal research design was employed.

4.4.5 Data collection

Taking account of the Covid-19 restrictions, two key methods of data collection were proposed: interviewing of participants and a reflexive account by the researcher, in consideration of, and to provide transparency of my role as an insider-researcher; acknowledging my professional role of paramedic.

Interviews are a key qualitative method for data collection in the social sciences and align with multivariate philosophical assumptions. Epistemologically, the participant is framed as the 'knower' (De-Jonckheere and Vaughn, 2019) due to their knowledge of the phenomena under study (McIntosh and Morse, 2015), thus providing rich insight often referred as 'thick description'. Through partly guided conversation, semi-structured interviewing offers the flexibility to use focused iterative pre-determined questions enabling focus on the area of inquiry, yet also allowed flexibility for follow-up and deep exploration of any interesting points that came to light (Ruslin et al, 2022). Whilst Alamri (2019) and Adams (2015) were critical of their time-consuming nature and reliance on the interviewing skills of the researcher, this method is particularly useful for exploration of psychosocial phenomena such as experiences and emotions in contexts that may be sensitive or personal. On this, two key points arise. Ruslin et al (2022, p.22) highlighted how 'as an inter-view, an interchange of views [takes place] between two persons conversing about a theme or topic of mutual interest'. Thus, when exploring potentially sensitive or emotive data, the researcher should hold self-awareness of their influence upon the research process including the interactions between themselves and the participant, and the epistemological assumptions that they make about the data (Mason, 2002). Reflexivity here is key to exploring positionality and acknowledges researcher non-objectivity. The second point is that of ensuring, as far as practical, the psychological safety of both researcher and participant. Nevertheless, this is a point that should be considered and planned for prior to data collection (Knott et al, 2022). Indeed, in this study, it formed part of the consent process where participants were made aware of the potential for harm. During the interviews, I was cognisant of distress arising within interactions between the participants and I. A more detailed discussion of this is provided in section 4.6.

In preparation for interview, participants were provided with information regarding the nature of questioning and guidance around the ideal need for privacy as a factor of psychological safety and

confidentiality – however, ultimately this was at the participants' discretion and dependent upon their social circumstance (Bennet, 2020). Given the lockdown restrictions, children and family members were confined to the home and during interviews, some participants naturally were distracted by childcare responsibilities, pets' needs etc. which briefly impacted the interview flow (Rahman et al, 2021). However, this was not felt to be significantly detrimental to the quality of the interviews. Interestingly, several participants did their interviews whilst sat in their cars – a symbolic reflection of the times where the car was one of the few places where individuals could have a level of privacy that was perhaps greater in several ways, than being at home.

Pre-designed interview schedules (Appendices D, E, and F) were prepared, with questions at each interview phase informed by knowledge gained from the literature review, from 'researcher intuition' (McIntosh and Morse, 2015, p.5), from my advancing knowledge of the unfolding pandemic situation, and reflexion upon the changes being witnessed within my employing ambulance service. The interview schedules were designed to be flexible as to the circumstances each participant presented, with scope to allow for any new lines of questioning to occur in response to interesting points made by the participants which were worthy of deeper exploration. As such, they provided good grounding of areas for investigation. Indeed, it was this knowledge that informed the extension of the study from two interview phases over three to six months, to three interview phases over one year – given the evolution of the contagion. Certainly, to achieve the richest, most insightful, high-quality data, one needed to be responsive, adaptable and flexible to the uncertainty presented by the unfolding pandemic (Rahman et al, 2021).

One possible drawback of this study is that a short pilot study testing out the interview questions was not undertaken. Whilst this may have confirmed the relevance and feasibility of the questions and whether they stimulated the content and depth of discussion pertinent to the research questions, thereby adding credibility and transparency to the data collection (McIntosh and Morse, 2015), this was not practical given the nature of the phenomenon under study and the time constraints faced in response to a rapidly evolving global infection.

The design of questions within the interview schedules were purposively devised to account for the sensitive nature of the context and to gently encourage participants to share their experiences (Bennett, 2020). Questions were specifically organised in a logical manner to allow building of rapport and trust (De-Jonckheere and Vaughn, 2019). Although participants were informed at the outset that I was an 'insider-researcher'; that is, as a paramedic, I was also an in-group member as well as being a researcher, the language utilised within interview questions implicitly conveyed shared meaningful nuances such that *a priori* knowledge and understanding of the processes associated with ambulance service and clinical work was reflected. McIntosh and Morse (2015, p.6) determined that such communication is

advantageous for 'instilling trust in the participant that he or she will be understood and may inspire fuller responses'. This was a particular consideration given that the literature highlighted how the close culture of ambulance practitioners often presented a mistrust of those perceived to be 'outsiders'. Indeed, primary questions in the first interviews allowed for the brief sharing of cultural understanding through discussion of our backgrounds and work experiences. Subsequent questions focused on key themes relating to the research subject. Follow-up questions enabled the flexibility to explore any new or interesting avenues arising from the participants narratives.

Whilst communication was predominantly verbal, emotional expression was also gained from the tone applied to what was being said and also, what was not said by participants. This was crucial in the absence of ability to observe body language as would have been the case with face-to-face interviewing. Silent pauses within participants' narration were held and respected. In this way, it allowed for the 'silent pain' and depth of emotional thought to be sensitively responded to, and thus arguably, added depth to the 'subjective insights [of] life' during the pandemic (Bennett et al, 2020, p.3).

All interviews were audio-recorded which allowed me to concentrate on rapport-building and the nuances of the interview rather than being distracted by taking notes. Recordings were uploaded to a password protected safe space, to which only I had access. Each participant was assigned a pseudonym only known to me, and this was the only way in which their interviews were identifiable. Use of a commercial transcription service or research software such as NVivo was considered. Whilst the time saving would have been advantageous, to further ensure confidentiality and security of data, much of which was sensitive and frequently had the potential to be distressing (Kiyimba and O'Reilly, 2015), I undertook all verbatim transcribing personally, capturing any particular tone of voice, shared moments of laughter, expressed emotions, or pauses. Once completed, transcriptions were re-checked against the voice recording to ensure accuracy of the data. In terms of using NVivo, the personal and time costs of learning how to use this system greatly outweighed the time constraints of this doctoral study, and therefore, this option was also discounted in favour of using traditional, manual means.

4.5 Research design – trustworthiness in a qualitative methodology

Given the subjective nature of the empirical data and knowledge generated from qualitative methodologies, crucially requires the establishment of trustworthiness in the findings as credible, transferable, dependable, and confirmable to ensure high quality research (Lincoln and Guba, 1985). Each of these elements will be discussed next.

4.5.1 Credibility and trustworthiness in the research

Critics often pounce upon qualitative inquiry, contending its ungeneralisable empirical data and making notions towards its 'truths' being questionable and insignificant (Denzin and Lincoln, 2000). Certainly, trustworthiness as applied to this methodology refers to 'the confidence that can be placed in the truth of the research findings' (Korstjens and Moser, 2018, p.121), and credibility inferred as 'how congruent…the findings [are] with reality' (Stahl and King, 2020). Nevertheless, these elements are open to subjectivity and judgement, and unsurprisingly, have been hotly contested by those more favourable toward structured and replicable data provided by quantitative methodology. This was particularly evident when reviewing the literature, where, at the macro- and meso-level, organisational and national policy makers tend to have an impervious preference towards quantitative statistics; measurable interconnected data that is viewed as 'scientific' and credible (Sallee and Flood, 2012). Debating this point, however, Phillips (1997, p.183) argued that qualitative approaches are a well-established means of 'scientific inquiry', with more contemporary researchers demonstrating the credibility and relevance of qualitative methods in advancing our knowledge and providing detailed insight into human behaviours in contexts such as terrorism, crisis response, and collective action for justice such as that in respect of the Grenfell Tower fire (Tekin and Drury, 2023; Strindberg, 2020; Witt and Lill, 2018; Bux and Coyne, 2009). Indeed, I argue for the unique positioning of qualitative research in providing data that is closely situated with human experience and is congruent to participants realities. I further argue that epistemological subjectivity is in fact, the essence of such holistic investigation and allows for individual and group tacit experiences to be deeply and contextually understood. It is these in-depth insights and understanding of human behaviour and complex social dynamics that are highly relevant to policy and practice by providing rich understanding of how and why particular behaviours develop and how they may be improved or enhanced.

Within this study, credibility is inferred in a number of ways. Data triangulation through the research methods of interviewing and a reflexive account, as a means to 'repeatedly establish identifiable patterns' (Stahl and King, 2020, p. 26), was planned to be used, albeit a written reflexive diary was stalled shortly after the first interviews for researcher welfare reasons (as will be discussed in section 4.6.3). Cognitive reflexivity was undertaken, where possible, and at regular points throughout the research journey instead. The exploratory nature of this study has generated immensely rich, thick description from up to thirty participants, from which there were close similarities in the nature of their narrative experiences as evidenced by the inclusion of multiple quotes in the empirical chapters. Indeed, this arguably builds upon existing knowledge and theory of a situational context unusual in England. Nevertheless, whilst member-checking was undertaken with participants during the interviews, it is accepted that due to time constraints, subsequent post-interview checking of data interpretations with participants was not undertaken. Employing this process may have enhanced clarity and verification of the results. To not include member checking at the data analysis stage leaves the findings open to subjective bias (Polit and

Beck, 2014) with potential for misassumptions based upon the researcher's own interpretations and worldviews (Denzin, 1983).

Despite these challenges, credibility may be cited from institutional checking in the form of academic supervision which served to ensure the relevant permissions, ethical procedures, and development of the research process were critically overseen. This process enabled me to stay true to the philosophical underpinnings of this study and shaped the analytical process and my interpretations with academic insight, in light of ethical considerations. Therefore, I argue that this can only add to the trustworthiness of the researcher in the research process. This is further bolstered by the longitudinal nature of this study, whereby I was immersed in the social experiences of the interviewees over a prolonged period of time and was able to build trust and rapport with them. This, I believe, coupled with cognitive reflexive self-analysis as to my influencing of the data, allowed me to become deeply familiar with their accounts and greatly assisted in the development of themes.

4.5.2 Transferability

It was Mason (2008, p.49) who challenged the preconception that qualitative data findings are non-transferable, by arguing that 'the complexity of empirical research does not neatly fit into tightly packaged generalisations which edit, abstract, and reduce real lives to sanitised measurement of experience. This process obscures the vitality of living and lived lives'. This is in contrast to Lincoln and Guba (1985) who claimed that the design of qualitative research means that it cannot be replicable. Williams (2000) on the other hand, asserted that in fact, a level of transferability is possible from studies undertaken from an interpretivist paradigm – perhaps not in terms of axiomatic determinants or in a statistical sense, but rather, '*in moderatum'* (p.221) given the inductive and ontological limits of the research.

Certainly, within the current study, the rich, thick description of participants' narratives (and my subsequent interpretations) provide meaningful understanding of their social experiences within the context of the pandemic. Thus, it is noted that some transferability of the findings to other contexts and populations may be possible (Stahl and King, 2020), particularly where there are similarities in working culture and experiencing of the pandemic. Potential similar populations include other emergency services workers and possibly nurses. Nevertheless, this potential transferability is not a substantive claim formulated from the research findings, especially given the number of variables that may influence the results, including the relatively small population sample size when compared to overall population numbers.

4.5.3 Dependability and confirmability

Institutional checking with my supervisory team allowed for academic debriefing, whereby my supervisors were able to read the drafts of my research analyses and findings and provide critical feedback. It is this trusting process that adds confirmability in the results and also adds a level of credibility. Arguably, dependability was also enhanced by my held anticipation that when complete, this doctoral thesis will likely be reviewed by the participants, peers, and others in the ambulance community. My knowledge of this encouraged me to ensure that the research findings are as robustly and as accurately reported as possible (Stahl and King, 2020). Researcher bias and assumptions are again relevant here, and this will be discussed in section 4.6.3.

4.6 Ethical considerations

Credible, contemporary research holds at its core the ethical positioning of the researcher – participant relationship including power dynamics, fundamental principles giving protection from harm, and promoting deontological or consequentialist focus in terms of participants' rights.

Taking a social constructionist approach within this research study, it is noted that, despite regulatory attention that has given rise to procedural ethics to encompass elements such as informed consent, beneficence, and non-maleficence, consideration must also be given to ethics that are formed from the researcher's epistemological positioning over the course of the study. Arguably, this holistic approach allows for consideration of variables including societal positioning and influence of group memberships and relationships.

4.6.1 Cultural ethical considerations

Social constructionists argue that researchers are inextricably immersed in shared social cultures and belief systems, thus informing their ontological and epistemological worldviews and thus, are unable to objectify (or bracket) themselves from this (Lahman and D'Amato, 2007). Subsequently, these dynamics and prior experiences of the researcher frames all aspects of the research process. A particular consideration in respect of the current research is that of my positioning as an 'insider-researcher' (Wilson et al, 2022).

It is both a strength and a limitation of this study, that I, as an experienced paramedic, am an 'insider' and therefore share an identity, social situatedness, and context with the participants; that of ambulance practitioners working for the NHS ambulance service during the Covid-19 pandemic. Insider research defines those researchers who have *a priori* knowledge (Merton, 1972) on an intimate or familiar basis of the group, organisation, or culture that they are studying (Tremblay et al, 2021; Greene, 2014). Such

positioning is in contrast to that of 'outsider'; an individual who has no previous experience or exposure to the group being researched. Whilst this insider-outsider researcher dichotomy is evident in methodological literature, some suggest that the concept may be viewed on a continuum, particularly as 'at times, the boundaries between insider/outsider status can be blurred' (Greene, 2014, p. 3).

Although only briefly discussed here, this argument highlights the importance of considering, through the process of reflexivity, one's own (as researcher/ paramedic) positionality and world views including one's own ontological and epistemological assumptions, values, and beliefs, given the influence (and potential biases) of these perspectives upon the ethical, methodological, and analytical stages of a study (Holmes, 2020; Greene, 2014). Indeed, it is argued that positionality is fundamental to understanding the contributing influences of the researcher to the phenomena under study and the research process.

Certainly, a predominantly 'insider' perspective of being immersed within the research setting may offer a unique perspective, gathered from specialist, informed subjective knowledge, deep understandings and more natural social interactions shared within close working communities. Insider researchers arguably have enhanced comprehension of some of the complexities that may present. Advantageously, their positionality allows their pre-existing knowledge of processes and cultural structures, as well as current and historical issues to formulate this understanding (Chavez, 2008). Being a social member of the community or culture being studied, an insider researcher is likely to be well-placed to explore deeply ingrained social psychological and emotional nuances and hidden aspects of organisations, that would potentially not be accessible to an external researcher (Greene, 2014). In this way, such research may 'project a more truthful, authentic understanding of the culture under study' (Merriam et al, 2001, p.411). Indeed, this positioning takes account of the researcher's place within social processes, from which we probably cannot truly objectify ourselves from (Hammersley and Atkinson, 1995).

It is, however, acknowledged that subjective influences associated with insider research may negatively bias data collection and analysis and pose ethical challenges. This is particularly the case whereby researchers are deeply (and perhaps, over-) familiar with the context and population of study, and which may lead to pre-held assumptions and beliefs that fail to allow the researcher to widen their understanding to new or perhaps, contrasting perspectives. Furthermore, the research may reveal challenges to practices within the organisation or community being studied, which, depending upon the researcher's role as an employee or member of that community, may raise ethical and professional issues which may potentially bias questions asked and data findings, thereby influencing the reported outcomes. This particularly may be the case if revelations reflect badly on those whom the researcher is connected with, or where they feel pressured to present a particular view on political bases. Additional biases may be inferred within the research process in terms of projecting one's own beliefs onto participants during data collection and analysis, for example.

Scholars pursuing a positivist philosophical tradition usually highlight the achievement of empirical objectivity through seemingly unbiased and prior unformed views (Simmel, 1950). Subsequently, subjective 'insider' research is frequently critiqued for its perceived lack of empirical rigour due to the closeness of the researcher to the participants (Brannick and Coghlan, 2007). Arguably, holding deep introspective, reflexive awareness of personal biases and identities, and the way they may influence all aspects of a research study is essential, as is taking mitigations to reduce their impact.

4.6.2 Relational ethical considerations

A central tenet to this study's methodological approach is the authentic relational connection between the researcher and the participants, contextualised with the wider paramedicine community in England. Indeed, Ellis (2007, p. 4) highlighted the importance of 'mutual respect, dignity, and connectedness between the researcher and researched, and between researchers and the communities they live and work in'. Further, this may be expanded to consider one's obligations towards those participating, their safety and wellbeing, and the interpersonal connection the researcher has with participants.

Ellis (2007) focused on the conflicting relational dichotomy between the roles of researcher and friend – an ethical challenge partly encountered within this study, as four participants were known to me as previous work colleagues. This dynamic, Ellis (2007) argued, 'may make loyalties, confidences, and awareness contexts more difficult for all to negotiate' (p.13). In response, researcher reflexivity allowed for personal scrutiny as to the ethical complexities that could arise. Furthermore, an open discussion was held between these participants and I, to explore these issues further. Fortunately, all were very receptive and were seemingly unperplexed by my positioning as a researcher. Indeed, their desire to share their contributions was unwavering. However, I was acutely aware that whilst their narratives may have been shared with greater depth due to the respectful professional friendship we had, contrastingly, their accounts may also have had elements of accustomed or non-disclosure, in an attempt to hide parts of self or social experiences that they wished to remain hidden from me, as their colleague or as the researcher – possibly to protect me from harm or distress or for another undisclosed reason. To do so, may have changed the relational dynamics thereafter, which may have been a concern for these participants, albeit this was not articulated by them. Throughout the research process, I reflexively wondered as to the emerging reality that they (and all participants) presented during their interviews, and how this reality was shaped within the context of our, researcher – participant relationship. At all times, however, their autonomy was respected (National Commission for the Protection of Human subjects of Biomedical & Behavioural Research, 1979).

Participant wellbeing and psychological safety was paramount to this study given its potentially sensitive and intrusive nature. Appropriate consideration was given to minimise harm by being aware of the acute distress and heightened emotional vulnerability being perceived or felt by healthcare workers during the pandemic as was frequently reported within the news, social media, policies, and research studies – and an anecdotal finding from the researcher's own experience (Pilbeam et al, 2022). The researcher was sensitive in acknowledging the interviews as potentially emotionally triggering for participants as they were likely to relive and share experiences that may have been personally and professionally challenging (Mitchell & Irvine, 2008). Indeed, the pandemic brought additional complexities in terms of the blurring of professional and personal boundaries – as the impact was not only felt in one's work but also within one's private world; two contexts which were inextricably entwined and featured heavily within participants' narrative experiences.

As the interviews commenced, it quickly became apparent that the pandemic restrictions were impacting the usual coping strategies of individuals including use of social support. In line with Pilbeam et al's (2022) assertions, rather than being a triggering experience as anticipated, rather, the interviews felt like they became a safe, cathartic, healing, and protected space whereby participants sought to use the time to reflect on, process, and make sense of the trauma being felt, and they seemingly valued the researcher listening and understanding their lived experiences (Pilbeam et al, 2022; Hutchinson et al, 1994). Indeed, Alexander et al's (2018) systematic review of vulnerable participants involved in the research of sensitive issues identified that many participants actually report positive benefits such as altruism and feeling socially re-connected rather than experiencing the harm associated with re-traumatisation and distress. Furthermore, the earlier works of Pennebaker and Seagal (1999) highlighted the critical therapeutic role of narrative construction in terms of enabling emotional expression and sense-making, in reducing intrusive traumatic and ruminative thoughts.

It was useful to consult with my primary supervisor who has expertise in undertaking research with emergency services and other vulnerable populations. We talked through practical fieldwork concerns in respect of participants' wellbeing in the midst of a pandemic, and brought together a discussion incorporating our professional, academic, and my clinical and therapeutic knowledge. This open reflection allowed me to feel more confident in my abilities and scope as a researcher, and that a sensitive, ethical approach to interviewing was being undertaken within this study.

To conduct interviews appropriately and with sensitivity, care to the participants extended from the moment they expressed an interest in the study, by providing them with relevant information about the research, potential risks, and benefits, and where support may be sought, through to the end of the study, and during the write up phase (Rahman et al, 2021). Whilst all those who participated in the first phase of interviews were invited to partake in the second phase, this was respectfully not insisted upon if no

response was received. Similarly, this was the case for those engaging with the second phase of interviews, and who were invited to attend the final phase. For each interview, the researcher paid particular attention to the ending, providing time for participants to process what they had shared, and debrief (Pilbeam et al, 2022). This was undertaken in a more conversational way and allowed participants space to safely gain closure – prior to returning to the business of their lives, some of whom had to continue working.

Importantly, Mitchell and Irvine (2008) examined the expression and containing of emotions within interviews and highlighted the work of Dickson-Swift et al (2006) who drew similarities between therapeutic contexts and qualitative interviewing in terms of active listening, expressed empathy, and providing a space for talking about issues at depth; features which resonate with the current research study. Critically, however, Mitchell and Irvine (2008, p.35) argued that 'a therapist listens with the aim of helping participants, whereas a researcher may listen attentively but ultimately takes the information away, offering little in the way of feedback...'. Whilst pseudo-therapy would be highly unethical particularly in this context, this statement was pivotal for self-reflexive examination in light of my background as a counsellor. It is, indeed, arguably advantageous that one's therapeutic training allows for the safe holding of deeply emotional responses and the provision of ethically appropriate support without becoming burdened, however, it also allowed me to recognise and reaffirm the limits of therapeutic intervention within the context of this research process and the need to establish clear boundaries within which to hold the psychological safety of participants and that of my own (British Association for Counselling & Psychotherapy, 2019). With this in mind, procedures were planned for formally managing participants should they feel distressed during or after the interviews. This included providing individuals with a list of support services available to both ambulance personnel and the public.

The wellbeing of the researcher was equally as important as that of the participants (Velardo & Elliott, 2018), especially given the personal and professional experiences being lived as the pandemic took hold within England and the world. At times, the research process was challenging – particularly with so many unknowns about the virus and the illness, and the impact that it was having upon our lives and our communities. Many participants shared harrowing narratives of exposure to death and those who were seriously ill. They shared their anxieties, distress, and fears around mortality and grief at multiple losses, which resonated with my own feelings and vulnerability. The intensity and depth of the feelings shared meant that vicarious trauma, moral distress, and emotional burnout was a real but considered risk for the researcher, not only during the interview stage but also within the transcription and analysis process (Kiyimba & O'Reilly, 2015). Fortunately, my academic supervisors offered regular virtual tutorials which allowed space for me to offload any particular concerns (with respect for participants' confidentiality) and to reflect upon and explore my analytical interpretations and responses to the fieldwork.

4.6.3 Reflexive ethical considerations

Synonymous with a qualitative methodological research process is the social construct of reflexivity. This is the ongoing, ubiquitous process throughout the lifecycle of the study by which researchers conduct, acknowledge, and make transparent their own deep self-inquiry (Bukamal, 2022). Researchers critique and seek to understand how their paradigmatic and philosophical positioning, pre-conceptions such as assumptions and judgements, and cultural inter-subjective experiences influence their positionality in the research (Holmes, 2020). In this way, beliefs, experiences, identity, and behaviours that may influence and bias the research are brought to the fore (Wilson et al, 2022; Willig, 2013).

Engaging in personal self-reflection of my own subjectivities and biases and how this impacted the research process was primarily documented in the form of a researcher journal from the start of this study. However, shortly after the first phase of interviews, personal circumstances and the demands of the pandemic meant that this was no longer possible for me to do. Reflexivity continued; however, it was undertaken solely as a cognitive rather than an iterative process. Thus, whilst there is no distinct written account, reflexivity in its tangible form has been considered throughout the research process and thesis, particularly within the review of methods and ethical considerations.

The process of reflexivity allowed me to explore the interplay between my social identities of paramedic, counsellor, researcher, and as a member of my local community, who too, was experiencing and impacted by the Covid-19 pandemic. Having a space to critically explore the complexities of these lived experiences, my own thoughts, fears, beliefs, contextualised with that of the research process, gave opportunity for depth of insight into how my personal responses to the social world interacted with the research topic. In addition, reflexivity also provided opportunity to explore socio-relational interactions and power dynamics between the participants and I (Wilson et al, 2022), and for consideration of any subliminal processes occurring through transference and/or countertransference. Arguably, this is critical for comprehending one's influence on the way knowledge was produced and interpreted.

Whilst it is considered appropriate and relevant within the context of immersive social research to inform the participants of the researcher's positionality as an insider-researcher as a paramedic, this disclosure, whilst promoting transparency and trustworthiness (Holmes, 2020), raised ethical quandaries. It raised personal scholarly curiosity as to the potential blurring of professional and academic boundaries and the impact this may have implicitly had on the participants in terms of sharing their narratives. Whilst the pros and cons regarding researcher disclosure have been discussed within the literature, my holding deep prior knowledge of shared professional culture determined that revealing my identity would serve as an important connection and facilitate rapport, trust, and likely acceptance by participants (Wilson et al, 2022). Arguably, this mutual understanding of the work, its processes and challenges, undoubtedly led to

enriched thick description offered by participants which was articulated through a shared language that was intuitive for us both.

Reflexion brought into consciousness how my understanding and knowledge of the phenomenon under study was being continually constructed and reconstructed in alignment with the evolution of the contagion. As events continued to unfold, having this sensitive awareness allowed me to also adapt as a researcher, to be ethically and morally responsive to the participants' and my own safety, wellbeing, dignity, and privacy. As discussed previously, this included reviewing the potential psychological risks versus benefits in conducting further interviews in light of the worsening levels of critical illness and deaths that paramedics were encountering, and the impact that potentially relaying these experiences may have had on them (and me) psychologically.

4.6.4 Procedural ethical considerations

In terms of ethics governance and good practice (UK Research Integrity Office, 2021), this study was approved following an application to the Health Research Authority (HRA) (IRAS ID - 282650) and the faculty research ethics committee at the University of York.

4.6.5 Data protection and confidentiality

Protecting participants and their personal information is regarded as critical to good ethical practice when conducting research and forms an essential criterion of legal and institutional ethical regulation (Vanclay et al, 2013). Nevertheless, this does raise controversial questions around whether this restricts the autonomy of participants in their right to determine their own anonymity or disclosure, and so, requires the researcher to weigh up how to respectfully negotiate this balance with maintaining data quality and integrity (Miller, 2015).

Within this study, upholding ethical standards in relation to confidentiality, anonymity, and data protection was an essential component of ethical approval to conduct the research. Therefore, specific measures were taken to ensure that regulatory best practice was met, and ethical principles upheld.

Pseudonyms, whilst not guaranteeing anonymity, are assumed to provide participants with a level of protection from being identified, and subsequently, those who are vulnerable, from being marginalised, stigmatised, or embarrassed (Vanclay et al, 2013). Furthermore, withholding the study respondents' personal details arguably enables a greater sense of empowered freedom to authentically share true experiences and feelings, that may otherwise be inhibited for fear of reprimand or retaliation.

Certainly, within this study there was an element of *a priori* assumption on my part. My understanding was that anonymising participants was linked with good ethical research practice and that respondents would likely prefer anonymity in pursuit of their own psychological wellbeing, given their close-knit work setting and the sensitive nature of the interview topics. As such, I decided that on this basis, all respondents would be anonymised, and their personal data concealed (which meant that any potentially identifiable information given by participants within their interview, was excluded). A pseudonym was respectfully, with cultural and gender sensitivity, allocated to each person by the researcher. Upon reflection, however, it is now recognised that use of pseudonyms may not always be ethical (Brear, 2018) particularly for someone who is transgender or gender non-conforming where a name may have special significance (Lahman, 2023). To counter this scenario, the inclusion of research participants in the naming process and providing choice in use of their everyday name or a pseudonym, is appropriate (Lahman, 2023; Vincent, 2018).

Contextual details relevant to the study, such as job role, were retained. Any identifiable place name used by participants (for example, the location of their workplace or name of ambulance service) were replaced with a non-descript alternative, thereby further anonymising and protecting the participant or their employer from being identified. In protecting participants' information further, UK data protection law (General Data Protection Regulation) was adhered to in respect of the safe storage (anonymised and password protected), restricted accessibility to the researcher only (and the participant should they have requested it), and destruction of participants' raw data (Information Commissioners Office, 2024).

No patient data or involvement was required for this study. However, in circumstances where patient description was given within participants' interviews, common sense, and professionalism of the researcher as a registered healthcare professional, determined whether the information was vague enough to be retained, or if it posed a risk of identification for the patient or the participant, in which case it was excluded from transcription and analysis. Should a participant registrant have disclosed any areas of practice that contravened the HCPC (2018) Standards of Conduct, Performance, and Ethics, the researcher would have been required to raise this formally with the regulator.

4.6.6 Informed consent

Prior to starting the interview process, all participants were provided with detailed information about the study, its benefits, potential risks of harm, and its intentions via a 'participant information sheet' (Appendix B), and follow-up details given should an individual wish to ask questions or know more details. Providing such information to respondents is viewed as central to the ethical process of gaining consent for participation in research studies (Crow et al, 2006). Once this information had been supplied, respondents were asked for their expressed written consent and agreement to the terms of the research

via a 'consent form' (Appendix C). This included details that participation was entirely voluntary with no monetary or gift enticement offered (National Commission for the Protection of Human subjects of Biomedical & Behavioural Research, 1979). Furthermore, before each interview was recorded, participants were given opportunity to ask any questions and verbal consent was sought. It was articulated both verbally and in writing to all, the right to withdraw from the study at any time, and details regarding the management of their data (Mitchell & Irvine, 2008). Fortunately, none of the respondents declined to participate in the first interview. However, by the second and third interviews, a small number of participants expressed their declination by not responding to the invitation email to take part in the next interview. Their decision was respected.

4.7 Data analysis

In keeping with a social constructionist paradigm, thematic analysis was undertaken from a theoretical perspective informed by social identity and self-categorisation theories, with a latent approach to examining the data. Through thematic analysis, interpretation of the data lends itself to theorised meanings of the findings (Braun and Clarke, 2006), such that in this study, it allowed for the uncovering of the underlying assumptions, beliefs, values, and inert social processes that are usually highly implicit and deeply embedded within social interactions yet hold the potential for considerable influence at the surface in terms of manipulating or effecting people's emotional and behavioural responses.

Aligning with the seminal works of Braun and Clarke (2006) who developed a six-stage framework for undertaking reflexive thematic analysis, the initial phase of familiarising myself with the data commenced with the collation of evidence through undertaking interviewing of participants myself. This provided me with fundamental knowledge of the data which sparked some early reflections around potential analytical outcomes. Nevertheless, it was verbatim transcription of all interviews which allowed for deep immersion into the data through paying close attention to what was being articulated – both verbally and non-verbally, and how it was being communicated. Subsequently, repeated reading of the data, thereafter, intensified my familiarity with its content and enabled me to seek out early interpretations, meanings, and patterns across the data set. Initial coding of the data was also undertaken manually to retain closeness to the research (Guest et al, 2012). Taking a systematic approach to all aspects of the data started to reveal repeating patterns and interesting points relevant to the research questions (Clarke and Braun, 2016). This coded data was captured within written notes and where there were similar codes, they were grouped together. Comparing these codes and the relationships between them started to formulate potential meanings about the data and which codes were representative of key empirical points of interest in relation to the theories of social identity and self-categorisation.

With the data set coded, the next phase of the analysis comprised the reviewing of codes and groups of codes for potential themes. This involved creating in note form, a thematic map to allow for visual representation and cognitive analysis of the relationships between different codes, thereby building a 'picture' of inter-relational patterns and meanings, further refining groups of codes into themes and sub-themes. This complex, rigorous process required repeatedly moving backwards and forwards amongst the codes and the whole data set, removing any themes that had little supporting evidence or splitting any themes that were derived from an overwhelming source of data. Following this process, refining of the themes was completed. Analysis of the data supporting each theme captured their essence, rich meanings, and complex relationship to the research questions and were anchored in the social identity approach.

4.8 Chapter summary

This chapter has provided justification and contextual understanding of the qualitative methodological design utilised within this study. The philosophical underpinnings of social constructionism and relativism have been critically discussed in terms of how they informed my choice of method and how they relate to the aims and purpose of this study. Rationale was given for employing focused ethnography and telephone interviewing as the primary method of data collection, with detail provided as to how the Covid-19 pandemic significantly affected this process. Subsequently, I have discussed how the study was adjusted in the light of these unforeseen problems. Finally, ethical issues have been considered at depth and clear detail provided as to the data analysis process.

The next three chapters present the empirical evidence and interpretations from data gathered from each of the phases of interviewing. Chapter five considers data from the first phase of interviews. Chapter six provides analysis of the evidence from the second phase of interviews, and finally, chapter seven explores the evidence collated in the third phase of data collection.

Chapter 5 – Navigating a Novel Contagion: Empirical Research Findings Phase One

5.1 Introduction

In this, and subsequent chapters, I present the qualitative findings from the three phases of my longitudinal research study, based upon the methodology and method of analysis outlined previously. Empirical evidence from the first phase of interviews is presented initially (Chapter Five), followed by data from those who contributed to phases two (Chapter Six) and three of the study (Chapter Seven). Appreciation of the context of the study is important given the evolving nature of the pandemic, thus each chapter will open with a brief overview of relevant, leading events occurring at the time of each phase of the interviews.

Aligned to the ontological and epistemological frameworks underpinning this research, the empirical chapters provide detailed evidence in the form of quotations from participants. These encapsulate interviewees' narrative lived experiences, from which the key themes were iteratively conceptualised. Subsequently, this chapter contains sub-sections within which these themes are explored; examining not only the details of the phenomena, but also relevant discourse, and how each theme is socially positioned, constructed, and shaped within specific accounts. Many aspects of these themes are interwoven, and the proceeding chapter, Chapter Eight, will situate these findings and their associated constructs within a discussion of the broader literature.

5.2 Situational context: March – May 2020

Thirty interviewees from across England participated in the first phase of interviews which were undertaken between 25th April 2020 and 27th May 2020. To give situational context, a timeline of events is provided (see Illustration 1, overleaf). As noted, the interviews commenced at a time whereby England had entered its first national lockdown, having been declared by the UK Government a few weeks previously. The restrictions meant that all non-essential businesses were closed. The public were legally required to 'stay at home' to 'protect the NHS' and 'save lives' and were only permitted to be outside for essential means such as grocery shopping or seeking medical assistance. At that time, individuals were not even warranted to leave home to undertake outdoor fitness activities (UK Parliament, 2021). By mid-May 2020 however, the government had started to loosen these restrictions.

Covid-19 statistics for 25th April 2020 indicated that 20,319 people had lost their lives with coronavirus-19 recorded as the underlying cause of death. Furthermore, 16,411 individuals were hospitalised at that

time across the UK (Home Office, 2020). Just five days later, more than 33,000 had died due to Covid-19 within England and Wales alone. The peak of the contagion was registered as 8th April 2020, whereby 1267 people lost their lives within a single day (Office for National Statistics, 2020a).

The number of hospital beds available nationwide during this surge was drastically short, despite utilising resources from across departments and postponing planned operations and treatments (British Medical Association, 2022). In particular, intensive care facilities, notably accessibility to ventilators, were, at times, limited (McCabe et al, 2020). Furthermore, news reports identified shortages of personal protective equipment (PPE) across the health and social care sector (Independent, 2020a; The Times, 2020; Unison, 2020); necessary for protecting staff from the contagion. A subsequent paper by the National Audit Office (2020) confirmed woefully inadequate supplies. Despite this, a letter to NHS staff noted that 'every coronavirus patient needing hospital care including ventilation, has been able to receive it' (Stevens and Pritchard, 2020).

Specifically, within the ambulance sector, whilst emergency calls were reportedly 5% above average in March 2020, they had reduced by 4% by May 2020. However, ambulance admissions to hospital over these three months dropped by 29% - reportedly a reduction of more than 4000 patients who were not transported to hospital per day: indicating considerable change of practice among ambulance clinicians within a very short time period (The Health Foundation, 2020a). Indeed, a greater number of people received 'see and treat' and 'hear and treat' care which included referral to community health and social care services.

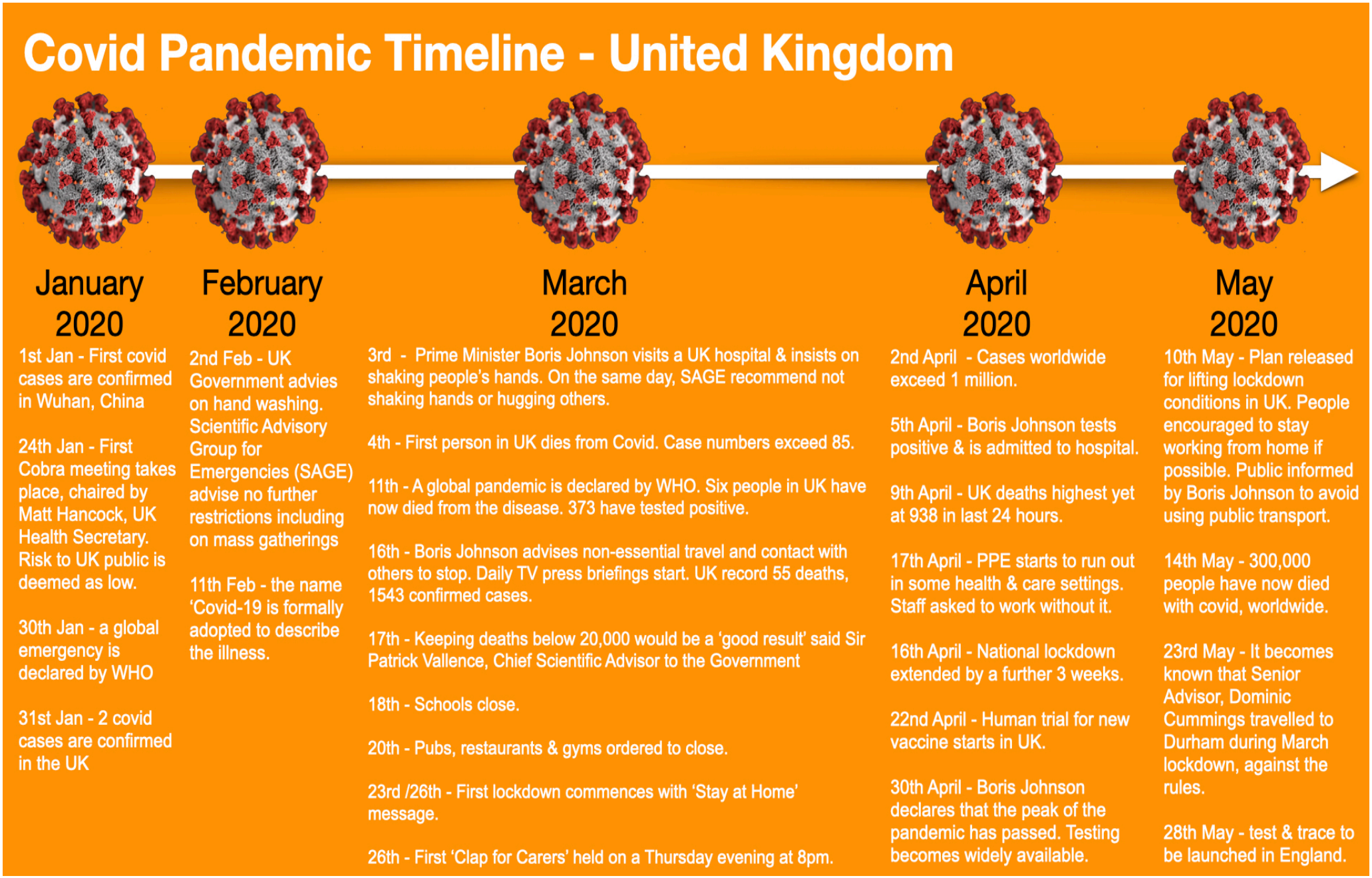
In preparation for demand in excess of that manageable via traditional means of business continuity plans and mutual aid, partnership agreements with fire services across the country saw firefighters trained to drive ambulance vehicles (London Fire Brigade, 2020; National Fire Chiefs Council, 2020). This was further extended to include military personnel in assisting some NHS ambulance trusts (ITV News, 2020) as well as calls for retired staff to re-join, and student paramedics assisting the frontline and in call centres.

Working on the frontline was not without risk. Indeed, across all occupations, ambulance staff and paramedics were rated as having one of the greatest risks of exposure to the disease (Office for National Statistics, 2020b). Sadly, by 22nd April 2020, five ambulance staff within the UK had lost their lives as a result of contracting coronavirus (Cook et al, 2020) and this number further increased during the study period.

April and May 2020, when my participants were first interviewed, was a time of considerable uncertainty, with surging case numbers and deaths, and much fear about how the disease would advance and its

impact at a personal, community, and national level. What follows are the themes that were conceptualised from their narratives; their experiences of working on the frontline during this time.

Illustration 1: Covid Pandemic Timeline – United Kingdom – January to May 2020:



5.3 Phase one data findings

As discussed in the previous chapter, data collated during the semi-structured interviews were analysed following a period of familiarisation with the content, and thematic coding. Taking a constructionist approach allowed for examination of how participants' realities and experiences were resultant of societal discourses and sociocultural contexts pertaining to the new phenomena of the pandemic. Identification of important elements and patterns of meaning arising from the data in relation to the research questions led to the development of key themes and associated subthemes.

The four key themes are:

1. The 'Emerging Beast' – the social representation and contextualisation of Covid-19 as a threat.
    a. The social representation of Covid-19 as a threat.
    b. Fear and uncertainty.
    c. Risks to intragroup and intergroup identities, relations, and processes.
    d. Individual and collective behavioural responses to the emerging threat.

2. Responding to the threat: Prosocial behaviour (belongingness, solidarity, & protecting identities, hero narrative) versus stigma (out-group boundaries)
    a. 'You lot are a bunch of plague spreaders' – stigma, discrimination, and antisocial behaviour.
    b. Community prosociality.
    c. In-group solidarity.

3. Moral and traumatic distress: The social, psychological, and behavioural impact.
    a. The present & the future.
    b. Complexities of Covid-19 social & psychological trauma – disruptions to core beliefs, disconnection, & disempowerment.
    c. Psycho-emotional responses to pandemic adversity.
    d. Social connectedness.

4. Organisational socio-cultural group processes.
    a. Transitioning and embodying symbolic cultural change within everyday practices.
    b. Organisational socio-cultural construction of knowledge about the pandemic.
    c. Group processes, social relations, & leadership.

Each of these themes will now be examined in light of supporting empirical evidence gathered during this study.

5.4 The 'Emerging Beast' – The social representation and contextualisation of Covid-19 as a threat

This theme may be understood as a collective of sub-themes; the social representation of covid as a threat; fear and uncertainty; risks to intragroup and intergroup identities, relations, and processes; and individual and collective behavioural responses to the threat.

5.4.1 The social representation of Covid-19 as a threat

The participants' narratives provide insight into how they, as individuals, and as group and societal members, were beginning to make sense of and develop (construct) collective social knowledge of this emerging and unfamiliar infectious disease and the threat that it posed. Importantly, their accounts highlight attempts to make familiar yet simultaneously objectify the contagion by referring to established symbolic metaphors and belief systems, which appear to be attempts to integrate this new, abstract, and confusing phenomenon into existing concrete world views. For example, throughout her narrative, paramedic Vicky consistently referred to Covid-19 as the '*emerging beast*' conjuring up the virus as a dangerous, looming ogre. Others made militaristic references such as '*going to war with an invisible man*' (Paul) and the '*invisible enemy…invading us*' (researcher's reflexive account, p.1), thus depicting the contagion not only as a phenomenon to put up defences to and fight, but also as an unknown enemy; one for which we had limited knowledge and understanding. Similarly, natural hazards which have the potential to pose significant threat to human life and infrastructure, were also mentioned. This included depicting the pandemic situation as '*the calm before the storm*' (Ollie).

In this way, engendering such a threat by comparing it to already known social frameworks, or social representations, arguably, not only attempted to bring a sense of meaningful understanding to a considerably uncertain and chaotic time, but also served as an attempt to reduce heightened psycho-emotional responses associated with an intense threat. However, it remained that the virus was an external danger that, at that time, was in the process of being defined, and there was considerable unknown about its epidemiology, spread, transmission, and how immunity may be generated.

5.4.2 Fear and uncertainty

Central to, and salient within all of the participants' narratives was a strong thread of personal and collective fear about the contagious nature and questionable risks associated with the disease, uncertainty about what the future held, and the potential implications for themselves, their family, their work, and their communities. In this way, fear could be regarded as a 'cultural artefact' (Tartaglia, 2022).

Dan stated, '*…in the back of your mind, I'm thinking 'am I gonna get it?' 'Am I waiting for it?'. It's a time bomb. That's the psychological effect of it because you don't know when you're gonna get it…'* [p.9].

Ava said, *'…it's quite scary going to work every day and not knowing if you're going to get Covid or not, and not knowing if you're going to be really unwell with it…'* [p.1].

Both Dan and Ava expressed how sitting with such uncertainty about the viral threat triggered latent and primitive insecurities around mortality, loss, and potential physical insult from this emergent disease. Indeed, replicated throughout all of the participants' narratives, was considerable fear at their exposed vulnerability, and internal anxiety around the unfamiliar and the challenges that the contagion posed to their social beliefs and understandings about the world. Whilst this was generally verbalised as an individual experience, the narrations particularly highlighted collective fear, which was prevalent within the participants' social groups.

It is entirely feasible that these fear-related representations about the nature of the threat were correlative with media communications broadcast at that time. Continuous news streams often depicted distressing footage of the impact of the contagion in other countries, for example, and is an important consideration for how our collective realities about the pandemic were socially constructed and understood, particularly in terms of an evolving dialogical ontological process within a societal context.

5.4.3 Risks to intragroup and intergroup identities, relations, and processes

Significant to this sub-theme, many participants implicitly and seemingly unconsciously articulated latent feelings of vulnerability and helplessness in response to their perceptions of the risks associated with contracting the virus. What was critical here was that their narratives revealed how deeply challenging these feelings were to their social identities as ambulance personnel. Indeed, it was notable from the empirical data how their pre-existing (and pre-pandemic) identities were inextricably bound by collectively held beliefs associated with emotional and psychological strength and stoicism, and how this new, emergent phenomenon was simply turning these held beliefs and shared views of self and each other, on their heads. The result of which was internal conflict and distress, and existential questioning around 'who am I now?' – the trauma aspect of which will be examined in a later theme.

Synonymous with the above finding was that some participants, particularly those with greater links to work-life transitions – those recently starting work within the ambulance sector and those nearing retirement, revealed how they were processing and accommodating the perceived risks associated with the threat in terms of self-relevance as per distinct social categorisations. This was most notable in the earliest interviews conducted. As seen in the quotes overleaf, participants who categorised themselves as

'young and healthy' tended to perceive the risk of morbidity as low - thus, forming held beliefs that 'I'll probably be okay'. On the other hand, participants who categorised themselves as older and who were aware of epidemiological data indicating a greater risk of serious illness and death from the disease, held views such as ambulance technician Dan, below, assimilating the belief that 'the chances are likely stacked against me'.

'You know, I'm 55 and they say that if you end up on a ventilator, your chances are less than a hundred, so you do think the worst case scenario and you think 'ooh crikey' but you can only protect yourself as much as you possibly can and at the end of the day, you do the job that you like to do and you just get on with it, and hope for the best, fingers crossed, keep sane, keep safe and just hope for the best…' [Dan, p.9]

Within these narratives, we see developing social constructions of associated risk and vulnerability in accordance with self-categorisations linked with age and state of health. However, interviews conducted later in phase one of the study identified that other participants seemingly categorised themselves differently, perhaps in respect of the increasing numbers of people, particularly healthcare workers, becoming seriously unwell and dying from the illness. From the below quote, paramedic Ffion utilises the categorisation of 'ambulance personnel' to shine a light on the existential threat of the disease and the profoundness at considering one's own risk of mortality:

'*As a whole, as a group on station,* ***people are a bit more open about how we're not all going to survive****. I don't know, paramedics on the whole, ambulance staff on the whole are pretty open, aren't they, and will talk about all sorts of things in the rest room but yeah, people are maybe a bit more honest about how they're feeling'* [Ffion, p.2].

Ava [p.3] added: '*It does worry me. I am worried about Covid. I am worried about getting it because I don't know… I mean, I'm fairly young, fit, and healthy, but I don't know how my body is going to react to it you know. People have died from it who have no past medical history and they're young, fit, and healthy. I took a patient in a little while back. He was young, fit, and healthy, had no past medical history and was very, very, very unwell with Covid and that that really hit home for me that one, because, you know, that was sort of, me really. He wasn't much older than me and that that could have been me, so yeah, and obviously where we are exposing ourselves to Covid on a daily basis, I mean, I am going to Covid positive patients probably four shifts out of my five, I would say, and that's confirmed Covid as well. We are on the frontline, and we are quite at risk really'.*

The above narrative is particularly interesting as Ava had initially positioned herself as at less risk of morbidity due to her young age. However, this was seemingly challenged as she experienced first-hand the devastating impact the virus can have on younger patients. Her narrative highlights a shift in constructed views towards a new perception of increasing risk and threat to herself and her colleagues, underlying which and transmitted through tone of voice, is unspoken fear and fright.

Whilst the virus was undoubtedly viewed as a primary external threat, the data highlighted how threats also featured/infiltrated within participants' in-groups in two particular ways: from group members, and the participant themselves as a contagious threat.

In the earliest days of the pandemic, guidance from government bodies did not stipulate the requirement for social distancing within NHS healthcare settings. However, this was quickly replaced by a number of infection control measures requiring adherence; the organisational aspect of which will be explored in a later theme. Importantly, in terms of the threat of contagion, interviewees shared how 'deviant' members of the professional groups that they identified with, refrained from complying with these rules, particularly around social distancing, and mask-wearing, for example.

John, a paramedic, describes a conversation he had with his first patient confirmed as having coronavirus infection and who also happened to be an ambulance colleague. John was ruminative in his narration of the apparent 'blasé' behaviours and attitudes of this colleague and others at work, in relation to the threat of the virus. He said:

'*I can't really get my head around it… he was just accepting that he was eventually going to get it… he didn't see the value of taking every precaution possible in trying to reduce the risk…'.* [John, p.1].

John found it challenging to process why his colleague had seemingly not adhered to the rules and not taken extra precautionary measures such as social distancing. This appeared to lead to an element of blame towards his colleague's overt risk-taking and subsequent contraction of the illness. Although unspoken within his account, it was notable that there were moments of reflexion for John, possibly for existential questioning of his shared identity, given these group members' new and undesirable norms and behaviours which challenged those held by himself.

Certainly, the self-serving social behaviour of deviant group members was spotlighted by a number of the participants, who also questioned their commitment and professionalism. Indeed, there was a great deal of anger articulated within these particular accounts, especially when participants deemed that deviant members' 'selfish' or anti-social behaviours were violating group norms and placing others at unnecessary and avoidable risk of catching the disease. Thus, these members became perceived by the participants as an intragroup threat and, in some cases, tensions ensued.

With frustration and annoyance in his tone of voice, Paul, a paramedic, commented:

'I do find it interesting that ambulance staff, no matter what station, as I say, I go to them all, make no attempt to distance from each other, and I've tried very hard to actually come away with an understanding of that but I kind of liken it to when a patient gets into an ambulance, they don't think they have to put a seatbelt on because they kind of feel safe, so within the ambulance service, we kind of feel safe within ourselves as well… falsely… It is very interesting' [Paul, p.4].

Critically, in his appraisal, Paul highlighted how ambulance staff appeared to draw upon previously utilised de-realism strategies to create an invisible and protective 'psychological shield' around them from, in this case, both physical and emotional threats. This mechanism arguably is also contextualised as providing an element of control over an uncertain and frightening situation.

Also, important to note, this intrapsychic strategy appeared to create a divisive psychological 'split' between the participant as 'in-group' and those who were external 'out-group'. Indeed, the interviewees' narratives highlighted subjective positioning of the contagion as associated with 'other' people rather than those in one's own social groups, and further leverages these categorisations with beliefs that the in-group will be less affected or less susceptible to illness in comparison to those in an out-group. Such mechanisms appear to be attempts to cope with the uncertainty, fear, and anxiety manifesting from the perceived threat. Furthermore, dissociating from and objectifying the viral insult in this way could be understood as intergroup denial.

Such denial, however, was seemingly called into question when awareness of one's own human vulnerability was exposed, and participants' interdependency as embodied social human beings was subsequently challenged. Indeed, for many, heightened anxiety developed at the traumatic realisation that they too, were a potential threat to others including in-group members. Participants awareness of their capacity to infect and kill was an intolerable and horrifying concept to these ambulance staff – particularly that they may do so through innocent physical connection such as holding another's hand or even talking or sneezing near to someone. Whilst the psycho-traumatic and practical aspects will be explored further in later themes, here, this concept is understood in terms of how this threat impacted participants' groups and challenged their social intimacy. Certainly, as those close to the interviewees started to become unwell with the illness, there is an apparent shift in collectively held beliefs, from determining the contagion as associated with out-groups, to 'we are a group under threat'. Subsequently, some narratives allude to the virus itself as being cast as 'out-group' as a means to further objectify it. Paramedic Joel told me that:

'*There's been a really high level of sickness in the ambulance service with regards to Covid and there's been several of my colleagues die from this virus, so I think that's at the forefront of everyone's minds now. It's stressing everyone out a little bit. I suppose it's an occupational hazard… However, it's…. yeah… shocking and sad'* [p.3].

In addition, in Natalie's experience as an emergency care assistant:

'I think in terms of getting ill themselves, certainly, now we've lost someone from our area that everyone knew and was very close to, it's really hit home that... you know, and I think with more people getting ill, I think, yeah, that's probably heightened our fear….' [p.7].

Willow, a clinical support manager, added:

'*This last week's been quite difficult… because we've had, a very popular member of staff has been on intensive care in hospital and ventilated, urm so that's upset a lot of staff as well, but we had good news at the weekend that he's off the ventilator and has managed to ring his family and have a short conversation with them so hopefully, he's on the way up now'.*

'I think it's hit a lot of people hard obviously because it's the first real person, real colleague that we urm know of that's been really, really ill with it. I know there's been deaths down in London and up in the North West um that's been on Facebook, but I think it's inevitable that it's going to affect us and personally, because of the risks of staff going out, the problem with the disease, we're all going to know somebody at some stage, um yeah, but you can't predict who, you can't predict when it's going to happen and you can't turn yourself inside out trying to work out what's going to happen and who's going to get it next. That would just destroy you I think if you spent too much time thinking about that' [p.7].

In these accounts, there is a devastating realisation as to the gravity of the threat and a conscious awareness of one's capacity to transmit and infect others. Subsequently, in some instances, this fear of other people including in-group members, as well as the virus, led to heightened suspicions and hypervigilance, as illustrated by ambulance technician, Simon:

'I've been keeping an eye on how many people on station have become confirmed cases, whether you've worked with them… or sat in a cab with them for ten hours, well, you don't just sit in the cab do you, we're out and about. Social distancing can't really apply' [Simon, p.2].

Such fear quickly extended to participants' family members; those whom they live with and those who live elsewhere and raised internalised conflict in terms of one's personal and professional responsibilities.

'*I think there's a bit more self-preservation and understandably, quite right because we've got families. The fact that you can bring it home and give it to your family, you know a lot of people I work with have got young children…. a couple of them actually live with their parents…. So, the risks are really, really high'* Dan [p.9].

'*I got bit upset the day before I came back off maternity leave because I, like I said, I came back early and then initially I was maybe a little bit naive but it feels like the right thing to do and colleagues are going off sick and they need some help and then the day before I actually went into work, I was really upset thinking 'is it really selfish of me really going back to work*

because what happens if I pick something up at work and then bring it back home to my family?', and I couldn't decide which, which way, you know, and then I was like, 'am I actually doing something bad by going back?' I couldn't decide' [Gianna, p.2].

Joel [p.3] added, *'I haven't seen my dad in, I don't even know how long, months… so there's that social aspect that I think people are missing family members and are worried about passing the virus on and getting the virus themselves'.*

Marcus, a newly qualified paramedic [p.4]: *'…there's a lot of people that have gone off work sick with symptoms of it, temperature, coughs… It worries me… about bringing it into my household with my partner. It would be erm… I don't want to put him at risk of getting anything as a result of me going to work.*

…. So, yeah, hearing about all the people that have died in the NHS as a result of the coronavirus does scare you, especially as a newly qualified member of staff as well, that's the last thing you want. I think it worries your family as well… they hear the news; they see what's going on and I think they worry about me going to work because they know what could potentially happen. I'll update them every now and then and let them know what's going on'.

Undoubtedly, the pandemic and the threat it posed brought into focus the group memberships that were important to individual participants. Their narratives indicated internal dilemmas associated with conflicting intergroup social identities (such as work groups, family, friends), what it meant to be a part of these groups, and the behaviours that were expected in line with sociocultural norms and values; a conflict that was experienced with considerable distress.

5.4.4 Individual and collective behavioural responses to the emerging threat

In attempts to mitigate the risk of contagion, have some meaningful control over a chaotic and uncertain situation, and to decrease the threat of passing the virus to others, many interviewees shared how they made significant behavioural changes in terms of heightened personal care and cleaning of their immediate environment – namely ambulance vehicles and equipment.

In response to a question whereby the interviewer asked if he had become more hypervigilant of his surroundings, Dan replied:

'*When we start the shift, the night shift will… say the bus [ambulance] is fine, so I'll take the truck [ambulance] but what we'll do is we'll wipe down the truck. We'll wipe down the steering wheel and the surfaces that the patient has touched, they've [the previous crew] touched, even if they've said they have, we'll go in the cab, wipe down the steering wheel, the hand brake, the gear lever, the door handle, you know all the things you would normally touch and we'll give it a bit of a wipe over so that we're thinking at the back of our minds that we've wiped it down so we should be ok to start the shift'*

'*I am washing me hands a lot more. I can tell coz me hands are really dry. We've got creams, we've got moisturiser in the trucks, so we've got everything we need… Every time we go to a hospital we drop the patient off, we dis-robe, wash our hands and off we go again. So, I'm washing my hands maybe three or four times more than I normally do. Even though we wear gloves, I'll take me gloves off and wash me hands. I wash me wrists as well coz we're bare below the elbows you see… Before you know it, you can get quite obsessed with it, a bit like OCD… We're a lot more careful of what we're picking up and what we're touching and obviously if we've been to a patient with Covid-19 confirmed, then we have these wipes that are a lot more disinfectant, so we'll wipe the whole truck, and we really clean everything down with them. We only use minimum equipment now. Everything's stowed away so that what we have to wipe down is minimised*' [Dan, p.6].

Dan illustrates how he had developed heightened awareness of micro-behaviours including what he was touching and coming into contact with. This was noted within many other interviews, where participants expanded upon their hypervigilance around potential fomite contamination of objects, as well as people.

Osian, a team leader, commented:

'*There are other cases where people are just walking into work; they're so stressed, and so worried about everything. They're walking around with a packet of Clinell [disinfectant] wipes, and if they haven't got alcogel in their hands then they're really anxious about it'* [p.7].

However, for Gareth, a paramedic with previously diagnosed obsessive compulsive disorder (OCD) and autism, he found the infection control measures and changes to routine exceptionally challenging and triggering and was worried that they may lead him to feel mentally unwell. He said:

'… to start with I was sort of getting a bit too obsessive with washing my hands and the old habits started to creep in and that concerned me' [p.2].

Concurrent with their hyper-awareness of routes of infectious transmission, respondents also shared how utterly exhausting these ritualistic cleaning practices were. This was further exacerbated by their intensive end-of-shift personal hygiene behaviours, primarily undertaken to protect one's family and oneself. Dan provided insight into his newly adopted rituals:

'*I've never come home from work and stood in the hallway and just took all me clothes off apart from me, well I've kept me pants on [laughs] but took me uniform off urm go straight in the kitchen, put it in the washing machine and washed it straight away, then I wash me hands, have a shower, then I've come down, then I've give [my wife] a hug, 'how's your day, blah, blah, blah' you know what I mean, that's the difference between just coming home from work and taking your top off and getting changed and leaving it there or putting it in the wash later on. The potential there for the bacteria being on your*

clothing is such a degree that everyone's got their own way of doing things. Everyone's doing a similar sort of thing, getting changed in the garage or they're getting changed at work in the, and they're going home in normal clothes sort of thing, I think, and they've all said, and lots of them have said that when it's all over they're gonna burn all their clothes and get new uniform' [p.3].

Emergency Care Practitioner, Alan, also shared that:

'*It's certainly changed my practices as regards coming and going to work. I mean traditionally, I always used to come and go to work in uniform, but my uniform doesn't come home now unless it's in a sealed plastic bag and then it goes straight in the washing machine'* [p.2].

For some, the terrifying realisation of life-threatening risk to family was deemed to be so great, particularly to those who were clinically vulnerable and shielding, that in their urge to protect and keep them safe, these ambulance staff moved into temporary accommodation whilst they continued their frontline work. Isolation from one's family, however, came at considerable personal cost including feeling alienated and lonely; particularly where the participant was a foreign national working in England but with a partner/ family in another country.

Wojciech, a newly qualified paramedic, said:

'...all my family and my soon to be wife are abroad and I cannot see them. It's not very nice' [p.1].

He added:

'*From my perspective of being an immigrant…if my parents catch it, if they go downhill with it and they sadly die, I won't be able to go. I won't be able to see them. There's no…these funny thoughts in the back of your mind… same as my fiancée – if she catches it…I can't be there with her…*'.

Wojciech explained how he felt:

'…very, very alone, especially when you want your parents, everyone, to be safe…' [p.2].

Indeed, his account gives insight into the importance of social connections and interpersonal relationships for one's psycho-emotional wellbeing.

Osian, a first line manager detailed:

'*We've had a conference call this morning. We've got at least five members of staff that have moved out of their homes and are currently staying in the local golf club up the road – they very kindly offered to put them up for free…'* [p.3].

Similarly, Simon noted:

'*I can think of at least three colleagues who have moved into hotels to protect their families'* [p.7].

Whilst narratives such as Osian's and Simon's affirmed the sacrificial altruistic motivations of ambulance staff in moving from their homes to protect relatives, other narratives depicted a contrasting experience of abuse and stigmatisation from family members, forcing them to leave and find refuge elsewhere. This scenario will be explored in greater detail in the next theme.

5.5 Responding to the threat: Prosocial versus antisocial behaviours and stigma

Linking with that prior, this theme is composed of three sub-themes: stigma and antisocial behaviour, community prosociality, and in-group solidarity.

5.5.1 'You lot are a bunch of plague spreaders': Stigma, discrimination, and antisocial behaviour

Not all the participants remarked on the stigmatising or antisocial behaviours of others. However, where they did, their accounts were stark and reflected perceived prejudices, and social role discrimination appeared bounded in fear of the contagion and of subsequent infection. This is particularly highlighted within paramedic Keisha's narrative in which she recounts visiting a local supermarket for groceries:

'…the supermarkets said for the first hour of the day um key workers and the elderly or vulnerable are allowed to come at this time and have priority shopping because they need it most, and then [ambulance] staff turned around and said 'why mix us with vulnerable people because we could, you know, we work for the NHS, we could be exposing them to it…' But the supermarket said ***'well, if you're a key worker, then you'll have to come at this time because you may have the virus****…There was one supermarket in particular that had this in their terms and conditions, [and] thought that [ambulance]staff were contaminated, and staff took offence…'*

Indeed, segregating healthcare workers for 'priority' shopping hours became commonplace. Whilst initial motivations may have been in recognition and gratitude for the difficult job these employees were facing, it was rather a double-edged sword in terms of separating these key workers from those members of the public who were deemed (or identify as) 'most healthy'. As Keisha indicated from her experience, this led to new, socially constructed prejudices and staff being labelled as 'plague spreaders' and 'carriers of

disease' akin to vermin. Furthermore, it was apparent that emanating from this discourse were collective negative beliefs around the 'dirty work' of healthcare workers and associated emotions of fear and disgust. As a result, discriminatory, disease-avoidant behaviours ensued, which psychologically impacted upon the ambulance staff being targeted. This further extended to feelings of devaluation and dehumanisation, which can be understood from paramedic Vicky's account:

'*Some of my colleagues have said they've had a bit of stigma in shops recently, 'oh look at them, they think they're heroes"* [Vicky, p. 6].

Through Vicky's reiteration of a member of the public's words, it illustrates a changing social shift in the power dynamics, whereby, through social relationship, attempts were made to shame ambulance colleagues and denounce their perceived 'hero' identity and status, whilst the member of public seemingly positioned themselves as dominant.

The physical environment of the supermarket was one example setting where participants experienced stigmatisation. However, this appeared to be magnified within the context of their habitation.

Keisha shared details of:

'*…anecdotal stories of landlords kicking out NHS staff because they were worried that they were going to bring the virus back into a block of flats or into their home or something and contaminate the landlord or other residents, and staff were outraged by this, and you'd see those ridiculous things that say 'name and shame this landlord', and you kind of think 'well, they've got the same anxieties as you have for your family, and they're doing exactly what you're doing, they're just trying to protect themselves and everyone else in their community*' [Keisha, p.7].

Indeed, such stories were also reported in the newspapers in relation to doctors (Giordano, 2020), paramedics (Jones, 2020; Mays, 2020), and NHS staff (Edwards, 2020). However, a subsequent article published a few weeks later highlighted the altruistic behaviours of some members of the public who mobilised to provide free accommodation to these workers (Lynch and Khoo, 2020).

Less reported within the media, but poignantly expressed within this study, was the stigmatisation that participants experienced within their own home and family setting.

Liz, a paramedic team leader, shared the sorrowful experience of providing support to a distressed member of her team who had been shunned from her family unit. Her narrative gave insight into the family members' attitudes and beliefs which at a deep level, are likely to have been a projection of their own inherent fears and distress, but at the more superficial level, are concurrent with a perception that the

stigmatised person had choice and control over their work, and that their decision to continue to work within paramedicine when faced with a contagious threat, was one only made due to flaws in their character. Indeed, the commentary below starkly highlights the attempts made to devalue the individual's professional identity and associated social attributes. Liz said that the team member was told

'…you're selfish for being a paramedic. You only want to work as a paramedic because you want the glory of everybody clapping you, and to say what a wonderful person you are. You're putting your daughter at risk. You're putting your parents at risk' because that was the family household dynamics. 'You're only doing this and working so much overtime because you're greedy and you want the money' and it was really, really hard for them, and they phoned me… in floods of tears' [Liz, p.2].

The deleterious effects on the member of staff were noted by Liz to include considerable guilt and shame, as well as conflicting and distressing thoughts and feelings around the morality of their actions and professional responsibilities in light of the potential exposure of family members to the virus.

Sadly, stigmatisation also extended to those with whom the participants worked alongside, including other emergency services personnel.

'*Anecdotally, I've heard there have been some issues on some tri- (or bi-) service stations where you've got fire service and police. …I've heard that at one particular station in [town], the fire service staff are going round wiping door handles after ambulance staff have been through, which isn't great for morale really*' [Alan, p.6].

To have those closest to you react with such ignominy was extremely difficult for the participants to bear, particularly when these were people with whom the participant shared an identity with and felt a deep sense of attachment and connection to. In these cases, the hurt from this rejection was unsurmountable although one from which some attempted to dissociate from, as will be explored in the next theme.

5.5.2 Community prosociality

In contrast to the last sub-theme, in which others' behaviours created subordinate divisiveness between different groups of people, the opposite was also identified in terms of collective solidarity and the formation of a common bond between community members in response to an external threat to which they were potentially vulnerable. As a result, many prosocial behaviours were experienced and recounted by the participants during the early stages of the pandemic.

'*We're driving down the road and people kept flashing me and waving at me, and I was thinking there was something wrong with the vehicle, and people are clapping us as we're driving along and they're waving at us, and that's quite bizarre!*' [Dan, p.7].

Collective support from the public for ambulance and other NHS workers continued to prevail and be demonstrated by the community in numerous ways including through the development of new prosocial norms for which behavioural acts of considerable generosity were shown. This included members of the public showing random acts of kindness manifested within a growing online movement that encouraged people to leave small (usually edible) gifts on the windscreen of an ambulance whilst it was parked up or delivering to an ambulance station. Colloquially referred to as 'hit the ambulance', these actions further extended to smiling, waving, and clapping emergency services vehicles and allowing staff in uniform to 'queue jump' if they were purchasing food/drink, for example.

In his narration, Dan added:

'*We've never been so popular which is lovely [laughs]*'.

He explained that after finishing at an emergency call, he, and his colleague:

'*…drove off round the corner to do the paperwork and this little girl came to me and offered me a cup of coffee. She came back with two coffees and sweets!*' [p.7].

'*We've had loads of gifts and chocolate, and all sorts of things turn up at the station, big bunches of flowers…. It's been lovely. The public's support for the ambulance service, well, the whole of the NHS has been amazing but erm, yeah. I think that's lifted people's spirits*' [Harper, p.4].

'*I think the support from the general public has given us that bolster and has really got us through. … whether it be food, a gift… knitting tags for you to hook your mask to. The support from the local community has really lifted us. We're quite fortunate, we have had food delivered to station. This morning, we had a cake, just to say thank you for what we do!*' [Vicky, p.3].

'*The support from the community has been absolutely amazing…. I can't even tell you how much, how many times we're on station and someone comes knocking because they've got some biscuits or some food. We've had restaurants, we've had all sorts of people coming round and giving us free food. I think the ambulance service has been really good as well because they've been paying for tea and coffee and milk on stations, which is not what they'd normally do. So, that's been really good. But yeah, the community has been amazing*' [Joel, p.3].

Seemingly, these acts provided collective focus for community members and gave them a sense of meaning, purpose, and responsibility, arguably as a means of developing solidarity and community resilience in the face of such adversity. Furthermore, the participants' narratives indicated that it appeared to be representative of a practical way of 'doing something to help', thus meeting a moral sense of obligation and responsibility amongst those carrying out the acts.

Indeed, their narratives gave insight into these public behaviours, which seemed representative of beliefs about the difficult and risky work being undertaken by healthcare workers. However, at times, despite their unwavering appreciation and the notable increased morale being felt, some participants explained that the transformative societal shift which had seen their status elevated and professional identity made hyper-visible, actually became an emotionally overwhelming intrapersonal experience, and led to humbled embarrassment at feeling unsure of the social expectations of how to react to this unusual level of attention.

'*The donations by the public have been overwhelming, absolutely overwhelming. We've got a lot of erm [sounds embarrassed] food, one of the people today dropped off another four boxes of crisps, chocolate bars and a load of other stuff. We've had people drop in PPE visors and ear savers for the elastic masks and asking if we need anything else'* [Osian, p.2].

'*I've found the gratitude of people I know and the general public, it's been nice but almost to the point of embarrassment'* [Pete, p.4].

Keisha explained:

'*I feel embarrassed by it… because I'm fit and healthy at the moment, so I don't mind standing in a queue…. I live alone & I enjoy the chats we're having in the queue…… urm people have tried to 'queue jump' me locally saying 'oh you're a paramedic, you can go ahead of me' 'no, no I'm happy to queue'. At the end of the day, we're all the same in this pandemic, we've all got to stand in a queue, why should we be selected differently because of the job we do? I fully understand why people are saying it and doing it, but I feel embarrassed to have that privilege because I'm just doing my job. I'm still in full time employment. I've still got a wage coming in…'* [p.7].

Critically, the Covid-19 pandemic presented prime opportunity for collective community action and social behaviours that were highly morally relevant given the perceptive threat being faced. Whilst initial outpourings of community generosity were perceived by the participants to 'raise spirits' and resilience amongst their teams, it also exposed dichotomous vulnerabilities and questionable immoral behaviours of in-group recipients seemingly favouring self-interest motivations, not dissimilar to hoarding behaviours seen within wider society when the pandemic was first declared. This was particularly apparent in the

context of food donations, with several participants commenting on the questionable moral integrity of their colleagues. Pete, an emergency care assistant, exclaimed:

'*I think the volumes of donations of food and other supplies to station has been a little embarrassing because we're still getting paid, whereas a lot of people who are struggling in the pandemic and who might be using food banks and stuff, so why are we getting all this stuff? And also, it's shown that one or two of our colleagues are a little greedy and selfish and take whatever comes in'* [p.2].

This was reiterated by Keisha, who upon receiving a food donation at her station said to her colleagues:

'*Look it all goes out of date 2nd May, let's just give it to the food bank, you know, because we're not going to eat it' and another member of staff turned around and bit my head off and said 'no, it's been given to us, we're going to have it all'…'this is where it affects you mentally because you just see the selfish side of people, and our job is to give and to care, but some people in our job are just being selfish and not thinking about the bigger picture*' [p.7].

Illustrated within these examples are the complexities around competing moral behaviours and moral identities, which sit uncomfortably in contrast with pre-existing socially constructed in-group norms associated with the shared identity of ambulance staff. This subsequently led to tensions and perceptions that some in-group members behaviours were selfish and self-fulfilling rather than selfless; an established identity trait held in high regard amongst fellow ambulance personnel.

John's account adds a further dimension, whereby prosociality was evaluated as anxiety-provoking in terms of heightening the risk and threat of viral transmission. Importantly, his account drew attention to the performative nature of these acts and their apparent juxtaposition with role modelling ethically and morally benevolent behaviours and questioned the professional identity of those working within the sector. Of those who were delivering food donations to healthcare workers, he said:

'*We don't know where else they've been. Have they just been to the Emergency Department up the road and walked into a hot [Covid-infected] area and then come out, got into their vans, and come down to our station and then just walked into our crew room and then exposed potentially five to ten people to the virus….?*" [p.3].

In response to this behaviour, John added:

'*We've seen in one of our local ambulance stations there are members of the public who insist on coming every Thursday to drop off hot food for the crews on that station and then you see some members of staff praising that sort of work… so we're just encouraging that unnecessary non-essential travel…The pictures I've seen on our private social media sites are social distancing isn't being adhered to and so again, we're potentially spreading this virus from one set of staff to another…*' [p.3].

Within these narratives, it is apparent how in response to the pandemic threat, public discourse towards essential healthcare workers such as ambulance staff had radically altered within a short timeframe. Indeed, these ritualistic, prosocial, and solidaritous acts shown by the public in thanks to NHS and key workers appeared to socially elevate the status of these personnel, but despite the positive framing of their work as meaningful and valued, this was increasingly in silent contrast to the depreciative narratives bonding those in-group, as they talked of 'just doing our job' as highlighted by senior manager, Adie:

'*You know, you feel very humble, and you feel sometimes that you're not deserving it because we're still doing what we would do normally*' [Adie, p.2].

The salience of this was further depicted in interview references to the symbolic and performative notion of harmonious 'clapping for carers' which saw millions of people across the country unite on their doorsteps at 8pm every Thursday between 26th March – 28th May 2020 during lockdown (The Guardian, 2020). This repeated moment of shared societal reality was discussed in-depth by many of the interviewees, with affective ambivalence at their heightened visibility which was in contrast with societal perceptions of their occupational role prior to the Covid-19 pandemic:

'*Sometimes when you're driving about and people start clapping, it's quite embarrassing. When I say quite embarrassing, when you're just not used to that, it's really weird to come across it because we're just doing our job. We're not doing anything else, so when people are clapping us, it's quite unnerving [laughs nervously]*' [Vicky, p.2].

Clinical Team Educator, Harper, recounted feelings of uncomfortableness:

'*This clap on Thursday's, as much as it's lovely, it's really awkward! I find it really awkward. I don't revel in it. My husband makes me go out every Thursday when I'm home, and actually, I'm there, and I'm like 'erm, thank you very much… but I am just doing my job'. It's a different job, but it's what I want to do. It's…. it's just what I do. I don't feel that I need any special recognition for it'* [p.2].

For Osian, the experience was one that was overwhelming and triggered emotional dysregulation and existential disorientation in relation to his self-identity. In his distressed words:

'*One thing that was really poignant for me during this crisis was the first clap for carers [sounds emotional] [breaks down] …. Sorry Jo…. [broken voice] ….as we were stood out…… and you could hear the whole street……. the whole town [crying]……clapping [struggling to get the word out] …. it was really…… and a lot of my colleagues felt the same to be fair [very upset] …… and you know, there were a lot of posts on Facebook… really positive messages so you know, when we all think about that clap and then everyone was saying 'I'm not sure about it' and then everyone afterwards was*

like, 'that was really emotional' …The public's support has been really, really good…. but yeah, it's been, certainly in the first few weeks, very emotional [cries] where I was breaking down A LOT urm…. [very upset] which is very strange for me…. I've never had that before…'. [p.3].

The social recognition powerfully and emotionally represented within the interviewees' accounts highlighted a transformative shift in societal hierarchical beliefs about the importance of their work, and the development of social constructions which depicted a sense of worthiness and prestige assigned to the professional identity of healthcare workers, not previously seen. Arguably, the media's narrative portrayal of paramedics and ambulance staff was of significant influence in these social constructions which subsequently became embedded into social norms, bringing a cultural shift in perceptions of the role of such 'key workers' as heroic – a status greatly in contrast with public discourse indicative of their 'dirty work' as previously highlighted. Despite this heroism narrative, participants emphasised their 'ordinariness' in their accounts and articulated their inner psychological conflict at the juxtaposition of this rhetoric with the reality of their lived experience, which was, in their eyes, far from heroic, particularly in the earlier part of the pandemic whereby emergency demand for ambulances was much reduced. Joel said:

'*At first, I was like, 'I don't know what you mean. I'm sitting on station and I'm getting to nap on station. I get to sit around and chat to my mates for a couple of hours on a shift whereas normally, we'd be back-to-back with jobs', and everyone's thinking 'I don't really deserve this [praise]*' [p.3].

Simon shared a similar experience:

'*I personally, was feeling a little bit embarrassed about all this NHS heroes and 'let's help them however we can', and I'm thinking, 'well, we're getting more down time than I've ever seen in eleven years', but then when we do go out… it just sort of puts that into context…*' [p.1].

Emergent role and social identity dissonance in relation to the valorising portrayal of ambulance personnel was brought sharply into focus for clinical support manager, Willow, who expressed emotional distress at societal expectations that she and other healthcare workers would heroically compromise their own personal safety to care for those infected with the virus, which was incongruent with her authentic feelings of fear and terror at the risks being (involuntarily) faced:

'*I do a quiz in the village on a Sunday night that one of the local chaps does and it's gone over to Facebook live, and the first night I joined it, they all gave me a round of applause… It's like I can't keep my head down and take the label off my head that I'm NHS. It is lovely, but I'm struggling, I am really [emphasized] struggling with the whole hero thing [voice drops, sounds fearful and frightened]*' [Willow, p.8].

Importantly, these quotes highlight the social relationship complexities between healthcare workers and the public in the context of the pandemic, and their esteemed value in society. Indeed, in the examples above, the transformative construction of ambulance personnel as heroes and the associated valoristic narrative led to psychological unease and raised internalised questions as to their moral obligations in terms of professional duty.

5.5.3 In-group solidarity

Notable within most of the interviewees' accounts was a distinct sense of solidarity and bonded togetherness in response to the collective sense of threat as well as the hegemonic narratives discussed prior. The ambulance practitioners shared how, as a primary coping mechanism to help them to continue in their frontline role, their in-group community became 'tighter knit' which subsequently enabled them to support each other:

'*I think staff are more bonded as a station. I think it's brought us all closer. It seems to be, I don't know, everyone just seems to be looking out for each other a little bit more, and checking in, making sure everyone's ok*' [Sunia, p.1].

Ava, a paramedic, highlighted how the sense of togetherness enabled the sharing of experiences, empathy, and comfort:

'*Overall, it's, it's been quite heart-warming really, working through the pandemic. We've all sort of pulled together as a team and we really care about each other…. We're definitely checking up on each other more and erm I feel, yeah, I feel I can still talk to my close friends at work about, you know, how I was feeling quite anxious about coming back to work and so we're all sorted in the same boat, and it sort of connected us a little bit as well*' [p.1].

Harper's narrative alludes to a shared understanding of being a collective group working against the threat:

'*Frontline staff realise that we are all in it together, and we just have to do our best… I think morale at the moment is pretty good. In fact, I think it's probably better than it's been for years…I think generally, the general public have been so warm and caring towards us and how we are, I think it's rubbed off on the staff as well. I think they feel… I don't know if appreciated is the right word, but they feel like they're making a difference*' [p.3].

Describing how existing bonds with colleagues were reinforced, Ffion said:

'*I think it's probably brought people together more; from the kind of conversations, we're having. I think because it's quite a small station, people are pretty close anyway*' [p.3].

This was further advocated by Pete, who succinctly reflected on team cohesiveness:

'*Green family. It's the bond between everyone*' [p.4].

Belongingness helped to counteract feelings of loneliness and isolation, particularly for those participants who were separated from family and friends. In addition, underpinning their accounts was insight into how in-group self-efficacy was important for developing new social norms that not only sought to protect their shared identity from threats (such as the heroic discourse) but also emancipate their collective yet distinctive social realities, particularly in relation to risks associated with the contagion and the traumatic and morally distressing events being faced.

5.6 Traumatic and moral distress: The social, psychological, and behavioural impact

5.6.1 The present and the future

The traumatic, distressing impact of the pandemic manifested within multiple novel ways, as already evidenced. In referring the reader back to the first theme, this primarily highlighted participants' experiencing of the contagion as a threat and their heightened emotional arousal including fear, in terms of contracting the virus, its potential life-threatening impact, and fear for the safety of participants family, friends, and colleagues. Indeed, these accounts give real-time insight into the terror and distress that many participants were experiencing. However, one key finding is particularly important to note. Whilst many of the interviewees shared their feelings of distress about the present situation and how the pandemic was unfolding, they also were notably distressed in anticipation of what may negatively occur into the future. This was most noticeable in the earliest conducted interviews, held not long after the pandemic had been declared and lockdown instigated. John said:

'*I've had the odd moment of tears thinking what on earth's going to happen and…. urm [sighs] more worried about other people than myself really*' [p.3].

The future traumatic impact was of considerable concern for other participants, with Osian showing compassionate concern for new members of staff including final year paramedic students who were being drafted onto the frontline ahead of qualifying:

'We've got a load of ECA's that have started, 19 years old, and a load of brand-new paramedics, you know, the year 3 paramedics they're chucking out… they're really out of the frying pan into the fire with it, and it's really difficult for them [empathic]. And I'm not sure that they're gonna get the support that they need at the moment, so it'll be brewing a problem. Those brand-new ECA's… you know, we're saying this isn't normal work, but this is all they know, so… they've only been on the road three weeks, so this is all they've known' [p.4].

Vicky also provided awareness into her feelings of future expectant unease:

'*We don't know what's coming around the corner, so we're always on tender hooks, but it's almost like adrenaline fuelled. It's when we come to the end, when we go back to normal, and I think that's where they'll be many psychological problems because people won't be able to adjust back… I think, and I might be completely wrong, and this is it, you don't know what's round the corner, so you're, we're guessing aren't we, speculating all the time… everyone deals with it differently, don't they…*' [p.7].

Drawing from the accounts above and those from other participants, not only are there references to anticipatory negative future events such as the fear of colleagues becoming psychologically unwell, or indeed, fear of loved ones catching the virus, but the narratives also provide indication that, at three to four months following declaration of the pandemic, participants were in the relative beginnings of experiencing heightened fear responses to an ongoing protracted threat and continuous uncertainty, which as noted below, was psychologically experienced as hypervigilance, vulnerability, anxiety and helplessness; which may be understood as peri-traumatic stress responses.

5.6.2 Complexities of Covid-19 social and psychological trauma: Disruptions to core beliefs, disconnection, and disempowerment

The complex nature of the traumas experienced were deeply apparent from the interviews. Aside from the continuous intense fear and threat as discussed, further traumatic exposures manifested within numerous other social and psychological contexts. Previous themes alluded to disturbances to social, familial, and professional life, the negative impact of social isolation in respect of sense of belonging to groups, and shared social identity, which transgressed perceptions of self and others' (in)vulnerability. Unpacking these contexts further, critically revealed three key traumatic disruptions to core beliefs and schematic assumptions about everyday life.

The findings suggest that a prominent underpinning discourse centred around feelings of **violation to participants' beliefs associated with safety and security**. Rooted within the primary emotion of fear - of contagion and impact upon self and others, such traumatic distress was particularly apparent in relation to inconsistent information regarding transmission of the virus, the validity of personal protective

equipment, and its availability - which in some regions of the country was lacking; a concern that was magnified in media reports. This, combined with beliefs that the world was now an unsafe, threatening place, manifested in adverse psycho-emotional affective states and behavioural adaptations - as was explored in the aptly named subtheme examined in theme one.

Whilst violation of one's previously held meaning structures pertaining to safety and security was mostly unknowingly discussed by all of the participants, Pete's narrative is particularly interesting. His articulation not only indicates the underlying fear and hyperarousal being experienced, but equally, provides insight into how he attempted to make tolerable his experiential reality and restore a sense of perceived invulnerability through submissive denial (avoidance) of the risk:

'…it's all a bit scary… The level of PPE [laughs] that we've been instructed to use has diminished all the time. So, now you're going in with a plastic apron and a piece of paper across your mouth and your gloves, but erm, now it's not particularly scary. It's just the day job now. Every job you go into, you've got your apron on and your mask. It's just business as usual now' [Pete, p.1].

For other participants, whilst using PPE was representative as a means of minimizing risk of contagion and thus, reducing susceptibility, avoidance presided cognitively in terms of diverting attention away from one's heightened emotions through ruminative worrying, seeking information – sometimes obsessively, intently focusing on positive aspects of the pandemic whilst minimising and denying negative aspects, and/or attempting to problem solve the tasks in hand, thus aiming to restore a sense of safety and security.

'*I try as much as I can to be quite stoical in my approach to doing things, so focusing on the present, do today's work today, just get this task done and move on to the next as opposed to not necessarily worrying about what that means for the bigger picture and stuff, but that in itself requires discipline and energy that you don't necessarily have*' [Ollie, p.4].

A thread running throughout the core of this prominent narrative discourse was conflictual feelings of trust versus mistrust, which were frequently projected towards those in leadership positions – whether that be local ambulance leaders or indeed, up to government ministers. Motivated by fears – of the contagion, of the unknown, of feeling inadequately protected and of shortages of PPE for example, this ruminative distress was exacerbated by perpetual changes to official safety guidance, with compounding reports in the media. Embodied within clinical operations manager, Adie's account, he disclosed a lack of agency, helplessness, and frustration at dealing with the heightened emotionality from his staff:

'…some people are, as I say, …getting themselves too worked up, it doesn't matter what you say, they won't believe it, and with all the things that keep coming on the telly, social media, they see things, hear things, and then they're saying 'these

masks are rubbish' and 'these people have got this' and 'we can't get that'… it doesn't make life easy when we're saying 'this is perfectly ok, we've got what we need, you don't need to worry, you can use these' [Adie, p.3].

What was fascinating about Adie's account was that as he continued to share his experience, the ruminative thoughts of his staff played out in his account and he repeatedly re-visited their worries (or 'paranoia', as he referred to) in a third-person voice. For example, '*Have we got the right PPE? Is it good enough?*' [p.2]. Articulating these thoughts, however, appeared to aid his processing of the situation, and allow for meaning-making such that he concluded that behind the 'paranoia' were actually deep feelings of being '*scared is the word I would use, that's err what most, people have been a bit more scared than they would normally be'*… which required *'…reassurance. That's all you can do really'* [p.3].

A second traumatic disruption to core beliefs was also evidenced from the empirical data in respect of a **violation of emotional, social, and physical connections**. Indeed, as already highlighted, the distress of human disconnection was profound for several interviewees during the first lockdown. For some, this seemingly triggered socio-relational attachment-related distress. This was tangible within Keisha's account as she felt alone and anxious when distressed, and desperately sought the company of others to emotionally regulate (soothe) her:

'…it's the lack of physical contact I think that's hitting me…. a hug would make me calm down, come back to being my normal-self quicker than having to… sob for twenty minutes [alone] [sounds sad] …We can't have that physical contact anymore, and that again hits you emotionally especially for somebody like myself who lives alone… I can't have contact with a household member when I get home from work but my colleague, they get to have a hug from their household…' [p.4].

In contrast however, John, a paramedic, disclosed avoidant dysconnectivity in his social relationships with colleagues. Talking of conversations with crew mates, he said:

'*I'm not interested in your kids or in the issues you're having at home. I think it's unfair to project your problems onto someone else who is essentially being paid to sit next to you coz they wouldn't be there if they weren't being paid, um and try and sort of force these relationships*' [p.15].

Indeed, within his narration, John's disconnection further extended to latent feelings of abandonment and rejection by authority figures such as managers, particularly in relation to his perception that their (in)actions were unreliable and were leaving staff at heightened risk of infection. He disclosed subsequent intrapsychic conflict in wanting to rectify (and make safe) the issues himself, yet was powerless to do so, thus leading to further dysconnectivity & distress which seemingly manifested as disengagement and frustration. Consequently, although he talked of indifference in terms of his social relationships with work colleagues, John also indicated a transgression of his sense of belonging to his work in-group and, by the

end of the interview, reflected upon the grave impact of this upon his social identity as a paramedic, and articulated self-protective feelings of wanting to withdrawal from his employment:

'They [managers] use things like '999 family', 'green family' all this sort of stuff and they reiterate those phrases so they make the workforce feel like they're one team but…… when it then comes to speaking out you're then made to feel sort of quite isolated and they'll use phrases like 'well, that's not what, other people haven't been saying that to us' …so they then sort of box you and isolate you and make you feel like you're a bit of an outlier' [John, p.10].

'*How's it making me feel? Pretty disheartened really um yeah. If I didn't have other opportunities in my role, I'd probably consider leaving and going some… going off to do something else*' [John, p.18].

Critically, empirical insights from the first phase of interviews further indicated considerable dissonance among all the participants, who wrestled with internal conflictions between perpetrated transgressive acts and behavioural omissions, that **violated deeply held collective beliefs around morality, professional duty of care, and ethical values.** Indeed, there were many examples whereby participants experienced moral and/or ethical violations, which primarily centred around juxtapositions as regards professional responsibility and behaviours that transgressed this, and secondly, featured the moral failure or perceived betrayal of trusted others – such as managers, or broader systems, such as the health service.

Many of the participants noted moral ambiguity and reported distress in relation to making difficult, ethically challenging, and complex clinical decisions in light of stretched resources. Indeed, heightened professional responsibility was felt particularly when these decisions carried the weight of life/death and transgressed usual clinical practice and one's core professional beliefs around providing life-saving treatment:

'*…making decisions about whether to start CPR or not… is resuscitating them the best thing to do? and maybe having to step back and not, not start a resuscitation… it just… it's from the pandemic point of view, you know, not normal working, really. It's different during the pandemic*' [Ava, p.3].

'*Last night, I dealt with some quite poorly people with Covid-19. I sat by the bedside of a person in their 90's dying with Covid-19 erm and tried to put in the right steps for her so that she had a good death, spoke to her family erm tried to make her as comfortable as possible and that was high-level decision-making that I think would have been beyond the scope of a normal ambulance paramedic… it's not just resuscitating, it's spotting those people for whom resuscitating would be really unfair and really unkind and erm she was one of those*' [Nicky, p.6].

Keisha expressed the emotional toll at weighing up violations to the patient's autonomy in making end-of-life decisions:

'*The emotions you're going through when you're dealing with a patient… I've cried in front of a family when I'm doing it, I've cried on the phone to the doctor as I'm doing it because you know it's the end, you can't say it's going to be six minutes or six months… you know…. You feel like you're taking the choice and liberty out of their hands in some ways but at the same time, you're giving them respect…*' [p.3].

Furthermore, paradigmatic shifts in clinical practice evoked collective ontological tensions between the quality of care that participants were being asked (or forced) to provide in light of infection control guidance, lack of resources, or reduction in specialist services (such as mental health) for example, versus their authentic, professional sense of morality around benevolent patient-centred care. This was particularly the case for Ava:

'…we were the second crew on scene and when it's a cardiac arrest in our Service, the second crew on scene stays outside until the Covid car[1] *turns up. So, for me that was, that felt very weird because knowing that there could be someone in cardiac arrest and I'm not allowed to go in that was quite hard for me to process that I think*' [p.2].

'…it's, it's not really human nature. You know, human nature for a paramedic is get hands on, get involved and do as much as you can, whereas if you're standing back and not you know, standing outside the house and not even going in for a cardiac arrest that's sometimes a bit tricky to process' [p.3].

'*Our Service is saying… [that] when you're doing chest compressions, you should have a tea towel over the patient head, and I just think that so inhumane. I understand why they're saying it, but you know that's just so very different to what we've ever done before and also from the relative's point of view it doesn't look very nice either*' [p.3].

Notably, Ava indicated a perceived sense of betrayal by her organisation – treatment guidelines had become dehumanising with practices that transgressed morality, empathy, compassion, and respect for the patient. Indeed, witnessing perceived inadequate (or inappropriate) clinical care was a significant shared experience of portrayed immorality and one that many of the participants tussled with and felt powerless against. Consequently, this conflicted with their social identity as paramedics and ambulance staff and challenged identity-based, deeply embodied core beliefs such as 'do no harm' – beliefs that could no longer be authentically enacted. Feelings of demoralisation and distress ensued – particularly when they genuinely could no longer say 'we did all we could', which was deeply incongruent with their sense of

[1] Covid car is a reference to a rapid response vehicle staffed by a team leader or supervisor, who would oversee the 'donning' and 'doffing' of PPE worn by ambulance practitioners. Guidance at the time required an ambulance crew arriving first on scene to a cardiac arrest to wear basic level PPE and only undertake basic life-saving procedures – excluding those associated with aerosol generating procedures (AGP's) such as clearing an airway with suction. The second ambulance crew to the incident were required to wait until their supervisor arrived on the 'Covid car' to assist them into highly protective suits and full respirator masks, thus enabling them to enter the scene and deliver full resuscitation including airway management.

self. Furthermore, the symbolic communications that emanated from apparent leadership advocation of such regimes led participants to existentially question their perceived moral worth and value by the organisation.

'*I left somebody at home who had Covid, and I was so borderline taking them into hospital, but I knew how busy it was and he was fit and well, and young… I rang the GP, and we went through it, and then for about two or three days afterwards even when I was going to bed, I kept thinking 'Oh God, I hope that guy was alright*' [Gianna, p.2].

Ambulance Technician, Greyson: *'…it just feels like sometimes I've felt like I've not cared for patients because…. I've been so hot and bothered or sore with the PPE that I just wanted to get the job done and out the way, so I've done the bare basics and… but because I've not been able to show my facial expressions properly or kind of, you know, put my hand on their shoulder or had that human contact, it feels like I've not fully cared for patients and their family which is, has kind of beaten me up and deflated me….*' [p.2].

The intra-personal moral distress as experienced by Greyson above, was representative of others in the sample, and thus, collectively they provide further insight into shared moral behaviours considered normative for paramedical staff as a group. Importantly, these narratives including Gareth's below, which highlights further transgression of professional morality, indicate the impact upon the self in relationship with their in-group, and the value the participants placed on being a part of (belonging to) the profession. Gareth has particular difficulty in articulating his profound discord at potentially doing harm to others when faced with prioritising the treatment of patients and being unable to act in accordance with his professional beliefs. Unequivocally, in-depth analysis revealed his internalised feelings of betrayal, guilt, and shame in being complicit in such acts even though doing so, was a shared reality of frontline working at that time.

, *'…it's completely changed our practice because it seems like we're making more…decisions based on moral ethics as opposed to using the JRCALC[2] guidelines or updates…. I found it difficult to…. it felt sometimes that you were sort of, people didn't qualify for treatment just because of their co-morbidities and their age, which sadly, I think, you know…. [sighs in dismay] you're, again… it's doing what's best for the patient. I've never been in a position where I've had to decide based on that…*' [Gareth, p.3].

The empirical data further revealed that the experience of comforting a critically ill or dying patient because pandemic guidelines would not allow relatives or close others to either attend their location or travel with them into hospital was exceptionally distressing for ambulance practitioners, particularly when this practice was counter to their core values regarding how patients who were dying should be with their

[2] JRCALC – Joint Royal College Ambulance Liaison Committee guidelines, produced on behalf of the Association of Ambulance Chief Executives, provide the clinical and some operational guidance for all UK NHS ambulance service clinicians. The guidelines cover a wide range of medical conditions and medications for administration by clinical ambulance staff.

loved ones rather than alone or with strangers. Vicky, Sunia, and Keisha's accounts highlight their felt trauma:

'*From an emotional point of view, I find it quite harrowing when families are saying goodbye to their loved ones, and there's… I don't think we've ever been exposed to it in that kind of level, where… you know, we take a patient into hospital and if their family do come in to say goodbye, we almost pretend that we're not there, but this, that's where I find it really poignant because they're saying goodbye and you're putting them on the ambulance, and you don't know whether they're ever going to see them again… and that is heart-breaking*' [Vicky, p.1].

'*Some of them [patients] have been really poorly, and you think to yourself 'I don't think they're going to make it'. But you can't let family come with them and that's quite sad, knowing that relatives have probably seen them for the last time, and you're taking them away sort of thing. They're not going to be able to visit*' [Sunia, p.1].

'*I've walked out, and I've burst into tears because of the emotional toll…. you know you're leaving them there to die…… but, you know, you're just grateful, I hope everybody's grateful; I'm doing for them what I would like somebody to do for me and my family… but it is emotionally draining [emphasized]…. having to play God….*' [Keisha, p.3].

Helplessness and shame at being unable to fulfil their professional ethical values and provide safe, appropriate, and compassionate care for their patients ran deeply throughout many of the participants' narratives in this phase of the interviews. Aligned with this was a deep sense of betrayal that manifested in many guises. As noted, some interviewees reflected on their aggrievement with national and local organisations who endorsed frequent changes in clinical and infection control guidance, which was perceived as out-of-touch with the reality of the frontline, seemingly not based upon scientific evidence, and not robust enough to guarantee the safety of healthcare workers from infection – leading to a deep violation of trust at the perceived unnecessary risks that intentionally placed them in harm's way. In addition, interviewees also drew attention to their indignance at managers who were perceived as detached from the realities of frontline work, preferring to remain in the safety of their office, thus compromising their duty of care to staff.

'*There seems to be a bit of distrust between us and management. They're stuck in their little office…They're not out on the ambulances like they usually would do… they're probably just as snowed under as we are, but it just feels very disjointed as a team on station. At the moment it's seems like everyone's breaking off and becoming frustrated with each other.*' [Greyson, p.3].

'*Management have been a little more elusive than normal, I guess. They're not as visible as normal*' [Pete, p.2].

Symbolically, disconnectedness reflected the quality of social relationships between managers and staff and subsequently, the participants' feelings of worth(lessness) relative to the organisation. Salient here, are the social representations that implicitly communicated dehumanisation and depersonalisation in the form of staff objectification. This was portrayed in terms of feeling inanimate and expendable:

'…it's like we're cannon fodder in the first world war…' [Dan, p.1].

'*It makes me feel worthless…. It makes us feel like cannon fodder at every job…….*' [Keisha, p.1].

5.6.3 Psycho-emotional responses to pandemic adversity

It is unsurprising that the empirical data featured considerable emotional dysregulation and distress, reflecting the profound social disruption and adversity being encountered. Arguably, all the interviewees elicited heightened emotional responses – with fear and sadness most prominent. However, as previous accounts have articulated, for some, these emotions also transitioned into the complexities of anger, distrust, and disgust. Frustration and helplessness were also commonplace in this first phase of interviews.

Interestingly, although these emotions were shared in the moment within the participant-researcher relationship, there was notable variance in participants' own emotional awareness, with some narratives indicating dissociative detachment (or a numbness) from one's feelings, particularly those that were intensely (non-)expressed within the interview. A particularly poignant commentary was shared by team leader, Liz, which illustrates this:

'…somebody made me cry in the garage the other day, and that was… very strange because I'm not that sort of person, but literally, I filled up my RRV [rapid response vehicle] with fuel, paid for it, I'd set the Costa machine off whilst I was waiting, just so that… and I went to pay for my coffee, and this voice said 'I'll get that' and I turned around and there's a lady there and she said, 'I'll get it for you'. All she said was 'I'll get that for you, thank you' and then proceeded to pay, and that's the only conversation we had, and ***I sat in my Land Rover, and I had tears streaming down my face and I really can't tell you why. I really… because I don't, that's not me, I don't do that sort of thing. So, I think for me, maybe I don't recognise my own feelings enough, I don't know.*** *And that is the only time that's happened. And people have said multiple thank you's to me now, and my ambulance has been 'hit' a few times, but that's the only time, and I don't know if it's just because the way in which she said it, the fact that she didn't go on and on. It was just a very matter of fact and the thank you was not gushing. It was just a simple thank you. I think that hit a chord. I think that, from her, it didn't appear to be a 'hey, look at me, everybody in the garage'. There was plenty of people there but if she had wanted to, she could have made a big thing about it, but she didn't. It was quietly done and for me that was great because I don't want that bells and whistles thing going on… but yeah, it was weird, and I couldn't really tell you how I felt because I was literally crying, and I was going 'why are you crying?'* [Liz, p.12].

When asked if anything during the pandemic had affected him, Paul, an established paramedic, said:

'*Nope. Not at all. Like I said, I don't personally get affected by erm any incident I attend unless I feel that I've had short comings myself*' [p.2].

He avoided further discussion of this.

Similarly, Wojciech also talked of his perceived affective neutrality, which arguably could be understood as emotional dissociative detachment:

'*Oh [voice drops] emotions are non-existent for me. Talking to someone, telling them about it, what happened, things like that. Then I have a lovely sleep and forget about it. I don't carry any emotional load. I just think that's healthy'* [p.2].

With eleven years' experience of working on the frontline, Simon explained his profound experience of desensitization and compassion fatigue:

'*I think it [the job] generally hardens you. I think there's a desensitisation that occurs incrementally, where I find that sometimes, and I'm quite conscious of it sometimes, that there's almost an empathy gap – I know I should be feeling something for this patient or situation, and I know what that feeling should be, but do I really feel it? Does it stop me delivering care? No it doesn't stop me, you know, being that person that the other person needs you to be in that moment, but ultimately, I don't think I have too much trouble in getting in my car and driving home and forgetting about it… which I would have said prior to doing this sort of work, I would have been horrified to think that, so I don't know if that's a kind of self-preservation thing or if it's just an incremental change that occurs by exposure… maybe it's an age thing as well…'* [p.5].

Other participants took an overtly pragmatic approach, all stating that in their experience everyone '*just gets on with it'*. Pete added "*It's life isn't it. You've just got to get on with it"* [p.4]. However, unpacking this further indicated a level of emotional suppression in order to allow them to focus on their work and meet organisational demands. Furthermore, this also provides insight into normative socio-cultural in-group expectations and feeling rules that guided emotional and behavioural responses towards those representative of being 'professional' and 'in control'.

Whilst the above extracts may be understood in light of individuals' emotional disconnection, suppression, and denial, Adie projected his emotionality within the context of his social in-group of managers, and referred to his own feelings through the collective pronouns of 'we', 'us' and 'you':

'*We're used to dealing with things*' but '*we're probably the worst offenders*' [in showing how *we* feel] [p.6].

It is possible that using this subconscious psychological defence allowed Adie a level of safety, distance, and control over intolerable feelings of distress and vulnerability. Dissociative, projected emotional expression was in fact prominent within several of the participants' accounts.

Interestingly, the data suggests that the social sharing of negative emotionality served primarily as a regulatory function for individual members of a group, and secondly to elicit social support to aid emotional recovery. However, whilst many of the participants articulated how this brought colleagues closer together (which will be explored in the final theme of this chapter), insight into this phenomenon from John, highlighted his uncertainty of how to integrate such intense emotions within his social space:

'…it's those staff who have really struggled and they're not necessarily the ones that have struggled with other issues in the past, so that was quite hard as well. For them to walk in, burst into tears and get very angry, [I was] thinking 'I'm not sure if I know how to deal with this person because I'm not used to dealing with their upset', if that makes sense?' [p.5].

In contrast, team leader Osian's vignette provided awareness into the social relations he had with his staff, such that he was able to identify with them and had an empathic sense of what they were experiencing:

'*I've had a couple of members of staff that have been in tears about it with me, literally just sat there talking through a job and just burst into tears and letting that emotion out and it is… I completely get where they're coming from because it is really hard*' [p.7].

Empirically, the data was rich in embodied emotional experiences which served as a magnifier for sociocultural norms and prescriptive emotional display rules, shaped by the social institutions and conditions within which the participants worked and lived. In the following transaction, military paramedic, Tony, indicates social awareness of an in-group normative (and arguably, gendered) expectation that one should conform to internally regulating one's emotions in response to distressing situations:

'*I know for a fact there's people there, not showing emotions in the crew room or on shift and wait until they get home because they don't wanna be that guy that got upset after a job*' [p.3].

Furthermore, Gianna, a newly qualified paramedic, said of expressing her emotions:

'*I would but only if I really had to. I don't think it's something I would do, or I would naturally do, no, I don't but I think it has to be something really, really, bad for me to I feel like I've needed to show emotion at work'* [p.3].

These accounts also draw attention to how these emotional constructs are linked to construal of the self and indeed, one's social identity within the context of in-group memberships and social relationships. This is also relevant to Simon's narrative below, which highlights the interconnection between his affective response and identities. Through this psychological mechanism, he seemingly 'protects' aspects of himself to enable his integration with social and organisational structures but also as a means to contain and potentially suppress (or detach from) the reality of his work and unpleasant emotions that this may surface – including that of vulnerability.

'[*Simon] with his uniform and [Simon] without his uniform, they're two different people effectively*' [p.6].

Importantly, this mechanism also featured in some participants' accounts whereby they intimated that distress associated with working frontline during the pandemic was too difficult and too painful to share with family and friends, whom they wished to protect from such a threat. Thus, participants utilised a variety of psychological strategies including that of dissociation and suppression in attempts to contain their emotional reactions relevant to their social context.

It was clear that shared identities, group memberships, and social relationships were central to the complex psycho-emotional responses that featured within the realities of these workers. Indeed, as prior vignettes have indicated, emotional trauma associated with working frontline during the pandemic had become an important part of their life experience and integrated into their world views that subsequently informed their sense of identity/ self. Appraising traumatic events as violations to one's core beliefs and values notably resulted in psychological distress. Within their interviews, participants disclosed intrusive, ruminative thoughts after attending scenes that were emotionally and morally challenging. They talked of hypervigilant behaviours such as intensive cleaning rituals. Through their narratives, analysis has also revealed the use of avoidance and other distancing mechanisms.

The embodied self and shared identities were also shaken through the phenomenon of traumatic loss of colleagues and close others who died from Covid-19, as well as a loss of safety and certainty, and loss of social connection, further emphasising collective emotional dysregulation. Indeed, the patterns of socio-affective behaviours emanant within the accounts were distinctively similar to the manifestations of traumatic distress previously noted.

In discussing his grief at the loss of a close colleague, Greyson shared how prescriptive social norms and feeling rules around emotional display provided collective affect regulation. The excerpt below illustrates how workplace cultural feeling rules led to the denial and suppression of authentic emotional expressions of grief and, rather, a socio-behavioural expectation to conform to stoical avoidance was upheld. This was

such that Greyson outwardly downplayed his inner distress (which was present and raw) as a means to reduce the discomfort of others and conform to group norms. However, this led to social disconnection and withdrawal from a close relationship. This was certainly not unusual as other participants and indeed, the researcher, equally validated similar experiences within NHS ambulance cultural settings to the extent of refraining from talking about the deceased in efforts to contain difficult emotions.

'…you don't want to offend anyone or... equally, you don't want to put them in a situation where they feel you're going to confront them, you know, give you a hug. One of my best friends on station, we're very huggy between me and her. We go out on walks together and just spend the day with each other, just laughing and joking, you know. Our relationship's changed completely. That's…that's been just as hard' [Greyson, p.4].

Vicky's autobiographical memories highlight the complex social nature of grief and gives a brief glimpse into the felt social pain and unprocessed shared loss of losing a loved crew mate and colleague. Her account alluded to her attempts at continuing to maintain attachment with the deceased, with ruminative pre-occupation and yearning for her colleague:

'*In all honesty, I drove into work one morning, and I saw someone that I work quite closely with, and she just looked broken… and I know it goes against social distancing, but we work in confined spaces on our station, and I just had to hug her… just… there's nothing more I could do… just reach out and… I think that was the hardest thing for me, not only losing him, but you can also hear him, you can see him, and I kept thinking I saw him, and it was somebody else [sounds so sad] at hospital, you know, just in uniform…… You see someone from the back, and you think it is, and then no it's not, and you have to keep checking… it was not only that, the loss for us all, but also seeing your friends and colleagues, just heartbroken… that was really hard [almost whispers] …*' [p.4]

Describing her friend as 'heartbroken' and hearing the deep sadness conveyed in her tone of voice, Vicky intimated through her narrative the profound socio-relational impact of grief and how the loss was collectively experienced as separation distress. Importantly, her account also highlighted the significance of support, intimacy, and feelings of togetherness amongst colleagues. Indeed, of those participants who had experienced bereavement during the study period, they frequently referred to descriptions intimating the closeness crew mates had with each other, and their need for 'shared understanding' of the friendships held with the deceased – particularly in the early stages of grief.

5.6.4 Social connectedness

As previously discussed, social networks provided interpersonal resources for the participants, influencing appraisal and interpretation of threatening events, emotional regulation, and psychosocial wellbeing during this first phase of the pandemic. Prior examination of themes has highlighted how shared identity

and group memberships were particularly influential in respect of social norms around participants' emotional and behavioural responses to the various aspects of the pandemic that manifested. However, one area where this was exceptionally notable was in respect of the giving and receiving of social support. Here, social identity salience was paramount to whether one received positively perceived social support and subsequently, in framing how participants appraised and experienced adverse/ threatening situations. A caveat to this, however, was the unavailability of social group networks during the enforced lockdown period due to imposed restrictions on social distancing. Where these connections were not as accessible or social identification with family/ friends had fragmented (in the case of stigmatisation, for example), participants talked of increased distress, lower self-esteem, and loneliness.

'*Normally, I'd go out for a walk with friends or my partner or arrange to meet up for coffee or one of us would go round to each other's houses and spend the evening or day with them to just go walking or doing something else. But it's been challenging not to… Erm, it's been quite frustrating'* [Greyson, p.2].

Findings from the interviews at this early stage in the pandemic revealed clear evidence that group membership and, more importantly, positively experienced relationships within occupational in-groups, were highly valued by the participants. The experiences of social connectedness and belonging were reported in all of the interview transcripts. Being physically in-work allowed participants to experience emotional connectedness and a collective sense of togetherness with those whom they shared a professional social identity. This clearly helped in terms of fulfilling social needs and provided a level of protection against threats to self-esteem and self-efficacy. It also helped to reduce their feelings of loneliness, isolation, and distress and, from their accounts, appeared to assist with emotional regulation. These benefits enabled participants to feel a sense of belonging through mutually affirmed relationships and to feel supported by other members of their group.

'*I've got some really good colleagues and one of my peers was, was, really good and erm I could talk to… she was working opposite shifts to me, so I was able to talk to her, you know, anytime, day or night and, and she really got me through it to be fair'* [Osian, p.3]

'*Even if it's someone that you've only worked with once or twice, they're always really supportive…just last night I was working with somebody that I've only ever worked with once before…and we were sharing stuff left, right, and centre. I mentioned about a particularly bad job I went to last year that I was urm….err….. that took quite a lot of counselling to get over. She shared her experience, and I shared mine, and I feel that really, really helped. We talked… about covid last night and the worst patients that we've been to that have been confirmed so yeah, I feel there's a lot of people that we can rely on to share experiences with. It just helps you with that emotional side, instead of bottling it up and two weeks down the line you're wondering why you're crying into your glass of wine. There'll be an ear to listen as long as you offer it back'* [Sally, p.3].

In addition, the data highlighted the vehement importance of having time for in-groups to come together as a collective, to talk through the difficult scenarios being faced, to share experiences and ways of managing and responding to the adversity which included that of collective normalising as a means for further reducing distress.

'The coffee room has always been the place where we share our stories and we talk about incidents and we take learning from other colleagues through that as well, and you know, the tales are very common. At the moment, they all have a strong theme of decision-making is very difficult, uncomfortable decisions as well, the number of younger people that we're attending in cardiac arrest, and that also plays on the emotions as well…' [Paul, p.5].

Important to note, however, was that whilst many of the interviewees' narratives positively reflected perceptions of themselves in relation to others at work resulting in feelings of social connectedness, that from other participants highlighted less affiliation with in-group members and thus, a weaker sense of belonging. In these instances, other significant relationships such as those with partners and/or external friends were generally felt by these participants to be more validating and more supportive, although this was not always the case.

'I think I'm more likely to come home and talk to somebody outside of work who I probably know better. I don't know if this is just me, but I don't feel like it would be professional of me to show a lot of emotion to my colleagues and I suppose because I'm probably a bit older as well and I'm a paramedic, I might be with a new technician I don't want it to seem you know, I wouldn't be bothered if they did, but I would feel like if I started to get really emotional about the job, but then they might feel is she, she OK? or yeah… I know, I know that's probably wrong as I know it's not a sign of weakness, but I'm more likely to bottle it up and get on with it at work and then come home and talk to my husband or ring my friends' [Gianna, p.4].

'…my partner's a police officer, he's here sometimes….his shifts are more erratic than mine [laughs] but when he's not about I access my friends a lot more than my family erm but even my partner…not a lot has changed for him in terms of how they operate and work, so I've found it frustrating that he's not fully understood the pressures I'm under or the things that I'm facing and the emotions that I'm going through because it… because we can't relate to it as we usually would do…' [Greyson, p.2].

5.7 Organisational socio-cultural processes

Data collated from the participants indicated the profound social psychological impact of the Covid-19 pandemic upon ambulance service cultures. Indeed, their narratives starkly highlighted how the early

months of the outbreak signified a time of rapid socio-cultural adaptation in terms of shared goals, interdependence, and utilitarian behavioural changes associated with strategies to contain virulent spread and mediate psychological harm.

As such, this theme may be understood in terms of three sub-themes: transitioning and embodying symbolic cultural change within everyday practices; conceptualisation of the social realities of the pandemic; and group processes, social relations, & leadership.

5.7.1 Transitioning and embodying symbolic cultural change within everyday practices

Critically, the earliest phase of the pandemic (between March – May 2020) effectuated a fundamental shift to almost every aspect of participants' occupational and social life. While individualistic experiencing was articulated through their narratives, also expressed were contextualised references to occupational practices which, through detailed qualitative analysis, provided insight into collective constitutions of organisational life and enlightened understanding as to the socio-cultural construction of knowledge and ontological meaning ascribed to this new phenomenon.

This was most notable in respect of the significant operational and clinical practice adaptations which were discussed in detail by all of the respondents. Meso-level analysis of the data uncovered that in response to the emergent threat, a social reality of top-down structural and procedural changes to habitual practices took place; these altered routinised patterns of behaviour that had ritualistically persisted over time. Indeed, previously taken-for-granted assumptions relevant to traditional practices (such as those associated with resuscitation and end-of-life care) were thrusted into interviewees' conscious awareness when national public health directives required new, modified procedures (some of which were deemed to be ethically questionable by the participants), to become quickly embodied within everyday norms and practice with no preparation.

'I think it's changed the service as a whole to be honest, not just the ambulance service but the NHS as a whole and how we deal with patients using a more hands-off technique and keeping that whole social distancing stuff. We're trying to assess patients without physically touching them as much as we can before we start doing observations... You find yourself leaning towards doing a temperature before you do anything else. It's like a complete change in practice in such a rapid space of time' [Sally, p.1].

'It does make things more awkward, and talking to patients when you've got a mask on brings challenges. You have to take more time to make sure that you explain things and that they can hear and understand what you're saying' [Alan, p.6].

Micro-level inquiry revealed how these new practices not only transformed participants' language to include vernacular terminology not previously part of their daily work-related vocabulary (such as 'social distancing', 'quarantine', and 'aerosol generating procedure') but also identified important changes to socio-cultural dynamics.

Transitioning overnight from established guidelines to new procedures was challenging for many of the interviewees. Some disclosed existential questioning around the morality and ethics of what was being asked of them; particularly around not transporting some critically ill patients to hospital, and not immediately carrying out the full range of clinical skills during a cardiac arrest (due to infection control and PPE requirements), for example. Indeed, silently articulated within their narratives, participants intimated that underpinning these adaptations was much unease at the transgression of previously held beliefs, norms, and assumptions assimilated through their clinical training, experience, and protocols, and how these could no longer be held as a true point of reference for their occupational life-world experiences.

'I think we've all been on a steep learning curve, clinically anyway, coz quite early on we were stopped from auscultating, and it just feels like you've lost a limb to be honest with you, because it's such a basic thing. I quite miss it! … It's a key corner stone of our practice. So, you're trying to form a clinical picture from a different way. That's been the topic of conversation amongst people – how they've adapted their practice to try and fit in line with the new regime…' [Simon, p.2].

'I think it's also the concern of what things aren't being treated at the moment especially in care homes where you've got patients who are… blanket sort of… ReSPECT forms[3] *being done and……. You treat what you can, but it's what's achievable, and what's realistically… it's mainly in the resuscitation situation, what are the co-morbidities, and looking at the JRCALC coronavirus algorithm, it's a nightmare to navigate. Looking at it, it is not the clearest'* [Alan, p.4].

'From when I started, first started working with the ambulance service to now, has hugely changed, I think. I have felt even in the three weeks, four weeks, I've been working there, that corners were hugely getting cut' [Tony, p.6].

Reflecting a time of considerable uncertainty with little known about the virus, saw some of the more experienced participants seemingly anchoring this new phenomenon in respect of similar prior outbreak experiences such as bird flu or SARS. However, the majority of the interviewees had no previous reference point and thus faced considerable behavioural adjustment to adapt to this new 'normal'. In this instance, analysis of their narratives informs that they often referred to established cultural beliefs, values,

[3] ReSPECT forms refer to Recommended Summary Plan for Emergency Care and Treatment. The document provides a clear advanced plan of recommendations for the named person's emergency clinical care when they no longer have the capacity to make their own decisions or express their choices or wishes. This can include decisions around resuscitation. Each plan should be completed on an individualised basis (rather than being a blanket policy to those fulfilling a particular status or demographic (such as 'the elderly') and should involve discussions with the person unless they are unable to (due to being unconscious, for example).

and assumptions which appeared to be important as a basis for making sense of, and constructing meanings about the crisis being faced, and rationalising the radical clinical and operational changes that were being asked of them by their employers.

'I've noticed that those who are finding it a little bit harder are classed as 'old school' paramedics who are used to doing things in a certain way, and they're probably finding it a little bit more difficult. But those of us that are in the education side of things, still going through that learning process, we're still quite young and we find it a bit easier to adapt our practice' [Sally, p.1].

In response to transitioning into the new measures, it was apparent that, via the establishment of new rules, guidelines, and operating procedures, as well as infiltration of new knowledge about the virus from other sources such as government briefings, social media, and the internet, participants developed individualised and collective mental representations about the viral contagion, providing an ambulance-centric cultural framework from which the pandemic was understood. Subsequently, these collective representations were seemingly influential in the resultant psycho-emotional responses that the participants experienced.

Importantly however, in developing these mental representations and attempting to 'normalise' their new reality in response to the viral threat, interviewees further indicated collective and conflicting juxtapositions which emphasised the de-stabilising of workplace practices. Their narratives suggested that profound social and clinical costs were felt in attempting to provide care for patients whilst simultaneously attempting to be physically distant, and similarly, protecting colleagues by sitting apart in crew rooms, yet working closely together on calls. As previously discussed, this often emotionally manifested as moral and/or traumatic distress.

'It seems a bit silly social distancing on station when you're spending most of your day in an ambulance with your crew mate, and you come back to station, and you've got to sit on opposite sides of the room. I can understand where they're coming from, they're trying to make things as best as they can, it just seems a bit unrealistic' [Marcus, p.2].

5.7.2 Conceptualisation of the social realities of the pandemic

In response to the unfolding crisis, internal communications between employees within ambulance trusts were re-modelled from established systems of information sharing to the rapid dissemination of critical information. Nonetheless, many of the participants felt that the organisational dynamics around communicating clinical and operational information was either exceptionally fast-paced or excessively slow, and not always transparent or accurate. Despite being informed by guidance from wider public

organisations, some participants questioned their scientific validity and credibility, and they took time to research information themselves as a means to evaluate the details being provided to them.

'Information was lacking and it's sort of dripped through different channels…' [John, p.2]

'My email box has gone mad with updates. We get constant updates, which is fair enough cause obviously, we're aware that everything is evolving everyday with the science and how we manage things, and things are working, or not working and you sort of expected that, really…. Where nobody's talking to each other, they all send the same emails, so you get it four times, unfortunately. It becomes a little bit tedious' [Rod, p.2].

Respondents subsequently expressed that internal communication interactions became chaotic, ambiguous, uncoordinated, and frequently repetitive. Communications were often difficult to keep up with and participants shared feelings of information overload, stress, and confusion about what was expected of them. Furthermore, they highlighted how resultant uncertainty increased fear, mistrust, and hindered sense-making as they felt greater disconnect between themselves and their employing organisation.

'The daily emails, it's like 'what have they changed today?'… It was very confusing at first' [Natalie, p.2].

'You just try and do the best you can but there's that much information getting thrown at you, left, right and centre, that there's things changing daily. Sometimes you might have three updates in one day. There's been a couple of days where one update came out and then something had changed on it, and within an hour, they'd sent out another process and you're like 'What am I doing? Am I doing this, or am I doing that?" [Marcus, p.5].

'The biggest issue was that on the hour, every hour things were changing so very quickly so, different hospitals were coming up with different plans for this, that, and the other. The firm was reacting to these and then we were having to put things in place, so err, initially, for the first month at least, it was a bit of a nightmare. Constantly, things were changing literally by the hour' [Adie, p.1].

'What immediately comes to mind is confusion and frustration. I think there's been a lot of miscommunication. It's felt like you're being bombarded with information, with Public Health England, the World Health Organisation, NHS England and [x] ambulance service, and the hospital trust that we go to have been bombarding us with information. At one point we were getting daily, if not twice daily updates from the ambulance service, so it made it really hard to keep up with what they want from us and what they expect from us, especially when it comes to levels of PPE' [Joel, p.1].

They did, however, acknowledge that scientific knowledge about the contagion was rapidly evolving which subsequently contributed to a gap between risk of transmission and the dissemination of guidance

and procedures that were to be implemented. Thus, there was a notable juxtaposition – a demand for the most up-to-date information on how to best mitigate the risks with clear instruction, yet a feeling that the intensity of communications was overwhelming and did not always deliver messages that made them feel reassured, safe, and supported.

5.7.3 Group processes, social relations, and leadership

The empirical evidence highlighted how, in the early phase of the pandemic, multiple complex challenges presented for emergency frontline responders at the operational and tactical level, and their respective organisations' strategic response. Occurring spontaneously, participants talked from the perspective of identifying as part of their collective group such as their combined 'fight' against the virus, and citing feelings of togetherness and a sense of belonging – whether that group was representative of a small number of peers, a station, an organisation, the NHS, or their profession as paramedics, nurses, etc. In contrast, however, when talking about their social relationships with leaders, there were polarising experiences. Some participants indicated how leaders were embodied as part of their in-group and with whom they shared a sense of connection and identity. In these instances, the leader was prototypically incorporated into the perspective of 'us' and 'we'. This was seemingly facilitated by pre-existing relationships, shared experiences, and social interactions whereby the leader was previously positively connected with and respected by in-group members. When talking of these leaders, participants showed reflective functioning within their narratives and an acknowledgement of the heavy burden and stress that their senior colleagues were likely experiencing in response to the pandemic. These were leaders for whom there was considerable trust and a sense of solidarity.

'I think the management do a really good job. They're always approachable…. they're on the end of the phone, we've all got their numbers – we can always give them a ring…. to be fair, they're all individuals and they all have their good points and their bad points but in general they've all been really, really good from my experience… everybody expects the management… to have all the answers but they're only human beings and they've never done it neither, so they're thinking 'well, what do I do?' well, hang on a minute, they're trying to work it out as well. Unfortunately, they're the ones who have to make the decisions and we're all going 'well come on then' but it's not as easy as that. If you put yourself in their position, with all the knowledge in the world you might not come up… because this is something brand spanking new. It's like 'well what do we do now?' and they're trying to think on their feet and make decisions as they go…' [Dan, p.11].

'As far as the managers are concerned, they've been working a little bit harder than they usually do. They're making sure everybody's got the equipment they need, and things are happening quicker than they used to. If we need anything or if anything breaks on vehicles or on station, it's being rectified fairly quickly' [Rod, p.4].

That said, a small number of participants indicated a level of disconnect between the hierarchical roles – such as referring to in-group members as 'us' and leaders as 'them'. This was particularly notable in terms of perceived non-prototypicality whereby these respondents felt that their leaders did not symbolically represent those behaviours, beliefs, and values that were collectively held in high esteem by other in-group members, and thus there was a disconnect in terms of a collective shared identity. Cited examples included perceptions of leaders who physically and emotionally distanced themselves from frontline workers, and appeared passively resistant to assist with calls, especially those to patients with probable Covid-19.

'There seems to be a bit of distrust between us and management. They're stuck in their little office and do the duty car just doing… just, because you know, that's what they're expected to do by the trust. I think a few of us understand that but in the grand scheme of things, they're not out on ambulances like they usually would do in their contact shifts or erm… or with their team… embedding themselves in the office, doing admin work, watching the jobs stack, restocking PPE… They're probably just as snowed under as we are, but it just feels very disjointed as a team on station. I kind of see it as we're one big family but at the moment it's seems like everyone's breaking off and becoming frustrated with each other' [Greyson, p.3].

'I don't think the managers are seeing the pressures we're seeing on the road because they're dealing with…. they don't actually see the emotional toll, the physical toll, the mental toll it's having on us because they're dealing with the other pressures of trying to co-ordinate everything and….' [Keisha, p.5].

The inter-relational social dynamics between leaders and followers was also noted. Interestingly, in a key finding from those participants who were leaders, some articulated reference to embodied categorisations that positioned 'staff' as depersonalised group members – thus pluralising individuals and separating them from the leaders' in-group of peers. Again, this was apparent in terms of use of social categorisations such as 'them' and 'us', and contextually emphasised the boundaries between in-group and out-group membership.

In comparison, other leader participants confirmed authentic salience, social connection, and identification with their staff who were much perceived as in-group team members. They typically displayed considerable concern for the psychological, emotional, and physical welfare of those colleagues for whom they felt a sense of responsibility and saw it their duty to ensure that staff had adequate resources to enable them to do the job. Where they were not able to enact a sense of duty to and be fully supportive of their teams due to factors such as organisational structural processes or situational circumstances, these participants talked of experiencing significant guilt.

'I had a guilt trip for a couple of months because as a first line manager, I'm not out and about as much as the rest of the staff and when there was all this clapping on a Thursday night, you know the clapping for key workers… I suffered a bit of

a guilt trip because I wasn't doing enough or I wasn't doing as much as people working on the frontline, & I didn't deserve the applause and support…but I've sort of got over that… I thought 'no, I've still got a role to play in all this. I'm still going out and doing a shift and I'm still helping by supporting staff in the background' [Willow, p.3].

Through their narratives, these respondents appeared to hold an appreciation of their relational self, were deeply invested in their team, and prioritised the promotion of equity and fairness amongst members. Indeed, this authentic approach was seemingly rewarded by enhanced levels of trust, as they told of staff who had in the face of the pandemic crisis, permitted themselves to be vulnerable with them and had sought their help and support in confidence.

'I've got a really good relationship with most of the people within my team. Most of them are very young and some of them are relatively new paramedics, less than five years, and it's been hard for them' [Harper, p.2].

'I'm not seeing the level of suffering of Covid patients that everybody else sees, so when I do come home, I'm coming home without having that stuff going through my head. I have the concerns of my staff going through my head, so I speak to people on my days off. Most people have my personal contact number, so they'll ring me if they're on shift but I'm not, and I will still talk to them and I'm discussing things with them on my days off, so my down time isn't 100% my down time but I would rather do that than ignore somebody who needs help…' [Liz, p.11].

Critically, the empirical data provided insight into how individuals saw themselves as part of their groups and in relation to others, such as leaders. However, more detailed narrative inquiry revealed much about relational dynamics in the context of a crisis - such as the cognitive-affective processes (or representations) deeply embedded within their interactions, upon social identities and organisational behaviours, and which subsequently mediated support and help-seeking in response to threat.

Indeed, some participant leaders symbolically intimated a parental conceptualisation of their role in socio-relationship with their team; taking on a nurturing identity and providing support, reassurance, and guidance, as well as safety and security – whilst internally holding their own fears and anxieties about the uncertainty of the situation and trying to calm team members when little was known and resources within some sectors were becoming challenged.

'I almost feel like their mum a lot of the time because obviously I'm that much older than them, but I feel like it's my duty to be able to, or to support them, and also… I feel that's part of me. I tend to like to look after people and I like to look after my team. I'm immensely proud of all of them… I suppose it's a bit of maternal instinct coming out around all of this, but yeah, I think they've struggled a bit and I feel like I need to be there to help them' [Harper, p.2].

'I… ask them if they're looking after themselves and make sure that they do look after themselves to which I tend to get the 'yes Mum' comment but I feel better for asking them' [Liz, p. 10].

Subsequently, follower dynamics were illustrated in terms of emotional and physical proximity seeking of connections with their leaders and others, including spending more time talking with them in their office or at the hospital, and seeking advice, for example.

Where a leader (or close colleague) was perceived to be physically or emotionally unavailable, unsupportive, and/or unable to provide advice or guidance in response to the rapid changes, or their responsiveness was perceived by followers to be lacking, some participants alluded to elements of separation distress including anxiety and avoidance behaviours. Keisha, for example, discussed a distressing incident that resulted in her finishing her shift four hours late. She explained that:

'*When I got back to station, we didn't get the debrief on the job, you know, the sort of things we would normally get, we didn't get 'are you ok?' 'do you need anything?' and all I wanted to do was sit and talk through what I'd done because doing a cardiac arrest Covid style is completely different to normal…. and the manager had no time, well appeared to have no time, so I just walked out…. And since then, nobody management wise is double checking – are you ok? They're checking up on the people that are sick as per normal but I think they're forgetting to check up on us that are working and there should be something in place where we could go, you know, we could talk about what we're feeling at work, but because we're still at work it's like you don't need the welfare check because you're in work, and actually sometimes, I think we do, we probably need it more……'* [p.3].

Asked how she felt this impacted the relationship between her and her leaders, she added, *'I'm avoiding managers now because they don't understand. That's the perception [sounds angry]. Urm, I won't go to a manager now… so it's actually putting up a wall between us….' [p.3].*

5.8 Conclusion

This chapter has captured the social realities of the participants in the first few months after the Covid-19 pandemic was declared within England. Presented here are the findings from the first phase of interviews which through latent level thematic analysis and interpretation, provides deep insight, taking the reader into the implicit social psychological dynamics operating within the socio-relational space of ambulance service culture and within the context of social relationships between participants and their peers, managers, and society. This level of analysis has allowed for the uncovering of beliefs, assumptions, and social structures that are inherently embedded within these communities. In this way, the discussions in this chapter have drawn conceptual connections with the theories of both social identity and self-

categorisation. As such, this chapter has explored themes arising from the participants' narratives including their experiences of prosocial and antisocial behaviours from the public and the dichotomising sense of appreciation yet threat to their social identities – particularly in respect of the 'hero' narrative underpinning which were societal expectations that ultimately, healthcare workers should be self-sacrificing, even if this meant giving their lives.

Psychological distress was a strong theme emanating from this period of time. The key findings here, were those of intense fear and a perceived deep, painful sense of betrayal by the participants' organisations. This led to ruminative distress at feeling inadequately protected by the personal protective equipment and at the perceived dehumanising and undignifying practices encountered in response to newly updated clinical and operational procedures. It was clear that almost all of the participants placed high regard in their belonging to and working for the ambulance service with a deep sense of duty to serve. It was this shared experiencing that I believe contributed towards their shared social identities of what it means to be an ambulance practitioner in the context of this pandemic, and as such they placed high importance upon their in-group memberships and social relationships. This gave a deep sense of togetherness and clearly was very relevant in terms of fulfilling their social needs and in collective emotional regulation when faced with a novel virus that was a significant threat to their lives and those of their families. Nevertheless, the data showed how such group entitativity underpinned by prescriptive norms and emotional feeling rules guided their responses to adversity and trauma. The evidence identifies how dissociation, avoidance, and suppression were drawn upon to 'manage' distress or difficult emotions to enable ambulance practitioners to continue to uphold the in-group normative beliefs, potentially so that they would not face isolation from other group members.

The next chapter will discuss the findings relating to the second phase of interviews.

Chapter 6 – Feeling the Strain:
Empirical Research Findings Phase Two

6.1 Introduction

The second phase of qualitative interviews were conducted between 11th September 2020 – 22nd October 2020. This chapter presents the empirical findings and analysis of data collated from the twenty-one participants who, following their involvement in the first round, continued to engage with the study and contributed to this stage of the research.

6.2 Situational context: May – October 2020

Between the end of May 2020 (the time the final interviews from phase one were completed) until the end of the second phase of interviewing, infections with Covid-19 had significantly multiplied across the world, particularly within England, with the death rate exceeding 40,000 people at the beginning of June.

During this six-month study period, a vaccine to halt the contagion was in the process of being developed, meaning that the only way of containing viral spread was simply understood to be via behavioural changes such as good hygiene practices, the wearing of PPE such as fluid repellent surgical masks, and continuing to physically distance and isolate from others if infected or susceptible to illness. Covid testing for key workers and those with suspected infections also became a tool for monitoring during this phase, with approximately 30,000-50,000 tests being taken per day in May and June 2020, rising to over four million by mid-August (Flynn et al, 2020).

Whilst the early summer months saw a decline in national infection rates, considerable uncertainty remained in respect of a second deadly wave developing. This was particularly feared by healthcare workers, in light of impending 'winter pressures' upon already stretched and exhausted health services.

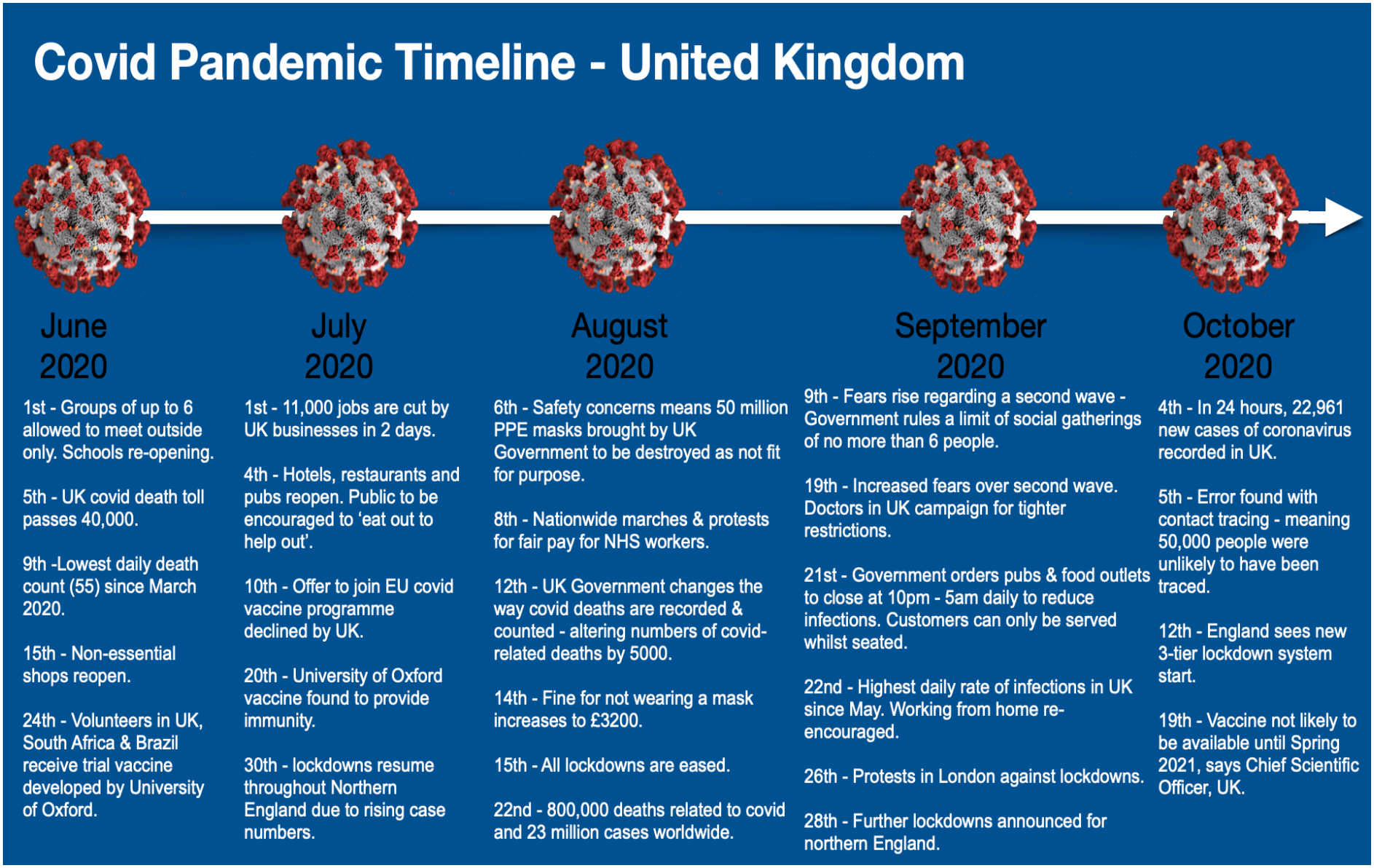
Indeed, the time between the first and second phase of interviews saw a considerable shift in landscape for urgent and emergency healthcare services within the UK. Figures for attendances at Emergency Departments reported a steady rise during this period (The Health Foundation, 2020b), which was arguably mirrored in terms of ambulance service demand. However, in contrast, October 2020 saw two million fewer GP appointments available than that month in the preceding year, and the numbers of patients referred from primary care to cancer services reduced by sixty percent (The Health Foundation, 2020b).

The disruptive transformation of national health services brought innovative ways of working and less bureaucratic processes leading to new, normalised care pathways in some specialities (Association of Ambulance Chief Executives, 2023). Despite this, as the pandemic continued, significant deficiencies and disparities in the delivery of care were being exposed – including that of socio-economic inequalities within wider healthcare and how a stark historical lack of investment in preventing ill-health had seen an increased prevalence of chronic diseases (Authority of the House of Lords, 2020).

Considerable efforts made to create additional capacity within the NHS during the first wave continued into the early summer. Financial incentives for ambulance services enabled enhanced capability in the form of mutual aid from partners such as the fire service, military, and St. John Ambulance, as well as resources from private ambulance companies. Furthermore, business-as-usual activities such as training and secondments were cancelled, and operational managers were deployed to frontline emergency response. This resulted in an extra 614 double-crewed ambulances available per 24-hour period within England (NHS Providers, 2020). By July 2020 however, such mitigations were becoming economically unsustainable and were subsequently withdrawn. Increasing contagion towards the autumn saw these measures briefly re-emerge, although this was short-lived despite the demand for ambulances continuing to rise further. Critically, additional pressures associated with social distancing and infection control measures (such as needing extra time to clean ambulances and equipment) (Morris, 2020), as well as rising levels of employee sickness absence, and protracted waits outside Emergency Departments leading to handover delays (quoted as 40,000 lost hours in September 2020 - NHS Providers, 2020), further compounded ambulance service response thus testing not only its organisational resilience but also that of its workforce (Authority of the House of Lords, 2020).

Illustration 2 overleaf summarises the key pandemic milestones within the United Kingdom during this time period.

Illustration 2: Covid Timeline – United Kingdom – June 2020 to October 2020



6.3 Phase two data findings

In relation to the research questions, thematic analysis of the qualitative data generated from the second phase of interviews revealed three interrelated themes and subthemes.

Key themes and sub themes:

1. Societal, group, & interpersonal expectations: Salient role identity dissonance and the pandemic as an identity challenging event.

2. Psychological Distress & Emotional (In)Expression.
    a. Moral incongruence, psycho-emotionality, psychological distress, and growth.
    b. 'Becoming battle weary': Emotional exhaustion, cynicism, and depersonalisation.
    c. Intrapsychic and collective psychological growth through adversity

3. 'Greedy' Organisations, Adapting Cultures, and Social Relations.
    a. 'Shutting the stable door after the horse has bolted': Social norms and social behaviours
    b. Toxic normality: Social relations, 'Bums on seats' and 'Getting on with the job'.
    c. 'Get the Kettle On': Prototypicality and the positive social role of ambulance leaders in a pandemic context.

Each of these themes will now be examined in light of supporting empirical evidence gathered during this study.

6.4 Societal, group, & interpersonal expectations: Salient role identity dissonance and the pandemic as an identity challenging event

Further to data analysis of the first phase of interviews which highlighted an unprecedented shift in public perception elevating the social value of paramedics and ambulance workers, data collated from this second phase indicated how participants' lived experiences of working on the frontline during the pandemic had changed; not only in terms of how they perceived themselves, but also how their work and occupation was viewed and valued by others.

Narratives from the first phase of interviews highlighted how social representations of the pandemic had elevated the professional status of ambulance workers and made their roles more socially visible. Whilst this was often acknowledged by them as embarrassing, many participants also felt appreciated and valued

for the service they were providing at such a critical time. For these participants, this resulted in an increased sense of worthiness, enhanced esteem, and sense of belonging to their occupational group. However, a level of scepticism also ensued as to the temporality of this public view and feelings of pressure transpired around societal expectations that, in being 'heroes', paramedical staff should place their own safety at risk to save others.

In the second stage of interviewing, however, participants shared how societal perceptions and expectations had again shifted, with their valorised 'hero' status in the process of being cast aside. No longer were members of the public standing on their doorsteps clapping key workers or lighting up buildings in NHS blue. Whilst this was experienced as a bit of a relief by the participants who intimated that they were keen to resume a level of invisibility, they highlighted that pre-pandemic deeply rooted sociocultural norms were starting to once again prevail, indicated by a changing attitude amongst some towards ambulance and other healthcare staff which, at times, was now less than appreciative and more akin to that experienced prior to the outbreak.

'It was a relief when that [hero discourse] died down a little bit… The public swell of focus on frontline staff has just disappeared really over the last couple of months, which led to some weird pressures on staff earlier in the year to perform to the expectations of members of the public, and thankfully, that's gone now so that's taken a little bit of the edge off it' [Willow, p.5].

In response, interviewees expressed an impending sense of worthlessness and dwindling professional fulfilment, particularly in relation to their increasing attendance at lower acuity calls which left them questioning the salience of their purposefulness and identity in relation to society. Indeed, attending such calls did not align with their social representations of paramedicine, whereby critical (often lifesaving) clinical decision-making and problem solving were highly valued, and had felt to have been reinforced by other professionals and members of the public during the earlier months of the pandemic. This cognitive dissonance at the returning day-to-day mundane reality of the work appeared to lead to collective introspection of the arguably incongruent expectations they held of their roles, profession, and organisation. Furthermore, it also seemingly led to subconsciously questioning 'who am I now?' and experientially reconstructing a sense of self based upon these re-emergent role identity meanings.

'It's a little bit harder now going to those jobs you know you don't need to go to because, I went to a 17-year-old with a nosebleed… That was on my last shift, and I literally said to my crew mate, if this was three months ago, we wouldn't be going to this, so that's quite hard… I think they're the same frustrations we probably had a year ago, but it just seems to be more obvious now because we've had some months without that, and we can see that, there's kind of, we managed it before so how can we be going back to this?' [Gianna, p.1].

'It's getting weary because you just look at the jobs and go 'oh here we go again' [sighs]…' [Natalie, p.1]

'The general public have… gone back to their old ways of calling for a headache or a tummy ache. I think the crews are again now seeing that this is all we're doing day in and day out…' [Liz, p.1].

Further examination of the data highlighted that the salience of their sense of purpose and meaningfulness as ambulance personnel was equally bound up within the socio-relational context of their role identity as perceived by key others. Foremost, this included their wider profession and employing organisation – which will be explored within the final theme of this chapter, but also included their perceived identity, value, and status positioning by other professionals such as General Practitioners. For some, this indicated a negative discrepancy between the perceived and enacted role of those working within paramedicine, and reflected a low sense of worth seemingly projected towards their identity from other professionals:

'The real bug bear I've got is GPs, the fact that they don't, that their right to life and not catching the virus is greater than mine because they will send for an ambulance to go and 'check a patient out' now, from behind their desk, whereas normally, they would have gone out or sent one of their team to go out and check the patient rather than expect the ambulance service to do it' [Pete, p.3].

'We get fed-up with being the doctor's bitches. The number of GPs that are now using us because they won't see the patient at the surgery. They're sending us out for us to have 'eyes on', for something that they should be dealing with which is inappropriate use… I was working a Friday day shift, and I'd done three 'eyes on' for one GP surgery. Those were my first 3 jobs…. That's what they're doing because they can't be bothered to go out or they don't want to go out because they don't want to get Covid... But we're the cannon fodder. And that's how it feels. The doctors don't see it like that. It's 'oh no, it's breathing diffs, you've got to go out'…. 'Err, they've got a chest infection. They told you over the phone that they've got a chest infection…. Why can't you see them?' [Keisha, p.1].

Concrete experiences such as the above arguably reinforced and threatened participants' role identities to which they aligned, and subsequently led to feelings of disillusionment and anger, particularly towards healthcare systemic processes viewed as perpetuating this ideological discourse.

It was interesting to note the term 'cannon fodder' was again utilised by several of the interviewees, representing a social identity perception that they were dispensable, exploitable, and of less value than others – which sat at odds to how they had been cast as heroes by society just a few months earlier, and equally, was also juxtaposed to how they saw their role and what they believed their role should be (someone who professionally responds to life-threatening emergencies).

Unpacking participants' narratives further highlighted the importance of role identity salience in relation to their sense of self. Despite role identity dissonance and disruption, almost all indicated an altruistic love for their job, which gave them a great sense of fulfilment. Indeed, being a 'paramedic' or 'ambulance person' featured as a significant part of their sense of self – which some participants alluded had become more meaningful and more prominent during the first six months of the pandemic compared to prior times. They talked of unwavering pride of being in their role and wearing the uniform. They intimated a deep sense of duty and dedication to providing emergency care and showed considerable identity allegiance to their service. Furthermore, many indicated a deep sense of belonging to those working within ambulance services, regarding them as 'green family'; green denoting the colour of the uniform and the Battenburg markings on ambulance vehicles. In this way, the job was seen as a vocation and a way of life that was strongly identified with.

'My work defines me to quite a large extent, and I'm not saying that it's all there is in my life, but it is a significant proportion of my life and I've made sacrifices to do this. It's cost me a marriage because my wife, her position was she was in a normal 9-5 job, and she didn't marry me to not see me. I was saying 'yes, but this is the job' and it did impact on the family and time we could spend together… It came down to a choice between the job and the marriage and I chose the job because I know that's there for me regardless – unless I do something really stupid. That's how important it is to me. Now, you might think 'what an idiot, why would he do that?' but I feel that strongly about doing the job and doing a good job. It's a very, very big part of my life. So, to answer your question I'm not completely defined by it, but there's a large part of me that is' [Simon, p.3].

'I think for me, it's more than a job. It's my vocation and I love going to work. I feel very proud to wear the uniform and treat patients. I think sometimes, as well, I think we can go into the worse scenes ever and bring a bit of normality and a bit of calmness. Equally we're allowed into people's homes that no one else has been in for months on end. We're the first person or human that they've seen, be it with a mask and an apron on, but you can still talk with them' [Greyson, p.3].

'I am proud to work as a paramedic…it's certainly part of my identity, part of who I am…' [Osian, p.7].

Interviewees' role identities provided them with purposeful focus and satisfaction, even if their role had changed in response to the rising contagion (for example, line managers taking on frontline roles). Interestingly, this was even the case where, implicit within their narratives, participants were experiencing early psychological distress, burnout, and moral injury associated with pandemic working. Harper, a first-line manager contrasted this, however, feeling that:

'My thoughts about work now are different to what they were six months ago. Six months ago, I wanted to be here as much as I possibly could because I wanted to be able to look after my team and support them, as well as see patients, obviously. But I don't think I feel the same now…' [Harper, p.6].

For Harper, her conceptualisation of self as a paramedic seemingly was no longer salient nor fulfilling. She unknowingly questioned her fit within her team and deliberated her sense of purpose. A disparity between her core beliefs and values were now juxtaposed to those held by members of her peer group, leading to a fractured sense of belonging. In this way, Harper's narrative shows how, over this period of the pandemic, her social identity was in the process of being re-calibrated in light of societal (and more specifically, organisational and in-group) expectations, and she repositioned her sense of self within the context of these changing beliefs, organisational and group norms, values, and ideologies.

Compellingly, the second phase narrative data further revealed the competing importance of other salient social role identities to participants – notably, the roles of 'partner', 'family member', and 'friend'. It was evident that pandemic conditions were unknowingly perceived as threatening to the stability of participants' salient role identities, thus creating cognitive dissonance, experienced as being disruptive and conflictual to their sense of self.

Correspondingly, this was revealed within some interviewees' narratives as a belief that they were unable to fulfil expected social role attributes (e.g., being physically present for family and friends) because of barriers such as mandated physical distancing, shift working, or being a risk of contagion, thus leading to internalised identity conflict and existential distress, and feeling that this part of self is in effect, threatened. Furthermore, for some, the human connection and belonging they felt to their social and familial groups, was disrupted and temporarily lost, leaving them feeling isolated. These narratives highlight how important human connections, and a sense of belonging are to the participants in respect of validating their social identities.

'I remember driving home one day and I remember feeling quite isolated… I think the reality hit me that my job had caused me to be isolated from friends and family because of everything that was going on and that opened my eyes a bit to that side of things' [Greyson, p. 1].

'I think it's um I suppose it's more to do with where work crosses into personal life, thinking about people that I know who are more susceptible like my girlfriend's mum and dad. They're in their 80's and quite frail… Then you've got to think about mixing with people, passing anything on to my girlfriend's mum and dad… I'll stay x distance away from them. I'll stay as far away as possible. No one else has got masks on so I'll leave mine off but will look down a bit more and look away from them and think about when I last came into contact with someone… so you run through all these risk factors in your mind before seeing people just to work out how big a risk you are' [Jeremy, p.1].

'I've lost things like book club and one or two other things that I used to do' [Willow, p.7].

'I suddenly realised yesterday that I'd not seen a lot of the mums [on the school run] because we don't mix because they've got a very strict one-way system to pick up from school, and in fact, to avoid that, I've been standing further back down the road and my son's been coming down to meet me, so I've lost some of the social contact, just casual daily contact that I'd have with other people. I could message them but that takes more time and effort, doesn't it, than just standing and chatting to 3-4 people in the space of 5 minutes when you're waiting on the school run, so that's been a bit…. yeah… it's been a bit odd' [Willow, p.7].

Yet, these 'other' personal identities were highly regarded as important parts of self, which were symbolically represented as an 'anchor' necessary for grounding them and creating context from which they could position (or define) themselves and their world views. Indeed, the data indicated that this, and the connection with family and friends, was vital to the social construction of their professional role identity, as well as their self-worth and sense of self.

Contrastingly, examination of sense of self in relation to others also revealed how, within the changing context of the pandemic, the salience of social role identities was often competing and conflictual for participants. This was most evident in terms of role identity transition whereby interviewees disclosed the heightened challenges associated with prioritising and switching from 'paramedic' or 'ambulance person' to other social roles held and adjusting the self to the shared attitudes, beliefs, and behaviours associated with those in-groups. At times, navigating these social role transitions was exceptionally difficult for interviewees and those whom they were in social relationships with, leading to feelings of self-inauthenticity; feeling that one could no longer be one's true self within these contexts nor share how they feel or display genuine emotions. As Willow's dialogue illustrates below, she worked hard to compartmentalise herself and her feelings, attempting to dissociate and detach from her occupational distress when her family roles were salient. Disentangling these conflicting aspects of self amongst the blurred boundaries between work and home led to high levels of emotional regulation which was exhausting, and seemingly reinforced her belief that 'I'm not understood':

'I just come home and have a cry on the way home and then try and re-focus on the family when I get back, really. It can be difficult here [home] sometimes because my husband works from home in IT so in a completely different job. The children don't always fully understand what I'm on about or what I'm going through. Sometimes I just feel that I'd have to explain it all, so I don't tend to bother…[sighs]' [Willow, p. 7].

Analysis of participant data further revealed that when loss of social identity was felt or this aspect of life was deemed less fulfilling, interviewee's professional identity became more salient to them and more deeply embodied, leading to greater integration within their sense of self and psychological wellbeing. Whilst there was some suggestion of associated feelings of psychological safety and collective bonding amongst their in-group, several narratives, such as Willow's account above, talked of how this actually

amplified feelings of derealisation and dissociation from those in the 'outside world' – as they were not seeing and experiencing the pandemic as the participants were. Thus, without this shared reality, 'others' became unrelatable to, leading, at times, to internal intrapsychic conflict and psycho-emotional distress for these respondents, which then further reinforced the salience of their professional identity and sense of belonging to their ambulance in-group.

6.5 Psychological distress and emotional (in)expression

This theme is characterised by three sub-themes; the first is that of 'moral incongruence, psycho-emotionality, psychological distress, and growth'. The second is entitled, "Becoming battle weary': Emotional exhaustion, cynicism, and depersonalisation'. The final sub-theme is 'Growing through adversity: Connecting & recovering as an individual and through group membership'.

6.5.1 Moral incongruence, psycho-emotionality, psychological distress, and growth

The last theme highlighted the gravity of role dissonance to the participants, and how for some, this incongruity between espoused role expectations and reality resulted in considerable emotional, psychological, and existential (moral) distress. While the organisational aspects of this will be discussed in the next theme, it is important that further mention of it is given here, in terms of psychological impact.

Detailed narrative analysis from the second phase of interviews highlighted how, during this time interval, violations to intrinsic beliefs associated with morality and professional duty of care continued to be transgressed – but to a greater extent and impact than that disclosed by participants in the first phase of interviews. Role identity dissonance is an important consideration here, particularly where participants held pre-pandemic socially constructed schematic representations of themselves as 'ambulance personnel' who should 'protect' those within their care. Being unable to provide the level of care that participants knew patients required, making decisions about patient's care that violated their beliefs core to clinical paramedicine, and feeling helpless in witnessing dying patients were beginning to take root on a chronic basis. For affected participants, they intimated feelings of guilt, shame, and loss of existential meaning at experiencing multiple situations that were transgressive of their moral and professional values.

In the below excerpt, Willow talked of being 'forced' to take elderly asymptomatic patients into a Covid-19 positive area of the emergency department, a situation that was also iterated by several other participants:

'*I think some are struggling with, still struggling with having to take people in, knowing that they're going to a potential Covid area in the hospital. …. It's quite upsetting when you feel forced into doing that. I know that causes a lot of our staff stress and anxiety when they take patients in…*'

She added, that in respect of the risk of contagion to staff entering these areas of the hospital:

'…they're not bothered about walking around the department, but they are very concerned about leaving patients, the frail and elderly in those sort of environments when they perhaps don't need to be there. They're very focused on wanting to ensure that the patients are in the right place, and they're protected as much as they can be' [Willow, p.4].

The above highlights the selflessness of these ambulance personnel, but also reflects their cultural beliefs around placing others (in this case, the patients) before themselves and protecting them. This implies a strong sense of duty and reinforces more deeply held, hidden beliefs around their physical and emotional needs being secondary to the job, which is linked to feelings of worthlessness, emotional suppression, and depersonalisation.

For other participants such as Keisha, donning of PPE at the scene of the most serious of calls was deemed as delaying life-saving patient care, subsequently leading to deep intrapsychic ethical conflict and emotional distress. Talking of her attendance at a paediatric cardiac arrest, she stated:

'*You get frustrated because you know you've got to dress up [in PPE] before you can do something, and then, at the back of your mind, if they die, you're thinking, 'well, if I hadn't had to spend ten minutes getting dressed, could I have made a big difference?' we'll never know….*'

Researcher: *'You're left feeling guilty'.*

Keisha: '*Yeah, guilt, anger, everything….*' [sounds deeply sad] [p.6]

In disclosing her felt moral emotions in response to this situation, Keisha primarily experienced guilt – representing a negative evaluation of her behaviour of taking 'too long' to 'get dressed' in PPE and was associated with remorse and regret at the impact this may have had on the child's condition. In this case, guilt could also be understood to have been representative of a violation in the social relationship Keisha briefly had when attending the child and their parents. In response, she felt a deep sense of responsibility for the distressing outcome of the child dying. This is displaced as anger towards the organisation for whom she worked, and the structural processes they instigated around PPE which Keisha perceived to have caused a violation of her conscience and her moral beliefs of providing immediate life-saving care to patients, and therefore she angrily blames them for the death.

The traumatogenic nature of the pandemic was more widely evidenced within narrations that continued to centralise around psychological distress, fear, and anxious uncertainty in terms of threat to life and the future, albeit not as prevalently discussed as in the first phase of interviews.

'…the work itself was very stressful in the beginning because of Covid and you know, the constant worry that you're going to get Covid, and not being able to see people outside of work whilst work was very stressful, I really struggled with that at the start but it's definitely a lot easier now because I am still meeting up with people so that's definitely helped…' [Ava, p.1].

Greyson poignantly articulated the accumulative and complex trauma-related distress he experienced in response to pandemic adversities, including the sudden death of a close colleague to coronavirus.

'It's been quite a rocky road is the best way to describe it because I went off in June with stress… We lost our colleague about a week or so before, and there were things at home going on as well which kind of tipped the balance and I know this sounds… I'm used to seeing poorly patients but seeing poorly patients day in, day out, pre-alerting them into hospital, and then cleaning the vehicle from top to bottom just took its toll on me completely so I think I crumbled under the pressure' [p.1].

He added:

'It just exhausted me. I was taking an antidepressant before the pandemic started. I was wanting to stop taking it and come off it, but I decided to stay on it. One of the side effects is that it makes you quite drowsy so it's fantastic when you've finished work - it shuts you down completely. I think that's taken its toll in terms of being exhausted and feeling quite drained and I thought that all the PPE was a barrier to being able to care for patients properly and I'd lost the human touch element from it. That…didn't sit right with me' [p.1].

Even in these short quotes, we gain a sense that between the first and second phase of interviews (undertaken at the end- April 2020 and mid-September 2020, respectively), there had been a significant psycho-emotional shift for Greyson. Indeed, the above account alludes to his attempts to manage his distress via peritraumatic dissociative means such as derealisation and depersonalisation. These strategies allowed him to continue to respond to a relentless workload that offered no time to process emotions between calls. This is indicated by his comments about the side-effects of his medication which seemingly promoted detachment (or numbing) from his emotions and those parts of himself related to his occupational role as an emergency care assistant, through which he was exposed to highly distressing situations. Whilst this may have provided temporary relief and served as a protective function, Greyson provided insight into his embodied emotional experience in terms of a sense of psychological

fragmentation and emotional exhaustion as, for example, exposure to disturbing scenes of 'poorly patients' – those for whom their condition was life-threatening - became unrelenting.

It is quite apparent that the pandemic had also profoundly affected his relational experience of being-in-the-world with others, as wearing PPE changed social behaviours and interactions with patients. Subsequently, the transference of empathy and compassion through reassuring touch was limited, causing a great deal of anxiety and distress for Greyson, and indeed, other participants within this study.

'…that's what kind of led to me going off in June, because I just couldn't handle everything at once. Dealing with poorly people shift after shift, ripping them away from their family was the other thing that upset me a lot because normally we'd say, 'oh yeah, you can meet us at hospital' but there was none of that, it was 'your loved ones going to go to hospital on their own and they may end up on a ward and you may not see them again'… That's quite a hard reality to get my head around as well' [Greyson, p.1].

For Greyson, his emotional responses were related to triggered activation states in response to the perceived threat of the virus. The following excerpt indicates the level of psychological dysregulation he had experienced which also presented physiologically.

'I was always thinking a lot and it got to the point before I went off, where I would purposefully be late for work, so I didn't have to face anyone. I could just walk straight to the vehicle and my crew mate and go out on shift. He [Greyson's crewmate] had a block of leave just before I went off [sick] and I didn't want to work with anyone I didn't know… and even when I came home, I struggled to switch off. I still felt like my mind was going a hundred miles an hour. Things have kind of calmed down from that. It's difficult to try and break that cycle. It did give me nightmares, but it was more difficulty getting to sleep. It felt like I didn't get a deep sleep because my mind was still ticking over. I'd wake up feeling so exhausted for work and it got to the point where I just felt so run down' [p.1].

This quote deepens our understanding as to Greyson's distress. Heightened anxiety and hyperarousal (e.g., racing thoughts and disrupted sleep) are referred to in the psychoform of intrusive nightmares, thus reflecting dysregulation. Intrapersonal vulnerability is expressed in terms of emotional avoidance of trauma-related stimulus which was symbolically communicated through his mediated behaviour of being late for work, for example. In addition, he sought to isolate himself from colleagues, who were potential sources of social support, perhaps as a buffering mechanism – as a way of avoiding conversations that may have been distress triggering or even deeply shameful for Greyson, if colleagues were to see that he was struggling to comply with in-group normative rules around emotional display – thus highlighting potential cultural stigma around mental ill-health. Indeed, in his account Greyson alludes to only feeling trusting and safe enough to work with his long-standing crew mate. This in itself, communicates a

reflection upon the organisational culture in which Greyson worked, and the emotion management rules held by those within his in-group.

This participant was not alone in how he felt. In this phase of interviews, several participants intimated traumatic distress and heightened affect regulation within their narratives in response to their lived experiences of working frontline during the pandemic. However, articulation of traumatic distress was not always explicit. When asked by the researcher about their feelings and emotional experiences, it was evident how interviewees' responses reflected an emotional avoidance culture, by deflecting and trying to reduce to a manageable level or hide their distress through strategies such as dissociative detachment and denial; a finding which resonates with that identified in the first phase of interviews. For a couple of the respondents, this presented as intense rumination, indicated within their narratives as cyclical, repetitive thinking about specific behavioural aspects of the operational response to the pandemic (such as management behaviours with regard to social distancing).

'Mentally, I would say, I can be a proper empty void, as cold as they come. Now, I don't know if that's a shield that you put up over time to do the job but there's not much gets through, and I've thought to myself 'does that mean I'm somewhere on the spectrum, or does it mean that I've just been hardened to things by exposure?' because I know there's things that I'm exposed to that should upset me, and I'm just like, 'nah, not really' [laughs], or somebody else is emotional and I should be able to identify that but I feel like I've got a bit of a blind spot, so…' [Simon, p.5].

One of the most striking findings from this phase of the data was that, in contrast to emotional avoidance of the events facing them in the present moment in respect of the pandemic, there was a tendency among these participants to paradoxically and spontaneously share details of, and emotionality connected with, distressing calls that had occurred either prior to, or during the pandemic but were not explicitly related to the coronavirus. One possible explanation for this is that pandemic-related adversities were considered of great personal threat whereby emotions were raw and unprocessed. As such, avoidance perhaps allowed participants to control their overwhelming thoughts and feelings at a pace manageable to them. It is feasible that non-pandemic related incidents posed differing intrapsychic challenges that respondents had processed enough that they felt able to share their emotionality in respect of these particular events.

Our understanding of this phenomenon is deepened by Osian's account in which he talked of attending a terror attack and how this psychologically contrasted to working frontline during the pandemic.

'I… [was] absolutely bricking myself. I've never been to such a significant multiple stabbing before… They [the wounds] were absolutely horrific… Compared to Covid, it, it didn't affect me as much as other things have done. But I think Covid, the pressures, I think the vulnerability you felt with Covid, you're so far out of your comfort zone, whereas that terror attack, felt quite… it was within my comfort zone, which was odd. [p.4].

Researcher: *'I guess with the terror attack you had a level of control…?'*

Osian: *'Yeah, very much so, and I didn't feel that personal risk…. You know you're not going to be taking that home to the family, are you? …You felt very safe with the volume of armed police that were alongside us and I certainly didn't feel at risk from an attacker, so….'* [p.4].

Osian continued his account by explaining that because he had a long drive to the incident, it gave him time:

'…to think about my actions and my next steps and get through the 'Oh my God' sort of feelings and get control of yourself and crack on'.

He added:

'No, it [terrorist attack] wasn't particularly distressing [for him personally] but Covid is quite different and also you know that the [terrorist incident] felt like something had happened and it wasn't going to carry on because they arrested the [offender]. Whereas with Covid, you just don't see an end to it. And it affects your daily life, everything you do, even going to the shops. Every time you go to do anything, it [the virus] affects everything'.

This participant articulated key significant psychological impacts associated with the coronavirus in contrast to the acute response to a terrorist attack. Although he did not openly allude to lasting psychological distress in relation to this incident, we do gain a sense of the meaning he has made of this event and those that are pandemic related. Osian acknowledged that the terror incident was one that had potential for mass casualties and was very untypical of his everyday work, despite stabbings not being unusual in his region. He later remarked that the scale of casualties did not exceed numbers that receiving hospitals could deal with, yet the scene presented as 'horrific' in terms of major trauma that was inflicted by another human. Osian indicated that this was not psychologically challenging to him, and rather, his narrative positively focused upon the preparation time he had had whilst driving to the incident, and the importance of effective teamwork and support from colleagues both during and after the emergency. Critically, the shared sense of identity and the collective bonds held between him and his co-workers during this incident appears to have been psychologically protective.

From his narrative, I would argue that a key moderator in terms of adverse psychological outcomes was Osian's perception of his own vulnerability and that of his co-workers. Despite his close proximity to the terrorist incident, he felt well protected by his police colleagues and thus felt no personal threat. Thus, feeling physically safe appears to have been associated with reduced emotional distress. This is in contrast

to his response to the pandemic whereby, as illustrated in his first interview, Osian was considerably disconcerted and fearful about the risk of harm to his family, to which he perceived he had little control over. This was experienced by him as profoundly traumatic, affected his sense of embodiment, and fragmented his existential assumptions about the world. Arguably, this could be described as anticipatory grief; a phenomena that was noted within other participants' narratives in terms of continued fears as to the impact upon friends and family. Although vaccinations were on the horizon, there was still considerable uncertainty around the future and what this would hold.

In the face of continuing adversity, a profound sense of traumatic loss was noted in respect of loss of participants' everyday lives as well as loss of family members and colleagues to the virus. In her poignant reflections of the pandemic thus far, Liz had engaged in introspection to seek out meaningfulness as a way of re-establishing a sense of order and safety within her world, thus reducing feelings of vulnerability. Through the process of grieving, this enabled her to assimilate and re-build her assumptive world, her sense of self, and her identity, such that her losses were accepted.

'You know when you go through grief you have all the different emotions of anger, sadness, lethargy, and that sort of thing, I've sort of gone through all those stages with Covid. If I look back, it looks like I've gone through that whole, the anxiety, fear, although my anxiety and fear of covid was never that high but I know that there was a level of 'Oooh, is that going to make me ill or not ill?' Then you get a little bit angry. It's like, you know, [sighs] 'who the hell are you to tell me that I can and can't do things' and you want to push back a little bit and you're in a little bit of denial – you know, 'it won't touch me' sort of attitude – like a teenager would have, and now I'm just at acceptance, just get on with it, it's here, there's nothing I can do about it, just deal with it and live my life and enjoy my life where I can, and there's lots of things I can do, you just have to change life around a little bit…' [Liz, p.2].

6.5.2 'Becoming battle weary': Emotional exhaustion, cynicism, and depersonalisation

Empirically, the second phase data so far has highlighted the complexity of participants' psychological distress within the context of their organisation and their work role. Conversely, their accounts detailing the social relationship that they had with their work was equally revealing. In part, analytical findings akin to this have already been described – such as socio-cultural and psychological issues in relation to participants self-sacrificing dedication to their role. In contrast to the first phase interviews, the realities of interviewees' experiences by this stage predominantly featured overwhelming exhaustion, cynicism, and feeling ineffective.

Many participants talked of physical and emotional weariness at the prolonged nature of the pandemic conditions in which they were working, and the increased workload being faced.

'We're tired because we're stressed, because we've got so many different working practices that we have to try and remember because it seems to change every day. There are people getting snappy. Somebody will get snappy over the silliest of things…' [Keisha, p.7].

'The crews are… tired. I still feel tired. Even having had two weeks off where I haven't even checked my emails or anything, coming back today was a bit like 'I'm not really sure I want to do this again', particularly as things are ramping up again for us' [Harper, p.1].

'Psychologically, I feel like, I feel 'battle weary' of it all. I've got a sore face from the masks, and I've got to get out of aprons on and gloves on every job and it's just…. I'm just getting fed up with it now… Wearing masks in the cab for 12 hours a day is tiring in itself and not a very nice experience. Your mouth is dry the whole time' [Osian, p.8].

Respondents communicated a new level of chronic exhaustion on top of that already felt from ambulance work and undertaking shifts. Experientially, this was pervasive – from those who were emergency care assistants through to leaders. Of interest here is divisional manager Ollie's narrative which encapsulates the feelings of overwhelm in the interpersonal and organisational context with focus upon his perceptions and socially constructed interpretations of workplace behaviours which was felt as emotional depletion and disengagement, and detachment from his job.

'I think from my point of view, from a manager point of view, it's been just absolutely exhausting, right from the off, you know, since we started going into the first wave February, March time, because we had that initial response period where we were trying to work out how we were going to do things differently quickly, and then support staff through that, and then come out the other side, but the workload behind the scenes, the unseen stuff, has just been…well, at times overwhelming…' [Ollie, p.1].

'It has been stressful, exhausting, I would say mentally and physically, and the personal resilience has been absolutely, at times, non-existent. It's had quite a detrimental impact on me I would say, certainly over the last 6-8 months right up until probably about 2-3 weeks ago. I got to the point where I was contemplating a period of absence because of the fatigue and almost feeling as though from a resilience point of view, there was just nothing really left. I just needed to recharge… I was…completely exhausted' [Ollie, p.2].

He continued to explain that the increased workload '*on top of the day-to-day stuff*' and associated expectations from senior managers to achieve seemingly unrealistic targets, led to a sense of responsibility that well exceeded that of his position, thus critically reflecting a negative impact on his sense of self and self-identity of what it meant to be a 'manager'. Subsequently, Ollie divulged that his capacity to be responsive to these demands transcended his perceived abilities, leading to feelings of a lack of personal

accomplishment. The resultant stress and arguably burnout, that he felt was therefore situated within a socio-relational context between himself and his managers.

One notable outcome of this, was that in order to make some demands more manageable, the subconscious depersonalisation of staff occurred through psychological distancing. This was evidenced within managers' narratives as disconnection from others, as highlighted by Willow:

'We are starting to feel a little bit more disconnected from people that we would normally see on a day-to-day basis and have contact with, so that's been a bit strange' [p.1].

Depersonalisation of colleagues also took the devaluing and anonymising form of referring to their identity numerically as performance measures, appraisal, or sickness numbers. Furthermore, there was an articulation indicating cognitive divisiveness in terms of categorisation of 'the staff' as out group and 'us managers' as in-group, which further served to depersonalise individuals. In this way, the narratives subtly indicated associated attitudes towards individuals in these groups and the normative behaviours expected from them (around conformity and compliance in adhering to guidelines, for example).

In contrast, participants who were non-managers reflected upon experiencing depersonalisation as feeling individually and collectively unvalued and unseen by managers who utilised this social comparator strategy and some felt regarded as an inanimate object that lacked human identity and was expendable. However, this was certainly not the case for everyone, and other participants talked highly of their manager and felt humanised within their social relationship. Likewise, several of the managers interviewed expressed considerable connection with their colleagues.

Cognitive distancing as a form of depersonalisation was also noted in terms of cynicism to the overwhelming work demands being made of respondents, regardless of role. Consequently, this reverberated as a sense of ineffectiveness and lack of accomplishment, which at its most extreme was experienced as absenteeism through stress symptoms, articulated as intention to leave their role, or finally, leaving their employment.

'I've seen shifts being uncovered halfway through the shifts with people going 'do you know what? I'm going home'… I think it's just pushed people over the edge…' [Tony, p.2].

"…We understand that staff are still wearing PPE and it's the hottest time of the year to be doing that. This is the way it's going to be from now on. You just need to put up with it'. I think there were a lot of people who were like, 'Do you know what? I don't need to put up with this, I'm going to leave' and I don't blame them, at all. I know three people that have left. They were like '100% I didn't sign up for this, it's absolute rubbish'…' [Tony, p.1].

'Morale is starting to slump now because this has been going on for so long' [Nicky, p.1].

'They all moan about the same things. Like the late finishes, meal breaks…' [Gianna, p.1].

'As we've moved through the last 6 or 7 months, it just became increasingly obvious to me, that…my wellbeing was on the slide and also, the job wasn't…sustainable…and it wasn't something that I wanted to try and sustain. I guess I've taken the ultimate control around that to limit that' [Ollie, p.5].

What is clear from the above excerpts is how draining the intrapersonal emotional and physical investments that participants were giving to the job were, and importantly, this demand upon them was now perceived as significantly outweighing the social returns or rewards for doing this work. With a sense of limited agency over the situation also felt, exhaustion was prevalent, and time for recovery within the shift, was limited.

'It's relentless… this is getting a bit much now. I could really do with half an hour just to catch my breath or to have a brew… people are just frying up. People are just overheating…they're now at snapping point' [Tony, p.1].

'So, knowing that when you do go to work it's absolutely full on, there is not a spare second of downtime where you can draw a breath… There hasn't been much of an opportunity or much in the way of being able to top up the emotional bank account, so it's been quite difficult' [Ollie, p.2].

Interestingly however, while depersonalisation was present in the guises discussed, and featured in social relationships between interviewees and those viewed as inappropriately or undeservedly calling for an ambulance, for those patients who were in genuine need, there was invested effort made in expressing authentic concern and empathy. Nonetheless, the researcher gleaned a sense that increasingly, this effort was taking more and more of their personal resources and depleting their sense of self.

6.5.3 Intrapsychic and collective psychological growth through adversity

While traumatic distress was a key feature within participants' testimonies, data from the second phase of interviews highlighted the complexity of responses that were manifold in terms of impact upon their experiencing of themselves, others, and their social relationships. Indeed, participants' reflections of their journey through the first six months of the pandemic revealed that through their emotional struggles and potentially life-changing realisation of shattered worldview assumptions, the process of finding meaning and accommodating or assimilating these events also brought cognitive and emotional experiencing of positive existential, intrapsychic, and social relational change.

Perhaps in response to the perilous threat of the virus to one's physical integrity, it is no surprise that a renewed appreciation for life significantly featured as part of interviewees' new life-world realities. This centred around the cognitive restructuring and rebuilding of one's core beliefs and values about the world, and overtly manifested in terms of affirmation of daily life positives and a re-considered sense of what was important to them.

'I think as an ambulance paramedic you're always acutely aware of your own mortality and that of your family, but I certainly think that the Covid thing has made you even more [emphasised] aware of making sure that you live life to the full and do all the things that you want to do because we've seen patients that have had it all taken away from them so quickly' [Harper, p.6].

'I would say that it's re-centred me a little bit on what's important and the fact that actually, the simple things are important more than the kind of commercial, the superficial things. You're lucky that you get out to see people, you're lucky that you've got a job, that you can go out and exercise, that you've got places nearby that you can go for a walk, and you've got family around you. I guess it's just kind of focusing on those things…' [Willow, p.4].

'It makes you realise what you take for granted and how things have changed in the past six months. You take for granted 'oh shall we just go out to the pub?'. It sort of opens your eyes a bit as to what we've taken for granted pre-Covid. It's become two separate entities in time. So, you've got the pre-Covid and well, now, during Covid. It's like BC and AD isn't it, really? Erm…yeah, it's opened my eyes to how quickly things can change' [Sally, p.4].

Here, even the simplest pleasures in life have taken on a deeper sense of existential meaning with associated gratuitous affect. Furthermore, changed priorities give a sense of appreciation for what one has, in contrast to what could have been lost – as alluded to by Willow, in her feeling of 'being lucky', or what was previously taken for granted – indicated by Sally, an ambulance technician. Importantly, Sally's narrative also highlighted how pandemic adversity had challenged her views about herself and her position in the world, such that she meaningfully conceptualised time, constructing the 'before' and 'during' the event, separating her life from that prior, to now, and redefining herself accordingly.

The centrality of adversity to participants' identity was also reflected in terms of re-evaluation of one's life and re-constructing oneself and one's identities in light of new opportunities and sense of purpose. Simon remarked how the experience of having Covid-19 had made him realise the value he placed on his life. He subsequently altered his perception of himself and his lifestyle with a view to adopting positive, potentially life-changing behaviours. Importantly, unpacking Simon's narrative further, illuminates how the uncertainty and uncontrollability of the pandemic had challenged his assumptions that his world was a just and controllable place. This incongruence between his reality and held beliefs thus appears to have

been the catalyst for personal change. Upon processing this information, he attempted to resolve this incongruence through behaviour change, and as a result, developed new assumptive worldviews reflecting a realisation that things must change and be accommodated to integrate this new reality. In this way, his growth, arguably, was a defence response to adversity, and his altered behaviours enabled him to take steps to reduce the risk and threat of the viral contagion to himself.

'Having tested positive and then having the mildest of journeys through Covid, it's left me feeling a) that I've been really lucky, but b) now that we're starting to hear stories about long-term Covid issues, it's made me a little bit wary. Getting episodes of slight breathlessness has made me feel a little bit anxious, because now I start to think 'well, I've not always looked after myself as well as I could do'. I probably fit the profile in all sorts of ways to have an MI[4] or a stroke… but just that little snapshot into covid has made me a little bit anxious about things… You immerse yourself in that world, don't you, where you see everybody's worst day, every day. If you could sort of block that off for yourself that would be brilliant, but I think there comes a point where you think 'well, either I'm being really, really lucky here, what's waiting for me?' so that's created a kind of anxiety, which is just another layer to stress, I guess. I try not to be obsessive about it or anything but it's there and it keeps popping up. So, it's made me think 'you need to do something about that' so hence the gym!' [Simon, p.4].

Similarly, Ollie reported that the pandemic had led to authentic reappraisal of his life priorities and re-evaluation of his values and goals. As such, he became intrinsically motivated to change occupational direction to facilitate congruence between his held beliefs and his self.

'It's enforced some things for me around what's important. A good example of that is my decision to leave the job that I am doing at the moment because I know that from a health perspective and also a career perspective, it's not where I want to be and it's not sustainable' [Ollie, p.5].

Finally, heightened meaningfulness extended into intrapersonal processes, recognising the centrality of human connections, for example. This was cited in terms of familial and friend social relationships being enhanced and more greatly valued, and a strengthened awareness of who they can depend upon for support and solidarity in the face of existential harms.

'I think I'm very lucky, you know. I've got my kids and my wife and my immediate family. None of us have got ill with Covid, yet…. so that's really good' [Osian, p.4].

'I think I'm a lot more family focused. I've seen some really, really poorly people, and seen people die from the virus that are young, younger than me. I've seen colleagues go through really hard times. I've recently been to a 23-year-old who has ongoing mental health conditions and killed herself, and I can't say that the lockdowns and the virus haven't played a part in that.

[4] 'MI' is an abbreviation for 'myocardial infarction' which is more commonly known as a heart attack.

So, in terms of the pandemic, yeah, my outlook on life has changed heaps. I'm probably a lot more family orientated and probably a lot more caring that I was before' [Joel, p.3].

Analysis of the above account emphasises how the socio-relational context and reconnecting with family became a motivating fundamental need for Joel in respect of his affective and cognitive processing of the distressing events he'd witnessed. A salient impact of enhancing positive relations with others was his ameliorating identity and prosocial behavioural change to becoming a more compassionate and kinder person.

6.6 Greedy organisations, adapting cultures, and social relations

This final theme is composed of three sub-themes. The first is 'Shutting the stable door after the horse has bolted: social norms and social behaviours'. The second sub-theme is entitled 'Toxic normality: Social relations, 'bums on seats' and 'getting on with the job', while the final sub-theme is 'Get the kettle on': Prototypicality and the positive social role of ambulance leaders in a pandemic context'. Each of these sub-themes will be considered next.

6.6.1 'Shutting the stable door after the horse has bolted': Social norms and social behaviours

In response to ambulance organisations' continued crisis management of the pandemic, the interplay between normative behaviours and social complexities were prevalent within respondents' accounts during this phase of the study. The empirical data examined in chapter five highlighted required adaptations in practitioner behaviour to reduce viral transmission for which new social norms were being constructed around hygiene, cleaning, and physical distancing, for example. Narrative evidence from the second phase of the research identified that these social behaviours, particularly those emanating from procedural regulations centralised on patient care, had become internally embedded, accepted, and normalised within ambulance culture. For example, Sally highlighted that:

'It's now become an accepted norm to wear a mask to everything. I think a lot of the public expect us to wear masks as well, less so the apron…' [p.1].

What the second phase data also tells us, however, is that despite some behaviours becoming normative such as the above, this was contextually dependent and relied on situational and social cues of others within the in-group. This is evident when contrasting participants' rich testimonies indicating a collectivist culture of high resistance and reduced conformity to viral transmission measures in specific settings. By way of illustration, participants criticised their organisation's readiness to implement updated clinical, and

infection, prevention, and control guidance in line with emerging virological advances in knowledge. Many articulated distain that new measures enforcing the wearing of masks within ambulance stations and the cab of service vehicles, for example, had been implemented some five or six months into the contagion, which was perceived by them as remiss and long overdue.

'…. making us wear masks in the cab [scowling voice] which should have been done first, straight away…it's just shutting the stable door after the horse has bolted' [Keisha, p.1].

'…around June time, maybe July, crews were getting asked to, were asked to start wearing masks in the cab…' [John, p.1].

'…you've now got to wear a mask in a cab with your crew mate [tone of voice – how ridiculous] and I just think common sense has been thrown out of the window. It makes absolutely no sense whatsoever' [Tony, p.1].

'We're shutting the gate after the horse has bolted, which challenges me, I don't like that. I think if we're going to do something, I think we should do it properly from the start, not just willy nilly, 'let's wait and see' attitude. I found that challenging' [Harper, p. 2].

Whilst at face value the above could simply be interpreted as vented frustrations and perhaps reflected current wider social controversy around the level of protection masks provided, these narratives and encompassing descriptions afford valuable insight into the tacit understanding and cultural dynamics around behavioural regularities and the heterogeneity of risk perception (beliefs) in validating new norms. Certainly, the late effectuation of mask wearing within non-patient areas was socially evaluated by ambulance crews as contrary to their existing norms around closeness to those within their in-group (such as sitting together in the cab) and was deemed to be highly questionable given that they had not been protected in this way throughout earlier months of the pandemic.

A lack of motivation to adhere to the new policy appeared to be bound with a perceived (low) risk for contagion within their in-group. Arguably, this also ties in with participants' attempts to protect their shared social identity representations of 'we are not contagious' in contrast to 'them'; members of the public who were considered a greater infection risk.

'It's almost like we feel that we're not going to catch it off each other but we'll wear masks and gloves when we're dealing with the patients' [Willow, p.1].

Furthermore, it is quite possible that correspondingly, and as a frame of reference, participants experienced internalised conflict between the tighter behavioural expectations required of them as

ambulance employees, in contrast to the increasingly relaxed behavioural expectations of individuals in wider society, as usual daily life began to resume. Thus, arguably, this undermined participants' engagement in the desired behaviour change.

'There's less of the social distancing now. Around some of the bigger stations, they started a one-way system a little while ago and I think that lasted for about a week' [Sally, p.1].

'Although we're supposed to wear masks in the cab, no one does but it doesn't seem to have impacted on anyone getting infected' [Jeremy, p. 2].

'…nobody was following that advice or guidance and what was quite interesting, was that the managers, and the senior managers as well were quite perplexed as to why staff weren't following that…' [John, p.1].

Participants who were managers on the other hand, articulated mixed thoughts on the matter. Willow, who worked for a different trust from John, added:

'We've had a real issue with getting crews to put them [masks] on in the front [cab]. I think it's partly because they spend so much time wearing masks the rest of the day, I think they feel that it's the only time they get a bit of a break from having these things on when they're in the cab. But we've had to really, erm, yeah, really encourage staff to wear them, and to wear them around the corridors and in the workplaces as well' [p.1].

Whereas Harper said:

'…there was uproar when masks were introduced in the front of cabs because people were saying it's too little too late. We should have been doing it months ago, and actually, I agree with them' [p.1].

Liz's trust had not yet implemented but were considering the more stringent rules around mask wearing. She pondered how this would be received:

'[It's] going to be hideous. It's going to have a massive kick-back but if it means you eradicate the spread, if that is what's going to happen, then that's what we need to do…. Now I'm like 'do you know what, just get on with it, we've all got to do it' [sounds apathetic] [p.2].

Non-conformity was further strengthened by conflicting organisational rules in respect of other operational duties, which led to confusion and ambiguity at the relevance of wearing masks within crew rooms and vehicle cabs.

'You're constantly working with different crew mates which puts our risk of Covid up because you don't know if they've worked with somebody with Covid. I've had seven different crew mates over seven different shifts… That is a lot of people who could be spreading it around without knowing. We keep saying that we should be in our own bubbles at work with people who always work together. And they shouldn't be sending people on relief from one station to another, because again, there was an incident at Redville where a PTS [patient transport service] person was positive to Covid, but they came into work, didn't tell anyone, and eleven people went down with it at Oxbridge city station' [Keisha, p.3].

Although these mandated actions were discussed by almost all of the participants and had been applied within a number of trusts, the following vignette provided by Harper speaks for several interviewees who commented on the challenges of adapting the regulations to organisational infrastructure.

'Our crew rooms aren't fit for purpose as they are, let alone trying to socially distance, so yeah, we're all just trying to make the best of a bad job. I think there's a push at the moment to get staff to take their meal breaks away from base now obviously, because they don't want too many people in there, but staff don't want to do that either. If you're not paid for your meal break, then you want to be away from the public eye and not be seen by everybody when you're eating your sandwiches. You don't want to be eating your lunch in the front of your vehicle, and you don't want to be sat in a hospital canteen where everybody's watching you, either' [Harper, p. 2].

Crucially, the above quote draws to the importance of social spaces for ambulance personnel. In her account, Harper made a distinction from the 'frontstage' performative environment of being in the public domain (whereby there is an expectation that one's behaviour follows a socially prescribed professional script), versus the 'backstage' private areas, where paramedics and their colleagues can relax and conduct themselves in ways that are more reflective of their authentic selves, thereby coming out of 'character' and dropping the performance (Goffman, 1959). Of further interest, this vignette implies a deeply entrenched social norm (and organisational policy) that members of the public and associated frontstage artifacts should not intrude into backstage areas such as the crew room which, as Harper alluded, is where staff attempt to buffer themselves from the demands of the outside world. For these participants, masks had become symbolic props, socially representative of not only frontstage working areas but also embodied pandemic working conditions, which as has been noted, was deeply distressing at times. Thus, the impact of their introduction into crew rooms and cabs of ambulances, was painstakingly evident.

6.6.2 Toxic normality: Social relations, 'bums on seats', and 'getting on with the job'

The salience of deconstructing social psychological processes was brought into focus within the last sub-theme in respect of the newly mandated wearing of masks within backstage regions. This sub-theme highlights how such social processes provide critical micro-level insight into the unconscious dynamics underpinning the depths of organisational culture, leadership, and social relations, especially within the

context of trauma. Indeed, the narratives revealed that obligatory mask wearing was contextually important as a symbolic example for understanding the complexity of intangible cultural elements such as espoused values and deeply embedded assumptions held within ambulance organisations, and unconsciously communicated through the participants, as employees.

Certainly, the transcripts strongly indicated an underpinning representation of trauma through a sense of organisational betrayal of trust; a finding also eminent in the first phase of interviews. Obligatory mask wearing was one example whereby what was perceived as should have happened contrasted with what was actually happening, leading to cognitive dissonance by undermining both participants' realities and their unconscious assumptions that leaders and the organisation - who in essence were held in mind as powerful 'parental' figures - would fulfil their nurturing, safety, and protective needs against external threats. However, this was not always the case. There were various illustrations given of perceived malfeasance and arguably, institutional gaslighting, which appeared to be deeply embedded within ambulance organisational culture, and not a new phenomenon experienced during the pandemic.

Trauma was seemingly perpetrated in social relationships whereby the participants had held a level of trust with leaders and their employing organisation. However, as their narratives revealed, this trust was betrayed through perceived acts of omission - of failing to act and failing to protect. In Joel's case, this was stark, leaving him feeling abandoned and of little value, and placed at unnecessary risk.

'The patient had taken hostage the [previous] ambulance crew and threatened them with knives. I spoke to EOC [control room], and they actually had a warning for this address but forgot to send it down to us. So, really, we shouldn't have been going to that without the police, but they just sent us in with absolutely no idea! I haven't even had an apology [sounds upset, betrayed, let down]. It was just like 'oh right, yeah, forgot, sorry'. There was no acknowledgement of the danger we'd been put in. I understand, because I mean, you've probably seen in the news that Blue Light Ambulance Service EOC has had a real big outbreak of Covid. They've had 150-odd people go off with Covid or through test and trace, so it's understandable that they're really busy and short staffed. But the fact that we were sent to this job without any warning at all and then no real acknowledgement of the danger we were put in… no, I don't think the ambulance service really care about us [half laughs in utter dismay] [Joel, p.2].

Even more worryingly, the betrayal of trust within these social relationships was further communicated, with symbolic representations given of hidden control and coercion.

'…because of the environment they're in, relationships at work just turn toxic and most sort of, and this is probably an extreme example, but in those sort of domestic abuse cases where the abusee is too afraid to speak up or leave because they're worried they'll get beaten down, I think there are sort of similar parallels with, yeah, definitely in the staff and their

relationship to managers, and for me, and I've sort of seen it in pockets… but something as big as this [Covid-19] which has really affected the system has really highlighted how this is probably a widespread issue' [John, p.3].

To draw parallels between the social dynamics presenting in abusive relationships and those within participants relations with managers and their organisation, is profound. At a deeper level, arguably, these socio-relational processes are indicative of an inherently held assumption of dependency of group members upon their leaders and organisation for safety and security. Thus, this relational context could be said to be representative of maladaptive loyalty, whereby staff are positioned by the nature of their role as lacking agency and autonomy, whilst the leader is depicted as omnipotent and omniscient. Furthermore, both the quote above and those below, allude to toxic social relationships which amplify fear – of speaking out and retribution, and effectively leads to employees who feel undermined and afraid to engage.

'When you try and voice any concerns and you get told off for voicing those concerns, it makes you not want to voice those concerns anymore, or voice anything' [Osian, first-line manager, p.6].

'I'm apprehensive of any senior managers that come down' [Greyson, p.3].

'…members of staff sort of feel trapped in this relationship because they don't want to go to another line manager …because the line managers are all mates and they all tell each other what's going on in their teams, and if someone speaks up, so, say I was to go to another line manager about my line manager, that would eventually get back to my line manager that I'd had that conversation…that relationship then becomes a bit hostile – 'well, why did you go to him about me? Why didn't you just come to me directly?' and then we go back to the whole gaslighting thing, and almost imposing that blame on the member of staff that rose the concern when they invariably had the right to do so' [John, p.3].

The above vignettes highlight social power imbalances between the participants and their managers, particularly in terms of ignominy leading to an inference of non-credibility towards the employee. Furthermore, John's account features a 'flipping' of the script, with the manager condemning the staff member for raising a concern about them. Whilst it is not known if there were social vulnerabilities or other inequalities that were important to this context, the outcome seemingly resulted in the participant's reality being denied, leading to micro-level silencing, disempowerment, a sense of worthlessness, and passive-aggressive behavioural change.

The dark side of organisational culture and leadership consistently featured within narratives that reflected upon management practices and heightened work intensification. Albeit in differing guises, there are examples given throughout the empirical chapters of this thesis such as hidden cultural assumptions that value high levels of employee commitment to their organisation – previously discussed in terms of participants' dedication to service and centralising work in one's life, prioritising it over all other non-

work socio-relational obligations, for example. Whilst this requirement for undivided commitment and loyalty continued to persist within respondents' accounts during this phase of interviews, there is evidence that these dutiful obligations now extended much further into participants social dimensions, for which there was little choice but to comply and sacrifice their time to meet organisational expectations for exclusivity.

'I just sort of fit my life around work' [Ava, p.4].

'I don't know what my job will be in 6 months' time. I'm terrified that I'm going to be invited in for a job interview with a 2–3-week-old or a one day old [baby] because they're looking to interview just about my due-date time' [Nicky, p.2].

'They expect us to do everything on Teams or be online. Erm you can't be online or on the phone when you're frontline…so you end up doing stuff in your own time' [Keisha, p.5].

This organisational pursuit for dedicated service also extended to first line managers, who were required to prioritise response to calls over administrative tasks. Yet also imperative was the mandated need to meet tight deadlines and performance targets which were being sharply brought into focus since the start of the pandemic. However, participants felt that the pressures placed upon them were unjust and conflictual, which greatly tested their loyalty and commitment to their institution. Moreover, the impact of this upon their psychological health was apparent.

'If we get sent out as responding managers, we have to cancel all our meetings…that's already happened on 2-3 days in September when it got busy. So, it's making it quite difficult and they're [senior managers] still insisting on the same targets [as prior to the pandemic] but we just don't know if we can meet them. It doesn't matter how many calculations we do, we just don't know, so that's causing us anxiety…' [Willow, p.3].

'…at the moment the focus has been back on targets again whereas 4-5 months ago, all the target stuff went out the window and nobody cared about that' [Harper, p.5].

'The senior management team really didn't understand just how much work and the sheer volume of work that was involved in doing what we did' [Ollie, p.4].

Underpinning the above was a sense of strong social norms that 'getting the job done' and patient care comes first and foremost; an unspoken work ideology that ambulance organisations required their employees to internalise and make salient. Indeed, interviewees portrayed an overarching sense that the work of the organisation – achieving targets and performance - was more greatly valued than the wellbeing of those working on the ground.

One of the most compelling narratives to emerge in this respect, was that of Tony, who succinctly described how he needed a short break from responding due to the exhaustion of wearing PPE. He starts by talking in the voice of his manager, followed by his own thoughts:

'Well, that's not really an option [to have a break]. You need to either go sick or carry on with your normal job'… There's not been that 'we understand that this is tough, we'll try and give you a bit of a break every now and then' [Tony, p.2].

Arguably, this 'greedy' all-or-nothing organisational management practice, demanded total and excessive commitment (and sacrifice) from its employees. The 'testing' of one's loyalty and worthiness to be part of the group would lead to temporary expulsion if they were unable to meet these rigid beliefs. Subsequently, Tony highlighted how staff tried to secretly negotiate meeting their own basic needs whilst feeling conflicted by their desire to retain a sense of belonging to their in-group bounded by the high expectations to place the 'needs' of the service (and patients) foremost.

'There isn't a way for people to say, 'I need five minutes out' without saying 'I need five minutes out'... There isn't that pause button option, and people are just frying up. So…they're saying, 'I need to go and re-stock kit' using that as an excuse for like, 'I need half an hour just to do nothing coz I am absolutely wiped'.

I think the problem with someone getting to the edge like that, they're now at that snapping point and when you say to them 'right, I know you're saying you need five minutes out but you either go sick or you carry on' that's the point where people are just going to go 'do you know what, I'm out' [Tony, p.2].

The shame of admitting physical and psychological exhaustion was neither socially accepted nor permitted within this culture and evidently did not fit with organisational behavioural norms nor the shared social identity of ambulance personnel who can and will 'deal with anything'. In a similar vein, it could be argued that those who were mandated to self-isolate were also unconsciously viewed as disloyal and non-committal, for which the organisation considered removal of reward.

'I know we've got to protect our capacity but there's talk about people not being paid if they've got to self-isolate for two weeks, and it's all a bit threatening' [Harper, p.2].

In conclusion, the ideological power of work devotion fostering an overcommitment to work at the expense of welfare and social life, appeared to be more prominent within this phase of interviews as the participants reported that work was taking up more and more of their time and energy in the quest to 'get the job done', which for some, was almost to the point of there being '*nothing left in the tank*' [Reflexive account, p.6]. Yet, whilst participants talked of their loyalty and desire to be committed to their roles, they

increasingly felt that they were unvalued, unprotected, and placed at risk by their organisation; such that their sense of safety in the world was deeply challenged. Subsequently, altered perceptions of themselves to be of little worth or value to their employer, was reflected in their perceived identity as just a 'bum on a seat':

'The longer that we go into this, I feel that it's all about maintaining bums on seats at any cost' [Harper, p.2].

6.6.3 'Get the kettle on': Prototypicality and the positive social role of ambulance leaders in a pandemic context

Leadership, organisational culture, and organisational behaviours continued to be a strong focus within the empirical data. Whilst many interviewees centralised their attention on the challenging aspects of social relations with management, more than half (n = 12/20) also discussed positive relationality which further enlightened understanding of the social processes at play and provided insight into ambulance leaders effectiveness during the pandemic crisis.

A key feature is that leadership was contextualised by participants to permeate in-group membership and was perceived as a shared social relationship between the leader and their subordinates or followers. Critically, what was important here, was the degree to which the participants saw or developed cognitive representations of the leader as an accepted, authentic member of their group, and with whom they shared an identity – thus creating a sense of 'we' ness. Consequentially, those leaders who were viewed as sharing collective group attributes were encompassed as 'belonging' to the group and were positively perceived as likeable and prototypical of other group members.

'I'm lucky with where I work that our managers are really understanding and really appreciative. They're really good to be honest… My manager in particular, is well known for coming into the mess room and making everyone a cup of tea. That's kind of unheard of in the ambulance service! He's fantastic and he is just a genuinely really caring guy and just really wants to make sure that everyone on station's looked after' [Joel, p.2].

In the above vignette, Joel's manager appears to have prototypically embodied the shared identity of the group. Although it is likely that past group history of the social relations between the manager and the team are pertinent here, the exampled simple act of making tea for his team enlightens us as to how demonstrated group-orientated behaviours symbolically communicated a sense of 'doing it for us' – signifying commitment to the team and going the extra mile – something that was not felt to be exemplified by other leaders within this context. Similar prototypical behaviours were also discussed by other participants such as Jeremy, an emergency care assistant who remarked that throughout the

pandemic, his supervisors had *'teamed up with people on DCA's [double-crewed ambulances]'* [p.2] rather than remain in their offices, which again demonstrated an allegiance with those working on the frontline.

Subsequently, the salience of the manager's membership within the group was arguably a key influencer of attitudes and social behaviours within the team, and notably, resulted in the manager being positively regarded as personable and accepted. Indeed, perceived prototypicality by participants was fundamental to a favourable evaluation of their supervisor.

The extent to which the manager was deemed to act within the best interests of the group was especially important in terms of their welfare. Indeed, for the majority of respondents, the perceived attributions of their manager to authentically and non-judgementally care about their wellbeing during this time of contagious threat, was hugely significant to them. Unpacking this further revealed how at an emotional level, trust, again, was at the core of these social relational dynamics. Being able to trust that the best interests of the team would be held at heart by their leader, was vital given the continuing uncertainty posed by the pandemic, the social power that they held over group members, and the gate-holding access they possessed to supports and resources.

'Locally, I get on well with my team leader. With me being off [work], it's shown me that he is quite trustworthy. … He talked through some of the updates which was really good. I don't think I'd have got that from anyone else' [Greyson, p.3].

'I would say the vast majority of our managers are very approachable. We can always approach them with anything. They're supportive and check up on you when you're ill, just to make sure things are going okay' [Sally, p.3].

'He's very friendly and very approachable and he's just very, very supportive in terms of welfare. I know that if I had a rubbish job, he'd have my back and he'd talk it through with me, reassure me, and refer me on to any extra help if I needed it. He's very, very hot on staff welfare, and just very easy to talk to really' [Ava, p.4].

The above excerpt from Ava signifies an engendered trust with the leader, that he was dependable, protective, and was, through identifying with the group, orientated towards their, or in this case, a team member's motivations and needs. Based upon her evaluation of his previous behaviours, Ava held a trusted belief that her manager would 'have her back' if needed. Thus, as a highly prototypical member of the team, he also served an important role in reducing and containing uncertainty and distress for her, and presumably other group members. In this way, he also seemingly navigated sense-making of emotionally traumatic situations experienced by his team, particularly those conjured up by a 'rubbish job' or from the challenges of pandemic frontline working. It is therefore easy to see how this manager was socially attractive, well liked, and highly regarded.

What really emanated from the interviewees' narratives in respect of this sub-theme was how, like trust, authenticity was deeply valued within these leader-follower social relationships. A particularly interesting quote from Liz highlighted that if a senior ambulance manager behaved authentically but was sub-consciously categorised by an established group (such as a team of frontline clinicians) as non-prototypical and social identity was not shared, they were, as Liz later added, perceived as relatively ineffective, were seen as less connected with the group, were less trusted and less influential than managers viewed as prototypical.

'Those in very, very senior management, directorship and just below, do not see what we see, all the hard suffering because of Covid, which then has an accumulative impact... I think they have to live it to get a good idea of what it's all about. I think they believe they've got our welfare at heart, and I think they believe that they do, what they say, and what they put across is helping us but…. I don't think they truly understand. It's a bit weird…. And I think they'd be quite hurt if they thought we didn't think they understood but… I also don't think they're willing to listen either' [Liz, p.4].

Certainly, Liz's account again confirms the importance of shared experiences and social connection between group members as influencers in the demarcation of collective social identity; who we are and creating a shared sense of 'us'.

6.7 Conclusion

This chapter has considered the empirical data collated from the second phase of interviews undertaken approximately six months after the first national lockdown was declared within England. In this time period, analysis of the participants' narratives revealed a changing turn in the tide with shifting societal attitudes towards ambulance practitioners, firmly re-situating their role identities within the context of their pre-pandemic social role status as 'dirty workers'. This sudden demotion of their social status away from that of 'hero' presented for many, a welcome relief, yet the results also show how impacting this was upon their conceptualisation of their social identities and self-esteem.

Importantly, captured within the data were the social processes of how the pandemic context blurred the boundaries between home and work, such that conflictual challenges were noted for some participants in terms of competing salience of the social identities held at work and at home. Subsequently, we saw how for these participants, there was a real struggle in disentangling one from another. Emanating from this was also a sense of conflict in terms of the social norms associated with the competing group memberships, and this played out in trying to manage one's emotionality, such that the featured participant in trying to compartmentalise her feelings and thoughts, attempted to dissociate and detach

from the distressing emotions experienced in relation to her work, and perform emotional labour, hiding away her authentic feelings when at home.

The analysis of the data also revealed that more pronounced experiencing of distress and psychological dysregulation in response to what was becoming a prolonged adversity, was accompanied with feelings of utter exhaustion. It was critical here to hear the voices of participants who were managers to understand that it was not just frontline workers who were feeling the detrimental impacts of working at high intensity for a protracted period of time. Indeed, they, like staff members, felt a lack of agency over the situation and the demands of the work were significantly outweighing the social returns. Nonetheless, despite the psychological challenges being felt, participants at this stage started to find meaning and assimilation or accommodation in the adversity. Cognitive restructuring and rebuilding of one's beliefs and values about the world was coupled with having a renewed appreciation for life. Furthermore, in terms of social identity, some participants alluded to the reconstructing of oneself in light of new opportunities and sense of purpose.

Finally, the thematic analysis highlighted empirical evidence capturing the dark side of organisational culture and leadership. Here, the extent to which toxicity prevailed within ambulance service communities was stark, with examples of institutional greed in terms of all-or-nothing management practice, gas-lighting, and hidden control and coerciveness. The data revealed organisational pursuit for loyalty such that the ideological power of work devotion fostered an overcommitment to work at the expense of the psychological wellbeing of the participants. Indeed, the evidence exposed underlying assumptive norms of 'getting the job done' and for many of the participants, internalisation of the organisation's needs over their own. In this way, loyalty was demonstrably maladaptive and among some participants, was associated with a deeply implicit sense of dependency upon their leaders and organisation for safety and security. When fractured due to perceived institutional betrayal, for example, this was deeply problematic, perpetrating traumatic experiences and distressing emotionality.

The remaining empirical chapter is next and provides the analytical findings from data gathered in phase three of the interviews.

Chapter 7 – The Prolonged Impact of the Pandemic: Empirical Findings Phase Three

7.1 Introduction

This final empirical chapter provides thematic data analysis pertaining to interviews undertaken with eighteen of the remaining interviewees who consented to take part in this third phase of the study. These participants were representative of six different NHS ambulance trusts across England.

7.2 Situational context: November 2020 – March 2021

The winter months denoted above continued to be a time of considerable uncertainty for many across England, and indeed, globally. With rising levels of infection, the numbers of those dying with coronavirus in this country exceeded sixty thousand by early December 2020. Incredibly, this number increased to seventy-five thousand just one month later. In the ten days' subsequently, a further twenty-five thousand people lost their lives in England alone. Horrifyingly, the virus became the leading cause of death during this study period, causing 'the biggest fall in life expectancy in England since World War II' (Kings Fund, 2022).

Whilst the highest mortality rates were recorded in London and north-west England, the least were identified in the south-west of the country (UK Health Security Agency, 2023). Due to a lack of nationally collated data, it remains unknown as to exactly how many healthcare workers or ambulance personnel had lost their lives to the illness. Unofficial records however, estimated that by March 2021, at least twelve ambulance staff and more than 245 health professionals had died (Broyd, 2021). In terms of sickness, NHS ambulance services reported the highest levels of all professional healthcare groups, with 7.1% absent with Covid-related symptoms in December 2020, rising to 9.2% in January 2021 (NHS Digital 2021a). For comparison, Consultants had the lowest level of sickness at 1.7% over the same period (NHS Digital, 2021b). Overall, poor mental health remained the greatest cause of sickness absence across the NHS (21.9%) followed by infectious diseases (14.2%), 'chest and respiratory' (11.9%) and 'coughs, colds, flu' (10.2%) (NHS England, 2023). There was no specific category for recording illness due to coronavirus infection.

With the incidence of the disease prevailing in those of older age, particularly in people over eighty suffering with comorbidities (Public Health England, 2020), it was unsurprising that this wave of the pandemic significantly challenged healthcare infrastructure, resources, and capacity. This included the systemic overwhelm of previously workable strategic and clinical processes given the limited capacity for

acute hospital admissions, thus resulting in extended handover delays for ambulance practitioners in seeking to offload their patients. An entire shift could now be spent waiting outside emergency departments rather than responding to calls (Independent, 2020b; Telegraph, 2020; BBC News, 2021, Independent, 2021a).

Such an enduring crisis situation became catastrophic within many regions of the country, with ambulance services reporting call volumes outstripping resources resulting in patients waiting exceptionally long periods of time for a response, leading to usually avoidable deaths in the community (Evening Standard, 2021). Indeed, the Mayor of London (2021) declared a major incident in January 2021, as did Yorkshire Ambulance NHS Trust (Independent, 2021b), and 'extreme pressure' was reported by North-West Ambulance Service NHS Trust (Lancs Live, 2021).

Hope for the future was finally delivered in the form of vaccination. The first person in the world to be immunised against Covid-19 occurred in the United Kingdom on 8th December 2020. A significant inoculation programme followed – however, its success was dependent upon behavioural uptake. Rather than a collective sense of unity as might be anticipated in response, increasing socio-political tensions centring on perceived coercion and power imbalances around control of information and narrative by government authorities (such as PHE) and distrust at pharmaceutical companies around vaccine testing and safety, arguably stirred up shared feelings of injustice – bringing solidarity and shared emotion in the form of protests and reverberations (House of Commons/ House of Lords, 2021). In some cases, this was linked with misinformation, denial, and 'conspiracy' theories, which were further magnified through social media (Ahmed, 2020) – a communication medium that many relied upon during lockdowns.

Indeed, the advent of vaccination against coronavirus became a hotly contested topic, raising yet greater societal uncertainty whilst the state debated as to whether inoculation would be mandatory for all, or as a required legal condition of employment for those working in frontline services such as healthcare, unless exempted (which became law in 2022) (NHS England, 2022b). Despite the scientific evidence indicating the benefits of vaccination, challenging ethical questions remained around what was proportionate and necessary in light of the health protection of individuals versus personal autonomy and freedom of choice (Bardosh et al, 2022).

While collective action narrowed the focus upon this public health measure to curb viral transmission, in contrast, a further contested policy arena emerged, representative of a critical interplay between competing and conflicting institutional interests and socio-political ideologies, versus credible scientific consensus on viral transmission routes emergent from new empirical data. This presented challenges to public health policy makers particularly in regard to providing guidance to healthcare workers. Critical arguments as to the perceived responsiveness of government institutions to 'follow the science' were

called into question by medical and healthcare staff (Health Service Journal, 2021; Socialist Worker, 2021; Torjesen, 2021), as scientific advances showed that coronavirus was in fact predominantly spread via aerosol-based airborne transmission rather than the previously assumed droplet transmission - upon which national infection control guidance continued to be based (Morawska & Milton, 2020; Zhang et al, 2020). Recognising the significant role that respirator masks (such as FFP3) played in mitigating transmission of the virus, and with growing scientific uncertainty around the level of protection offered by fluid repellent surgical masks against aerosol transmission, professional bodies such as the College of Paramedics advocated for a review of personal protective equipment recommendations for ambulance practitioners. This was specifically to address the perceived heightened risks to health given the worsening context of hospital queuing whereby paramedics could be seated in the small, enclosed, confined space of an ambulance without adequate ventilation and in close proximity to infected patients for many hours – and thus, assumed to be at greater risk of exposure to virus laden aerosols (Joint Response, 2021; Health & Safety Executive, 2008). Consequently, in response, Public Health England (2021) maintained their position that coronavirus was not primarily transmitted by aerosol airborne means through breathing, talking and coughing, for example. On this basis, they advised that clinicians should 'avoid sitting face to face with patients' adding that 'there is no requirement to increase the level of PPE worn by clinicians…as there is no evidence' to suggest that respirators 'provide any additional protection' in such circumstances. However, they simultaneously and paradoxically recognised the heightened risks of infection from interventions classed as 'aerosol generating procedures' such as chest compressions and airway management, recommending clinicians use of respirators in these instances (Public Health England, 2021; World Health Organisation, 2020d).

The surge in coronavirus cases in December 2020 led to calls by the Scientific Advisory Group for Emergencies (SAGE) for further social control measures in the form of a third national lockdown. Nevertheless, this was highly controversial given the economic, social, and psychological consequences, as well as polarised political fallout from those who would end up footing the bill. Subsequently, containment restrictions were commenced from 6th January 2021 until March 2021 (Independent, 2020c). Despite this, it was seemingly too late to prevent a second epidemiological peak of infections occurring in mid-January, corresponding with an increase in hospital admissions (Illustration 3, SAGE, 2022); a situation that continued into February 2021, prior to case numbers declining (SAGE, 2021).

Illustration 3: (SAGE, 2022).

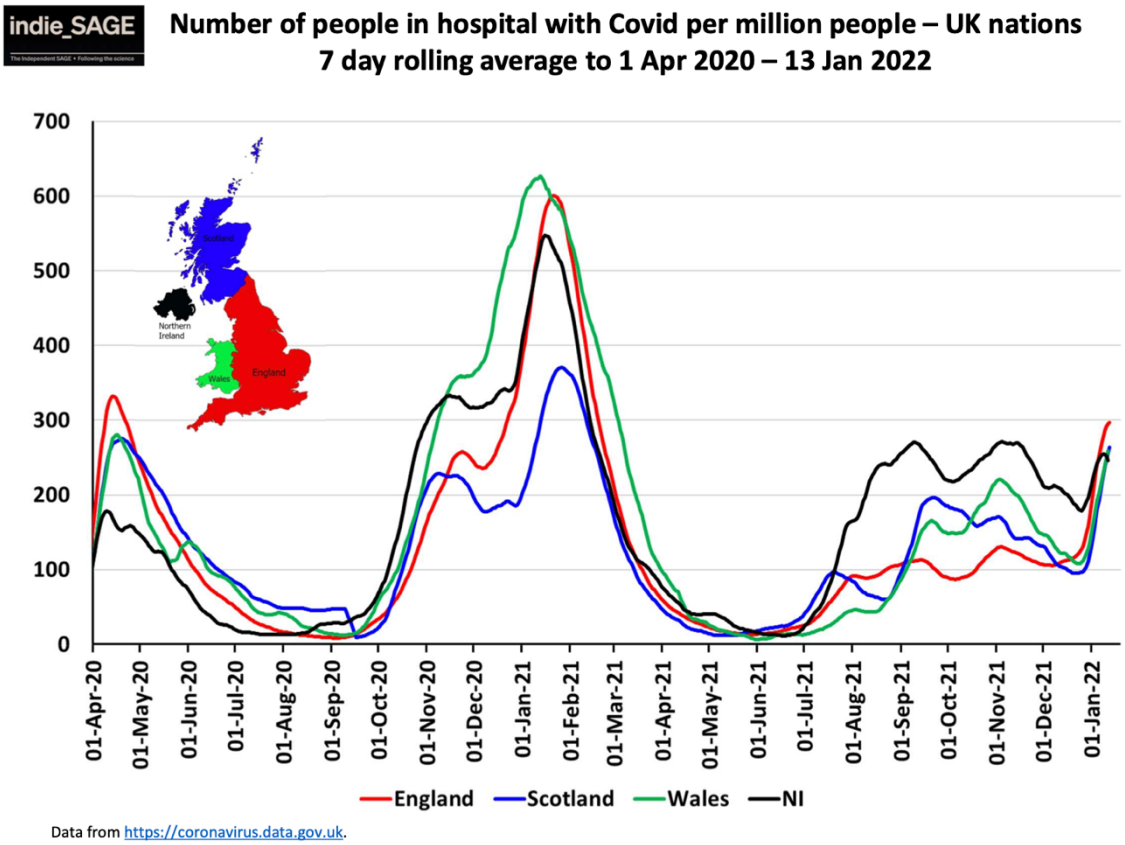
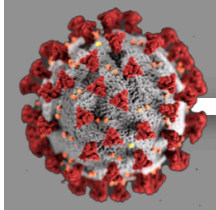


Illustration 4 overleaf illustrates the key milestones during this phase of the pandemic within the UK.

Illustration 4: Covid Timeline – United Kingdom – November 2020 to March 2021

Covid Pandemic Timeline - United Kingdom



November 2020

5th - 2nd National lockdown comes into force in England. People unable to leave home except for education, work, exercise, shopping, or to care for the vulnerable.

7th - Hospitals in Manchester suspend all non-urgent care.

8th - Hundreds of protestors gather in Manchester to protest against lockdown.

9th - Pfizer announced that vaccine is 90% effective.

10th - UK reports highest daily death toll since May.

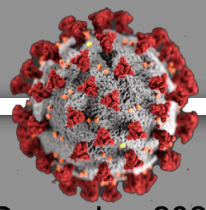
13th - One of several Downing St parties held.

22nd - UK cases of Covid-19 exceed 1.5 million.

24th - PM announces that over 5 day Xmas break, up to 3 households can mix.

27th - After a Covid-19 lab error, more than 1300 people in UK are incorrectly told they have the virus.

28th. - Anti-lockdown protests in London sees over 150 people arrested.



December 2020

2nd - 2nd Lockdown ends & England returns to strict 3 tier system of restrictions.

3rd - UK total death toll from/with Covid-19 exceeds 60,000.

8th - First dose of vaccine administered outside of clinical trials.

10th - another secret party held by government.

14th - Conservative Party HQ party takes place. WHO declare that Santa is immune to Covid-19.

18th - Downing St Christmas party.

19th - A new strain of C-19 is identified in SE England, with suggestion that it could be 70% more transmissible. PM announces tougher restrictions for London, SE England and a new Tier 4 alert level introduced. Christmas mixing rules tightened.

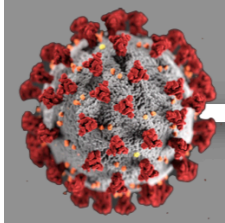
21st - More than 500,000 people in UK have been vaccinated.

25th - 570 deaths recorded today. More areas are placed under Tier 4 restrictions.

28th - 40,000 new cases reported in the UK in 24 hours.

29th - 50,000 new cases reported in the UK in 24 hours.

30th - AstraZeneca vaccine approved for use in UK.



January 2021

3rd - Death toll in UK exceeds 75,000.

4th - Children to return to school but English restrictions to get tougher. At 8pm, PM announces 3rd national lockdown. First AstraZeneca vaccine given in UK.

5th - More than 60,000 cases recorded in 24 hours. GCSE/ A level exams cancelled for this year.

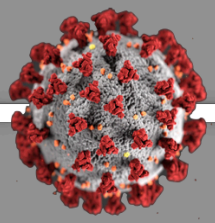
6th - 3rd national lockdown starts.

7th - 1162 deaths of people with Covid-19 confirmed today - the highest figure since April 2020.

8th - NHS England states that healthcare workers to be prioritised for vaccine. Major incident declared in London due to surge in cases. Peak of 2nd wave with 68,053 cases recorded in UK.

13th - 100,000 people have now died with Covid-19 in UK.

19th - The highest number of deaths in UK in one day - 1368.



February 2021

8th - Mortality rates slowing - 333 deaths recorded within the UK.

14th - Vaccine programme sees 15 million UK residents immunised.

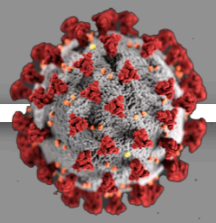
15th - Travellers arriving in UK from 'high-risk' countries required to quarantine in hotels.

19th - UK government deemed by courts to have broken the law by failing to publish details of spending on PPE within 30 days of contracts being awarded.

20th - All adults in UK to be offered a first dose of vaccine by July 2021.

22nd - A roadmap for emerging from lockdown is published by PM.

27th - Lowest case rate in 5 months recorded today.



March 2021

8th - 3rd national lockdown ends. Schools in England planning for students to return. Visits to care homes to recommence. A 70% reduction of transmission of Covid-19 observed in healthcare workers who had the first dose of the vaccine.

19th - PM has his first dose of AstraZeneca vaccine.

22nd - The first anniversary of the first lockdown. Candles lit in remembrance of the lives lost.

27th - 25 million doses of first vaccine administered within the UK.

30th - PM announces that Nightingale Hospitals are to be decommissioned.

31st - Total deaths of people with Covid-19 in UK = 5011 and 138,879 cases were recorded this month.

7.3 Phase three data findings

The most striking findings from the data analysis of the third phase of interviews were categorised into the key themes and subthemes denoted below.

Key themes and subthemes:

1. The complex, changing social ontological realities of Covid-19 and the emergent influence of social relations and institutional power.

2. Relational and intrapsychic affectivity: Individual and collective traumatogenic narratives in response to continuing adversity.
    a. Emotional labour and affective regulation as an intrapsychic and relational process – emotional intentionality salience.
    b. Emotional dissonance and performativity.
    c. Social identity and in-group membership shapes individual and collective traumatogenic responses to continuing adversity.
    d. The chronic traumatogenic and psycho-emotional aftermath of witnessing profound human vulnerability.

Each of these themes and sub themes will now be considered.

7.4 The complex, changing social ontological realities of Covid-19 and the emergent influence of social relations and institutional power

This iteration of interviews presented a sense amongst the respondents that through an evolving, dynamic ontological process, their social realities had, as a result of the perseverance of the pandemic, been disrupted and reshaped by the social world in which they operated. The constructed reality of everyday life had transformed through social structures not only within the workplace but also in the context of wider society; changes that evoked confrontation between social group urges for bonding and connection versus social and political policies that enforced and regulated a new social reality symbolised through artefacts such as lockdowns and mask-wearing.

While previously discussed in the context of the empirical data, the participants evolving construal of shared epistemological and social knowledge about the pandemic and coronavirus is an important

consideration here in terms of how their social realities were constructed and reported on during this phase of the interviews.

Prior evidence identified how the participants drew upon established anchors to make sense of new phenomena. This included normative shared social practices guided by deeply rooted historical epistemic ties – such as those deeply embedded within the core fabric of ambulance service culture, and which resonate with its hierarchical militaristic past. Ontological security was also drawn from social group routine processes and practices, collective social identities, and social dynamics that were likely shaped by prior life and organisational experiences. However, the participants narratives clearly highlighted how Covid restrictions had created a new social reality that not only interrupted these social practices and turned much of their everyday life on its head, but subsequently affected their sense of being in the world as well as their ontological security, as a result of continuing feelings of vulnerability due to perceptions of risk that their working environment presented.

As the data within this phase of interviews highlights, government mandates on healthcare professional practices continued to enforce this newly constructed social reality; a phenomenon that was elevated by media reports, and subsequently reinforced by participants' own experiencing of attending patients who were infected and unwell, seriously ill, or dying. This new reality had quickly infiltrated ambulance organisations through symbolic artefacts such as heightened infection control procedures and physical distancing regimes. They represented a form of social control that challenged traditional socio-relational features of ambulance service working life that were highly valued such as face-to-face interactions with patients and colleagues, and the strong, cohesive bonds held between peers. The much-discussed top-down implementation of tougher restrictions and protective measures for frontline ambulance service workers issued by Public Health England in response to the surge of Covid-19 positive cases, provides an example worthy of examination here.

To contextually re-cap, evidence from the second phase of interviews, some three months' earlier, provided insight into individuals' micro-level responses and group prosocial attitudes towards the new requirement for mask wearing when in the presence of patients. Prior analysis identified that in response to this, the emergence of internalised, shared beliefs had developed, and the conceptualisation of a new social reality was being formed. The consequent in-group social norms and embodied collective behavioural effort prevailed in attempts to mitigate the threat.

Emanating from these narratives was a perceptive belief indicating that at that time, respondents generally held an internalised view that most other colleagues were committed to and had prosocially adapted their behaviours to conform to the new infection control measures and it had become a descriptive normative

response. In this way, arguably, national policy had socially influenced collective cultural norms and behaviours within ambulance organisations to define a new social reality.

By this third phase of interviews, more stringent, mandated national guidance updates were enforced by ambulance trusts as mechanisms of social control and behavioural regulation – such as compulsory mask-wearing within 'backstage' social spaces including ambulance cabs and station crew rooms. Despite the rationale of health protection and viral containment, the restrictions powerfully confined social functioning between ambulance colleagues and represented an objective social reality over which individuals themselves seemingly had diminishing control. Nonetheless, acceptance and internalisation of these objective structures was challenged by several of the participants, who articulated that whilst mask-wearing continued to be mostly enacted when in the presence of patients, this was not the case when in backstage social contexts. Indeed, the mandated behavioural norms of wearing masks within these background areas were not socialised into in-group accepted practices, and thus, several interviewees vehemently expressed distain about their use in these circumstances. Consequently, they did not conform to the rules either all or some of the time. Moreover, subsequent emotional responses centring around frustration, anger, and a sense of betrayal by their employer, were seemingly disruptive to the ongoing production of this aspect of social reality and in legitimising the more general wearing of other personal protective equipment. Accordingly, this was representative of a notable confrontational shift in collective beliefs and socially accepted in-group behavioural responses.

'…there's been a bit of a shift in terms of the wearing of PPE now. So, some of them [colleagues] aren't wearing level two [PPE] completely, so they're not wearing their aprons because they are pain in the bum and they get in the way' [Harper, p.2].

Unpacking this further, the participants' narratives highlighted how they and their colleagues' behaviours were not so much a matter of individual choice but rather, were again, subject to social influences and were collectively highly moralised, resulting in attitudinal and socio-behavioural embodied performances with regards to complying with infection prevention guidance. Indeed, repeated in-group expressions of disenchantment with regards mask wearing in backstage regions had seemingly become culturally representative and integrated within collective social behaviours of protest and confrontation – indicating a dynamic tension between individual freedoms to socially bond, collective threat, and the rationality of government interventions perceived to have been enacted far too late; a feeling that was common within society more generally at that time, particularly in relation to Covid vaccination and lockdown adherence.

'I think people just feel messed around. I think people are like, 'why do we have to wear…?'. When two people are working in an ambulance together, it's ridiculous that you both have to wear a mask because I'm working with this person all day, every day. I see them more than I see my wife, and I don't have to wear a mask with her' [Tony. P.6].

'Some people have become really complacent with PPE, and not everyone's wearing it properly or… I think people are just getting that fed up and bored of it all, and wishing it was all over and done with' [Greyson, p.1].

'I'd say, maybe 25% of the people who I work with on a shift don't routinely put their aprons on. They do put gloves and a mask on. Maybe 30% don't wear a visor of any sort' [Jeremy, p.2].

In the above, Tony iterated beliefs of being 'messed around' which were linked with a perception of 'behavioural complacency'. However, deeper analysis reveals how such articulation provides insight into the objectification of this new social reality and how rudimentary power tensions around authoritarianism and social control were in existential conflict with the participants' strong social urge to bond and freely connect with colleagues. Coupled with a widening rift of mistrust in legislative and regulatory directives issued by government, some participants began to acquiescence their behaviour in passive assent to the new orders, or, ultimately, were entirely non-compliant.

In earlier interviews, the moral imperative for adhering to the infection control measures appears to have been a significant influencer in collective behavioural action. Yet, at this stage of interviewing, it is questionable as to whether this moral leverage was still a prominent motivator and a feature within cultural norms given the challenges around behavioural adherence. Furthermore, to comply with the increasing restrictions required effort, adaptation to new social realities (such as adjusting one's communication whilst wearing masks) and required social sacrifice and abandonment of some meaningful, structured culturally ritualistic traditions that previously would have provided a sense of unity, social connection, and a medium for sharing emotional experiences. By this point in the pandemic, however, many of the participants reported feeling chronically fatigued and exhausted due to a demanding workload and rapidly evolving systemic changes to organisational and clinical practices. In addition, chronic hypervigilance was also prevalent within their accounts, and thus, it is no wonder that they experienced little energy or enthusiasm towards changing their behaviours further, in spaces that were collectively deemed as private.

John's excerpt below touches on this and reflects what he sees as complacency reflected in the attitudes and behaviours of many colleagues and leaders.

'I was expecting to see both at a leadership level and also at a staff level, a reignition of the risk mitigation and the safety policies and social distancing, PPE and all that sort of stuff. I would've expected to see that being pushed a lot more and staff challenged when they weren't adhering to it, and frankly, I've been doing shifts where perhaps I've been on the car and I've been top to toe in PPE sitting in a house full of Covid positive patients waiting for back up and colleagues have rocked up just with a fluid repellent mask on their face and being quite nonchalant about the whole situation and I really don't

understand if it's because our colleagues have already caught Covid and so think that they've had it, so that's it, or they're just desensitized by it all, or they just don't understand the risks' [John, p.2].

This point was further established by Harper:

'…we went to a resus the other day and my colleague, and I were in Level 3[PPE], and we started the resuscitation attempt and then we had a conversation with the wife, and she said 'no, you know, we, he hasn't got a DNACPR[5], but he wouldn't have wanted to be resuscitated. He's a really ill man'. So, I said 'that's fine, we'll stop', just as the team leader (TL) walks in with the Lucas [a chest compression device] with no PPE on at all! So yeah, so you know, on the one hand you get TL's saying, 'you must do these things and we're going to, you know, discipline you if you don't' and then they walk in with nothing on at all!! You just think 'right, okay'! [Harper, p.2].

These quotes subtly allude to the inter-relational performativity between prototypical leaders and followers whereby the incongruency of leaders' and colleagues' behaviours in the context of the guidance was perceived as a dichotomous in-group polarisation. Non-conformism, particularly from leaders, was surprising and seen to violate social norms – especially the supposed shared understanding of what was deemed acceptable behaviours. This raised questions around morality and power dynamics for both Harper and John, who inferred that the disregard shown for social norms was influential in negatively shaping the adaptive behaviours of followers (other staff) and subsequent disenactment of the guidance. Indeed, in these extracts, the incongruency of leaders' behaviours in the context of those expected, was perceived as hypocritical with a frustrated sense of injustice with 'one rule for them, one rule for us' – perhaps incidentally magnifying the leaders' perceived higher status in acting at their own will and demonstrating potentially costly behaviours, yet also subconsciously calling into question the social and moral role of those in leadership positions.

Conceived power within the work social context is an interesting finding of a complex dynamic, based upon unequal participation by leaders and staff members. As the above illustrates, power dynamics were critical to the social construction of the new organisational reality facing the participants. This point is further amplified when examining the perception of leaders in their readiness to reinforce normative behaviours when they were deemed to have been violated.

The excerpt overleaf exposes how the coercive power of some senior leaders influenced the social construction of reality at the frontline. Although the new restrictions challenged internalised traditional

[5] A 'DNACPR' (Do Not Attempt Cardio-Pulmonary Resuscitation) is a legal document recording the expressed advanced wishes of the patient not to be resuscitated, or where a doctor believes that to resuscitate the patient would be detrimentally harmful or futile (NHS, 2023).

socio-cultural norms, the quote shows how the externalised reality had, in essence, become objectified through highlighting the transmissive impact of Covid-19 in terms of spread and rising number of staff cases within ambulance trusts. The hierarchical power of senior leaders arguably created a new social reality whereby employees, more so those in lower status positions, were intentionally mandated to adapt their behaviours in effort to curb the contagion. Whilst perhaps the intention was to account for enhanced workplace safety, in the extract, Harper alludes to a perception at the micro-level that leaders were utilising their social power in coercive ways to actively blame those staff who had seemingly not internalised and legitimised the new regulations to adequately form the desired new social reality, and thus, this was used to rationalise the rising number of infective cases among staff groups without obvious consideration for other remitting factors. Critically, the quote further highlights how sanctions and punishments in the form of surveillance and disciplinary action against those seen to be violating the new regulations was to be used as a means of behavioural control and threat. Crucially, this led to conflict within leader-follower relations and a hostile working environment whereby the participant reflected a feeling that the accusations were defamatory, unjustified, and uncalled for, even if they had admitted to non-adherence of the rules. Combined with the pressures facing the frontline as the pandemic continued to ramp up, Harper indicated that she and her colleagues felt resentful, and this was underpinned by deep feelings of powerlessness, mistrust, and lack of control. This was now becoming their social reality, driving, for some, a widening dichotomising social identity and polarising relational split between the groups of 'staff' and 'leaders'.

"We've had lots of staff sickness, and our station was put into a bubble because we had a big outbreak. Everybody was going down like flies and I think what was upsetting the staff was that it was, you know, they felt like ***they were being blamed*** *by, by, you know, by senior managers* ***'it's your fault*** *that…* ***you're obviously not taking the right precautions****. You're not wearing your PPE properly', and there was talk about being disciplined if you arrived back on station and you were seen in your vehicle without your mask on. Most people weren't, you know, they weren't knowingly doing it, but sometimes, like everything, you forget to put it on. A few people had some quite frank conversations with the managers, apologising first that they didn't have it on but, when you're being accused of flouting the rules or putting colleagues at risk and stuff, that was a bit below the belt, so people were upset. They were tired, fed up, and there are not enough vehicles out on the road. So, people were obviously working harder and harder when they are already tired… so yeah, it's been it's pretty horrible"* [Harper, p.1].

While the routine rituals of ambulance work such as both crew sitting in the cab when not engaged on emergency calls, are clearly behaviours situated within historical service culture, it is this social context that also made the implementation of stringent infection control measures and social distancing more problematic to implement and sustain. Thus, it could be said that adaptation to this new social reality was not easy and was, as discussed, further influenced by the relational power dynamics held between leaders and lower status colleagues. Subsequently, the empirical findings suggest the critical influence of social

relationships within the workplace, and how these relationships underpinned cultural ideological discourse, norms, social hierarchies, and power dynamics, which ultimately influenced how the participants socially constructed their 'new' Covid-19 reality.

This is further illustrated when contrasted with a simultaneously occurring everyday 'routine' activity relating to the social spaces of ambulance vehicles and hospital emergency departments, and the social realities of those habituating these contexts as professional social actors. 'Hospital queuing' or 'ramping', are terms socially constructed to represent the context whereby hospital emergency departments are full and ambulance clinicians are unable to offload patients from their vehicles. It is not a new phenomenon. However, it is a context that more recently has occurred frequently and has become challenging to manage, with ambulance staff ultimately caring for even the sickest of patients for extended periods of time whilst parked outside the hospital.

'Queueing at hospital, at times, is awful. I had a patient that queued for twelve-and-a-half hours. I was on a night shift, and I got sent to relieve the day shift. When I got to them, we were number eleven in the queue, and we still had to wait five-and-a-half hours to offload' [Keisha, p.1].

The onerous waiting to offload patients into the emergency department was a bone of contention that almost all respondents discussed. Sometimes, this wait could take many hours, driving psychological angst in terms of boredom, frustration, pensiveness, exhaustion, and increasing fear and anxiety at having to sit in close proximity with patients with Covid-19, whilst only wearing a fluid repellent surgical mask in a confined space with inadequate ventilation. Within this context, participants felt vulnerable. They felt unnecessarily exposed and inadequately protected from what was now widely scientifically understood to primarily be an airborne virus (Greenhalgh et al, 2021). However, this transmissive route of infection remained publicly contested by nationally governing bodies and international health organisations, who continued to promote a competing, partisan narrative of droplet transmission of SARS-CoV-2 which was situationally airborne only when in the context of aerosol generating procedures (Simblet and Dayle, 2023; Lewis, 2022).

For the participants, this brought to the fore challenging questions reflecting their clinical reality, particularly around the perceived unwillingness of authoritative bodies to upgrade guidance pertaining to respiratory protection - from fluid repellent surgical masks to respirator masks (which were understood to counter aerosol airborne viral transmission). Whilst examination of the scientific and strategic arguments is beyond the scope of this thesis, what is important here is how this social drama was framed and symbolically experienced by the participants. Their view of themselves and their emotional responses were unconsciously situated within the context of the relationship between themselves, their employing organisation, and Public Health England - who had refuted the change in PPE practice. Perceiving this to

be a dismissive, hurtful act of betraying their safety, these participants internalised this response as being socially representative of their lives as immaterial and worthless, and their frontline realities as insignificant. While some responded passively, others who commented showed defiance in taking matters into their own hands because 'nobody else is going to look out for us':

'So that's been a bit of a frustration. Everyone's been quite angry about… the fact that we're not really being protected… because when we are sitting in the back of an ambulance with a patient for two hours at hospital, people don't feel comfortable sitting there with a known Covid positive patient in a surgical mask. So, people are upgrading to the FFP3 or the grey half mask and there's been loads of emails coming out [from management] saying 'don't do that!! Stop doing that. Stop upgrading' [half-laughs]. People don't feel like they're being protected well enough….' [Ava, p.1].

Ava's thoughts are interesting not least because her use of language reflects the underpinning neoliberal discourses that feature in the guidance of government bodies in their guidance, whereby paradoxically, the 'freedom' from the epistemic knowledge of scientific experts ultimately indicated relative 'freedom' from protection against the virus. Subsequently, she infers to feelings of powerlessness and frustration in that her and her colleagues' voices of concern were perceived as not heard, acknowledged, or valued by the institutions in which they worked, or indeed by wider public health organisations at the macro level. Thus, driven by continued fear of the epidemiological threat of the virus, and a collective social framing of protection as empowered individual choice and responsibility, the data shows how Ava and her colleagues were oppressively motivated to take matters into their own hands and to adapt their social practices by wearing the higher-grade respiratory masks for protection. As Ava remarked however, this came at a price with senior ambulance leaders quashing such behaviours without apparent opportunity for debate or discussion, following the long traditions of 'command and control' management. Requiring authority and obedience in such a context of injustice reflects an authoritarian approach whereby the social relations between senior leaders (or institutions) and employees is effectively reduced to power dynamics whereby coercion and threats are ultimately played to maintain control. Subsequently, in this context, surgical masks arguably became artefacts symbolic of oppression in the face of authoritarian leadership practices, and constant reminders of the apparent socially constructed worthlessness of one's life as a frontline healthcare worker.

'I think because the trust has said 'we're going on what the guidance is, that comes out' which I think they probably are, but people have just had enough now. I think constantly being told that they're [the staff] not doing things properly… I just think they just feel like wherever they turn, they are being told what to do or monitored or whatever. They're just tired and short fused, and you know, have had enough. I know there's a lot, there's a lot of unrest about double standards…' [Harper, p.2].

Harper's quote alludes to internal anguish as projected representations of the collective feeling in response to enforcement of the guidance. Indeed, she further shines a light on how some ambulance staff were challenging the core narratives of expected organisational practices. In addition, Harper reflects, in similarity to Ava, upon the hierarchical top-down instigation of partisan and narrowed policymaking which perhaps conveyed false certainty, resulting in lowered morale and frustration at street level.

This was also noted in John's account, whereby in contrast to colleagues increasing their vigilance around transmission of the virus, others responded with passive dissent in being lax around aspects of the guidance. It is unclear from the quote below (and no other participants intimated to performing these behaviours) as to the reasoning why. Potential explanations could include chronic exhaustion, demotivation, and a strong desire to return to normalcy – points that were present within many respondents' narratives at that time, and again, was reflected within wider society with the phrase 'we need to learn to live with Covid' starting to become popular belief.

'…if you've got a prolonged wait and you're in an enclosed space then you'll be at increased risk. Although, interestingly, people haven't been doing this and there's been cases where staff have had to wait 4-6 hours at hospital and both members of the crew have been in the back with the patient. And when there's been comments about 'why don't you just rotate every 15 minutes or just not stay in the back?', they've been quite defensive about that, and I don't understand why [raises tone of voice to surprised]. Some staff find it quite boring just being one-to-one with a patient because I can imagine it's quite difficult to keep the conversation going for six hours, but likewise, I don't understand why you wouldn't want to rotate, knowing the risks' [John, p.2].

7.5 Relational and intrapsychic affectivity: Individual and collective traumatogenic narratives in response to continuing adversity

In response to the continuing adversity, examination of the empirical data highlighted individual and collective traumatogenic narratives which were expressed within affective and relational phenomena within the social domains of the ambulance service organisational cultural environment. Participants described relational scenes, in which they, as social actors, were part of emotional interactions between themselves and others such as leaders and allied healthcare professionals. Examining the micro-dynamics presenting within the participants' narratives highlights a dynamic relationality within such social contexts and spotlights individual and collective experiential affective states that reflect the traumatogenic nature of working as ambulance personnel during this stage of the pandemic.

This social psychological sub-theme presents the salience of human emotionality, and the intra-active relational dynamic of affect shared by the participants, and how the situatedness of this affect within

social experiences can exert embodied cultural influence on their traumatic responses. Whilst, of course, this study does not physically observe the dyadic relational-affective interactions between people (such as gesturing, body language, eye contact, and posture), the interviews allowed for an immersive experience not only in terms of verbal articulation but also in terms of tone and pitch of voice, and its movement and rhythm. In this instance, the socio-relational connection between myself as the researcher, and the participants was vital for gaining this deep insight.

7.5.1 Emotional labour and affective regulation as an intrapsychic and relational process – emotional intentionality salience

Participants indicated their commitment (and perhaps entitlement) towards their management and display of emotional affect, which was rule dependent determined by factors such as their values, social identity, and role expectations. Indeed, in this sense, insight is given into the participants' socio-emotional norms in the context of their salient in-group social community. Here, it appeared that group members subtly held the participants to these often unspoken yet implicit social rules by way of influential, focused criticism - thereby providing socio-relational emotional regulation of individuals' affective interactions.

Specifically, the relational scenes that are most illuminated within participants' narratives feature dynamic interactions between firstly, themselves (as professionals) and patients; particularly around managing patient and relative expectations, and secondly, between themselves, peers, and either ambulance leaders or staff.

For participants who were primarily patient-facing, particular social domains such as attendance at patients with Covid and/or waiting to unload patients at hospital, highlighted the complex relational dynamic between both groups of actors, and the structured emotional repertoire required of the clinical professional. The social arrangements of queuing outside the hospital, as previously discussed, was particularly challenging for participants. Presenting themselves in their professional role for many hours and interacting with patients in ways that accounted for highly structured habituated, bounded norms of affective interaction in an environment that was less than ideal for the length of the wait, was experienced by participants as emotionally demanding and chronically exhausting.

When asked to describe the experiencing of waiting for extended periods with a patient, paramedic Keisha replied:

'Urgh…. [sighs]… it's difficult because you really need to rotate round in the back of the ambulance. You're trying to explain to the patient, keep them stable, keep them happy, keep them calm. If we're crewed with either the military or fire responders, we can only let them in the back for so long, so that we can run to the toilet and get back again' [Keisha, p.2].

Within this social domain, the greater responsibility for patients rested with Keisha, meaning that, as a clinician, she was required to remain with them throughout the wait. Subsequently, the emotional labour of affective relationality with patients rested almost entirely with her. She explained that modulating and regulating her emotions and appearing 'on stage' with patients for extended periods of time, was exhausting. Although not explicated within her excerpt, Keisha's highlighting of being crewed with non-clinical or non-ambulance colleagues (such as fire service personnel who were acting as drivers) raises important questions around the performative interdependency of two colleagues when crewed together, and the relational and psychological impact of singular rather than joint emotional performance. As such, underpinning intrapsychic and relational tensions may arise within one of the partners when this dynamic is perceived to be out of balance.

The complexities of transpersonal affectivity was further highlighted in the relational and situational dynamics between participants and patients/ their relatives who intentionally sought assistance from the ambulance service for mild covid-related symptoms. Socially categorised as the 'worried well', participants endured high levels of emotional performativity and relational affect during these scenes which was evident within the enthralling use of tone, speed, and depth of voice in their articulations. Informed by their sense of shared social identity, their narratives captured a tangible sense of shared 'we-ness' and othering and conveyed their irritation and frustration, which was effortfully modulated when on stage in the presence of patients.

'At the start of early December, we'd be seeing people who were very worried about Covid, so you're getting calls to 'I'm worried I've got Covid, I've got a cough and a temperature'. 'Well, you might have. You need to book yourself a test and follow the guidelines. So, isolate, book a test. Go and get the test and then if you're negative, fine, and if you're not, keep isolating but, in the meantime, treat it as you would flu, rest, plenty of fluids'. But people have been saying, 'yeah, but shouldn't I be going to hospital?', and then you're sort of like, 'well, you're obviously… you don't need to. You're not desaturating rapidly, which is a typical Covid thing, so whether you've got it or not, you wouldn't be doing any good in hospital because if you haven't got it, you might pick it up, and if you have got it, you might pass it on to someone else. So, it's a lose, lose, all the way round. And they wouldn't do anything with you at this stage anyway'. And the number of people like that saying, 'yep, I've got a temperature and a cough, here I am with my bag and I'm waiting to go to hospital'. 'Yeah, but you're not bad enough. There wouldn't be any benefit'.

One guy was really dismayed, put out. Yeah, a bit aggressive, not horribly so. He was a bit of an arse, I suppose. He said, 'well, that's terrible! I'm going to put in a complaint if you're saying if I haven't got Covid, or if I have got Covid, and you're not taking me to hospital'. I said, 'that's fine…'. He was just sort of anxious and kicking off because he wanted someone to take his problem away, I suppose' [Jeremy, p.3].

'I think there's far too much of us just going to check them out. We are not a 'checking up' service [said with defiance] and certainly not at the moment. We shouldn't be going [anger in her voice]. I've got colleagues permanently in and out of Covid homes. They're going to one patient where 3-4 people have tested positive in a property and none of them have got masks on when we walk in, and then people [colleagues] are calling to check them out in the vehicle so they're not in the house with them and they're getting abuse from people for doing so' [Willow, p.6].

Giving a specific example, Willow further shared that:

'…it was a collapse query cause, and I walked in and realised that they'd just had a gender reveal party. So, this lady's daughter is pregnant and there's about 20-30 people in the house and there were still ten people in there when I got there, and yeah, this woman then told me that she worked in a care home. Just unbelievable. She was drunk and had a head injury. She stayed at home…but I went outside to fill in the paperwork. I certainly wasn't staying in the house with that number of people in there. It was only a two-up, two-down terrace. It wasn't a big property. And colleagues are constantly coming up with stories like that – house parties, and people who just want 'checking out' for breathing difficulties. We should be protecting our crews from walking in to all this. That's causing a lot of frustration and emotional fatigue with the staff at the minute' [Willow, p.6].

The above accounts are typical of those expressed by almost all of the participants and, importantly, provide insight into how their affective energy diminishes when the patient is perceived to metaphorically 'cross' social boundaries leading to a breaking down of sociality. Subsequently, as in Willow's account, the language and articulation of the encounter becomes very matter of fact. This scenario is clearly a source of deep irritation for her (and other participants), as captivated by the affective intensity of her words and tone of voice. Having examined all the empirical data contextualising this sub-theme, it is highly apparent that it is this intense feeling of irritation, this immersive shared lived experience, that appears to grip all the participants, to the extent that it further illuminates their tangible sense of togetherness and relationality, heightening collective dynamics but also extenuated feelings of disconnection between themselves and these socially categorised patients.

Participants who were managers articulated relational-affective positions that were culturally patterned and an intra-active dynamic whereby normative social and ethical principles were clearly guiding their emotionality within their communications with staff members and peers.

'Everybody was focused on the emotional labour element of directly providing care and the risks around that, but what people have been doing behind the scenes is a massive amount of emotional labour by the managers and leaders who have been trying to keep going with the day job but also take on the extra stuff, and how people have been affected by what's going on through the pandemic' [Ollie, p.4].

In these relational scenes, managers such as Ollie demonstrated how they had become emotional anchors for colleagues, particularly junior staff, whilst simultaneously managing their own internal affective states through normative principles ascribed through their cultural values. This included, for example, enacting socially expected emotions whilst simultaneously regulating one's authentic emotional responses, which Ollie highlights later in his account.

Talking of her interactions with staff, the excerpt below from Liz focuses on the affective relatedness between her and her team members. Like Ollie, Liz also becomes an anchor, holding and containing the distressing emotional experiences of her staff – she articulates a sense of responsibility for her staff members' welfare and a sense of in-group solidarity and belonging is indicated by the normative patterning of her responses – which are consistent with affective relatedness, affection, and compassion for them.

'I've got one [member of staff] that went off for six weeks with anxiety and stress over Covid and everything else going on. I've got another one at the moment who currently is on DMA's [double-manned ambulances] only because they're just so stressed with everything with Covid and so tired, that they're worried they're going to make a mistake on a car. So, we've taken them off the car for a couple of months just to allow them some time to sort of prove to themselves that they can do it but at the same time take that stress away. I am so worried about how it's going to affect the team and how we're going to be a year down the line post-Covid when everything is settled. I don't think Covid is ever going to go' [Liz, p.3].

For Liz and for Ollie, their embeddedness within the ambulance occupational culture, their social identity as ambulance managers, as well as their operational working environment, no doubt contributed to the structuring and display regulation of their relational affect in the interactions between themselves and their staff. These informal, socially constructed codes of conduct, about what it means to be a manager and how an ambulance manager should (emotionally and socially) behave, also appeared to provide some form of rationalisation when faced with conflicting emotions regarding their management responsibilities.

'I'd love to go and spend time standing outside the acute hospitals and giving cups of tea out, to discuss when they [the staff] come in or just checking that they're alright but there's just not enough time in the day. There's not enough time for me to do that. There is so much more we could do if we have the time…' [Willow, p.5]

In the above excerpt, Willow clearly feels torn, wanting to support her colleagues, yet feels pressured by the organisational demands of the other tasks required of her role. Regulating her emotions allows Willow to rationalise and arguably avoid her internalised feelings of dissonance at her conflictual management responsibilities. In this way, rationalisation allows for a level of inward justification and her emotions subsequently become more manageable.

The subtleness of emotional regulation utilised by participant managers appeared to be socio-culturally influenced by such organisational 'feeling rules' (as reflected in their language and articulation of events) and was a notable factor for determining the experiencing and outward expression of their emotions – whether these be authentically, superficially, or more deeply acted within a relational context with colleagues. Indeed, the scenes in which emotional display was culturally permitted appeared to be highly regulated. However, whilst this regulation served to aid these participants in terms of job performance, emotional suppression appeared to result in the subjective experiencing of intrapsychic tensions, as examined within the next sub-theme.

7.5.2 Emotional dissonance and performativity

Participants appeared to strongly identify with the emotional performativity required of their occupational role. In many instances, this clearly advocated a sense of meaningfulness, purposefulness, and job satisfaction and arguably reinforced their sense of identity as a paramedic/ ambulance person. However, where chronic emotional dissonance was experienced in terms of authentically felt emotions versus emotional enactment, there were connotations indicative of profound emotional exhaustion, depersonalisation, and cynicism.

Bound up in held values of their in-group, the pressures upon participants to continue to feel and act in certain ways was, particularly at this stage in the pandemic, often challenging to maintain both intra-psychically and in terms of relational enactment to acquiesce to collective emotions and in-group solidarity. Thus, it was unsurprising that social practices and social interactions within these occupational communities were now showing significant signs of relational affective strain and deterioration – more so than that highlighted in prior interviews.

'*There are lots of arguments going on [between staff] …at the moment people just, just look ground down, and tired and worn out, and there's no respite at home for anybody either particularly, with schools or being off as well everyone just seems a bit flat. I mean it's never a great time of year. The weather's not so great and it's cold and it's dark. I think it's all just so… it's a perfect storm. Even the best people struggle sometimes with their… with keeping everything positive and ticking along. Yeah, it's been a bit difficult'* [Willow, p.4].

Most notably, emotionally regulated performativity in the context of repeated, high-level exposure to emotive situations including deaths and patients with critical illnesses on the one hand versus attendances to those with minor illnesses, was taking its toll upon the participants. Furthermore, the necessity for emotional control and suppression, that is, inhibiting emotional displays, to allow them to appropriately deal with these situations as well as rising levels of public aggression towards them, was exhausting and often contributed to the development of cynicism and depersonalisation towards patients.

'I'm definitely less resilient, tired. It feels like this is probably the hardest point out of all of the pandemic since it started. This has definitely been the most difficult for me. A lot of people are finding that, too, but this time round it's much more difficult. It seems to be a general kind of feeling' [Ffion, p.2].

'We're ten months in now and as we said at the start of this conversation, I'd have thought by now it would all have been history, and it isn't. It's… I think that's the wearing thing. It's that background stress. Maybe I have a level of depression that I'm not acknowledging because I am tired. I am really tired. Emotionally exhausted. To the point where I am going to bed earlier than I would have done, not necessarily sleeping as well as I would have done, and not wanting to get up [laughs]. I know there's an element of that being shift work there but that is, has been more pronounced over these past ten months for definite' [Simon, p.6].

'I think now, everyone's starting, I mean, myself personally I'm starting to feel like erm like someone's turned off the light at the end of the tunnel. It feels like this is never going to end and we're just repeating the same stuff and nothing different is happening… I feel worn out to be honest. I think the majority of healthcare professionals in the UK are feeling like that, especially in the ambulance service' [Joel, p.1].

The sense of weariness was palpable in these shared experiences. This is further elaborated on by Liz who framed the complexities of juggling relational-affective demands, expected professional and cultural behavioural norms versus her authentic felt emotions, and her desire for social support from friends and family to ease the intense pressure she was feeling. Liz's account highlights how her feelings of frustration, of exhaustion, are normative, valued-based felt evaluations that are critically situated within the relational context between herself and members of the public. Thus, Liz's affective experience was not a solely individual experience – but rather dynamically situated and co-created within relationships. Subsequently, the salience and intensity of her authentic felt emotions in response to the public's antisocial behaviours meant that her attempts to emotionally regulate in accordance with normative principles pertaining to her role and status within her employing organisation, was much harder and required greater effort. Meeting these normative demands through intensive enactment during these scenes was exhausting.

'…you don't have that social outlet that you normally have, so it is difficult when you come home and you're knackered and you want to, basically, just chill out with people and you can't. So, it is hard and then I see and hear of people that aren't following the rules, the guidelines set by the government and the laws, and everything else, and then the next thing you hear it is moaning about Covid and you're like 'well, if you just did what you were told, we wouldn't be in such a bad mess'. Covid wouldn't be gone but we wouldn't be where we are and you have to drop that attitude, I suppose for want of a better word, when you're at work because I can't go to a patient and say, 'well, if you had done this, that, and the other, it would be okay wouldn't it?' because that's not professional. So, it's really difficult sometimes when you see people that are being a bit stupid.

I am out and about mainly when I'm at work because I'm driving from one location to another. You see it. You want to react to it, but you can't react to it, and then when you go home, when you're on your days off, because you're not out and about and you're staying at home as much as possible, there's no outlet, you know, so, not that I would actually go up the street to shout at people, but it just feels… strange, so yeah' [Liz, p.2].

Unpacking Liz's excerpt further, it is notable how she uses small shifts in language when recounting her experience. The way she expresses herself through personal pronouns provides us with real-time insight into how she was conceptualising herself and her identity within the social context of the researcher-participant relationship. At first glance, Liz's second-person pronoun use of 'you' gives a sense of her being embedded within a social world and of generalised reflecting upon her own experiences. She then spontaneously switches back to the use of 'I', indicating personal introspection – reflecting upon her own experiencing rather than from a social perspective.

Deeper consideration, however, highlights how Liz uses the second person pronoun when articulating feelings and emotions, with the linguistic shift to 'you' providing a degree of psychological distancing from herself and her internalised emotional experiencing. This is possibly to give cognitive space to sense-making of this distressing event and to lessen the felt rawness of difficult emotions. In contrast, Liz reserves 'I' for the more practical and professional elements of her narrative, indicating the salience of her social identity as a paramedic/manager. Observing this pronoun shift arguably provides brief yet valuable insight into the psychological mechanisms by which Liz emotionally regulated and maintained self-control at the time of the event. It also highlights how the salience of social identity is paramount in its subtle influence of one's emotional experiencing and display.

7.5.3 Social identity and in-group membership shapes individual and collective traumatogenic responses to continuing adversity

Building on the prior findings discussed above and in previous themes, the participants' narratives also revealed the extent to which salient social identities continued to shape their perceptions and interpretation of events, and their traumatogenic responses to adversity. Throughout all of the conducted interviews, participants alluded to a deep sense of belonging to their professional and occupational groups. Belonging to these groups was relevant to informing their social identities, their self-concept, and relationality between the participant and other group members. However, where social identity was perceived to be emotionally and psychologically threatened within the context of the scale and chronic longevity of the pandemic, participants interpreted this as heightening their vulnerability, which was subsequently experienced as stressful and disorientating.

As the empirical findings have already discovered, vulnerability does not sit well with the social identity of paramedics and ambulance personnel, and such feelings caused the participants considerable emotional and role dissonance and discomfort. However, what is highlighted within this third phase of the study, is how profound this dissonance was, and the lengths participants went to, to protect their embodied social identities and protect themselves as individuals and as a collective, from threats such as feeling distressing emotions.

Tony's account is particularly relevant for discussion here. Tony strongly embodied his group membership and social identity as a military paramedic, which notably developed in intensity over the course of the study period, as the pandemic continued to wage. This is an important observation when contextualised with deeper level analysis of his narrative, which reveals the relevance of social and relational group processes towards influencing his appraisal of incidents and his subsequent emotional regulation. The excerpt below relating to his attendance at critical incidents provides a summary illustration of this.

'I prefer high pressured environments than being sat around doing nothing. I quite enjoy it, although that sounds pretty sick. But it's the fast-paced high-pressure stuff, that's kinda where I thrive' [Tony, p.3].

On the face of it, Tony appraises potentially traumatic events as professionally stimulating. Yet, his acknowledging of his viewpoint as sounding 'pretty sick' reveals an inner conflictual dissonance, in which he recognises the cultural appropriateness of his appraisal associated with his in-group membership as a military paramedic, versus the cultural inappropriateness when it is considered from out group perspectives. Indeed, his response tells us much about how his interpretation of a potentially traumatic incident was moderated by the cultural normative standards of his salient in-group and the resultant expected affective enactment, which likely sits in contrast to those values held by others outside of the group.

By holding a greater sense of belonging to his military paramedic in-group (and subsequently, a more salient social identity), it is feasible that when faced with performative situations (such as a critical incident) that may evoke deeply distressing emotionality, the socio-relational means by which he appraised these events was such that he did not perceive them as traumatogenic. Rather, he embraced them positively. Arguably, this mechanism provided a means for protecting his self-concept and social identity from possible vulnerability threats.

Through the process of developing a deeper social identity salience, it is quite possible that acting in a prototypical way of embodying the normative attitudes, behaviours, and values of his salient in-group positively orientated Tony towards the group's social and cultural role expectations. Arguably, it is this

unwavering socio-relational context that ultimately served to protect him (and possibly other in-group members) from experiencing any difficult emotions when at potentially traumatic scenes. In this way, any subliminal fears of being socially devalued by his in-group for not maintaining the groups emotional and behavioural norms and of questions being raised by them as to his social role and place within the group, are contained, thus reducing further any felt distress or trauma.

However, whilst this mechanism of adhering to these normative feeling and emotional display rules may have provided a degree of psychological preservation and pseudo-equanimity whilst immersed in the incident, Simon (below) alluded that, in the longer term, the mechanism of dissociating from and suppressing one's authentic emotional experiences was detrimental in terms of altering and disrupting one's sense of self. He reflected that when his social identity as a paramedic was salient and considered in respect of potentially traumatic incidents that he had attended, he was able to recognise an internal emotional disconnection and felt somewhat detached from this part of his being. This is notable in his opening words:

'…there's stuff that I can look at as if I'm in the third person and think, in inverted commas, that a 'normal person' would be quite upset by that, and I don't really. I've got a bit of an empathy bypass or something. I don't know how to describe it [sounds confused as to what it could be or what words could describe this feeling] … I think there's an element of, and this might be just where I'm at in my length of service, but there's an element of desensitisation to it… Maybe that's a self-protection thing [said quickly, almost in justification], I don't know'.
[Simon, p.3].

In his articulation, Simon disclosed depersonalisation, which can occur when an individual self-categorises themselves within the context of salient in-groups, and fully aligns the regulation of their emotions and behaviours to that of the in-group prototypical norms. Essentially, a person then comes to see themselves as fully immersed into and identifying with that group, thereby depersonalising their personal identity such that they no longer perceive themselves as a unique entity with their own individual differences. This can lead to emotional detachment or feeling 'numb' (Pietkiewicz et al, 2023). Certainly, the dissociative flags within Simon's account (such as viewing himself as objectified and thus disconnected from his authentic self) indicate that depersonalisation was prominent. This was also a finding from several other (although, not all) participants during this study period who disclosed feeling as though they were 'robotic' and 'devoid' of emotions and feelings.

Simon's labelling of 'desensitisation' shows objectified insight for his reduced emotional responsiveness. Given repeated exposures to witnessing distressing scenes, this phenomenon may be viewed through the lens of traumatogenic derealisation whereby Simon's feeling of disconnection from the reality of the situation and his surroundings when at potentially traumatic events evidently left him struggling to

emotionally connect with himself. It could be postulated that a similar derealisation process also underpinned Tony's incident appraisal process, whereby his positive take when faced with potentially distressing scenes was, in essence, a displacement (or dissociative) tactic, such that viewing the incidents in a more positive light offered a psychological 'escape', disembodying him from the horror that he may have witnessed as well as preserving his social identity. Indeed, concluding Simon's excerpt is his insightful sense-making that his engagement of both derealisation and depersonalisation were viewed as self-protective mechanisms buffering him from the adversities, traumas, and distress that he had repeatedly experienced throughout his service as a paramedic, and more so during the pandemic.

Importantly, analysis of Greyson's narrative draws further insights. The excerpt below captures his emotional dissonance and his attempts at making sense of his authentic feelings of distress in response to witnessing emotionally provoking incidents, noting his surprise at the significance of emotional connection to patients and their relatives as a central feature in the moderation of his personal distress.

'I've done a couple of typically bad jobs recently, and they've not really impacted me as much as the ones where I was talking to families and taking their family members away from them… which has been quite strange because, to me, those jobs aren't your typical traumatic, horrendous jobs where you expected to have a TRiM assessment[6] from. But no one has really spoken about the jobs, the little jobs, which have had a huge impact on…' [Greyson, p.8].

Crucially, Greyson's reference to the collective silence around the traumatic experiencing of these 'little jobs' provides further evidence of the influence of the socio-emotional in-group rules pertaining to incident appraisal and emotional display. Here, there appeared to be an unspoken, previously established (pre-pandemic) consensus that in-group members should 'hold it together' when faced with highly emotive situations that pose a real threat to the group's social identity norms (to show emotional distress is a threat to their self-concept and increases their vulnerability). This is confirmed in the continuing narrative below, whereby the researcher probes deeper into Greyson's experiencing of this:

Researcher: *'How have you dealt with these 'little' jobs?*

Greyson: *Probably not the way I should have done. It's just kind of trying to shove them out [of my mind] or do something different. I think as well, because they're not your typical traumatic job, you don't really feel like you need to look at them or should talk about them. Having said that, one of my close friends on station, we talk quite often about jobs and both of us have said a similar thing. These jobs aren't really spoken about - the ones that actually impact us. Because they're not your typical traumatic job, which you are expected to have flashbacks to and everything else.*

[6] TRiM (trauma risk management) is a system of trauma-informed peer support that is used within some emergency services. Trained peer practitioners undertake a short course to enable them to provide 'active monitoring' for individuals who may experience trauma-related symptoms after a distressing incident.

Researcher: *That's really interesting, because it's almost like… perhaps, there's something around not having permission to feel like it's a traumatic job because it's not a 'traditionally' seen to be a traumatic job?*

Greyson: *Yeah, yeah. That's it.*

Researcher: *And then, as you're saying, the TRiM isn't there because it's not 'traumatic', but in actual fact, it really is.*

Greyson: *Yeah. That's absolutely right'* [Greyson, p.9].

The emphasis placed on the need to regulate one's authentic emotions to conform to in-group rules in these particular social contexts is profound. This was likely further intensified by wider organisational expectations that unwittingly deny the permission to feel in response to the 'little jobs'. This was alluded to by Greyson's reference to formal trauma risk management support (TRiM) which was only actively offered to employees in response to their attendance at incidents deemed by the organisation (rather than the individual) to be potentially traumatic. Thus, the unspoken transference of feeling in response to this organisational behaviour was one whereby personal emotional distress felt in certain situations (i.e. 'non-critical' incidents) must be managed and contained to maintain the salience of, and social identity of the group as professionals who can deal with anything, thereby protecting the group from threats and vulnerabilities. Yet, the pandemic had continued to present the participants with some of the most challenging and emotionally difficult situations that were way outside their usual level of exposure:

'I see an awful lot of dead people. I mainly go to cardiac arrests and major jobs, and so I see more dead people than I see living people and I see more families that are upset and families that are grieving and families that are surprised that their loved ones have died so quickly. So yeah. So… that's been quite tough' [heavy sigh] [Liz, p.1].

For Greyson, Liz, and for other participants who commented on this phenomenon, the management and emotional regulation of heightened emotions in the face of adversity, through suppression, dissociation, and avoidance, at this stage in the pandemic, had become utterly emotionally exhausting and untenable. This psychological impact upon participants will be visited in the next sub-theme.

7.5.4 The chronic traumatogenic and psycho-emotional aftermath of witnessing profound human vulnerability

Recurrent exposure to traumatic scenes of profound human vulnerability was taking its toll on the participants who, by this stage in the pandemic, had witnessed more deaths than they would usually (as indicated by Liz in the quote above). Furthermore, they had also witnessed countless people experiencing

critical illness, for which difficult clinical decisions raising ethical debates around treatments versus death, were sometimes having to be made by the interviewees, outside their scope of practice. These scenes took place against a backdrop of a tsunami in the number of calls to the 'worried well' as previously highlighted, and a perceived desire amongst some organisations to swiftly return to the everyday work of 'business as usual'. Thus presented a sense of compounded, chronic chaos. Through examination of the participants' narratives, two inter-linked sub-themes appeared to be particularly resonant: that of intense, internalised feelings of disconnection and those of disempowerment.

Throughout the narrative analysis of the third phase of interviews, disconnection from one's own emotionality has been discussed in terms of participant's engagement of emotional suppression, avoidance, and dissociative strategies for regulating their authentic affective states. Disconnection has also been presented with regards to participants' social identity and their social relationships with in- and out-group members (such as colleagues, managers, and other healthcare or emergency services professionals). However, disconnection also appeared to take other forms; that, for some, also destabilised their sense of self and impacted their social relationships with others, leading to feelings of disempowerment.

Almost one year into the declaration of the pandemic in the UK, the respondents' narratives continued to embody a deep sense of fear, motivated by held perceptions that the world had become a dangerous and threatening place – a sense that was being reinforced by the repeated exposures they'd had to people dying or seriously unwell with the virus. Indeed, fear served as an unwanted and painful reminder of their own and their family's vulnerability and was disclosed in their statements as examples of chronic hyperarousal and hypervigilance of their surroundings and interactions with others and indicated a shattering of their basic assumptions of their world as a good, just, place.

'I've not seen any family for eleven weeks now, because I won't put them at risk. I won't even do garden visits wearing a mask…. [almost whispers] because I'm scared…… [a silence like she's going to cry] …and yes, there is a hell of a lot of anger at the moment… a build-up. You know, like they say when the tray is overloaded and…' [sense of distress felt by the researcher (transference)] [Keisha, p.2].

'I'm holding my breath when I get within two metres of people, and two metres past when I'm running. I'll cross the road or set out a route to avoid people' [Jeremy, p.2].

'I'm more self-aware of people and even like when I go shopping, I'm very self-aware, very clean, and I'm kind of in a way, quite anal about making sure everything that I put in the shopping trolley is clean. I've got hand gel galore in my car. I've even got a bin in the back of my car. So, the mask comes off and I'll clean my hands before I actually get in behind the steering wheel. I've got hand gel and hand wipes to make sure that I am clean. Even at home, there is hand gel at the front door. If anyone comes in, I'm making sure that they have hand gelled before they come in. I've brought a tympanic

[thermometer] and a pulse oximeter for my family and my partner's family, just so they're there. We're armed if anything happens. Even then, we've been out with friends, and I don't think I'll ever go back to going out for a drink in the same way I have done previously' [Greyson, p.4].

In each of the excerpts above, fear continued to influence participants' avoidance from seeking safety and connection with others, particularly with those individuals who were outside of their working group. This presented a considerable challenge for Keisha, Jeremy, Greyson, and others, who wrestled with their heightened sense of their own mortality and that of their loved ones, versus their basic human social needs versus their deep fears of social isolation and disconnection. This inner, embodied conflict appeared to deepen their felt distress.

Importantly, the participants contextualised their fears not only from an individual perspective but also as situated within their organisational culture. Whilst this was certainly not the experience of all interviewees, these participants felt unable to authentically express their fears within their workplace. They perceived that their fears were denied and unwittingly silenced by leaders (through unsupportive behaviours), and they held a belief that to show fear and distress would be construed as a sign of weakness, further impacting their social relationships with important others.

Deeper analysis revealed an internalised sense of unworthiness – that fear was inflicting an assault on the participants' self-esteem and was associated with feelings of helplessness, guilt, and shame at being frightened and vulnerable. This was in juxtaposition to the behavioural and emotional expectations linked with their professional social identity of being 'strong' and 'able to deal with anything'. Consequently, dissociating from aspects of themselves (through mechanisms such as emotional suppression) and disconnecting from others (through avoidance) were psychological strategies that interviewees utilised to separate themselves from their distressing thoughts and subsequent affect. Indeed, some participants articulated the 'massive' impact that working throughout the pandemic had upon them, yet as identified in previous analyses, tactically diverted the conversation, often drawing focus to the incident's attended thereby avoiding further discussion of their own emotionality and vulnerability.

With the threat of the viral pathogen remaining salient, the emotional response of fear persisted to the core of the continuing traumatogenic impact of pandemic frontline working upon those interviewed. For some, the ramifications of this prolonged exposure also led to attempts to disconnect from the intensity of their distress through the use of alcohol. Talking about this, Osian said:

'*The shifts over the last weekend were tough with supporting crew at paed arrests [child deaths] and then supporting another crew with a 48-year-old cardiac arrest. We've had a lot of death, but a lot of people have died before we got there. There have been a lot of delays, but people were probably still dying before that. I felt very low, I felt pretty crap. I felt… to be fair, after*

that I did struggle for the next few days… It feels very much like there's no light at the end of the tunnel. There's nothing to look forward to. The weather's miserable and everything's miserable. It's certainly taken a toll. [p.2].

On Sunday, the January Blues really hit me, and I was feeling very down. There's no end in sight… I think personally, I've probably been drinking too much again this this month, but not massively. I'm drinking most nights rather than just one or two nights a week and then probably exercising too hard because my legs seem to have picked up some niggles and injuries now. I've been out running more than I would do normally…am trying to get out the house to try and get that release. I mean, I've done 30km of running in the last seven days. I'm running from stuff but am trying to keep myself on the even keel because I need to. [Osian, p.3].

I've had a good chat with colleagues and it's my colleagues and my family that have kept me going. I met up with a colleague today and chatted with him and am trying to make a few plans and to start thinking about the future a bit, and just trying to find something to look forward to' [Osian, p.4].

In this excerpt we gain a sense of Osian's inner world versus his outer reality of facing multiple deaths, which by this point, he had had considerable exposure to. Importantly, deep examination of Osian's quote in the context of his overall narrative, reveals that the high-adrenaline states associated with paramedicine work; of attending cardiac arrests, particularly those affecting younger people and children, were experienced within him as hyperarousal affective states. What is crucial to note here is how repeated exposure was leaving him within prolonged survival mode, whereby it may be understood that his experiencing of low mood and hopelessness was akin to hypoarousal, a state of emotional dysregulation in which an individual emotionally shuts down when presented with high stress or perceived inescapable adversity (Corrigan et al, 2010).

This excerpt is critical in illustrating the challenges of assimilating experiences of high-activation, high arousal states of responding to high stress calls, in contrast to, when away from the scene and away from work, becoming emotionally exhausted as associated with a hypoarousal affective state. Further interpretation of Osian's quote highlights how the use of alcohol may have been an attempt to self-regulate, to gain some control over his negative affect, and also to create a sense of safety, increase feelings of wellbeing, and decrease fear and his sense of powerlessness. In previous interviews, Osian had shared how running was a natural behavioural coping strategy for him to modulate stress and distress. In this quote however, he shared how his running had greatly intensified – indicating his increased (unconscious) efforts at trying to regulate his overwhelming emotions.

In the final part of his quote, Osian emphasised how his membership and identification with his work social group was a basis for him in feeling connected to other group members. Feeling connected to others seemingly helped him to re-connect to himself and his sense of belonging appeared to provide

support and solidarity, thus helping him to safely regulate his emotions and decrease his distress, such that they 'kept [him] going'. Moreover, 'having a good chat' was an opportunity to tell his story with those who have shared experiences, further increasing his sense of relational security. Resultantly, Osian articulated feeling more empowered and enabled to have control over his life – evidenced by his positive shift in thinking towards future plans.

This interviewee was not alone in experiencing hypoarousal in response to chronic trauma exposure. Similarities can also be drawn from Jeremy's experience, which is set in the context of the recent loss of a friend and the serious illness of two members of his running club. Jeremy's embodied affective experiences were ones of indifference and reduced affect display (emotional numbing) that he dubiously contended with in the interview.

'I don't feel particularly stressed. I don't feel emotionally exhausted. If anything, a tiny bit sad, and I can't work out why. It might be my friend dying but that's something that you semi-expect… I think it might just be that lack of interaction. I really don't know. It's not debilitating, I'm just aware that there's that little bit of sadness and I don't really know where it's from. I don't feel particularly anxious although that background anxiety about my own mortality becomes just a bit more focused possibly through covid and those two runners having [serious illnesses]. It's never been an issue in the past. I don't know. It's a tough one.

I've come home from a shift and if there's enough time and a slot to have a couple of beers eleven hours before the next shift, I'll have a couple of beers and think, 'yeah, I think I could use my time better by not having a beer and doing lots of constructive stuff around the house and then going to bed and getting up with a clearer head'. But I think 'sod it, I'll have the beer!'. So, maybe that bit of disappointment is with myself rather than doing that and saying, 'I'm going to soldier on and do this, that and the other'.…It's quite fun at the time. It's a way to unwind. Maybe I'm a bit sad because I'm not doing the best thing and thinking that's not good for me either. Hmmm. That's an interesting one [sounds intrigued]. [Jeremy, p.6].

When faced with overwhelming, difficult emotions in the here and now, such as that of sadness, Jeremy articulated that he had little awareness of this. To him, this feeling didn't seem to make any sense. Correspondingly, this disconnect in terms of not feeling much at all, or not being aware of one's feeling states, arguably reflects his response to exposure to distressing and traumatic experiences – including the recent bereavements of friends, which was further emphasised in his following quote:

'A couple of friends from the running club have had strokes – query Covid related because they didn't have any stroke risk factors, and they're both quite young. One was 47 and the other, 36, and that kind of hit me, thinking these are people younger and fitter than I am, being quite severely affected by possibly covid, well, might not have been, but chances are... so, I've kind of re-doubled, always wear the PPE, do the best you can but be weary, it could be nasty' [Jeremy, p.6].

Unpacking this excerpt, one gains a sense of the underlying fear and distress that is embodied within Jeremy's subjective emotional experience of the horrors of directly facing the impact that covid has had upon his friends. In similarity with Osian, in this context, 'having a beer' could be explained as a way of self-soothing, in an attempt to regulate and reduce the intensity of his emotions.

Interestingly, the conversational quote below between Greyson and I provides intimate insight into a different mechanism that he used in attempt to navigate, contain, and tolerate the overwhelming emotions and threats he was experiencing at work; that of compartmentalising (or splitting) the cognitive spaces in his mind between work and home. Whilst home appears to provide a safe place to withdraw to and a means to separate from his work social identity, he alluded that his ontological segmentation of reality wasn't always helpful. 'Pretending life doesn't exist' was a means to emotional survival yet Greyson found that it was not always possible to shut the door on his traumatic distress or the threats outside.

Researcher: *You've got boundaries, you do work at work, and then home is home?*

Greyson: *Yeah, yeah. I think it's strange that the separation of the two has helped in as much as it hasn't. It's been nice to come home to a little sanctuary and shut the world out behind the door and focus on something really different.*

Researcher: *Yeah, you can leave it all out there, shut the door, close the curtains.*

Greyson: *Yeah, pretend life doesn't exist.*

Researcher: *The virus won't get you…*

Greyson: *Yeah.*

[Greyson, p.6].

The traumatic nature of fear in the face of significant adversity was interlinked with the atrocities of repeatedly being confronted by multitudinous situations that deeply challenged the interviewees' sense of morality. Indeed, the data highlighted many examples of this. Especially poignant were narratives capturing participants' continuing distress and angst at, by force of circumstances, being unable to provide the care they knew their patients needed, or 'taking patients away' from their families knowing that they were likely to die in hospital.

'…it is very much the relatives for me, that it makes it that makes it very tough. I think there are a lot more people with DNACPRs at home at the moment' [Willow, p.4].

'I went to people who were waiting twelve hours for an ambulance and the last place we went to that shift; the patient was really unwell. They actually had a bowel obstruction, and you know like, the pain… [sounds anguished] and she was in pain and waiting that long. The impact of waiting that long and her condition was quite horrific really' [Ffion, p.1].

'…the next day we went to someone who…had really severe difficulty in breathing. So, we pre-alerted the hospital, but they had nowhere to put us. Resus was full. They had space where they could open up a new area to accept him, but they had no staff to man it. So, we were literally stood in the corridor with a patient who was peri arrest [about to die] and I've never had that situation before like that in all my career. When I've rung up with someone who's really poorly, there's always been someone there to receive them so that was, yeah, just a real eye opener to me. The reality of the situation we were in...' [Ffion, p.1].

Underpinning the narratives above is a real sense of helplessness and disempowerment. Both Willow and Ffion knew that their patients and relatives needed more than they could give them but were blocked in doing so by systemic pressures and hospital capacity issues, leaving them feeling not only powerless but violated and compromised as to their beliefs, values, and sense of integrity and duty to care. Greyson, in the quotation below, shared how such feelings were distressing and left him feeling incredibly guilty. Furthermore, although not explicitly verbally articulated, his tone of voice, use of silences, and additional responses to the researcher's questions indicated an associated feeling of shame.

'I feel terrible now about having to take a patient into hospital because in my view, I'm ripping them away from their family. You know, sometimes they may not see them again. And that is…I feel the pressure and the weight from that, you know. It's awful trying to communicate that to families sometimes. I've never felt like that before. I think you just take it for granted that people are ok to go to hospital, but I feel responsible if that patient then doesn't go home. …. guilt is probably a really good word to use about it. I've never really thought about it that way…' [Greyson, p.4].

Significant to note here is how Greyson's belief that hospitals are a safe place, is shattered. The burden and 'weight' of responsibility he feels for potentially perpetrating the loss of people's loved one's in respect of this, is profound. Furthermore, his account alludes to self-blaming negative appraisal of his behaviours through the morally evaluative emotions of guilt and shame; indicating that his held beliefs and values have been transgressed. For Greyson, this realisation later left him wondering as to who he is – this person who would knowingly take people into hospital to die. This challenged his social identity as an ambulance person, as these experiences were self and socially disconnecting, holding at their core shattered beliefs around one's role in doing good for and not harming others. Such psychological and emotional distress was exhausting, let alone the emotional labour enacted within patient interactions:

'*It's quite draining coz you've got to kind of battle with the patient that is quite unwell to take them to hospital and you never normally have to do that. It was quite rare. A really good example - we went to a gentlemen who was only 56 and was having some severe chest pains and he had very minimal ECG changes*[7]*. But we were quite worried about him, and the gentleman refused to go to hospital, didn't want to go, point blank. We tried everything. We escalated it to one of our advanced paramedics. They spoke with him again and he point blank refused. So, we ended up ringing an out-of-hours Doctor and the Doctor prescribed him GTN [glycerol trinitrate] spray*[8] *and a bottle of Oramorph*[9]*, and said, you know, 'crack on'….'* [Greyson, p.4].

The moral complexities of clinical situations also extended to perceptions of perpetration of harm by organisations (and the government) rather than individuals themselves, who were delegated to enact the decisions and practices to which they had little to no input or influence over.

'I think probably most days we're making decisions that are more complicated than they were before the pandemic, and I think that's only going to increase exponentially. The city that I work in, all the ICUs [Intensive Care Unit's] are now full. Well, they're over capacity. They're at 140% capacity. So, I think increasingly, we're going to be asked to make very, very complex decisions about patients care and patient destination, and frankly, the ambulance service is paying lip service to supporting frontline staff but is doing little more… the ambulance service has put out a senior support cell for crews to contact, to help make complex decisions, which is great but most days, there's only one person in that cell to cover the whole of Green-shire' [Pete, p.2].

Pete's account and those below highlight the reality of a continuing sense of violation of their own ethical principles including those central to their social identity, that they were unable to change and felt powerless against. Like Greyson, Pete and others expressed concerns about being complicit in or seen to be supporting these new ways of working that were challenging their professional practice. They, too, felt helpless and lacked the institutional authority to challenge these wider decisions that were impacting patient care and were at juxtaposition to one's own moral convictions. In response, Pete demonstrated anger and cynicism towards his ambulance service, feeling betrayed that the organisation was only providing minimal support to clinicians who were faced with witnessing these incidents and were being placed in ethically very difficult positions. Moreover, his anger could also be deemed as an outlet expression of his integrity, at not wanting to be put in such morally challenging positions that bequest

[7] Minimal changes to the electrocardiogram (ECG) refers to the heart monitoring not showing any active changes to indicate a heart attack or the heart being an obvious cause of his chest pain.

[8] GTN (glyceryl trinitrate spray) is a medicine used to treat chest pain associated with angina; a condition caused by inadequate blood supply to the heart. GTN spray works by dilating the arteries within the heart thus increasing blood flow and oxygen supply, relieving any chest pain.

[9] Oramorph is a liquid form of morphine which is used to treat severe pain and sometimes breathlessness.

him to provide what he felt was sub-optimal care. This was also experienced by John, whose quote below captures his fight for his patients. Here, he articulates his defiance at participating in these systemic and institutionally perpetrated violations and he takes a stand to question the practices of not segregating those with infections to protect vulnerable, at-risk patients. Yet, his concerns were met with silent resistance, were evaded, and disregarded by those within the institutional hierarchy, leaving him also feeling betrayed, abandoned, and disempowered.

'…when we take patients into hospital…patients with COPD [chronic obstructive pulmonary disease], with perhaps shortness of breath, these patients would automatically get put into a red area or a Covid area, just as a default, and I struggled with that, with the hospitals err… and I challenged this with probably every patient I had. I mean, even if they were going in for a non-respiratory related issue, they'd still end up in the Covid area, and I couldn't get an answer as to why, from our ED [emergency department] or our local managers, when I raised it with them, and it just seemed really unfair that we were taking this vulnerable patient group into an area that was particularly high risk. If they didn't have covid, they were definitely going to catch it' [John, p.5].

Carrying out decisions that feel contrary to one's moral code was further expressed by Greyson in another example. In this quote, he starts by reciting verbatim details of a recent organisational directive. His feeling of powerlessness is palpable, as is the sense of being pressured to comply with taking actions that he felt to be wrong, and for which he felt was a betrayal of the patient's right to life and treatment.

'If they're elderly or unlikely to survive an ICU admission or have a DNACPR in place, please consider alternatives'. So, we've been ringing GPs, who've then put end-of-life management plans in place for patients, and that's felt really uncomfortable to do because we are in a way, not taking a patient to hospital that needs to go in because we can see the long term, well, we're being asked to see the long-term view of it, whether or not they're going to survive with the additional support. There are not many patients we've done that for, but that kind of support or that expectation's been there from the trust all the same' [Greyson, p.8].

Navigating ethically challenging situations were not just confined to staff members. Liz, a first line manager articulated the morally salient aspects of her work in supporting crews to make end of life decisions and the intense emotional labour involved in this as well as communicating with patients' families. Through articulation, she explored and attempted to find sense and meaning into her decision-making, weighing up the moral costs versus compromises, and then, delivering her actions in a compassionate and caring way.

'…whether we take someone to hospital or not, whether we treat somebody, whether we even start treating somebody… because the ICUs don't have capacity. The hospital won't actively treat a certain demographic of patient - based not only on age but their co-morbidities and their quality of life. This kind of decision-making has to be made by us in the community

now and that's tough to communicate to a family. To turn around and say, 'I know this is your loved one and actually, pre-Covid, we would have taken you to hospital, but right now, we're not going to, and they will die'… [voice trails off and there is a long, silent pause] ….

I think, this lockdown, we're not having to make these decisions as much because more people are already deceased. In the first lockdown, they were acutely unwell, and we knew that they could get really unwell, but they weren't dying in the community. So, there was a reasonable chance we could take them to hospital. But this time around, they're actually dying at home and we're making decisions to leave them at home. This sounds really horrible, and there's no emotion involved in this, but basically, we have to do it to keep the bed free for someone that would live rather than taking it up by someone who won't live. That's tough. That's hard.

Sometimes that decision is placed upon me because the crews don't wanna make it. So, they asked me to go out and support them knowing full well that that's what they're asking me to do, or they'll ring me and then we discuss it through on the phone and then they have that conversation and thought process with the family but there is a lot of pressure upon all of us to do that. So, yeah, that is tough. That is hard. You still have to go through everything to do with that patient to then understand that they are dying… You can have a pretty tough day when you've been out to a number of either deceased patients or acutely unwell or you've made those decisions in conjunction with the crew that is attending…

I don't know if we're expected to have more resilience than the general crews or not, but each crew will ring you with maybe one patient per shift thinking that 'it's okay because I'm only ringing for one patient' not knowing that however many other crews are also ringing in for that one patient, you know…' [Liz, p.4].

This poignant excerpt provides further insight into the cumulative and chronic emotional exhaustion experienced by those who had recurrently been exposed to profoundly distressing situations prior to and over the course of the pandemic. Indeed, the longer-term consequences of facing unprocessed and unresolved affective overwhelm were notably becoming apparent during this phase of the interviews, with each traumatogenic encounter gradually wearing down the resilience and moral integrity of the beholder, their emotions becoming heightened. For Liz, this also included being confronted with the challenging limits of her own autonomy as a manager in the context of her organisation's policies and systemic processes and her questioning of her moral agency in her ability to continue to act in line with her own standards and those expected of her role.

7.6 Conclusion

This chapter brought together the interpretive analysis of data gathered from participants interviewed in the third phase of this study. Encompassed within the first theme was ontological insight into the

evolving social realities of the participants. The data analysis uncovered highly socially influential micro-dynamics of power hierarchy and status. Unpacking the social relational processes inherent within the participants' narratives pertaining to their managers, the ambulance service, and public health organisations, captured oppressive tensions in social prestige and conflict within shared social meaning systems, which played a central, dominating influence in the construction of new social realities experienced by the participants in response to the changing pandemic context.

Hierarchy and power status within intergroup relations and social interactions was prevalent in influencing individual participants' thoughts, feelings, and behaviours. The effects of power, however, was paradoxical; creating a sense of dependency and reliance between participants and their managers, yet also creating oppressive toxicity which thwarted individuals' freedoms to express themselves and to act with professional autonomy and agency. Furthermore, these social process dynamics coercively enforced perceived injustices through modification of behavioural changes that were not aligned with the social norms held in-group yet were authoritatively implemented by leaders with the punitive threat of punishment for non-compliance.

The second theme examined the prolonged impact of exposure to traumatic and distressing experiences encountered by participants in their work. This part of the chapter considered the dynamic influence of social relationships between participants and patients, and between participants, leaders, and their employing organisation. Data analysis revealed deep insight into the social processes that underpinned emotion management and how social identity, and group memberships shape collective responses to adversity. Importantly, this section further revealed the extent to which ambulance organisations and their cultures very subtly but greatly influenced the participants' trauma responses by determining expected affective and behavioural reactions in given situations, for example.

Highlighted within this theme were interviewees' perceptions of organisational disconnect in terms of an acknowledgement of the social realities being faced at street level. This was illustrated in terms of the institutional move towards 'business as usual' activities yet practitioners' realities were far from normal. Indeed, at the frontline, the data gave an overwhelming sense of both hyper- and hypo-arousal resulting from prolonged, frequent exposure to high-adrenaline, high-intensity, and morally charged scenarios involving death, dying, and profound human vulnerability, which left many participants in a state of emotional dysregulation and prolonged survival mode. Subsequently, the chapter has brought attention to the impacts of chronic trauma exposure.

Disconnecting from one's emotionality was one way in which participants attempted to mediate their distress. However, dissociation, depersonalisation, and derealisation were also frequently employed. Nevertheless, the longitudinal nature of this study has captured the longer-term consequences of holding

unprocessed and unresolved affective overwhelm, in that these participants were showing signs of chronic distress and emotional exhaustion that were greatly impacting their psychological wellbeing.

Chapter 8 – Discussion

8.1 Introduction

In this study, I was interested in advancing our understanding of how social group processes operating at the hidden level of ambulance culture deeply influences employees' thoughts, feelings, and behaviours when faced with prolonged adversity and potentially traumatic experiences such as those associated with the Covid-19 pandemic. As we now know, this disease outbreak was extraordinary, causing widespread mortality and morbidity on a scale not previously seen within a generation in England. We also know that in times of crises, people come together, forging increased solidarity and social cohesion (Abrams et al, 2020). Ambulance personnel work in close-knit teams and are frequently exposed to situations that are emotionally and psychologically challenging. So, it was surprising that research has not previously established how they collectively psychologically experience and react to adverse and traumatic events. This study therefore aimed to investigate this phenomenon through a social identity lens.

For recollection, the four research questions that have guided this work are:

1. To what extent did organisational practices influence the social identities of ambulance personnel and their social group processes during the first year of the Covid-19 pandemic?

2. Through a social psychological lens, how did ambulance personnel respond to prolonged adversity and potential trauma experienced over the study period?

3. How did social psychological dynamics operating within the social relationships between ambulance service leaders and employees shape their interactions, emotionality, and behaviours during the pandemic?

4. How did ambulance personnel as a collective group come to be seen by wider society during the first year of the pandemic, and how did this impact their sense of self?

From a research perspective, Covid-19 presented a metaphorical magnifying glass that exposed how social group processes prevalent within ambulance teams not only influenced the participants' social realities and perceptions of the contagion but also their social identities, emotionality, peri-traumatic stress responses, and worldviews. Indeed, it was here that the merits of qualitative inquiry to explore complex social phenomena came into their own.

This research highlights the distinct influential contribution that organisational and social group processes had upon the behavioural and psycho-emotional responses of the interviewees. It clearly demonstrates the usefulness of the social identity approach as a theoretical framework for studying the implicit social psychological dynamics influencing the emotionality and behavioural responses of frontline ambulance personnel and the conferral of leadership to this.

Empirical data gathered from the three phases of interviews with ambulance personnel from across England over the first year of the outbreak was detailed in the three previous chapters. Analytical interpretation was undertaken against an epistemological backdrop of social constructionism, which valued the participants' narratives as implicit in reproducing social meanings of their contextualised experiences of working in this sustained crisis. Subsequently, a number of themes were generated, uncovering underlying social psychological processes that shape these dynamics and behavioural actions. For the reader's ease, a summary illustration of these key themes across each phase of the study is provided below (Illustration 5):

Illustration 5: Identified themes across time

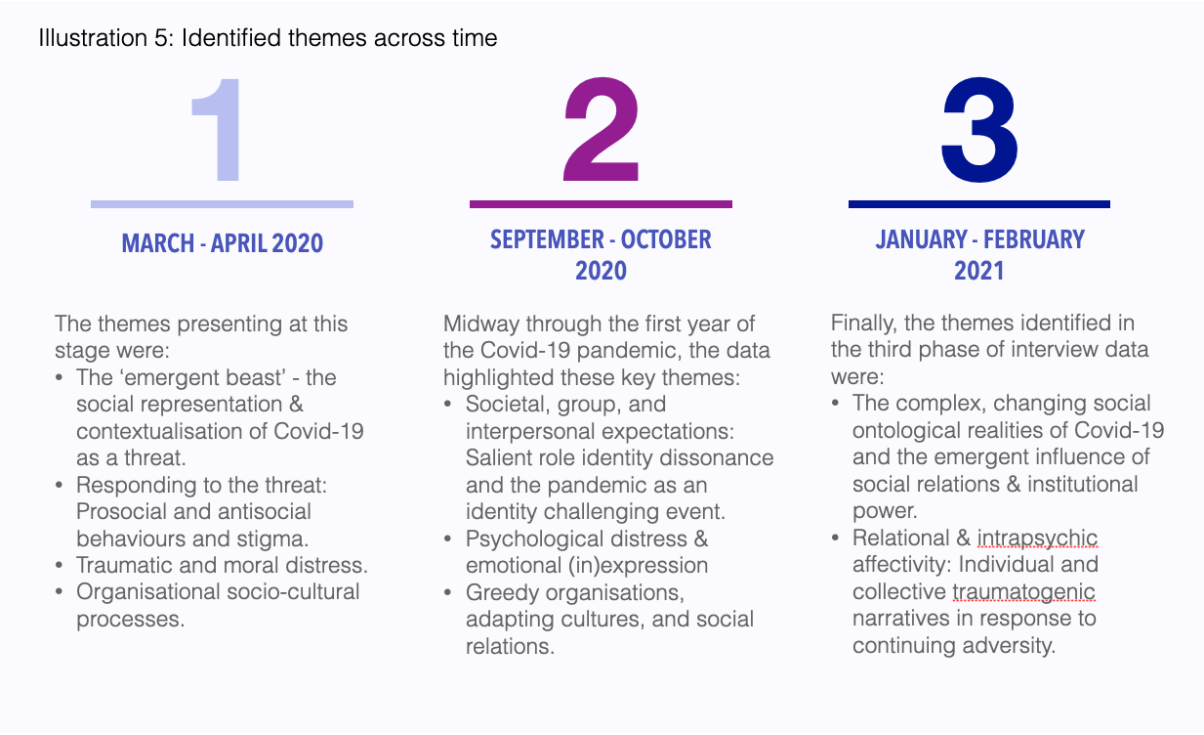
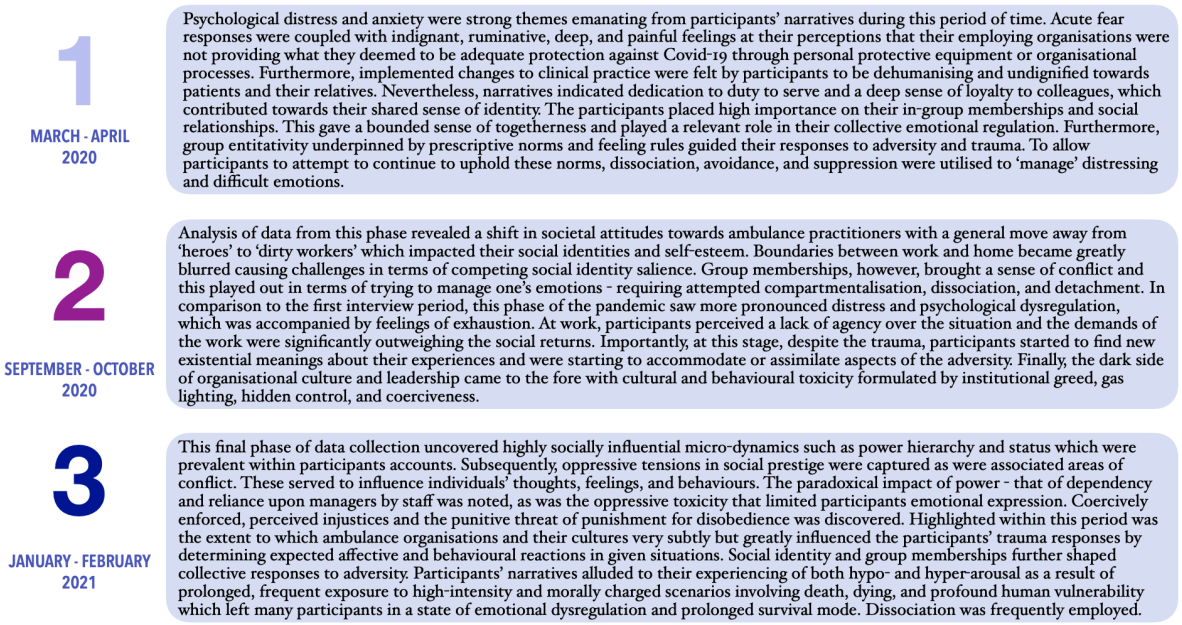


Illustration 6, overleaf, provides a synopsis of the major findings during the three distinct study periods over the course of the year.

Illustration 6: Key findings across time/ from each phase of the research study



The purpose of this chapter is to provide a synthesis of the key findings from this study and present their meaningfulness and importance when considered in light of current literature and the theoretical framework of the social identity approach. In the next four sections, I highlight how the empirics answer the research questions posed and, in doing so, I argue that this thesis presents detailed understanding of the research problem and thereby generates new knowledge, making not only a powerful, but also a relevant and timely contribution to the field.

It is important to note that whilst the next sections consider the research questions singularly, the elements, concepts, and themes discussed within, are not isolated. Rather, they are intricately entangled, messily woven together into a complex, multidimensional bricolage that has many layers of depth that intertwine and overlap. In discussing the findings, it must also be acknowledged that they are not absolute. They have been generated following detailed interviewing of the participants and depict their experiences and the issues that were most concerning to them as they lived and worked through the pandemic. Thus, it is recognised that this study cannot represent the totality of perceptions of all ambulance personnel in England or beyond. Indeed, it is feasible that with a larger study population with greater geographical expanse, other influencing phenomena not discussed here may have brought additional understanding to this context. The limitations and implications of this study, however, will be discussed in greater depth in the subsequent concluding chapter. Next, this chapter will review and answer each of the research questions in turn.

8.2 To what extent did organisational practices influence the social identities of ambulance personnel and their social group processes during the first year of the Covid-19 pandemic?

Elucidating knowledge of social psychological dynamics operating within the context of workplace teams brings valuable insight for understanding how group members relate to and interact with one another, how they perceive themselves and others, and how their associated thoughts and beliefs are inextricably linked with their behaviours. Indeed, from the literature, it is understood that institutions provide unspoken, implicit social frameworks that subtly shape the social relationships and social identities of employees (Neville et al, 2021), yet also have considerable influence upon organisational purpose and performance.

In this study, the empirical evidence relevant to this research question is multitudinous and presents many examples that may be drawn upon in response. However, the principal findings most worthy of discussion here relate to how institutional discourse influenced participants' social identities and behaviours through cultural components such as demands for exclusive loyalty and high levels of commitment. Indeed, in response to this research question, I argue that during the Covid-19 pandemic ambulance services, as hierarchical social systems, sought to harness the 'total commitment' of their frontline employees, influencing their behaviour and drawing parallels with Coser's (1974, p.4) conceptual metaphor of a 'greedy institution'.

Unequivocally, the data highlighted, from the participants' perspectives, how organisational manipulation of the salience and perceived distinctiveness of its internal groups has considerable influence over workers' social identification and attachment to them in contrast to out-groups. As such, the study outlined that whilst this drove a deep sense of belonging and camaraderie on the one hand, lurking beneath were structural, behavioural, and emotional derivations of toxicity and cultural dysfunction that ultimately weakens organisational social systems and transgresses the ideals of a 'healthy workplace' (Härtel, 2008).

Whilst the current study findings provide evidence which, in combination with further research, could be useful for examining this phenomenon at the macro and meso-level, the focus here was primarily at the micro-level. This level of inquiry is of critical importance particularly as it is this detail that is largely missing from independent cultural reviews which have brought to public attention widespread concerns surrounding mistrust, injustice, and unfairness operating within the depths of ambulance service culture (NHS England, 2024; Manolchev and Lewis, 2021; Lewis, 2017; 2018; NHS Employers, 2018). Therefore, these findings build upon and extend that documented in these reports.

In support of this argument, three key elements depicted in the data were most striking in how they highlighted the ways in which ambulance service culture defined invisible boundaries to their membership. Enforced through shared norms, beliefs, and assumptions that guided social interactions and relationships within the institution, these elements, which will be briefly discussed next, include the influencing of social identity, promoting group differentiation and weakening social ties, and demands for exclusive loyalty – which, taken together, clearly point to Coser's (1974, p.4) claim that institutions who make 'total claims on their members' are deemed 'greedy' (Burchielli et al, 2008).

The empirical findings highlighted the extent to which almost all participants shared strong social identification with their colleagues, their organisation, as well as the NHS as a whole. It was evident how these identifications were firmly 'anchored in the symbolic universe of the institution' (Coser, 1974, p.7-8); meaning that their identity was inextricably bound with the ambulance service, causing them to deeply internalise the associated values and beliefs entrenched within. Indeed, many participants painted a picture of an institutional culture that they were fully immersed and embedded within. Certainly, in the first phase of interviewing, participants disclosed a deep sense of dutiful connection to their role and unwavering pride in wearing the uniform. Arguably, this symbolically represented their sense of belonging to, and strengthened their identification and solidarity with their in-group and organisation – which is not an uncommon finding when faced with imminent social instability, threat and uncertainty (Drury et al, 2019; Drury and Reicher, 2000). Indeed, prior research recognises this coming together in adverse circumstances as a form of psychological protection (Abrams et al, 2021; Jetten et al, 2020).

In terms of promoting group differentiation and weakening social ties, it was compelling how the strength of participants' social identification inadvertently created group insularity and a level of isolation from other sources of identity that may have subtly been in competition. By way of illustration, this was evidenced in terms of how the heightened sense of belonging emanating from a close-knit culture reflected a tendency to primarily draw upon social identity resources such as social support from in-group members, rather than seeking solace and comfort from partners, family members, 'outside' friends or agencies, for example. Whilst this is a finding that has been well-reported in other studies (McCann, 2022; Corman, 2017; De Soir, 2005; Regehr and Bober, 2005), applying a social identity lens to examining this phenomenon has brought a new perspective for understanding how one's self-categorisation and affiliation with a group and organisation can become deeply embedded within one's self-concept and understanding of who one is in the context of what one does. Indeed, the findings of this research demonstrate how an insular organisation such as the ambulance service 'can begin to take over the 'total personality' of its members' (Peterson and Uhnoo, 2012, p.8) by subtly and persuasively applying implicit 'pressures on individual members to 'weaken their ties or not form any ties with other institutions [or other people] …that pose a threat to their loyalty' (Peterson and Uhnoo, 2012, p.6).

Indeed, loyalty to one's in-group and membership of the organisation was a powerful imperative, particularly at the outset and height of the pandemic when the contagion posed a real threat. For some, this created an influential, relational dependence upon one another and between them and their service which, arguably, was seated on an implicit anticipation that it would provide psychological protection from the fear of threat being felt, as well as preserving shared identity and self-esteem from the challenges and risks associated with the work. To illustrate, the resultant unparalleled shift to work practices and the social aspects of occupational life in the opening months of the pandemic required rapid adaptation and entailed intensive behavioural actions (such as new, intense cleaning rituals) in an overwhelming attempt to mitigate the virulent spread. From the evidence, it is clear that this changed context led to the discontinuation of some entrenched norms and beliefs within ambulance services, to be replaced with those that served the purpose of reducing uncertainty and guiding group behaviours in response to the threat of infection. In the process, this influenced not only how the work was now to be done (representing changed social reality), but importantly, also exposed how participants existentially questioned their sense of self and place in the social world of the ambulance service versus the 'outside' world in relation to the viral threat and these new ways of working. Correspondingly, situational change also reflected in the meaning participants attached to their social relationships with both in-group and outgroup members, evoking social comparison, thereby tightening the close-knit culture and forging a sense of 'us-ness' and 'we're all in this together' particularly in the early stages of the outbreak. This appeared to further widen the comparative gap between 'us' and 'them', making the bonds and loyalty between ambulance personnel stronger yet also reinforced social isolation from external influences (Peterson and Uhnoo, 2012).

Nevertheless, uncovering the data a layer deeper exposed how, during the year of study, ambulance organisations and indeed, the wider NHS, Government, and society, utilised micro-levels of social identity control to capitalise upon employees' loyalty and commitment to their cause. Examples were provided of how services placed considerable expectations upon their workers, with senior leaders and organisational processes making demands upon their time and relying heavily upon compliance to enact this. For frontline staff, this included work intensification strategies that ultimately demanded self-sacrificing dedication to their role. In the most rudimentary terms, this was captured with regards to longer working hours evoked through shift working and late finishes, which impacted upon employees' social and familial lives, causing conflicts of loyalty. Furthermore, the increased demands to attend calls at the expense of any 'down time' or rest breaks was hugely apparent in terms of the negative impact upon interviewees' psychological health. However, during pandemic conditions, participants displayed the ultimate loyalty in continuing to come to work despite the real risks and threat of morbidity and mortality that the virus posed not only to themselves but also to the health of their families.

Critical here is a discussion of the frightening realisation that, in undertaking their duty to provide healthcare, emergent societal and organisational expectations were that, *in extremis*, this could now incur the giving of one's own life (Smith et al, 2009). Indeed, similar findings were identified by Smith et al (2018) whose participants in response to a prior epidemic, showed internalised ambivalence, fear, and distress at this thought, with many indicating a sense that these obligations should not be considered 'unlimited' or 'absolute' (p.193). Underpinning these works, but not articulated, appears to be an anxiousness from the participants that such work intensification was bound up with what Burchielli et al (2008) referred to as organisational (and societal) 'exploitation, alienation, and subordination of labour (i.e. separating a worker from her control over her work) for the purpose of 'extracting surplus value" (Larson and Nissen, 1987, p.134). This is certainly apparent from the current study results and provides meaning to the organisational 'tests' for which employees had to 'prove' their exclusive and undivided loyalty and worthiness in order to retain their accepted belonging to the organisation. Such an example included participants moving out of their family homes into hotels to enable them to continue to dutifully serve their community; placing the needs of others before themselves – at the expense of not seeing their own family – albeit this also served to protect them from the contagion that the participant may have been exposed to through their work. Furthermore, loyalty was also 'tested' with regards organisational mandates on personal protective equipment that participants deemed to be wholly inadequate in certain contexts (such as sitting in the confines of the saloon of the ambulance with a patient who was infected with Covid-19 for many hours whilst queuing outside hospitals). The data showed how practices such as these that were seen to potentially jeopardise and put their health at risk, led participants to feel emotional embitterment, as also identified by Barrett et al (2024) and Rees et al (2021). However, I extend this literature by highlighting how this resentfulness at the extreme demands for loyalty implied by their service contrasted with participants' feeling that their safety (and worth to the organisation – thus impacting their self-esteem) was being betrayed. Such feelings were heightened further when participants were challenged by managers who 'chastised' them for defying organisational rules by wearing the more protective face masks (Forbes, 2024; Scottish Covid-19 Inquiry, 2024).

This was a particularly interesting dynamic to uncover within the data nonetheless because of its powerful juxtaposition with how deeply some participants had internalised their social identification with their in-groups and their organisation, to the extent that they felt an overwhelming sense of responsibility to meet the needs of the organisation – displacing those of their own and attempting to meet them at costs to themselves. Their deep sense of loyalty, their sense of duty to serve, meant that they often felt subconsciously compelled to push themselves to their physical and psychological limits – often to their personal detriment and to avoid inferred guilt and shame from those within their in-group and organisation – to attempt to achieve the goals and values of the service in providing an emergency response to patients and meeting organisational response targets. Indeed, although further research focusing upon this is needed, there is some evidence here that current performance management systems

are contributing to workplace toxicity in the form of compounding the 'greediness' of ambulance services' demands upon its employees, from which participants shared personal feelings of overwhelming exhaustion, burnout and psychological distress, particularly towards the end of the study period. Furthermore, these demands for significant commitment also negatively impacted upon their families and friendship groups outside of the ambulance service.

Although some participants, including those who were first line and middle managers, attempted to challenge the levels of endured commitment demanded by their organisation, they reported not feeling listened to, that their concerns were not taken seriously, or that, following micro-aggressive leadership behaviours, they were effectively silenced by those with greater authority. Furthermore, in response, there was a sense of pessimistic resignation that one should 'just get on with the job' as to raise concerns will achieve little, so 'why bother?' – a finding that draws similarities with broader cultural issues identified by The National Guardians Office (2023) and NHS England (2024). Nevertheless, the findings of this study indicated wider structural issues that equally compounded participant managers' perceived lack of agency and a sense that they were not able to break free from the inflexibility of organisational structures – feeling stuck and unable to challenge some of the practices they were instructed by senior leaders to implement.

This realisation was deeply troubling for these participants, calling into question and reframing their social identities of who they are as ambulance personnel and, where appropriate, managers. Given the evidence cited here and within the empirical chapters, it is apparent that during the first year of the pandemic, ambulance services did make 'total claims' upon their employees (Coser, 1974). In doing so, the data suggests that participants' social identity was manipulated by their employing organisation, requiring their loyalty and ultimate commitment, thereby impacting their sense of self. Underpinning this was the assumptive belief that if participants assimilated this identity and made it salient, they would retain the status of being a member of this exclusive club. Yet, for participants unable to match up to these expectations, or where they enacted inauthentic behaviours to socially fit in, this eventually led to feelings of degradation, unease, mistrust, distress, feelings of worthlessness and a lack of accomplishment, the latter being associated with the syndrome of burnout.

Towards the end of the study, several interviewees had resigned or were in the process of finding alternative employment, citing that they were tired and exhausted from giving it their all but felt that their efforts were worthless to the organisation and that they were dispensable. In some cases, participants felt that their social fit no longer matched that of a prototypical in-group member; they felt existentially changed as a person, and no longer felt aligned to the beliefs and values of the service to which they had been dedicated. Nevertheless, despite talking about leaving, some participants were hindered by their continued strong loyalty and commitment to the organisation, and their dedication to their job. Here,

again, the social identity approach as applied to Coser's framework is useful for understanding the strength of commitment exhibited by some participants and how this is intimately connected with their social identity, such that they may have experienced what Goffman (1961) referred to as 'release anxiety' at the thought of leaving this insular world. Indeed, Scott (2011, p.44) noted how, in become a member of an institution, 'one [loses] one's former identity and social network…' leading to depersonalisation and group entitativity which subsequently provides one's existential reference point for every aspect of one's life and 'how one should behave'. Thus, it can be extremely challenging to leave when one's whole being and support system is tied into this way of life.

For one participant living with autism and obsessive compulsive disorder, these expectations, changed normative practices, and complex tensions from competing demands were particularly challenging. The radical changes to routine behaviours challenged his cognitive and existential framework, such that it subsequently threatened his self-esteem and self-efficacy or confidence in his ability to deal with these changes. The research showed how this upended his normative understanding of, and social scripts for, interacting and communicating with the social world. Despite his desire to connect with others, it deeply destabilised his sense of identification with the team, which was confusing and emotionally exhausting. As such, this participant's insightful contribution to this study, which is worthy of more detailed research, highlights how social dynamics and group processes mediated and manipulated by organisations could have significant psychological impact upon those living with neurodiversity. It is a significant weakness that social identity theory has not been well-applied to understanding the experiences of people living with autism, especially in the context of the Covid-19 pandemic. Therefore, it is a strength of this study that it captured and provided a voice for this participant's experience of living with neurodiversity whilst working on the frontline during a global crisis.

8.3 Through a social identity lens, how did ambulance personnel respond to prolonged adversity and potential trauma experienced over the study period?

Typically, research examining psychological trauma responses amongst ambulance practitioner populations has inclined to draw upon clinical approaches focusing upon individuals' symptoms as a consequence of traumatic stress. This interpretation arguably does not capture the *social* elements of trauma including those who face resulting isolation and disconnection – which were to become prominent features of the Covid-19 pandemic. In this study, I sought to radically re-examine our knowledge and understanding of psychological trauma and adversity, by demonstrating how these phenomena are actually socially situated and collectively experienced by ambulance teams, who, as the literature has illustrated, work closely together and have a high level of group entitativity. At present, this continues to be poorly understood in terms of prior literature examining how shared traumatic

experiences affect the self in the social context of salient group memberships. Indeed, scholarship reminds us that the social context in which trauma and adversity experiences occur are also the contexts within which individuals collectively process and recover from such encounters (Muldoon et al, 2019). Thus, the shared experiencing of trauma is an important consideration when building our understanding of how social identity dynamics and group memberships influence internal psycho-emotional experiences, processes, and associated behavioural actions of ambulance personnel as potentially traumatic events occur and, in their aftermath (Eyerman, 2013). A wealth of evidence was collated in respect of this research question, and only the most striking findings are discussed here.

One of the most important findings from this study regards the complex interplay between social identity, group membership and the collective experiencing of distressing emotions in response to trauma and adversity exposure. Application of the social identity approach to analyse the interview data revealed how social categorisations, social identity, and group processes highly influenced interviewees' responses. Indeed, when their identity as ambulance personnel was salient, this was central to their collective experiencing, sense-making of, and psycho-emotional reactions to adversity encountered during the Covid-19 pandemic.

Perhaps the most compelling example here was the extent to which the participants' narratives uncovered a subconscious mind and body disconnection, such that many had little conscious awareness of their own internal emotionality nor that of their psycho-affective and social needs. In particular, some interviews narratives alluded to peri-traumatic dissociation in the form of depersonalisation and derealisation – a natural response when faced with threat and has previously been linked with those employed in high-risk occupations (Pietkiewicz et al, 2023). Whilst these findings are relatable to the feelings of dissociative detachment identified in paramedics by Pietkiewicz et al (2023) and Bennett et al (2005), the current study emphasised the relevance for understanding how group membership influenced this conjecture in terms of the impact upon the participants' self and social identity and the collective implications of this in terms of trauma trajectories.

Certainly, building on the discussions of group entitativity in the prior section of this chapter, it was notable how group membership and associated depersonalised identity influenced how participants interpreted, experienced, processed and responded to adversity. As previously highlighted, highly entitative groups such as those operating within the emergency services, can, through implicit social processes, lead individuals to depersonalise from their personal identities in order to adopt and maintain the group's social identity and conform to group norms to extenuate a sense of fitting in and belonging (Hogg and Rinella, 2018; Hogg, 2009).

In terms of this research question, the data provided insight into how, by displacing their own needs and understandings of their sense of self in favour of the identity and needs of their in-group and organisation, it was notable how this deeply implicit social psychological process shaped and regulated the participants' psycho-emotional and behavioural responses to trauma and adversity. In the face of such a threat, participants who inferred a strong, salient social identity conferred with their group membership, sought to maintain this sense of belonging and distinctiveness at almost all costs. Conforming to powerful in-group beliefs and norms was one way towards achieving this. Several participants in their implicit efforts to comply and maintain group expectations pertaining to emotional regulation, utilised dissociation – or detachment, as a means to avoid or control the intensity of emotional experiences, which in relation to the Covid-19 pandemic, often centred around distress, fear, anxiety, and grief. In some cases, this was to the extent that interviewees no longer acknowledged or recognised their own emotions, and when asked about how they felt, they were perplexed and unable to say, potentially indicating alexithymia[10], as was identified in paramedics in prior literature (Halpern et al, 2012a).

The findings, of which similar results were reported in a very small number of studies (Halpern et al, 2012b; Jonsson and Segesten, 2004), suggested that this process enabled participants' attempts to maintain their shared social identity of ambulance personnel entrenched within the associated historically situated belief that they are 'able to deal with anything' (Bounds, 2006; Steen et al, 1997) – thus also conforming to the group's normative beliefs around emotional display (Halpern et al, 2012b). Indeed, analysis of the participants narratives revealed the great extent to which, as part of their social identity and self-categorisation as ambulance personnel, they subconsciously regulated their emotions and behaviours to be prototypically representative of that of their group. Application of social identity theory here would suggest that the reason individuals behave in this way is to avoid rejection or shame from in-group members for not matching up to group expectations, thereby perpetuating stigma – as is well referenced in the paramedicine literature in terms of seeking help and support for mental health difficulties (Halpern et al, 2012a; 2012b). Nevertheless, the downside of this, as Bounds (2006, p.126) highlighted is that 'this 'bravado' prevents many emergency medical services personnel from feeling comfortable asking for help' – thus perpetuating a cycle of battling to emotionally suppress one's feelings from emerging in socio-relationships with in-group members.

In times of adversity, this inability to introspectively recognise one's internal states and articulate a sense of self is highly problematic (Bennett et al, 2005). Whilst socially identifying with one's in-group typically provides homogenised enacted group behaviours leading to a sense of 'us' manifested in solidarity, camaraderie, and a sense of togetherness, which are powerful socio-relational connectors in guiding us

[10] Alexithymia is a term used to describe when an individual has disrupted emotional awareness impacting their ability to experience, process, identify, and articulate their emotions. Whilst it is not classified as a psychological disorder, alexithymia has links to traumatic distress, particularly that manifesting from interpersonal violence.

through challenging times, it also means that we, as individuals, are more likely to experience psychological anguish when we struggle to match up to the social norms and beliefs ascribed by our in-group. This was exemplified within the empirical chapters of this study through analytical discussion of the difficulties participants had in conforming to emotional regulation norms which required management of feelings and behavioural display that was incongruent with their true emotions; theorised as emotional labour by Hochschild (1983). Indeed, the data highlighted that holding a sense that one is unable to match up to such group expectations, because, for example, the intensity of one's emotions are too great to avoid or conceal (Jonsson and Segesten, 2004), can induce deeply permeating and profound beliefs that one is psychologically weak and not worthy of group membership – thus affecting their sense of belonging and increasing feelings of isolation, or are in some way inadequate – leading to insurmountable feelings of guilt and shame, thereby impacting self-esteem and sense of self.

The deleterious and traumatogenic effects of pandemic adversity were further demonstrated by the data in terms of participants' revisions of their self-perceptions and self-worth which appeared to be linked with a re-evaluation of their fundamental, assumptive beliefs about the benevolence and meaningfulness of the world. Indeed, the data alludes to the participants experiencing uncertainty, threat, and fear as an 'ontological assault' (Crossley, 2000) of disrupted basic assumptions such as the world is a safe, predictable, and benevolent place. This was particularly evident towards the later months of the study, when interviewees were weary and had by this point endured prolonged exposure to adversity created by the pandemic.

Thus, the study findings add further support for the renowned theoretical contributions of Janoff-Bulman (1992), who considered that, in efforts to make sense of adversity, individuals attempt to assimilate information about the event into prior held worldviews. She postulated that in the profoundness of adverse experiencing, such structural belief systems can become 'shattered', leaving the individual with difficulty in interpreting the new and overwhelming information created by the traumatic situation such that a person's perspective is altered to account that the world is no longer seen as a safe, predictable, and just place. Rather, these perceptions are replaced with worldviews that the world is unsafe and is unpredictable. This was certainly identified from the empirical evidence generated by this study, which revealed how, through participants' emotional struggles and their realisation of shattered worldview assumptions, the process of finding meaning, and accommodating or assimilating these events also brought cognitive and emotional re-structuring and re-building of one's core beliefs and values about the world.

Whilst the data highlights how this was a challenging experience for participants in the early phases of the pandemic - in light of the uncertainty and threat that the outbreak brought to one's lives, later evidence also captured positive experiences of existential psychological growth such as a new realisation that the

self is worthy, with a renewed appreciation for life and a reconsidered sense of what was meaningful and important to them. This study provides new knowledge by capturing this unfolding subconscious psychological process in real time as the participants grappled with the insult to their ontological realities that caused them to question their worldviews. Indeed, this study bears witness to the impact of trauma and adversity upon ambulance workers' sense of self and their sense of social positioning in comparison to in-group members and those from other groups, and through their articulations, observes how they integrated the new social reality of the pandemic into their conceptual social meaning system. The relevance and importance of this finding is notable as prior research has linked shattered beliefs with the development of psychological trauma sequalae such as traumatic stress.

Associated with the above is the finding that throughout the study period, interviewees also disclosed heightened distress at perceived violations to their benevolent worldviews, namely that of betrayal believed to be perpetrated by their organisation or themselves (Cahill et al, 2023). Indeed, it is useful here to draw again upon Janoff-Bulman's (1992) shattered assumptions theory as a framework with which to integrate Shay's (2014) conceptualisation of moral injury. As previously noted, the notion of moral injury suggests that the effects of trauma and adversity may be understood as a series of violations to one's basic assumptions that transgress one's moral code (Shay, 2014). Certainly, the findings from this study highlighted that the social and relational contexts associated with the perceived violations was highly influential in interviewees' responses to adversity; for example, witnessing human suffering and the gravity of illness, leaving patients at home knowing that they were prematurely approaching the end-of-life or transporting them to hospital with awareness that relatives would never see them alive again, was extremely distressing and uncovered a number of ethical and existential disruptions to their core beliefs about what was right and just (Murray, 2019; Shay, 2014; Jameton, 1984). Subsequently, feelings of guilt, shame, and helplessness were uncovered within many interviews over the course of the year – a finding that corresponds with Janoff-Bulman's (1992) assertion that such violations challenge one's inherent assumption that 'the self is worthy' – as how can one be worthy when one perpetrates such moral injustices? Through a social identity lens this is understood as being disparaging to one's self-esteem and social identity. In the case of this study, this extended to the participants' perceived worth to their organisation, such that this betrayal led them to feel unvalued and discardable.

In terms of research focusing on moral injury in emergency services workers, the results of this study are consistent with those of Smith-MacDonald et al (2021) who drew attention to how this population tends to utilise emotional regulation strategies such as avoidance and suppression in attempts to lessen the psycho-emotional impact of unresolved moral feelings, a finding frequently exampled throughout this thesis. Nevertheless, this study expands on this research by unpacking how such strategies used in the context of perceived assumptive violations impact upon the social relationships and social group processes prevalent within ambulance teams. Furthermore, the data highlighted how moral assaults on

one's self-esteem ultimately impacted the social behaviours of the group as they came together to maintain and protect their shared social identity from perceived threats. Indeed, this study contributes new understandings of how a disaster such as a pandemic manifests a magnitude of transgressive socio-relational acts for those working within the field of paramedicine, and how influential these acts are in terms of the effect upon one's sense of self and that of the social behavioural responses of salient in-group members.

To bring this section to a close, I argue that the pandemic, in the vastness of its reach in terms of morbidity and mortality, exposed a collective trauma field of psychological responses to adversity. Indeed, there is a real sense from the empirical evidence that ambulance services harboured a traumatised culture within their socio-relationships, in which there was considerable psychological fragmentation, with some aspects of the culture held in a state of dissociation and emotional detachment (drawing relevance to the trauma 'freeze' response[11]), and others concealing chronic hypervigilance and reactivity, of which being in a prolonged state of high alert and survival mode is likely to magnify traumatic stress and associated sequalae. Furthermore, in following the participants over a year of the outbreak, it was highly noticeable how they also represented a chronically traumatised community in terms of supressing their own basic needs to meet those of their organisation, such that they sacrificed their own emotional and psychological health – in some cases to the extent that the participants had lost sight of their own needs being a priority (likened to the 'fawn' response[12] to trauma). As the results demonstrated, this led to interviewees becoming overwhelmed and burnt out. For some, their only resolve was to leave the service. In this way, I argue that organisational culture implicitly perpetuated trauma.

My concern is that if this collective trauma remains unresolved within this community, it will likely become an intergenerational problem well into the future – such that the trauma becomes normalised and integrated into the 'everyday' without recourse. Without the collective strategies to process collective trauma, the implicit responses will remain bound up within the psyche of ambulance personnel, making it more difficult to integrate subsequent traumatic experiences, thereby potentially leading to greater psychological sequalae. Indeed, on this note, what might appear today as a lack of support from leaders and the organisation, arguably could be representative of an implicit adaptation to historically chronic

[11] A freeze response is sometimes encountered by individuals when faced with a perceived threat. It is a hyperarousal survival state of physical immobility and emotional dysregulation whereby the person may become temporarily motionless, silent, with a fixed gaze, tense muscles, rapid, shallow breathing and a fast heart rate. However, the person is hyper-alert to all around them. 'Freeze' is likened to the 'rabbit in the headlights' analogy whereby temporary immobilisation is an innate, involuntary protective mechanism.

[12] A fawn response is a coping mechanism when, in the face of complex trauma, a person behaves in a people-pleasing way, suppressing their own personal feelings, thoughts, and needs for those of others. Whilst other responses to trauma might see people becoming aggressive (fight response) or attempt to run away (flight response), this unconscious response is a means to avoiding conflict (and potentially violence) and is undertaken in an effort to establish a sense of personal safety. Within the context of a toxic relationship, this can, however, create co-dependency.

trauma experiences – and the worry is that this could be further perpetuated in the future with regards pandemic-related trauma that occurred during the study period and is likely still occurring now.

The empirical evidence from this study leads me to argue that trauma and adversity as experienced by my participants is inherently a social and relational phenomenon. Whilst there are merits to understanding the impact of trauma through individualistic paradigms that centre on the self, cultural and social collective experiencing of adversity within theoretical discourse (which has been largely overlooked), is of critical importance for responding to the extent of collective impoverishment expressed by the participants in this research. Through combined application of the social identity approach and a collective trauma lens, we may understand how ambulance communities and cultures are cumulatively impacted by prolonged exposure to adversity and how this affects their sense of connection, belonging, and positioning in the world, and the meaning that they make from it.

I suggest that the collective experiencing of trauma by social groups is not something that an individual member will be able to easily process and either assimilate or accommodate on their own. Collective trauma in ambulance service frontline populations necessitates collective support to enhance processing and healing. In the case of the first year of the pandemic, we saw how, early on, when demand for ambulances reduced in some areas, the re-integration of previously lost communal traditions such as spending time together in crew rooms, particularly after distressing calls amounted to much more than its social elements and rather, had apparent psychologically healing properties in fostering time for connection and the sharing of experiences and social support. Without sufficient supportive mechanisms, I would argue that the processing of traumatic and adverse experiences cannot be fully reconciled, leading individuals and teams to implicitly draw upon psychological survival strategies such as denial, dissociation, and emotional suppression in order to regulate their emotions. Indeed, it is through social relationships, connection, and sense of belonging that the conditions are created for therapeutic restoration and the maintenance sense of self and self-esteem. Nevertheless, as operational demand has since picked up again, it leaves currently unanswered questions as to whether these communal traditions will again be lost and begs for an understanding of how organisations may collectively rebuild support and enable communal recovery in ambulance personnel.

8.4 How did social psychological dynamics operating within the social relationships between ambulance service leaders and employees shape their interactions, emotionality, and behaviours during the pandemic?

In answering this question, I was interested in examining the unconscious social psychological dynamics operating within the relational space between leaders (ambulance managers) and followers (staff

members) and how this relationship was affected by group membership. Existing literature published prior to the Covid-19 pandemic and recent cultural reviews have highlighted the pervading yet orthodox dynamic tensions interplaying between individuals performing these roles and their negative psychological effects upon ambulance teams (The National Guardians Office, 2023; Lewis, 2018; 2017). The pandemic represented an evolving crisis situation unlike the everyday context, however, and therefore presented a unique opportunity to examine how, in the face of prolonged adversity, both leaders' and followers' social identities interacted with dynamic relational processes to influence emotionality and behaviour. Indeed, this study takes the view that leadership is an evolving, dynamic process situated and socially constructed within the shared space between ambulance service leaders and members of their team and, more specifically, is based upon the perceptions of the leader as being viewed as an in-group member.

This is especially of importance given that empirical contributions have identified that, in crises, followers are typically motivated to seek proximity and protection from leaders as a means to reduce difficult feelings associated with uncertainty and in effort to retain a perceived sense of collective control when one's own agency is limited (Abrams et al, 2021; Davidovitz et al, 2007). Thus, given that previous scholarly work has uncovered ambulance leaders' deleterious behaviours (McCann, 2022; McCann and Granter, 2019), it posed questions as to how these dynamics would play out in this context. Furthermore, findings from the current study contrast with much of the wider leadership literature that, in seeking to understand what makes leaders effective, tends to be constrained by an individual meta-theoretical approach with focus on personality traits, leadership skills, and styles (Haslam and Reicher, 2006). Therefore, this research contributes to the very limited research base examining ambulance service leadership from a social, psychological, and relational perspective (Johnson et al, 2018; Mercer et al, 2018). It also draws parallels with the social identity approach to leadership (Hogg, 2001).

Importantly, the current study shows that for both first line and middle managers and staff, their interpretation of leadership-followership positioning was a critical influencer in determining the relational process between individuals holding these roles and subsequent emotional and behavioural outcomes. In essence, how leaders and followers conceptualised and identified themselves as such, their relationship to each other, and associated role expectations and obligations were found to be key. In alignment with social identity theory (Tajfel and Turner, 1979), my study determined that central to this relationship was the perceived prototypicality of the leader by staff; that is, the extent to which the leader was perceived by group members to embody the 'shared social reality associated with the group's social identity' (Steffens et al, 2020, p.39) and are 'representative of attributes that are shared by in-group members…[and]…those things that distinguish the in-group from other out-groups' (Steffens et al, 2020, p.41).

Arguably, these quotes allude to the fact that prototypicality is not a static entity and evolves in alignment with changing social realities. This was highly apparent within this longitudinal study which captured how,

in the early months of the pandemic, frontline workers sought support and guidance from leaders who were perceived as strong and who operated from a 'command-and-control' stance. However, this contrasted to later opinions, as will be discussed next.

Leaders who were seen to, overall, be more prototypical of street level in-group members such that they provided 'a meaningful translation between social identity and the normative context for behaviour' (Abrams et al, 2021, p. 203), were associated with narrative expressions indicating that they were more trusted by staff and crucially, were seen to have a shared sense of identity and connection with them (Abrams et al, 2021; Hasel, 2013; Giessner and van Knippenberg, 2008; Hogg, 2001). In these instances, the leader was prototypically embedded into the perspective of 'we' and 'one of us' road staff, and several participants who were leaders confirmed authentic salience, social connection, and identification with staff in-group members. This appeared to have been facilitated by existing relationships, shared experiences, and social interactions whereby the leader was previously positively connected with and respected by in-group members. Thus, when the pandemic hit and uncertainty ensued, these already established relationships were drawn upon as a basis for determining leader prototypicality and trustfulness in light of the shared crisis.

Leaders who were perceived as, and personally felt prototypical, commonly displayed considerable concern for the psychological, emotional, and physical welfare of their staff – which was representative of what was felt to be valuable to in-group members. Where they were not able to enact a sense of duty to fully support their team due to organisational, structural, or policy processes, these participants experienced significant guilt, frustration, anger, and stress. It was evident via their narratives that these interviewees held an appreciation of their relational self, were deeply invested in their team, and prioritised the promotion of equity and fairness amongst members. This authentic approach was rewarded by enhanced levels of commitment and trust from in-group members (Giessner and van Knippenberg, 2008). Critically, it was this that subconsciously gave staff a sense of permission to be emotionally vulnerable and seek their support and help when they experienced heightened emotionality such as distress.

Perceived prototypicality held within the relational space also benefitted first-line and middle managers in influencing a sense of in-group togetherness, collegiality, and prosociality embedded against a backdrop of self-categorised intergroup comparison with 'others' (Tajfel and Turner, 1979) such as the public, or indeed, other members of the ambulance service who were perceived not to have similar shared experiencing of working at the frontline. As the results clearly highlighted, leader prototypicality was met with group members' reciprocal solidarity and empathy towards them, particularly in the early phase of the study where there was an almost unanimous acknowledgement of the heavy burden and stress that senior colleagues were experiencing in relation to the chaotic and evolving nature of the pandemic. This

was, in part, expressed through their desire to 'do their bit to help' them – therefore providing empirical evidence that supports the proposition that leaders receive greater support from followers when leaders are perceived to be prototypical of the group (Ulrich et al, 2009). This psycho-emotional responsiveness further added to a sense of togetherness, and in this way, we saw how shared social identity brought leaders and followers together, collectively united in responding to a threat, and it was this dynamic, that was particularly important in terms of maintaining a positive sense of self and self-esteem and appeared to enhance resilience and a sense of coping with uncertainty and adversity for those in-group members, regardless of roles. Indeed, this finding from my research is consistent with the argument proposed by Steffens et al (2020, p.36) that 'leaders' capacity to influence others is contingent on leaders' engagement with a social identity that is shared by leaders and followers'.

Nevertheless, a significant but unsurprising finding from this study is that not all leaders were viewed by staff as holding prototypical group membership. In fact, there were many illustrations whereby group members' mental representations of their leaders' prototypicality fluctuated. This was particularly the case in the later months of this study, which corresponds with Abrams et al's (2021, p.204) observations whereby 'identification with and perception of a superordinate homogeneous in-group will tend to fade or at least to fluctuate'. Indeed, these authors highlighted how the prolonged uncertainty associated with the Covid-19 pandemic emphasised differentiation, leading people to start 'questioning the superordinate identity, leadership, rules, and restrictions' (p.204).

Where it was perceived by group members that the leader did not share a social identity with them or this was weak, or leaders did not act in ways that were seen to be in the best interests or safety and security needs of the group such that they were not 'doing it for us' (Haslam and Platow, 2001), this was expressed with contempt, anger, and a vehement sense of betrayal. This was particularly notable when respondents felt that their leaders did not, or no longer represented, or threatened the established normative behaviours, beliefs, and values that were collectively held by in-group members. Thus, there was a disconnect and leaders posed a threat to their internalised shared identity and group esteem. Cited examples include a perception of leaders who physically and emotionally distanced themselves from frontline workers, failed to provide them with support and, of those managers who were also operational, who appeared passively resistant to assisting with calls, especially to patients with Covid-19.

In addition, a strong theme reported by participants was that of leaders' transgressions of their basic and moral assumptions and beliefs – such as a violation of one's ability to care and provide treatment to patients, which was perceived by participants to transgress behavioural norms. This notably had a detrimental impact upon participants' sense of self and self-esteem, as such violations were deemed incompatible with their collective understanding of 'who we are' and 'what we do'. In some cases, participants experienced considerable psychological distress in response, and it caused them to re-evaluate

their identity and membership of the group and the profession. Indeed, by the end of the study, several of these participants had left or were in the process of leaving the service; drawing focus upon the considerable impact that perceived leadership transgressions and leader non-prototypicality potentially had upon work dissatisfaction and employee attrition. These findings align with prior research that demonstrates that perceived leader transgressions have a negative impact upon group social identity (Ditrich et al, 2019).

Building upon self-categorisation theory, I argue that these points are of critical importance particularly for understanding how group members responded to the lack of perceived group homogeneity with their leader(s) which, under the conditions of extreme uncertainty and adversity, exacerbated a sense of group distinctiveness, weakening the leader's identification with the in-group (and vice versa) and challenging followers' perceptions of leadership effectiveness and trust. The longitudinal nature of this study allowed time to observe how this distinctiveness drove a polarising divide between street level ambulance workers and their non-prototypical leaders into a contrasting 'them' and 'us' scenario (McCann, 2022); a sense of feeling articulated by participants who were first line and middle managers, and ambulance practitioners, which became more divisive towards the later phases of the study, leading to conflict and depersonalisation. It must be noted, however, that a limitation is that no senior leaders consented to participate in this research and therefore, we do not gain a sense of this phenomenon from their perspective.

8.5 How did ambulance personnel as a collective group come to be seen by wider society during the first year of the pandemic, and how did this impact their sense of self?

A defining theme throughout this study has been that of the transformational shift over time in public perceptions, or social evaluations, towards ambulance personnel – a turbulent measure that encompassed overwhelming expressions of gratitude and solidarity, elevating participants' social status to that of 'hero' (Rees et al, 2022) yet also prejudicing conceptualisations of 'dirty' (Hughes, 1962), infective workers, lowering their status considerably. Indeed, the pandemic provided a niche landscape for examining the social relationship between the popular beliefs and attitudes held by the public in respect of those working within paramedicine and how the participants viewed their sense of collective and individual self, and self-concept in relative position to others.

My findings documented how this interplay of social psychological dynamics shaped and impacted participants' social and self-esteem, thus, drawing epistemological connections with the seminal works of Cooley's (1902) 'looking glass self' analogy that posits that individuals reshape their sense of self in response to others' reactions to them. As such, the findings of my research have important implications

for scholarly understanding of social evaluations spanning heroism and dirty workers in respect of the self-categorisation and social identity of those whom the evaluations are aimed at. Indeed, these findings contribute to the field by highlighting how social evaluations by others disrupt social identities not in the binary sense as prior literature has examined (for example – experiencing either valorisation or stigmatisation) (Rapp et al, 2023), but as was established from the empirical evidence in this study, in the multivariate sense – as the data pointed to the fact that participants were concurrently viewed prosocially as heroes yet also, at the same time, faced contrasting negative social evaluations in the form of prejudice from being socially constructed and categorised as dirty workers.

In this vein, paramedicine is conceptually an interesting occupation in that it transgresses usual social rules regarding stigmatisation of dirty workers whom the public tend to semantically and psychologically place distance between ('I couldn't do your job') yet, paradoxically, it is a profession that is pivotal to society, to provide emergency care to patients, and when in need, individuals are often only too pleased to see 'the paramedics' turn up; thus, drawing mixed evaluations from the public, albeit, for the most part, these are often very positive. This observation was highlighted by Ashforth (2020) who identified that in firefighters and first responders, and De Camargo and Whiley (2021) in their study of police officers, undertaking their 'dirty work', it is precisely because they are perceived to do life-saving beneficent work and face personal risks that society tends to positively position them, and their roles attract occupational prestige. Indeed, a detailed discussion of ambulance service occupational culture was provided in the literature review and briefly explored some of the social privileges associated with the work including how public interest in the job (often dramatized in the media) links with workers' feelings of pride and positive self-esteem (Ashforth and Kreiner, 1999).

Nevertheless, in the extraordinary times of the Covid-19 pandemic, the data highlighted how these social evaluations were amplified to the extent that there was arguably a level of occupational reappraisal by the public, thereby altering how ambulance personnel were perceived and categorised (Rapp et al, 2023). Subsequently, for the participants, regardless of whether these appraisals were positive or negative, this appeared to lead to dissonance in terms of their own perceptions of their social and role identities versus that held by outsiders (who they really are versus who they are perceived to be) (Lazarsfeld-Jensen, 2014). Indeed, as Rapp et al (2023, p.26) established, these 'antagonistic evaluations did not simply cancel out or invalidate the other'. Thus, whilst ambulance personnel were, on the one hand, morally viewed as heroic, they also paradoxically experienced public stigmatisation due to their close proximity to the infection through their exposure to unwell patients.

In terms of positive social evaluations, the empirical evidence showed how prosocial, collective expressions of support from the public during the early stages of the pandemic were overwhelming with acts of considerable generosity and kindness such as the delivery of food including that associated with

'hit the ambulance' – the prosocial public acts of leaving treats on the windscreens of ambulances, home-made improvised personal protective equipment brought to ambulance stations, and, of course, the outpouring of public thanks incorporating the Thursday evening 'clap for carers'. Interestingly, these findings were in contrast to those of Rapp et al (2023, p.26) who in their study of United States healthcare workers found that 'they were being idealised at a distance in a way that seemed like a defence compensation for outsiders not having to 'get their hands dirty' by dealing with the actual problems of the pandemic'. In this study the opposite was generally the case as the public often placed themselves at close proximity to ambulance personnel by delivering treats to ambulance stations, for example.

Whilst this research did not examine the motivations and psychological processes underpinning these public behaviours, MacDonald et al's (2018) work suggests that this may be intended to capture hope for the future as well as societal empowerment in the form of solidarity (Hennekam et al, 2020). Indeed, in his thought-provoking observations, Cooley (1902, p.346) noted that 'most people are not interested in the hero, but in what the hero can make them feel' – providing an understanding that such prosocial acts potentially concealed an inherent emphasis upon individuals' management of their own fears and emotions bound up and projected into the hero narrative aimed at healthcare and key workers.

The idealisation of ambulance personnel (and all healthcare professionals) by the public and subsequent elevated occupational prestige, however, bears resemblance to Rapp et al (2023, p.27) in which they stated how it '…turned them from complex individuals into hero caricatures in a way not too dissimilar to how stigmas 'reduce' an individual from a 'whole and usual person to a tainted, discounted one' (Goffman, 1963, p.3)'. It is a limitation of this study that the powerful influence of the media and socio-political dynamics upon societal thinking was not more fully explored as it appears likely that it played a significant part in conflating these stereotypes (Rees et al, 2022; Mohammed et al, 2021).

It might be surprising to the reader that the data showed that this heroic conceptualisation had only limited positive impact upon the participants' sense of self and self-esteem in a sense of feeling acknowledged and appreciated (Hennekam et al, 2020). Rather, after unpacking the results at depth, it revealed competing tensions - a rippled state of unease and sense of being sacrificial, which became more prominent for some interviewees than others and served as a reminder of their exposure to death and unwanted risk – although there was a tendency to view their enhanced occupational prestige as temporary and therefore not meaningful, and thus was also held with scepticism. This finding was not surprising, however, as prior literature has reported similar in paramedics who were depreciatory of the heroic discourse associated with their work (McCann, 2022; Tangherlini, 2000).

These findings are not outliers and share similarities with the limited scholarly works undertaken by other authors studying ambulance and similar populations (Rapp et al, 2023, Rees et al, 2022). Nevertheless,

herein lies an interesting finding showing that, in being socially evaluated, the participants, in response, evaluated those evaluations – thereby providing evidence that they were not passive recipients of these public-induced categorisations, as some literatures appear to proclaim. Indeed, the data showed how some interviewees determined that they did not warrant the heightened heroic status as they were 'just doing our job, as always'; a finding also identified by Rees et al (2021b) and Hennekam et al (2020), thus, they discounted the associated praise, and it was not assimilated into their shared social identity. Therefore, it is suggestable that enhancing one's (or the in-group's) self-esteem was not the focal point here as social identity theory might suggest. Rather, authentic concordance was of greater importance.

The heroic narrative was also rather problematic in terms of how participants negotiated their responses to distress, trauma, and adversity. Arguably, this social categorisation was underpinned with conceptualisations and inherent assumptions that positioned emphasis on a prototypical masculinised identity associated with hardiness, strength, and 'heroes as protectors' (Furness et al, 2021) and draws some similarities with Mitchell and Bray's (1990) highly contested yet early depiction of paramedics as holding a 'rescue personality'. Indeed, peeling back the layers of the participants' narratives revealed a riptide, a deep undercurrent, that was acutely disempowering and exacerbated their challenges in articulating their vulnerable selves (Stokes-Parish et al, 2020). Furthermore, it reinforced in-group beliefs associated with placing others' (or the organisations) needs first and overlooking those of their own. Again, this draws this discussion back to the cultural challenges the participants faced in terms of attempting to manage hegemonic emotionality whilst negotiating social norms and identity expectations, which exacerbated the ramifications upon their self-esteem and social identity when they perceived they were unable to match up (Wagner, 2005). Idealisation of ambulance personnel with a heroic identity equally inferred psychological challenges in terms of accessing and accepting support, as the mythical configuration of the healthcare hero who goes 'beyond the call of duty' to protect others and keep everyone safe, does not sit well with the image of someone who is distressed and in need of support and help (Cox, 2020). In this regard, I argue that the discourse of 'heroism' can be silencing and can be psychologically harmful. Whilst we have since moved beyond the height of the Covid-19 pandemic, these results provide an epistemological example for widening our knowledge and understanding of how positively-meaning social evaluations made within the context of social relationships between the public and ambulance service personnel inadvertently can place unrealistic demands upon them to enact and behave in accordance with the heroic discourse. As the results of this study indicate, this can be hugely problematic from a professional and psychological perspective.

In contrast to the above exploring the participants' responses in terms of reshaping their sense of self to positive social evaluations from public appraisals were mixed, and thus were also less favourable. Indeed, the empirical evidence drew parallels with Hughes' (1962) conceptualisation of dirty workers in respect of stigmatisation of those doing work that society deems to have elements of danger and risk, exposure to

human bodies and bodily fluids, and contact with infected individuals, and therefore adds to this body of literature. Certainly, the World Health Organisation (2020e) predicted that healthcare workers would experience widespread stigmatisation in response to this pandemic, and this was confirmed by several participants in this study who faced a plethora of denigrating social evaluations aimed at their role identity, which was centralised around public fear of contamination and infection (prior to the advent of Covid vaccines).

From the data, we saw how participants, as ambulance personnel, were likened to 'plague spreaders' and 'carriers of disease' by some members of society. Through these examples and others illustrating 'softer' prejudices and discrimination, it gave a real sense of how stigma as negative social validation posed a threat to their social identity and self-concept and invoked emotional and role dissonance between individuals' self-presentations enacted frontstage and backstage (Swann, 1987; Goffman, 1959). As such, feelings of ostracization led participants in some instances to experience distress, heightened worry and anxiety, hypervigilance, stress, and reduced self-esteem; findings also established in other healthcare workers during the Covid-19 pandemic (Ramaci et al, 2020). Those who experienced stigmatisation sought closeness from colleagues, further embracing an insular culture and an in-group reliance that serves to differentiate oneself from outsiders and mitigates against social isolation (Carbajal et al, 2021). For several participants, stigmatisation occurred seemingly randomly – from unknown members of the public at the supermarket, for example, which added a sense of uncertainty and unease as to how interviewees would be perceived by others. However, one participant's account of being highly stigmatised by family members led to her experiencing intense distress, and a loss of belonging and sense of betrayal by them, as she was harassed with an ultimatum of leaving home if she chose to continue to do the work. Hence, the socio-relational consequences of micro-aggressive stigmatisation were psychologically profound in some cases, particularly when the source of negative social evaluations were from those whom the participant was close to, such that their words were more personal.

The Covid-19 pandemic provided a unique situation enabling exploration of how ambulance personnel in treating patients unwell or infected with the virus were both supported and stigmatised by the public. Taken together as a multivariate of contradictory social evaluations experienced within the course of this study period, concurrent positive and negative appraisals, referred to as mixed evaluations, had considerable impact upon the social identities of participants when that of 'ambulance personnel' was salient. Indeed, participants intimated a sense of confliction, of internal versus external identity dissonance and, subsequently, for some, raised existential questioning as to their sense of who they were and impacted their self-esteem.

Moreover, in light of these social evaluations, the data importantly identified implications for how disruption to their social identities due to stigmatisation led to feelings of stress and anxiety. Nevertheless,

in examining this process, it is important to acknowledge that, in response to public evaluations, ambulance personnel are not passive recipients albeit they are confined by their professional boundaries. Rather, as the results demonstrate, they play an active part in the social construction of these evaluations and, in some instances, such categorisations are challenged. In these ways, the findings of this research make important contributions to the social psychological literature and indeed, social identity theory.

8.6 Conclusion

The aim of this chapter was to provide a synthesis and discussion of the key findings from this study in relation to the research questions and to present their meaningfulness and importance when considered in light of current literature and the theoretical framework of the social identity approach. It must be noted that aspects of this field have previously received little investigation nor conceptualisation within this theoretical discipline as applied to paramedicine, and therefore, this discussion attracted comparable and contrasting literatures from which knowledge and understanding has informed this 'gap'.

In the next and final chapter of this thesis, I further expand upon the contributions to knowledge that this study makes. I also bring together the strengths and limitations of this work and make recommendations for future research and implementation in practice.

Chapter 9 – Conclusion

9.1 Introduction

This study has evidenced how the Covid-19 pandemic was contextualised as a period of extreme adversity by ambulance personnel. It has captured their experiencing of working on the frontline during the height of the contagion whilst the country was facing huge waves of coronaviral transmission causing rapidly rising levels of mortality and morbidity, and society was placed under significant and prolonged social and physical restrictions by the UK government. The participants' narratives provided unique insights into the impacts of the pandemic upon their social worlds, relationships, emotionality, psychology, and social group behaviours in the workplace. Furthermore, in-depth analysis revealed how the social identity and social categorisation of the self as ambulance practitioners influenced how they individually and collectively perceived, processed, and responded to psychological trauma and adversity. In addition, the study has examined the role leadership and organisational dynamics played in influencing psycho-emotionality within the relational space between leaders and followers and highlighted how these interactions impacted and shaped ambulance service frontline cultures.

To recap this thesis, chapter one introduced the study, including background detail pertaining to the key elements being researched: working within the NHS ambulance service, pandemics as disasters, and the relevance of social psychology, in particular, the social identity approach for examining this field. Chapter two provided a detailed literature review, evidencing the epistemological 'gap' in knowledge and justification for the need for this research. In chapter three, the theoretical orientation of the social identity approach was critically evaluated, and its use explained and justified. Chapter four detailed the methodology and research methods employed within this study. Chapters five, six, and seven presented empirical evidence gained from the interviewing of participants at three points across a timeline of one year, commencing shortly after the pandemic was declared in the UK. In chapter eight, I explained in detail how the study achieved the research aims and objectives and research questions. The results were discussed and contextualised in terms of the prior published literature and theoretical framework.

In concluding this thesis, this final chapter seeks to examine the original contributions this study makes to trauma psychology, the social identity approach, and paramedicine through its key findings. It will also review the strengths and limitations and looks forwards in terms of recommendations for further research, and application of the findings to practice and policy.

9.2 Study summary

The impetus for this research arose from my own experiencing of being a frontline paramedic for many years and from personally observing and being curious as to the subconscious processes at play that seemed to be influencing how colleagues held back on displaying their emotions after a difficult incident even when 'backstage' and out of public view. Coupled with extensive study into this field, it became increasingly apparent that the ways in which trauma and adversity had been researched thus far, (albeit papers were relatively limited at that time), appeared to consistently place responsibility upon individuals for their psychological responses as a purely individual phenomenon. Yet, I knew that ambulance staff work closely, in teams, and in crews, and through experience I noticed how, when one crew attended a difficult call and they shared narrative of the events with colleagues, this sometimes had a ripple effect, of a vicarious nature. Despite time passing, poor psychological health has worsened within the field, leading me to further question whether the best approaches were being taken to understanding this phenomenon.

When the pandemic hit, I feared how it may be catastrophic for my colleagues, and I was also concerned that this may not be fully captured within research focusing on healthcare practitioners and perhaps even suppressed and not acknowledged within the organisational setting or indeed, at a strategic level nationally. Therefore, I was motivated to complete this study to ensure that paramedics' and ambulance practitioners' voices were heard and their experiences documented, with a view to developing new knowledge that can better account for our culture and the way in which trauma and adversity are understood and collectively mediated within ambulance services.

This study aimed to understand the social psychological dynamics operating at the 'hidden' level of ambulance culture. In doing so, it intended to explore how these dynamics influence social behaviours and relationships including the experiencing of trauma and regulation of emotions by paramedics in response to prolonged adversity. It also endeavoured to explore the influence of social identity and self-categorisation in mediating these processes. These aims, detailing this study's focus and purpose, and indeed, the aligning research objectives and research questions were woven throughout the entirety of this thesis and informed not only the literature review, research design and methodology, but also shaped the empirical analysis, and conclusions from this research.

In the next section, I outline how this study addresses these research problems and why that matters, in the context of how the study makes original contributions to knowledge. Intertwined with this summarisation are recommendations for future research.

9.3 Original contributions to knowledge and recommendations for future research

Whilst the original contributions to knowledge made by this study are presented within each of the empirical chapters and discussed in the last chapter, they are encapsulated here in terms of their empirical, theoretical, and professional significance to paramedicine, particularly given the context of currently limited literature within the field.

As Haslam (2014, p.1) noted, 'the emergence of social identity theorising as a (and possibly the) major framework for understanding intergroup relations in psychology is well documented'. Nevertheless, its application to adversity and trauma, and to ambulance populations, has barely been understood. This study sought to change this. It makes important empirical and professional contributions to understanding how ambulance personnel structure their social world experiences and behaviours, not merely in terms of their sense of self as an individual, but rather, by their sense of connection to others in the form of their memberships of social groups. This understanding captured within this study broadens our knowledge of the social psychological dynamics shaping interactions and reactions between group members, and of the implicit way these strategies influence not only a distinctive and collective sense of self but also shape their emotionality and the ways in which they respond to adversity and trauma.

In terms of theoretical contributions, as noted, the social identity approach appeared not to have previously been applied to ambulance service communities as a framework for understanding the social group processes that sit behind their group and individual behaviours. Application of this approach has provided significant conceptual contributions for bringing new understanding to the pervading tensions and psychological dynamics found to permeate the organisational culture within the context of prolonged adversity. Indeed, due to a lack of research examining this, little has been known as to how group processes operating within ambulance service teams subtly influence and impact individuals' and groups' thoughts, collective emotionality, and social behaviours. This study has addressed this – showing how intragroup dynamics bolster in-group cohesion and self-esteem – giving rise to a powerful and entitative sense of 'us', including who 'we' are, what 'we' do, and how 'we' do it. Yet, equally, this research has captured downsides to this group tightness, highlighting how these social psychological processes that deeply permeate ambulance service life, can foster depersonalisation and, further along the continuum, can generate toxicity and organisational greed that implicitly operates at such a deep level that these dynamics are barely noticed, yet have colossal influence and implications at both the micro interpersonal level and meso-level of operational and cultural practices and policy implementation. These findings that build upon those from recent cultural reviews and add to our understanding of how social dynamics subtly operating within the leader-follower relational space can conceal abuse in terms of coercion, bullying, micromanagement, and threatened enforcement of rules requiring conformity and obedience, that ultimately silences staff, thwarts innovation and productivity, and are associated with cultural

breeding of poor morale, despondence, and psychological ill-health. I argue that this knowledge, particularly through application of self-categorisation theory, is crucial to informing our understanding of social influence (Turner, 1991) as applied to the ambulance service, especially in crisis situations when in-group members are vulnerable and facing impending threat.

Ultimately, application of the social identity approach has proved useful for examining how social behaviours and group norms exert influence over one another, to the extent that individuals implicitly embody the social identity of the group and/or organisation leading to in-group differentiation and entitativity. Indeed, this study provides a comprehensive understanding of how social identity processes such as intergroup relations played a critical role in determining the social behaviours of ambulance personnel. The present study lays the groundwork for future research to examine at depth how this approach can be harnessed to bring about behavioural and cultural change. Nevertheless, having awareness of the pervasive impact of these psychological dynamics, as highlighted here, is the first step in this change process. The potential impact of this developed knowledge could be very substantial.

The findings reported within this study also shed new light, expanding upon prior studies examining ambulance service leadership, of which very few take a social and/or psychological standpoint. Here, application of the social identity approach to the data confirms, in alignment with the literature, how the leader-follower relationship is fundamental in influencing the self-concept, social identity, and self-esteem of individuals holding these roles. This is a two-way street, affecting those holding the role of leader as much as those holding a more subordinate position. Interestingly, this research exposed how leaders' perceived prototypicality was central to influencing group membership in terms of how they pervasively crafted (or didn't craft) a sense of 'us' and 'we-ness' as the outbreak hit, and how this was maintained (or not) over the time of this study. This perceived prototypicality further extended towards leaders' significant influence in the development of new socio-cultural beliefs, values, and norms – particularly in respect of emotional regulation and responses to trauma and adversity – and the results further contribute to our understanding of how these cultural dynamics subsequently influenced participants' shared sense of identity and sense of self – which has important implications for their psychological wellbeing.

When leaders were perceived as prototypical by group members, they tended to hold a contemporary, open approach towards emotionality and the psychologically impactful aspects of the work that was generally valued. However, this was in contrast with other accounts alluding to leader-mediated enculturation of deeply embedded, hegemonic masculinist assumptions towards emotional expression such as 'man up and get on with it'. As was highlighted, this subsequently impacted participants' social identity encompassed within held beliefs that ambulance personnel are psychologically tough and are 'able to deal with anything' – which prior literature has found to be associated with poor long-term psychological outcomes. However, it was precisely this that showed us how individuals will often make

personal sacrifice, such that in the extreme, causes psychological distress – as identified here. Yet, these norms continue to be conformed to by individuals, in the perceptive knowledge that they are contributing to the needs and success of the group. Thus, arguably, this point further contributes to our knowledge of just how important understanding of social identity and group processes are for informing our awareness of how ambulance personnel and leaders 'structure (and restructure) [their] perception[s] and behaviour[s]: their values, norms, and goals; their orientations, relationships, and interactions; what they think, what they do, and what they achieve' (Haslam, 2014, p.4), and the individual and collective impact that this can have.

Empirically, the social identity approach as applied to the professional context of health is gathering momentum, particularly in terms of examining stress. However, as the literature review alluded, this metatheoretical conceptual framework arguably remains in its infancy in terms of exploring the concepts of adversity and trauma, despite the great seminal works by Muldoon (2012; Muldoon et al, 2019, 2021).

Certainly, this study presents the argument that there is a real need to rethink how we conceptualise and make sense of adversity and trauma within the context of the ambulance service, and to revise the distinctions that have previously been made in this field. The literature examining psychological trauma has overwhelmingly been dominated by monodisciplinary approaches to understanding and interpreting the complexities of trauma responses, taking an individualistic lens upon which interventions have been structured. However, my findings, building on the notion that ambulance personnel work in and form close-knit teams, has revealed how traumatic and adverse experiences encountered through their work are collectively negotiated, regulated, and experienced by these cohorts – therefore contributing empirical knowledge that widens our ontological positioning of trauma. This study has built on the argument that social psychological processes inherent within the participants' groups and organisations played a vital and critical role in shaping how they perceive and manage such adversity. This approach will no doubt prove insightful for further expanding our understanding of how traumatic distress responses may be responded to and managed better within the workplace. Certainly, a natural progression of this work would be to analyse how this may be best achieved – and whether we actually need to rethink some of the individual-centred psychological interventions that are used with ambulance personnel. Arguably, the findings of this study point to a need for an inter-relational collective framework that accounts for and works to enhance a shared sense of identity between ambulance personnel, in order to reap the positive social and psychological effects that being in a team has upon members' sense of self and self-esteem. In practice, this may, for example, feature team psychological supervision sessions, particularly for managers who face their own unique challenges yet typically receive very little pastoral support. However, for this to be beneficial and successful, there is a real need for psychological safety to firstly be established within the everyday lifeworld within which ambulance personnel reside, and this will require significant buy-in from leaders to engage with, value, and promote their groups' social identities (Haslam, 2014).

Another similar yet distinct key area of inquiry in this research was that of the part social beliefs and norms play in influencing how group members collectively and individually manage their emotions, feelings, and responses. As such, it was somewhat surprising to identify the extent to which social norms and practices imposed by ambulance organisations influenced the ways that individual employees (in this case, the participants) regulate and manage their emotions whilst undertaking their work, or circumstances when their role identity is salient. Indeed, a principal finding of this study is that in the process of individuals holding the responsibility for managing their emotions in order to conform to the prevailing norms, ambulance services, in effect, systematically structured, imposed, and influenced the ways in which the participants managed their emotional and traumatic experiences. Subsequently, it is through this understanding that the research shows how the social psychological dynamics combined as organisational culture impacted the emotional and behavioural responses of ambulance personnel when faced with exposure to distressing, adverse, and traumatic events whilst undertaking their role. Arguably, this contribution to knowledge is profound as it reconceptualises the nature of how adversity and trauma have previously been portrayed within the literature as well as in the reality of everyday ambulance practice. Critically, this knowledge shapes our understanding of how, and to what extent, ambulance organisations implicitly perpetuated the participants' emotional and psychological responses to trauma and adversity. Acknowledging this standpoint therefore opens up opportunities to bring about positive behavioural change through moderation of social interactions and cultural discourse that feed into the development of social norms, practice, and policy from which organisations can become more emotionally inclusive, and arguably, could lead to reduced exposure to adversity and trauma.

Taking this beyond the pandemic context raises many questions for how such dynamics diffusely operate within ambulance services in other crisis situations and, as such, has potential applicability in terms of adversity collectively experienced by ambulance teams in response to other distressing incidents and events. Indeed, it is of great concern, given that ambulance services in their everyday environment are arguably functioning within a consistent heightened state of hypervigilance and reactivity. Thus, it is concludable that this study contributes original knowledge in terms of the extent to which social norms operating within ambulance cultures influence the emotionality experienced by these workers and the relational context in which social norms contribute to, preserve, and can challenge one's sense of self as an ambulance worker and/or manager. Drawing upon the social identity approach here has enhanced our insight into how ambulance service cultures unconsciously, and very subtly, steer an ambulance practitioner's everyday thoughts, feelings, and behaviours, and then, how these underlying forces impenetrate their emotionality when faced with challenging situations such as highly distressing and traumatic experiences encountered through their work, and potentially leads to the development of psychological sequalae. Arguably, taking a broader framework, as is associated with the social identity

perspective, enables us to take a compelling approach to understanding how trauma emerges in the collective context, and how it ripples through and is contained within social relationships.

On this point, this study contributes to the existing literature on the importance of social support in the face of adversity. By providing deeper insight, the research advances our knowledge of how, in forming and organising social interactions, social identification and self-categorisation hold an important role for how ambulance personnel draw upon the social capital of social identity resources. Indeed, the research contributes to our understanding of their motivations in seeking an enhanced sense of belonging as a means for gaining group-based psychological security and comfort, thereby attempting to mitigate perceived social identity threats. In this way, we are enlightened into how these processes can alleviate social isolation and may reduce the experiencing of difficult emotions such as fear, fright, and distress. Unquestionably, this is one of the reasons why a strong link has been recognised between social identification and psychological wellbeing (Haslam et al, 2009). These findings will certainly be of interest to fellow scholars from the fields of paramedicine, psychology, and the social sciences, and form a firm basis for future work to examine the connections between social identity, support, and psychological wellbeing in ambulance populations.

Importantly, as the literature review highlighted, almost all the papers examining trauma and adversity as experienced by paramedics and ambulance personnel were done so retrospectively and in light of relatively short-lived exposures. This study is unique in its consideration of the impact of prolonged exposure. Its longitudinal design - again, another uncommon finding in this research field - allowed for data gathering that showed how this impact upon the participants changed over time. To date, as I conclude this thesis, it remains that no other longitudinal studies over a year or more investigating the impacts of prolonged adversity and trauma associated with a pandemic disaster upon paramedics in England, appear to have been undertaken.

With large-scale and prolonged disasters being rare within the UK, this study makes further empirical contributions in terms of capturing the social and psychological realities of ambulance personnel working at the coalface; at the intersection between the public and the virus. I argued that ambulance professionals are distinctly different from other healthcare and emergency services colleagues in this context, as they are often the first healthcare professionals to encounter patients with infectious diseases within the community setting. They also face additional practical and environmental challenges that sets their working locale in a quite different context to that of the in-hospital or clinic setting. Yet, frequently within research, they are poor-relation populations – being in the minority in studies into healthcare professionals. Thus, documenting their lived experiences of what it has been like for them to work at the frontline during this most challenging of times is critical – especially given that it is postulated by

scientists that the advent of further pandemics in the future is becoming an increasing reality (The Guardian, 2024; Mishra et al, 2023).

9.4 Strengths and limitations of this study

The significance of the study is primarily in its original contributions to knowledge as noted in the previous section. However, there were also additional strengths which are important to note. The in-depth approach to collating and analysing the data allowed a unique space, empowering the experiential voices of ambulance personnel to be heard, thus capturing the ontological and existential realities of those working at the frontline of healthcare. Indeed, this *sui generis* opportunity enabled privileged insight into participants' personal narratives and their psycho-emotional responses to adversity and potentially traumatic events.

It is my belief that my positioning as an 'insider-researcher' (Labaree, 2002) facilitated an equitable, enhanced connection with the participants through our shared identity as ambulance personnel. Indeed, as part of this process I noticed how, within the early introductions and interactions with participants, we implicitly co-established our social categorisation and social status as members of the in-group; that is, holding a shared belonging to frontline ambulance teams. My reflections on this relational process, however, led me to notice that whilst the sharing of professional roles with participants engendered shared assumptive expectations for knowledge about the work and how the work gets done, it was the sharing of unique social world experiences through our common language and *a priori* understanding of ambulance service processes, cultural beliefs, values, rituals, and traditions, as well as the clinical and technical aspects of the work, that allowed for shared frames of reference at a much deeper socio-relational level. In my view, this connection not only informed our co-constructed interpretive meaning and sense-making of their subjective experiences, but also helped facilitate rapport and trust, and the balance of power (Denzin and Lincoln, 2018), that an 'outsider-researcher' may have found much more challenging to access (Chavez, 2008). Thus, I argue that holding this level of cultural familiarity and interpretive insight with participants enabled me, as the 'instrument of data collection' (Tremblay et al, 2021, p. 4), to deeply explore their thoughts, feelings, and behaviours, held in context of the cultures and social work groups within which they occupationally reside. Supporting this argument was the informal feedback from several participants who expressed how they looked forward to our interviews as it gave them a unique safe space to offload their experiences and worries and be listened to without judgement. In this way, these participants found the interviews emotionally cathartic and psychologically beneficial.

Whilst these were certainly the strengths of being an insider-researcher, this must be held in balance with the limitations of this relationship. Thus, firstly, I acknowledge that my shared social standing with

participants may have also confounded our interactions – particularly given the in-group normative beliefs surrounding emotional expression and the pervasive cultural attitude of 'man up and get on with it'. Reflecting upon this point, I am cognisant to the fact that being a paramedic myself may have hindered some interviewees in sharing their experiences due to multivariate factors including an inherent motivational need to conform to the social norms – thereby, suppressing, dissociating from, denying, or simply choosing not to share their felt emotions, perhaps for fear of showing vulnerability, not quite trusting me, or other reasons.

Secondly, my salient identity within the interviews was bivariate – in these contexts, aside from being a fellow paramedic, I was also a researcher, and this will undoubtedly have influenced participants' perceptions of me and of the social psychological dynamics subtly operating within our relationship. During the initial introductions, a few participants seemed a little wary of my researcher role and the information I asked for. However, this was generally overcome by placing greater emphasis on building trust with them through enhanced rapport, whilst maintaining an ethically sound researcher-participant connection. Nevertheless, it is notable that participant numbers dwindled over the course of the year, and although reasons for not continuing were not collated, it cannot be dismissed that one possible reason for this could have been related to researcher-participant dynamics.

Lastly, being an insider-researcher meant that there was a possibility that my familiarity with the ambulance service and being a paramedic, could have inadvertently led me to subconsciously make predetermined judgements about the participants' experiences and analysis of their data based upon unintentional biases (such as confirmational bias) heralded from my own experiences of working for a similar organisation. It is not escapable that insider research is potentially limited in terms of implicit tendencies by the researcher to interpret data such that it aligns with their worldview - their held beliefs, values, and assumptions about the phenomenon in question. Reflexivity is a valuable tool in mitigating against this, which brings me to a further limitation of this study. As part of the study design, I intended to enrich and validate my research into complex human social behaviours through triangulation of interviewing of participants and personal reflexivity (Noble and Heale, 2019). However, despite starting the reflexive diary during the empirical data collection phase of this study, the overwhelming pressures of working within paramedicine at the height of the pandemic, experiencing personal bereavements, and the emotional demands associated with this research, brought challenges to this process leading to inconsistencies in its completion. Subsequently, for my own wellbeing, the written reflexive piece was abandoned as a practical self-care strategy (Kumar and Cavallaro, 2017). Nevertheless, introspective cognitive reflection on the research process was undertaken, enabling critical consideration and questioning of the generation of knowledge from the study findings (Mortari, 2015) as highlighted by the discussions throughout this thesis. Thus, I argue that trustworthiness in the research process and data findings is maintained.

From a methodological perspective, this study's strengths also arose from its longitudinal nature and responsive research design which was adapted to the social and physical restrictions imposed upon society in response to the highly contagious nature of Covid-19. Taking place over the first year of the pandemic and capturing the experiences of participants over this time, enabled me to build a detailed account of not only how social psychological processes manifest and influenced participants sense of self and ways of relating to others, but also how these changed over time in the context of emerging and subsequently prolonged adversity (Tremblay et al, 2021). Furthermore, as data was being captured in real time, it excluded or reduced participant recall bias – a limitation of many studies exploring psychological phenomena including trauma. Nevertheless, there were some downsides to the longitudinal design. As highlighted, participant attrition occurred over the year, with the final, third phase of interviews seeing only half the number of participants compared with the first phase. Due to time and resource constraints, there was no follow-up of those who did not continue to take part and therefore, their reasons for withdrawal from the study are unknown (Caruana et al, 2015). In contrast, in light of the continuing pandemic, further follow-up of those participants who completed all three phases of interviewing, could have led to greater insight into the longer-term impact of these social conditions upon cultural group dynamics and psychological wellbeing (Anstey and Hofer, 2004). This, however, could be undertaken as a follow-up study.

Continuing on the theme of methodological limitations, this study was arguably constrained in that three of the ten ambulance trusts in England declined approval for participant recruitment or did not reply to my correspondence. The reasons for this, where given, were due to these trusts already participating in a number of other research studies. Resultantly, there was no geographical representation of interviewees from these areas of the country. Furthermore, of the participant role mix, there were no representatives holding senior leadership positions – which is an interesting point for reflection, as these individuals were not excluded from the study. Why they did not take part is unknown. However, potentially, their inclusion could have been better promoted in the study's 'call to participate' information. This study also faces a limitation in that it did not include patient nor public involvement; contributions that could have brought new insights into how the research was designed and undertaken and could have potentially expanded the study to examine how these pervasive cultural processes subsequently impact patients and the public (Health Research Authority, 2024). Nevertheless, time constraints associated with the rapid developments of the pandemic at the start of the study, meant that this was not feasible to undertake. It therefore remains as a limitation of this research.

9.5 Concluding summary

So, as the title of this thesis posed, were we all in this together? Certainly, this study concludes that social identity processes played a significant and influential role in determining how the ambulance practitioners featured in this study individually and collectively experienced adversity and trauma during the Covid-19 pandemic. The study has highlighted that, when facing threat, holding a sense of belonging to a group was at the core of feeling a sense of togetherness and connection, enhancing social identification and self-esteem particularly at the grassroots level of the ambulance service. As such, strong bonds between ambulance practitioners appeared, in the main, to engender solidarity, support, and collective endeavour in the shared reality of 'fighting' against the virus in the face of incredible risk to themselves and their families.

Indeed, this research demonstrates how the social identity approach is highly relevant in its application to this emergency services setting. It is a metatheoretical framework that enabled examination of deeply complex phenomena such as cultural challenges and leadership, and, important to this study, its application provided real-world understanding of how the participants made sense of themselves in the context of each other and of their experiences. Moreover, it provided the vehicle for exploring how adversity and trauma are socially constructed, profoundly embedded, and yet, subtly ubiquitous within the implicit social psychological structures harbouring at the foundational levels of ambulance service culture. However, in exposing and analysing these concepts at depth, the insights showed just how extensive and pervading these dynamics present within institutional life were in influencing participants' perceptions, interpretations, and emotionality in response to adverse situations. Subsequently, it is these findings that arguably contribute to advancing trauma research, widening the lens from a primarily individualistic conceptualisation towards a collective social construct – accounting for how distressing occupational events are usually experienced by ambulance personnel operating in teams or crews, who reside in a typically close-knit community.

Poor psychological health of employees in respect of adversity and trauma remains a huge challenge for the ambulance service, reflected in high levels of sickness, attrition, and poor morale. Relevant here is how the prolonged nature of the pandemic had a profound psychological impact upon many of the interviewees such that, by the end of the study, several had left or were in the process of leaving the ambulance service. As this research showed, social norms and associated behaviours found to be pivotal in determining these social world experiences of the participants also extended into the realms of a toxic organisational culture and it is here that understanding is gained that 'we' were *not* all in this together, at all.

As the research found, vehement emphasis on solidarity at the surface of social interactions cloaked the dark reality of intersectional oppression causing fissures at the depths of organisational culture such that not everyone felt part of the collective experience during this pandemic. This extended from senior leaders who were seen by participants to be disconnected from the reality of the risks being faced at the frontline, to leaders' role and power in influencing followers' thoughts, feelings, behaviours, and social identification with their in-group and institution. Although some leaders were experienced by participants as prototypical to, and supportive of the group, there was a distinct sense of hurtful betrayal and injustice when leaders were not perceived to be 'in it together' with them, especially when they were risking their lives and simply trying to survive.

The challenge, which arguably may be applicable to any crisis event faced by ambulance services, is in leaders' ability to develop cohesion amongst their team and to be entrepreneurial in terms of fostering a shared sense of social identity. Being prototypically representative of their identity and interests of the in-group, go hand-in-hand with forging a positive way ahead taking account of, and where necessary adapting social norms to promote social behaviours and developing a shared sense of responsibility and agency towards assured collective endeavour.

Examination of these conceptualisations as applied to the ambulance service context are in their infancy. To gain a more detailed picture, there is much research still to do. Here, my analysis draws inference with the social identity approach, determining it to be a powerful framework through which we can not only understand the social psychological worlds of those practicing within paramedicine but can also contribute new knowledge to the scholarly field of psychological trauma. This research therefore links theory, knowledge, and practice calling our attention to the relevance of group memberships to the experiences of trauma. Furthermore, the social identity approach raises awareness of how adversity and trauma may give rise to significant distress on the one hand, yet also can lead to psychological restoration and growth on the other.

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Appendix A: Professional groups working within NHS ambulance practice.

Role title	Abbreviation	Role description
Emergency Care Assistant/ Emergency Care Support Worker	ECA/ ECSW	Role holders are non-clinical crew members who support clinical staff, and are trained in emergency and advanced driving, the taking of patient observations such as blood pressure, pulse, blood glucose readings and applying heart monitoring.
Associate Ambulance Practitioner/ Emergency Medical Technician/ Ambulance Technician	AAP/ EMT Tech	This is a clinical role; however, role holders are not registered healthcare professionals. The skills incorporated within this role are not standard across all ambulance services and varies across the country. Typical skills associated with these roles include intermediate level of clinical assessment, administration of a small number of medications, and defibrillation. They are not trained in invasive techniques such as cannulation or intubation.
Paramedic		Individuals holding this role are autonomous clinical practitioners who must be registered with the Health & Care Professions Council (HCPC) to practise. Now, it is a requirement that all those studying to become a paramedic must hold either an undergraduate or post-graduate degree relating to paramedicine. Paramedics can undertake a wide range of clinical assessments, treatments and skills including cannulation and administration of a range of medications. They are also trained in advanced/ emergency driving.
Ambulance Nurse	AN	Ambulance nurses are experienced nurses who have completed an undergraduate degree in nursing and are registered with the Nursing and Midwifery Council (NMC). These nurses undertake additional training to prepare them for out-of-hospital practise. They are autonomous clinical practitioners and hold a skillset similar to that of a paramedic.
Specialist Paramedic SP in Critical Care SP in Urgent Care Emergency Care Practitioner Advanced Paramedic Advanced Care Paramedic	SP SPCC SPUC ECP AP ACP	Individuals holding these roles are very experienced paramedics who have undertaken post-graduate education and clinical supervision that enables them to practise skills additional to that held by a paramedic. Typically, these skills were often traditionally undertaken by doctors. Such skills include prescribing medication, administering a wider range of drugs, and life-saving surgical procedures.
Consultant Paramedic		This is a role that a few ambulance trusts have implemented within the last decade. It has only recently been expanded to a greater number of ambulance services. Consultant paramedics are highly experienced within their field and have expertise within clinical paramedicine or in an associated clinical area including that of education and/or research. Holding a PhD is desirable at this level, although is not yet a formal requirement. Working in the high-level environment, postholders provide clinical leadership, working alongside other senior leaders within an ambulance trust. They provide clinical guidance and operate strategically in terms of implementing new treatments, care pathways, etc.
Ambulance Doctor		Doctors working within the ambulance service are often situated alongside helicopter emergency medical services (HEMS), provide senior medical advice to ambulance clinicians, and attend incidents to provide clinical treatments, anaesthesia, and/or surgical interventions to patients via the British Association for Immediate Care Scheme (BASICS).
Ambulance Managers		Managers working within an ambulance trust range from general management through to leadership of specialist teams. Each ambulance service has its own management structure. Typically, within a frontline operational setting, the hierarchy is: Frontline clinician Team Leader Clinical Operations Manager Area Manager/ Head of Operations Associate Director of Operations Director of Operations Postholders usually are promoted through the ranks, thus most managers have experience of being an ambulance clinician at some point in their career. Those who are in more junior management positions will tend to have a hybrid role mix of being a clinical practitioner and a manager.

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PARTICIPANT INFORMATION SHEET

Study Title

The Psychosocial, Emotional and Relational Consequences of Occupational Trauma Exposure During A Pandemic: Insights from NHS Ambulance Personnel in England.

Invitation paragraph

You are being invited to participate in a research study forming part of a doctoral study at the University of York.
Before you decide to consent to take part, please take time to read the following information carefully, and weigh up your decision.

What is the purpose of the study?

The purpose of this study is to seek understanding of the psychosocial and emotional impact upon ambulance personnel, working within the emergency NHS ambulance services in England during the pandemic, covid-19.
In particular, the study is interested in the experiences of currently serving NHS ambulance staff and managers as individuals and as a collective culture.

Analysis of the data will help give greater understanding of how traumatic distress features within the ambulance occupational environment. The study also aims to use the data findings to develop recommendations for promoting and supporting the psychological, social and emotional wellbeing of ambulance personnel after large scale incidents such as a pandemic, disaster, or other traumatic event.

Why have I been invited?
You have been invited to take part in this study as you are currently employed in an NHS Ambulance Service in England and work within an operational response, patient-facing, emergency ambulance role in either a clinical or non-clinical grade, or as an operational manager.
To participate in this study, you must;

- Be currently employed within the NHS Ambulance Services in England, either full-time or part-time, within any patient-facing operational response and/or operational management role. This role must form the participants' main part of your regular work.
- Be employed as above, in a frontline (emergency ambulance) capacity during the COVID-19 pandemic.
- Be aged 18 or over.
- Able to speak, read and write fluently in English.
- Be capable of giving informed consent.

Do I have to take part?
Taking part in the research is entirely voluntary. It is up to you to decide. The researcher (Principal Investigator) will describe the study and go through this information sheet, which she will send to you electronically. She will then ask you to sign a consent form to show you agreed to take part. You are however, free to withdraw from the study at any time, without needing to give a reason. However, any non-identifiable data submitted by that point will be retained and used for the study.

What will happen to me if I take part?
The Principal Investigator will agree a day/time to talk with you about your experiences. This will be in the form of a one-to-one interview on the telephone or via Skype (or similar).

One-to-one interviews – To understand what it is really like for you, and to get a sense of the impact of working as an ambulance professional during the covid-19 pandemic, you will be asked to speak with the Principal Investigator on a one-to-one basis, on a minimum of two occasions.

The **first interview** will be held during the pandemic response, and the **second interview** will aim to be held within three months after the peak of the pandemic.

You will be asked some questions about your experiences to enable the Principal Investigator to know and understand more about what this was like for you.

Additional follow-up interviews with the Principal Investigator may be helpful to ascertain your psychological and emotional experiences.

The meeting will be sound recorded, and then transcribed by the Principal Investigator. Information you provide will be anonymised and you will be known only by a pseudonym. Transcribed data will feature within the Principal Investigator's PhD thesis and will be analysed into relevant themes. This may be published at a later date.

The interview length will vary between participants as it depends upon what is discussed. However, on average, they will tend to be around one hour.

What are the possible disadvantages and risks of taking part?
There is a possibility that you may experience some distress from recollecting unpleasant memories and feelings. This may leave you feeling exposed and vulnerable. The exact impact of this is difficult to predict, and it may be that you have no adverse effects at all or may even experience a sense of relief from being able to tell your story.
To maintain your safety, should you experience distress, the Principal Investigator will stop the interview and provide welfare support to you. It will be your decision if you wish to continue or stop and opt out of the study. The Principal Investigator will be able to recommend further support and signpost you to counselling/ advisory services if required.
Following the interview, and if necessary, a follow-up will be offered. Furthermore, all participants will have supports available to them via their organisation's employee assistance programme for independent counselling if required.

What are the possible benefits of taking part?
There is no promise that the study will help you, but it is possible that in completing the interviews, you may find psychological benefit. Similar studies of this nature often find that participants experience positive and beneficial effects from having the opportunity to have their experiences heard. Talking about traumatic memories in a confidential space can sometimes lead to personal growth and the opportunity to bring about positive personal change.

What if there is a problem?
If you have a concern about any aspect of this study you should contact the Principal Investigator, and she will do her best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this through the University of York complaints procedure or refer to the Chief Investigator; Professor Leo McCann.

Will my taking part in the study be kept confidential?
The anonymity and privacy of individuals who agree to participate in this study will be protected as thoroughly as is reasonably possible and within the law, throughout the life of the research study.
Interviews will be undertaken by telephone/ skype, with steps taken by the Principal Investigator to ensure the least risk of the conversation being overheard as possible.

What will happen to my personal data?
The basic demographic information you give will be used to provide background information about you. This will include general data such as gender, length of service, area of work (e.g HEMS/ frontline ambulance) and marital status. Specific details such as your name, address, and exact location of work (including the name of your employing organisation) will not be included in this study.

The Principal Investigator will use your name and contact details to contact you about the research study and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. All demographic information which is collected about you during the course of the research will be kept strictly confidential.

Individuals from the University of York and regulatory organisations may look at your research records to check the accuracy of the research study. The Principal Investigator will pass these details to the University of York along with the information collected from you. The only people at the University of York who will have access to information that identifies you will be people who need to contact you or audit the data collection process. The person who analyses the information (the Principal Investigator) will know of your name and contact details. However, the Principal Investigator

will ensure that the data collated and reported will not personally identify you and the data will not disclose your name or contact details.

Data will be handled as per the Data Protection Act 2018 and the EU's General Data Protection Regulation 2018. The University of York will keep your contact details for only as long as necessary to manage your participation in the research. A copy of your signed consent form will be kept for up to 5 years after the study has finished for the purposes of verifying the research. All identifiable information will be securely destroyed when it is no longer required for the study.

What will happen to the information I provide in the interview?
Your research data will be coded using a pseudonym which will only be known by the Principal Investigator and yourself. A master list identifying participants to the research codes data will be held on a password protected computer file accessed only by the Principal Investigator. Electronic data will be stored on a password-protected computer file via the University of York, known only by Principal Investigator.

The data that you provide during the interview will be sound recorded by the Principal Investigator. This recording will be safely stored in an electronic medium as noted above. The audio recording of your interview will be transferred as soon as possible to the University of York secure servers in a password-protected file and will be deleted from the recording device.

The data you provide will be transcribed by the Principal Investigator, and once complete, the interview recording will be confidentially and safely destroyed. The recordings themselves will not feature within the Principal Investigator's PhD thesis and will not be published.

The data gathered will be used for this study and potentially in future studies undertaken by the Principal Investigator. This means that quotes may be included in the study report and in any published papers in the future. Your data will be completely anonymous and only referred to by pseudonym.

There is a risk that your colleagues may recognise you from your quotes about any incident details given. However, it is anticipated that this risk is small. When the data are incorporated into the PhD thesis itself then all potentially identifying elements relating to place or time will be removed.

The University of York is the sponsor for this study based in England. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

The University of York is a publicly funded organization that conducts research to improve health, care, and services. Research following the UK Policy Framework for Health and Social Care Research is conducted to serve the interests of society as whole. This means that the University of York is using the legal basis of a 'task in the public interest' to use your personal data for this research. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate.

You can find out more about how we use your information and your data protection rights - please see the University's Data Protection Pages.

What will happen if I don't carry on with the study?
If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. All the information and data collected from you, to date, will be confidentially held in line with the Data Protection Act 2018/ EU General Data Protection Regulation 2018.

What will happen to the results of the research study?
The results of the study will be written up in the Principal Investigator's thesis. It is possible that the results may be published at a later date or referred to during conference presentations etc. You will not be personally identified in any report/publication/talk unless you have given your consent.

You can request a copy of the results from the Principal Investigator if you wish. Should they wish to receive it, a copy of the completed study will be available to your employing ambulance service. Quotes from your interview may be included, but again, your identity will be protected as will your specific place of work.

Who is organising or sponsoring the research?
This research study is organised on behalf of the University of York. The University of York is also the sponsor.

Has the study received ethical approval to take place?
Yes, the study has been ethically approved by the NHS Health Research Authority who have strict regulations about how a study is conducted.

Further information and contact details:
If you would like any of the following:

1. General information about the research
2. Specific information about this research project
3. Advice as to whether they should participate.
4. Who you should approach if unhappy with the study.

You may contact the Principal Investigator at jm2651@york.ac.uk in the first instance.
The Chief Investigator; Professor Leo McCann may be contacted at Leo.Mccann@york.ac.uk
If you have any concerns regarding the personal data collected from you, our Data Protection Officer, Durham Burt can be contacted at durham.burt@york.ac.uk

You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see: https://ico.org.uk/global/contact-us/

What happens next?
If you are happy to be involved in the study, please confirm by email reply to the Principal Investigator; jm2651@york.ac.uk
The Principal Investigator will respond by asking you to confirm that you meet the inclusion criteria for the study. Once received, she will electronically provide you with a consent form which you will need to read and sign before participating in the study. The Principal Investigator will then ask you for your availability to undertake the first telephone/ skype interview.

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PARTICIPANT CONSENT FORM

Title of Project:

The Psychosocial, Emotional and Relational Consequences of Occupational Trauma Exposure During a Pandemic: Insights from NHS Ambulance Personnel in England

Name of Researcher: Joanne Mildenhall

Please initial each statement to confirm your agreement:

1. I confirm that I have read and understood participant information sheet version 2.0 dated 10th April 2020 for the above project and have had the opportunity to ask questions about the interview procedure.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason to the named researcher.
3. I understand that my responses will be audio recorded and used for analysis for this research project.
4. I give permission for the non-identifiable data to be archived as part of this research project, making it available for future research.
5. I give permission for non-identifiable quotes of things that I say within the interview to be used with the thesis and any published works that arise from the study or future studies undertaken by the Principal Investigator.
6. I understand that my responses will remain anonymous.
7. I would like to be informed of the research findings via email or post.
8. I agree to take part in the above research project.

Preferred address at which I can be sent a copy of the transcript/ research findings:

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

To be signed and dated in presence of the participant.

Once signed, you will receive a copy of your signed and dated consent form.

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

Appendix D: Interview Schedule (Phase One)

Interview Topic Guide – First Interview:

A) Introduction to researcher and research project, welcome.
B) Outline of study.
C) Instructions regarding the interview. Discussion of risks. Participation is voluntary and they can stop participating or decline to answer at any time. Confirm consent. Explain that I will make notes in case I want to come back to anything later. Interview will be audio recorded.
D) Researcher to ask participants to introduce themselves. Length of service, role, age.
E) Ask questions such as:

Main Questions	Additional Questions	Clarifying Questions
1. Background information about interviewee- current and any prior relevant roles/ responsibilities, training, duration in employment.	• Can you tell me a little about you and where you work? • Elicit important others outside of work.	
2. Identify and elicit what their role is, and how they fit into the organisation, key relationships, what it is like to work where they do.	• How is it for you, working within this area? • Who else is in your work network?	• Can you please clarify what you meant by….? • Can you please expand a little on…? • Could you give an example of that..? What do you think of that?
3. Identify and elicit details about their experiences of working in emergency ambulance operations during/after the pandemic crisis.	• What are your experiences of this? • How did you find things afterwards (emotionally, psychologically, psychosocially)?	• What was that like for you? How did you feel? • Could you tell me a bit more about that..?
4. Supports available, impact of social groups within the culture. Relational context of psychological distress.	• What does support mean to you? • What role does the organisation play in supporting you? • How do you feel attending this/these incidents impacted upon your relationship with others? And their relationship with you? Did this influence the support you felt able to access/not access?	• Typically, what would happen after you have attended a difficult call? • Do you feel able to ask for support/ help? • What helped/ didn't help you? What was your experience of support from others? What was your experience of others following this call?
5. Emotions during/ following working in the pandemic	• How did you feel? What emotions did you feel?	• What was this like for you and for others close to you?
6. From an occupational perspective, emotional display/ suppression – during & after the pandemic	• What cultural rules and norms are there at work, around emotional display/ suppression? Are you expected to emotionally behave at	• Did you feel that you could really show how you felt afterwards? ..Why? if not, what do you think happened to those feelings you had?

	work in a certain way? How did this influence how you dealt with and coped with the experience?	
7. Impact of emotional display & suppression on processing (work related) traumatic/ distressing experiences		• You mentioned…. Tell me more about that. • What did it feel like? • What was it like for you?
8. Explore the impact upon their organisational culture	From your experiences, how do you think the impact of working during/after the pandemic affects or maybe benefits the culture of where you work?	
9. Explore what they feel they need or needed to help them to cope, and why they might need it (psychosocial needs, recommendations for future). Did they received the support that they needed…? What may have helped?		• What would that look like…? • What else do you think would be helpful? Why? Do you feel there are any barriers/ challenges to implementing this?
10. Summary and conclude		

Interview Topic Guide – Second Interview:

F) Welcome and thank participant for their time and taking part in the interview/ study.
G) Brief reminder of the outline of study.
H) Instructions regarding the interview. Reminder of the potential risks of discussing distressing things during the interview. Give a reminder that participation is voluntary, and they can stop participating or decline to answer at any time. Confirm consent. Explain that I will make notes in case I want to come back to anything later. Interview will be audio recorded.
I) Researcher to ask participant questions such as;

Main Questions	Additional Questions	Clarifying Questions
11. Can you tell me a little about your role during the covid-19 outbreak?	• Can you tell me a little about your role and the work that you have been undertaking?	
12. Identify and elicit details about their experiences of working in emergency ambulance operations during/after the pandemic crisis.	• What are your experiences of this? • How have you found things after the peak of the pandemic? (emotionally, psychologically, psychosocially)?	• What was that like for you? How did you feel? Could you tell me a bit more about that..?
13. Supports available, impact of social groups within the culture. 14. Relational context of psychological distress.	• Has their experiences/ thoughts around support changed since the first interview? • How/why? • How do you feel attending this/these incidents impacted upon your relationship with others? And their relationship with you? Did this influence the support you felt able to access/not access?	• Do you feel able to ask for support/ help? (explore) • What helped/ didn't help you? What was your experience of support from others? What was your experience of others following this incident?
15. Emotions during/ following working in the pandemic	How did you feel? What emotions did you feel?	• What was this like for you and for others close to you?
16. From an occupational perspective, emotional display/ suppression – during & after the pandemic	• What cultural rules and norms are there at work, around emotional display/ suppression? • Have these changed during/ after the pandemic? • Have you been expected to emotionally behave at work in a certain way? How did this influence how you dealt with and coped with the experience?	

17. Impact of emotional display & suppression on processing (work related) traumatic/ distressing experiences	• Did you feel that you could really show how you felt afterwards? ..Why? if not, what do you think happened to those feelings you had?	• You mentioned…. Tell me more about that. • What did it feel like? • What was it like for you?
18. Explore the impact upon their organisational culture	• From your experiences, how do you think the impact of working during/after the pandemic affects or maybe benefits the culture of where you work?	•
19. Explore what they feel they need or needed to help them to cope, and why they might need it (psychosocial needs, recommendations for future). Did they received the support that they needed…?		• What would that look like…? • What else do you think would be helpful? Why? Do you feel there are any barriers/ challenges to implementing this?
20. What else may have helped?		
21. Summary and conclude		

Appendix F: Interview Schedule (Phase Three)

Not all questions were asked of all participants.

Interview 3

Work:

1. How have things been at work since we last spoke?
2. How have things been, personally, for you? (work and out of work)
3. How are you at the moment?
4. How have you felt about going into work for a shift?
5. Have you found yourself questioning your fundamental beliefs and values about work or life in general?
6. Tell me a bit about how you've been managing up to now. (probe alcohol, friends, avoidance, loss of interest etc). Managing at work, managing how you feel, looking after yourself.
7. Have you felt troubled by the things that you've seen or been asked to do or not do?
8. Do you feel supported by your leaders and/or colleagues?
9. Do you feel that your organisation has done/ is doing enough to protect you and your psychological health and wellbeing?
10. Looking back over the last year, do you feel that your organisation adequately prepared you for dealing with the pandemic?
11. Relationships – leaders, supportive? Felt valued?
12. How are you feeling now about your job, your work? Do you see this as a career that you will continue with? / How do you see your future?
13. Have you felt put in a position where you've had to make morally challenging decisions? Or, had to choose between very difficult options?
14. Would you say that your outlook on life has changed in any way since the pandemic started in March 2020?

Other:

1. Are you worried about the current situation/ coronavirus pandemic?
2. Do you feel that your behaviours have changed as a result of the pandemic – i.e. taking more precautions to prevent infections, following all the news updates, stockpiling supplies etc.
3. Do you feel emotionally exhausted? Explore.
4. Feelings of stress, anxiety.
5. Has having the vaccination had any impact upon you psychologically?

Traumatic experiences:

1. Have you felt that your life, or the lives of those close to you, have been at risk?
2. Have you felt overly exposed to the virus? Has this played on your mind?
3. Have you been feeling cut-off from those you are normally close to?
4. Have you found that some jobs have been whizzing around in your mind and you've thought about them more, whereas normally they might not normally bother you? Intrusive.
5. How has your sleep been?

Life:

1. Tell me a bit about your days off, how do you use your time away from work? (check out if they have been less interested in activities etc)
2. Have you received any formal support such as counselling or psychotherapy?

Ending:

1. How would you really like things to be in the future for you as a professional? As a person? (this asks them to imagine the future that they desire, hope. From this can gain an understanding of who they are, their beliefs, values etc)