I'M FINE: SYSTEMIC AFFECT OF CRITICAL INCIDENTS IN EMERGENCY MEDICAL SERVICE PERSONNEL COMMUNICATION

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DEDICATION

Mary Lee Deason is my biggest cheerleader, nonunderstanderer of my ramblings but pretends to listen listener, constant fire lighter, and all-around cuddly love of my lifer. She has tolerated an EMS career then an academic journey that started off with a 41-mile move to complete only my bachelor's but ended up with an 1100 mile move into the frozen Hoosier tundra for 5 years before coming home…I don't know if she would have asked me out for our first date in August 1997 if she had known this would happen. With all my heart!!!

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Aaron Sterling Deason

I'M FINE: SYSTEMIC AFFECT OF CRITICAL INCIDENTS IN EMERGENCY MEDICAL SERVICE PERSONNEL COMMUNICATION

EMS personnel experience emotionally charged calls, such as CPR, trauma, or domestic violence. This study examined the changes on communication by these events. Communication Complex metaframework allowed use of other disciplines. There is a lack of scholarship surrounding EMS communication. Research from other military and other fields was translated into the EMS community. Mental illness is a growing concern in EMS as 37% contemplate suicide and 6% complete it. Part of understanding the affect is an exploration of how the culture of EMS (i.e. training, traditions, machismo) shapes the way new EMS are acculturated. EMS have repeated exposure to trauma over a career. These exposures change communication patterns.

Using a three-chapter autoethnography, I was able to examine my communication and mental status changes from rookie until retiring 14 years later with PTSD and constant suicidal ideation. Ethnographic interviews of veteran EMS provided insight into the old school ideology of emotional repression and shelving.

I analyzed using the NREMT Patient Assessment skill sheet as a guide in a three-step process to discover and reassess themes. The primary survey indicated common job-related stressors- pedi calls and staffing problems. The secondary survey revealed themes of emotions, senses, and support. Finally, the reassessment revealed subtle changes in EMS culture, including decreased PTSD stigma, increased resiliency training, and increased administrative support. Future research could examine the effect of spousal support and changes in cultural emotional suppression. The goal is to develop programs to help allies understand the emotionality in EMS and create dedicated support structures to increase EMS mental health.

John Parrish-Sprowl, PhD, Chair

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Introduction

"Out of suffering have emerged the strongest souls; the most massive characters are seared with scars." -Kahlil Gibran

This dissertation is ugly, scarred, and chaotic. It will seem rambling until the reader realizes I am a paramedic masquerading as a researcher. I am a MEDLAR (See Picture 1.1). There are long pauses when I insert my voice and lived experiences. These asides are like my preceptors stepping in to offer guidance when I struggled as a medic student. I was a volunteer firefighter (1994-2008) and in Emergency Medical Services as an EMT (1997- 2001) and Paramedic (2001- 2017). I saw bad shit during those years. These mind-seared moments unwelcomely return from sensory triggers. My stories are presented unedited. They are raw, nasty, graphic, and dirty. I need to share the blood, guts, and gore as partner. I need you to squirm as my partner. I need you to be uncomfortable as my partner. I need you to viscerally experience EMS as my partner...

Picture 1.1 January 24, 2010 ER after ambulance wreck

Carly was alive when I left the station on Monday, January 24, 2011 at 1:32 pm. I had worked many shifts with her at that station. On Saturday, January 29, 2011, Carly Smith, a Champion EMS-Holly Lake Ranch station EMT was found unresponsive at her home. I never knew the exact cause of death, but I suspect alcohol and drug overdose (possibly unintentional, possibly not). The cause seems irrelevant considering she was only 23. Too young….

On Saturday, October 15, 2016, David Dangerfield, an Indian River County Fire Rescue Battalion Chief, posted on Facebook:

> PTSD for firefighters is real. If your love one is experiencing signs get them help quickly. 27 years of deaths and babies dying in your hands is a memory that you will never get rid of. It haunted me daily

> until now. My love to my crews. Be safe, take care. I love you all (Stancil, 2016, "Veteran IRC firefighter," para. 7).

At 10:30 p.m., he called 911 and told dispatchers where his body could be found. Deputies found him dead from a self-inflicted gunshot. Between December 2018- February 2019, three first responders in the Tampa Bay area committed suicide (Taylor, 2019).

The Centers for Disease Control and Prevention (2012) found the national average for suicidal contemplation in United States adults is 3.7%. Suicidal ideation, which refers to thinking of a detailed plan to commit suicide (Nordqvist, 2016), has reached a critical level among first responders (mainly EMS personnel) with 37% reporting suicide contemplation as well as 6.6% reporting suicide attempts (Newland, Barber, Rose, & Young, 2015). The rate of suicidal ideation in EMS providers is 10 times higher than the national adult average. Identifying suicidal ideation in EMS personnel is essential, but that is near the end. Why not try to catch the jumpers before they start climbing up the stairs to the roof? Other disciplines have explored, but they are academic projects conducted by academics. As partners, we will use our stories as research because too many of our EMS family are dead**. TOO. DAMN. MANY. DEAD!!!**

Effect, Affect, and Systemic Affect

My mind was confused for a long time on the concept of affect versus effect versus systemic affect. Dwyer (2012) wrote:

> In April, Rory Staunton, a sixth grader from Queens, died of severe septic shock after he became infected, apparently through a cut he suffered while playing basketball. The severity of his illness was not recognized when he was treated in the emergency room at NYU Langone Medical Center. He was sent home with a diagnosis of an ordinary bellyache. Hours later, alarming laboratory results became available that suggested he was critically ill, but neither he nor his family was contacted. (n.p.)

Rory did not die from the cut. The local swelling did not kill him. The infection festered and multiplied until the infection spread throughout his 12-year-old body creating irreversible multiple-organ dysfunction disorder (MODS) septic shock. Healthy to dead in less than seven days. Amazing!

As with Rory, the systemic affect takes time most often through multiple incidents over an extended time. However, affect (emotions) can be learned for others. Like a virus, this transmittal from person to person is called a contagion. Emotional contagion has been

defined as “the tendency to automatically mimic and synchronize facial expressions, vocalizations, postures, and movements with those of another person and, consequently, to converge emotionally” (Hatfield et al. 1994, p. 5). An example of emotional contagion affect is burn out. Bakker, Le Blanc, and Schaufeli (2005) found:

> Nurses who reported the highest prevalence of burnout among their colleagues were most likely to experience high levels of burnout themselves. Moreover, perceived burnout complaints among colleagues had a positive, independent impact on each of the three burnout dimensions (i.e. emotional exhaustion, depersonalization and reduced personal accomplishment), even after controlling for the impact of well-known job-stressors. (p. 284)

In other words, burn out in nurses may be an institutionally enduring transmitted contagion. Burn out is the long-term effect caused by negative affect. EMS, like nursing, has similar burn out issues; however, “On days when they reported more work-related stress, paramedics also reported more rumination and interpersonal withdrawal at home, responses shown to further exacerbate marital tension” (King, 2013, p. 111). The stressed-out EMS personnel in O’Neill and Rothbard (2017) had increased alcohol use and PTSD. In this scenario, the stressor created an affect (i.e., mood, feeling, emotion) producing an effect (i.e. burnout) leading to affect (i.e. PTSD). However, not every affect creates effect or affect nor does every effect lead to affect. Sometimes, a feeling is momentary, or burn out goes away after a long weekend fishing.

In 2003, The Los Vegas Convention and Visitors Authority partnered with advertising agency R&R Partners to create the iconic slogan ‘What happens in Vegas, stays in Vegas.” The slogan is great for tourism- suppress/hide/don’t talk about it, but terrible in real world applications. Emotional suppression has lasting implications. College students engaging in emotion suppression during the first 10 weeks of transition to college had lower social functioning, social support, and closeness. (Srivastava et al., 2009). Emotion suppression and conflict with family decreases firefighters’ abilities to recover from on the job stressors (O’Neill & Rothbard, 2017). “As affect tends to reinforce itself, a small affect induction may lead to continue effect.” (Halverson, 2004, p. 81). Thus, a single episode usually does not induce enduring emotional suppression. Affect (psychological change) tends to occur when affect(feelings) and effect (job stressors) linger.

Think back to our introductory tale about Rory. The infection moved from local to a complete body take over resulting in death. Simple became complex quick. The same things when discussing affect versus systemic affect where means multiple systems are involved. In my case, I have PTSD and alexithymia years removed from my last ambulance call. I have an enduring hyperaroused state where I am hypervigilant to the point I do not sleep soundly where a normal night's rest is about 4 hours with 90-95% awake and non-REM sleep and 5% REM compared to the recommended 7-9 hours for a 48 old year male with 75% non-REM and 25% REM sleep (Shrivastava et al, 2014). Physiologically, I have hypertension and GERD. My irritability increases due to no sleep and constant heart burn. And sometimes, the combination affect (emotions) and effect (psychological and physiological) creates a perfect storm where I unexpectedly explode everywhere. This is systemic affect…and it lingers… until like Carly, David, Charlie, Rodrigo, and countless others it ends through suicide.

I add a unique voice to health communication as I explore EMS personnel communication patterns and experiences. So, prepare to experience my world of sunshine and storms. The first chapters will prepare you to get on my ambulance. You will learn the skills needed to be my partner. I will be your preceptor… and in the end, we will share our stories in the ER driveway… and you will understand how the continual stream of badness affects my communication systemically.

Chapter One: Mental Health and Communication

All people have mental health. The state of a person's mental health is in constant flux with responses to the activities of daily living. Some situations affecting mental health might include failing a test (sadness), being asked to the prom (joy), burning oneself while cooking (pain), making fun of a classmate (remorse), or watching a scary movie (fear). Fluctuations in mental health are considered normal and return to homeostatic status. In other words, the effects are temporary not lingering. When the episode lingers to the point the festering wound affects health, people reluctantly seek an intervention to drain the cankerous, fetid abscess.

Depression is the first thought when mental health is discussed. This may be due to the fact over 300 million people, or 4.4% of the global population, suffer from depression (World Health Organization, 2017). Another 150 million have other mental or neurological disorders. Mental disorders are "among the leading causes of ill-health and disability worldwide expecting to rank second by 2020 behind ischemic heart disease." (World Health Organization, 2001). While the number of afflicted persons is small globally, the Centers for Disease Control reported 8.1% of US adults over age 20 experienced depression in any given two-week period (Brody, Pratt & Hughes, 2018). This is a lot of rancid drainage on the world's floor for mental health professionals to try to clean up.

The World Health Organization (WHO) and the American Psychiatric Association (APA) offer criteria for mental health assessment by professionals. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) offers limited insight as it is:

> Intended to serve as a practical, functional, and flexible guide for organizing information than can aid in the accurate diagnosis and treatment of mental disorders. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings. DSM-5 is a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. (APA, 2013, Preface)

The World Health Organization's mental health definition goes beyond assessment and includes:

> Not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports. (World Health Organization, 2012, p. 5)

The difference between these definitions is astounding. European professionals are apt to follow the WHO definition for a holistic approach with discussion of lived experience, signs, and symptoms for a diagnosis. Whereas, United States mental health professionals rely on the DSM-5 tend to focus on a biomedical tradition of signs and symptoms to guide treatment modalities. Thus, where the person has a mental health episode determines which approach is used. Consider the following story of Mark, my brother:

> *My brother, Mark, is 54 years old. Mark showed signs of bipolar and schizophrenia at age 14 in the early 1980s. He left home when my parents discovered he was growing marijuana in his bedroom and had been drinking mushroom tea. For years, he lived in abandoned houses or a tent in the woods because he hears the electricity flowing through the lines. Mark looks like a homeless person- tattered clothes, matted haired, unshowered and unshaven. He finally received a psychiatric diagnosis after an "encounter" with law enforcement led to a six-month involuntary commitment in a state mental facility in 2010.*
>
> *Several years ago, he was in the middle of his annual winter migration to Padre Island in south Texas when he began hearing the voices. He had been off his meds for a month. He drank and toked the voices into submission. He was arrested because he called 9-1-1 three times when the minutes ran out on his "Obama" phone. The third time he asked the dispatcher what color her panties were. He spent 3 weeks in the local mental health facility*.

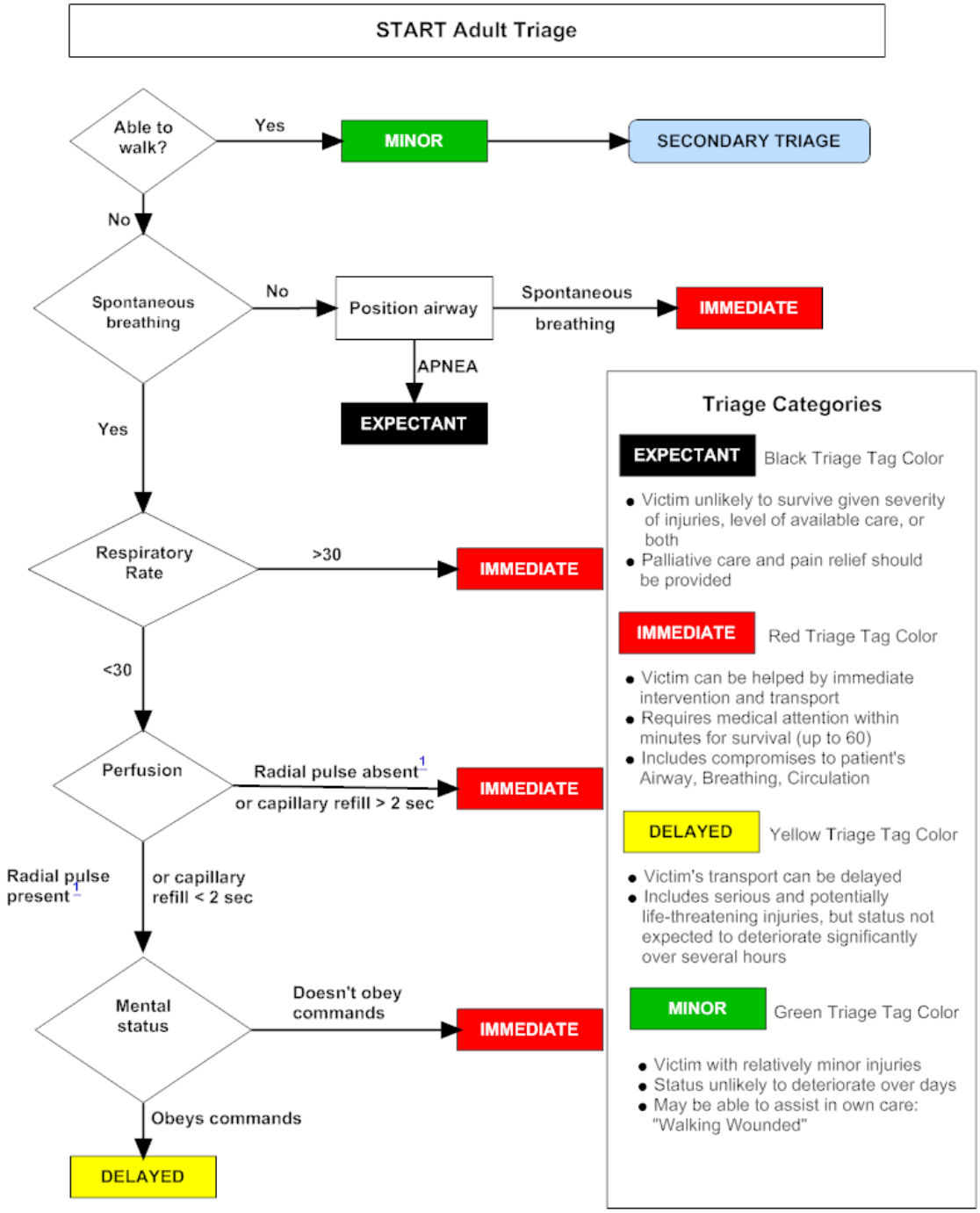
My brother could not explain his erratic behavior. One element in understanding mental health is taking time to listen to the narratives. In the case of my brother, the police did not want to listen to his story. They did not know he been off his medication for a month. If they had known he uses drugs and alcohol to stop the voices in his head, how would the conversation have changed that night? It seems there was, as Captain in Cool Hand Luke says to the prisoners, "a failure to communicate." This failure happens too

often when people with mental illness are involved. What tools can communication scholars offer to help?

Communication as a START toward a holistic communication model

In 1999, Robert Craig argued communication lacked coherency as a field. To become legitimate as a discipline, he posited, "an academic discipline (needs) to establish its social relevance by showing that it has something interesting to say about culturally salient themes and practical problems." (Craig, 1999, p. 131). One challenge in becoming relevant is "social-scientific theories traditionally have been designed to provide generalizable, empirically testable explanations that enable prediction and control of phenomena." (Barge & Craig, 2004, p. 131). Communication is unpredictable and uncontrolled chiefly because people are involved. Communication scholars need "to include developing self-awareness and the capacity to listen to the whole body, as well learning a range of practices that evoke effective conversational patterns." (Parrish-Sprowl, 2014, p. 212). Communication is uniquely positioned to explore mental health.

I began my Emergency Medical Services career as an EMT in 1997. Two years later I began paramedic school, which is an intense two-year study of human systems, disease etiologies, interventions, and patient management skills. We learned signs and symptoms of diseases. We were taught to ask specific, directed questions to find underlying issues for quick treatment. The final five months were devoted to trauma with two weeks devoted to mass casualty incident (MCI) management. Mass casualty incidents occur when the number and severity of casualties overwhelm the personnel and resources at any scene. We learned the Simple Triage And Rapid Treatment (START) method (see Appendix E), which was developed by Newport Fire Department and Hoag Hospital in 1982. START was revised by Benson, Koenig, Schultz (1996) refined the process so EMS personnel could assess and classify a single patient within 15 seconds based on spontaneous breathing, respiratory rate, perfusion, and mentation. We did drill after drill to hone our skills so if ever needed we could function properly. The algorithm is illustrated in Picture 1.2; a detailed explanation is provided in Appendix E. Using the START method, EMS quickly determine patient treatment priority. How does the START method fit within a communication discussion?



Picture 1.2 START Adult Triage Algorithm, courtesy of Los Angeles Fire Dept

It is impossible to separate paramedic as the knowledge and experiences are etched in my mind. When I left EMS in 2011, I lacked a theoretical framing to make sense of the

experience. I put paramedic Aaron in the waiting room and began learning communication. Much like my medic classes, each COMM class added to my foundation. The clinician had to learn how to be a researcher. Health Communication allowed me to combine clinical practice and communication theories. As a paramedic, I followed a biomedical approach. In my Fall 2015 COMM 510 Patient-Provider Communication class, Dr. Maria Brann explained the underlying ideas of the biomedical model are:

- All health is physical (explain, identify, and treat with physical means).
- Separation of the mind and body
- Focus on pathology
- Causal explanations for abnormal pathology
- Focused and specific; efficient and definitive
- Talk focuses on physical signs of illness (patient does little talk)

In practice and function, the biomedical model is cybernetics. Cybernetics, like START, eliminates outside influences to see a better picture of the event. In early experiments, Ashby used a homeostat in his experiments to create a stabilized environment is systems. The homeostat recognized when a system was out of order and would reconfigure until the system came back to order (Pickering, 2002). The idea is that systems want to be stable. People may not tolerate dissonance or instability eventually seeking a course correction. Cybernetics is "the study of control and communication in the animal and the machine." (Wiener, 1948, p. 112). In extending this to communication, Wiener believed that a person could communicate with a person of an unknown language by being "alert to those moments of interest and discover the language" (Wiener 1965, p. 157) through observation. Wiener denies Ashby's homeostatic idea by using the gameplay in Monopoly where a person may "get along" with others while secretly plotting to backstab his alliance to win the game. Thus, the systemic approach of cybernetics is doomed from the start as it ignores the simplest element- emotions.

A cybernetic approach is useful when the communication chain or system is being examined. The clinicalized and systematic reduction to the simplest parts makes cybernetics a good start to "fix" problems, especially in health communication. For example, many EMS companies have an unspoken feud between dispatch and the ground units. Crews think dispatchers play favorites and give "junk" calls to crews who have upset them. Cybernetics allows the researcher to see HOW each group operates as an independently dependent part within the larger system. Once the differences are found, the

researcher would be able to pinpoint areas of conflict and help administrators make corrections.

The quantitative nature of cybernetics could miss the humanity within the communicative act. It is a sterile and clinical consideration. Cybernetics does not account that "the listener determines the meaning of an utterance, and the listener's past lived experience is a major contributor to this meaning; thus, the listener's context is also of interest" (Baron, 2016, p. 93). In other words, the meaning-making process is left out (Craig, 1999). Cybernetics considers emotions as ancillary rather than driving in communication. This is the downside of cybernetics; its observational outward look does not account for the inner facing emotions and motives. Thus, the emotions, which are ignored by the cybernetic tradition, could lead to an incorrect analysis of the communication episode resulting in a response leading that causes a breakdown in communication (Bateson, Jackson, Haley & Weakland, 1956). As a tradition, it is useful, then, for organizational studies in communication but not to correct a patient-provider issue. Cybernetics can be useful to find disease etiologies, however, without emotional input as shown in the WHO definition is incomplete. A combination of other communication traditions for better holistic discussion of mental health.

I have taught the basic public speaking course for institutions in Tyler (Texas), Indianapolis (Indiana), and, now, Victoria (Texas). Each institution had different student populations. I realized the power in understanding the audience to construct appealing messages. This comes from a careful study of the demographics of the audience. Knowing the age, race, sex, gender, orientation, religion, etc. helps me create a better message. However, demographics is not enough. The rhetor must know the psychographics of the audience. These can be best summed as building-blocked ideas- beliefs, attitudes, values, and actions. Beliefs are, according to the dictionary.com, an acceptance that something is true regardless of information to confirm or rebut. When people believe, they develop an attitude which is "a settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behavior" (dictionary.com). This attitude then creates the value or worth they place on what is being said. The combination of attitude and values leads people to act. When a rhetor can determine the current actions of a group, he can backtrack to understand the underlying beliefs, attitudes, and values. Once the

demographics and psychographics have been determined, the rhetor begins to craft the message with the best combination of ethos, logos, and pathos to influence the audience.

Rhetoric examines the use of words to influence people. In ancient times, Aristotle wanted to understand how words could persuade people to action. Aristotle took what her learned from Plato and applied his scientific training to create a system to categorize objectively the various facets of rhetoric in an antiseptic way, much like cybernetics. Aristotle taught the Canon would allow the speaker to create the best speech to influence an audience. Additionally, the speaker must employ *ethos, logos, and pathos* to further the persuasion. While audience centered in the invention stage, classic rhetoric has a unidirectional message idea without consideration of audience feedback.

Rhetoric omits a discussion of audience agency. If does give a cursory nod to some sociality, it ignores the social structures that prevent message reception and adaptation. It is a sterile and emotionless study of the message. Thus, messages, even though artfully created, may miss the audience completely simply because audience members may not have $100 to pay for the medication that would save their lives.

Rhetoric examines artifacts to see how they inspire/persuade/influence others. After finding the meaning, rhetoric seeks to employ the best methods to create and deploy that message a health rhetorical scholar would consider which words would be useful in creating the best messages to advocate change in a society. The rhetor ~~understands~~ enhances the power of words to ~~increase~~ amplify personal credibility and reception with the audience.

The question is how is rhetoric useful in health communication? Scholars can push messages forward for public inquiry and deliberation. By doing this, they can refine messages to meet the collective audience better. Rhetoric allows a foregrounding of exigent causes of the day, whether it is the 1980s AIDS epidemic or the 2016 Zika virus outbreak. Rhetoric is formulaic and has not changed much since antiquity. By following the same pattern for creation and analysis, the scientific art evaluates the art of discourse. While message creation and delivery are fundamental to rhetoric; the utility to a health communication scholar comes from analysis of message after deployment. Researchers want to know if the messages have created the desired actions in the audience.

Both cybernetics and rhetoric have useful tools to begin an understanding of health communication. The analytic side of cybernetics to understand the systems and structures in society; rhetoric is useful for message creation and analysis. However, these traditions are alexithymic in nature. "Alexithymia is a construct useful for characterizing patients who seem not to understand the feelings they obviously experience, patients who seem to lack the words to describe these feelings to others" (Muller 2000, 1). In other words, the person has difficult with emotions and tend to suppress those emotions (Taylor, 1984; Wastell, 2002). People, or approaches in this case, with alexithymia have difficulty recognizing emotions in real-time and due to being externally oriented, are robots like the Tin Man in The Wizard of Oz (Thompson, 2009). These approaches lack humanity and an understanding of cultural implications. Thus, the biomedical approach lacks legs to address mental health effectively. One needs to find a more capable grounding to START assessing EMS communication.

Intercultural Understanding

To become an effective health communication scholar, one must observe peoples, surroundings, and circumstances, to understand the beliefs, attitudes, values, and actions of a group (Haring, 1949). This psychographics of a culture, discussed previously, are basis for the "knowledge, belief, arts, morals, law, custom, and any other capabilities and habits acquired by man as a member of society." (Tylor, 1891, p. 1). Hofstede (1984) expanded this definition of culture; he says culture is:

> The collective programming of the mind which distinguishes the members of one group or society from those of another. Culture consists of the patterns of thinking that parents **transfer** to their children, teachers to their students, friends to their friends, leaders to their followers, and followers to their leaders. Culture is reflected in the meanings people attach to various aspects of life; their way of looking at the world and their role in it; in their values, that is, in what they consider as "good" and as "evil"; in their collective beliefs, what they consider as "true" and as "false"; in their artistic expressions, what they consider as "beautiful" and as "ugly". Culture, although basically reside in people's minds, becomes crystallized in the institutions and tangible products of a society, which reinforce the mental programmes (sic) in their turn. (p. 82)

Hofstede's adding of "transfer of information" makes cybernetics useful as one can then trace transmission sources. Sociocultural goes beyond identification and categorization in a culture. "Conflicts, misunderstandings, and difficulties in coordination increase when

social conditions afford a scarcity of shared rituals, rules, and expectations among members" (Craig, 1999, 145). People exist in a society of other peoples.

Health communication cannot ignore the others surrounding the target audience and accept their help in persuading or dissuading action in health messages. It is through understanding how societal structures influence its members to think and act. This is where the combination of sociology AND culture have the power in health communication. Of the sociocultural communication tradition, Craig (1999) states:

> Communication in these traditions is typically theorized as a symbolic process that produces and reproduces shared sociocultural patterns. So conceived, communication explains how social order (a macrolevel phenomenon) is created, realized, sustained, and transformed in microlevel interaction processes. We exist in a sociocultural environment that is **constituted and maintained** in large part by symbolic codes and media of communication (p. 144).

The key word here is the idea that the environment is created for and maintained by the masses. The reason is that "culture is learned through interactions… It usually is not consciously taught, or consciously learned. That is why it seems so natural and effortless." (Nieto, 2008, p. 138). It is how communication traditions work together. Thus, I can use parts of cybernetics and rhetoric to better understand how people communicate collectively about societal issues. However, people maintain individuality and personal responsibility within the sociocultural tradition. Consider the following:

> Sociocultural theory challenges our tendencies to take for granted the absolute reality of our own and others' personal identities, to think of social institutions as if they were inevitable natural phenomena, to be ethnocentric or insensitive to cultural differences, and to overattribute moral responsibility to individuals for problems, like poverty and crime, that are largely societal in origin. (Craig, 1998, p. 146).

The sociocultural tradition offers keen insights into the human condition not found in other traditions. Health communicators wanting to induce change must find the society while regarding individuality… except… something is missing in communication traditions.

Communication Complex as a Holistic Answer

Many communication traditions, especially cybernetics and rhetoric, rely on the transmission model, or Sender-Message-Receiver, of communication. This over simplistic views do not account for things beyond the surface. As shown, the human condition is

quite complex needing more examination beyond SMR. "Moving from a communication simple to a Communication Complex (CC) approach opens our thinking to strategic and programmatic possibilities that place public health professionals in a better position to meet the challenges faced around the world." (Parrish-Sprowl, 2013, p.3) While other frameworks are available, CC provides a different insight into how, why, and where communication takes place. CC is complexly simple. Communication is the root of the entire experience and interaction with other disciplines (e.g. sociology, psychology, interpersonal neurobiology, physics, creative writing) added to understand the contexts in EMS communication. Thus, Communication Complex MUST be the foundation for this dissertation.

Due to the nature of the occupation, Emergency Medical Service personnel (EMS) are exposed to critical incidents at greater rates than other medical professionals (Beaton, 1998; Regehr, Goldberg, Glancy & Knott, 2002). These critical incidents "surpass normal coping methods or (are) cases charged with emotion" (Donnelly & Bennett 2014, p. 1). Some common examples of critical incidents are CPR on adult or pediatric patients, mass casualty incidents (4 or more patients), and motor vehicle collisions where patient(s) have multi-system trauma. After these critical calls, EMS personnel have multiple conversations with themselves (interpersonally) and other EMS personnel (interpersonally) (Parrish-Sprowl, 2014). These internal and external conversations create emotions and emotional states in people that is unacceptable (Parrish-Sprowl, 2013). These are called perturbations within and must be resolved to keep positive mental health.

One cultural way EMS personnel deal with these perturbations is through storytelling. It is through the humorously strange and dark tales noobie EMTs are indoctrinated and taught new medics the hidden cultural norms of paramedicine (Kuiper, 2012; Rowe and Regehr, 2010, Tangherlini, 2000). The EMS culture is within yet without the medical culture (Deason, 2014). Fortunately, "Communication Complex shifts our attention to the pattern that is created when people talk. The pattern offers a much richer unit of analysis for improving communication. We become more interested in what people are creating together than in what each person is doing" (Parrish-Sprowl, 2013, p 5). The social constructionist nature of CC allows the scholar to delve deeper into the enacted communication of EMS personnel storytelling and how that act shapes the interaction.

From a neurobiological perspective, the brain relies on neural inputs to make sense of reality around it. The brain "is polysensory (in that) all our sense receptors translate different kinds of energy from the external world, no matter what the source, into electrical patterns that are sent down our nerves" (Doidge, 2007, 18). Our senses, then, are directly linked to the neural networks in the brain. Furthermore, the neural coding that occurs in these neural networks allows the brain to interact with the present environment at the same time the environment is interacting with the senses (Northoff, 2010). The brain obtains and processes information while simultaneously creating new neural pathways. This consciousness occurs when something is experienced through the senses, and a neural network is established (Wendt, 2015). Thus, pathophysiology becomes intricately ingrained in the communicative act.

The idea of senses creating neural pathways in intrinsic to emotion recall and creation of cultural identity. The brain is not linear as neural pathways link to different memories created through an interaction process. This process creates a "temporal non-locality (where) correlations can occur between events separated in time" (Wendt, 2015, p. 54). In simpler terms, the brain links senses to past events. For example, a person smells a certain perfume and remembers his long-deceased grandmother. In that moment, he is transported back to her kitchen 50 years earlier. He experiences total recall of events of that happy time in his childhood. "What we do in the present is instantly correlated with what happened in our past" (Wendt, 2015, p. 56). Thus, to our point of temporal non-locality and emotional recall, the person is experiencing the smell TODAY yet remembering the smell 50 years prior. It is this ability to cross years instantly that allows for present manipulation of reality while adhering to the social stability of by gone times. Time is not measured in segments or episodes; rather, "our awareness of temporal unfolding is on terms of its various rhythms. We have complexity rather than multiplicity where our experience of durance has no identifiable backward boundary" (Moore, 1996, p. 65). In other words, time is a social construction we use to understand our current reality, which changes with each experience and memory.

One might think a discussion of time/place/space is "hokey" or useless. Many communication scholars and mental health people forget that context matters (Parrish-Sprowl, 2013). What, when, where, and how a sense is actuated directly effects

communication, behavior, feelings, etc. in the present conversations. The idea that senses can transport is reflected in popular culture in songs, movies, and television shows. In 2015, Twenty-One Pilots released *Stressed Out.* Selling over 2.5 million copies and hitting number 1 on radio charts across the globe, it discusses the challenges of transitioning from youth to adulthood. They wrote:

> Sometimes a certain smell will take me back to when I was young
> How come I'm never able to identify where it's coming from
> I'd make a candle out of it if I ever found it

The singers, like many people, experience a trigger, but cannot identify the source. The scene plays out in the mind even though the exact first experience may never be replicated as the context changes through each subsequent exposure or memory. Each thought, then, becomes a part of the communication act. It is through these experiences individuals form relational patterns where "multiple conversations shape and are shaped by the actions of themselves and others" (Parrish-Sprowl, 2014, p. 212) irrelevant of time and place. The brain, then, changes its structure with each interaction (Doidge, 2007). With CC, attention is shifted "to the pattern that is created when people talk" (Parrish-Sprowl, 2013, p. 4). The shifting patterns inherently shape social order, but it not so much about the social order as it is the meanings created in the communicative act.

Communication Complex looks at the interactions creating society. CC's quantum framework allows actions and conversations to become part of transmittable/transferable social reality. While this seems like Symbolic Convergence, it is different as the communication acts define society. The social construction inherent in Communication Complex allows interpersonal neurobiology to insert itself into the context of the communicative act and the resulting interaction without interference. Communication becomes a biological function…even instinctive? Consider this, "only about 5% of our life is run with our conscious creative mind, while 95% of our life is actually coming from the programs in the subconscious mind." (Lipton & Buczynski, n.d. p. 19). Daily communication runs as a background program processing data twenty-four hour per day. CC looks for outward manifestations of the subconscious that express themselves in conversations. Thus, memories become communication to self…then others as told in stories, which then change the brain which shapes communication with self…then others

when told in stories, which then change the brain… in a never-ending loop. With this perspective, communication becomes an exciting forensic excursion into self!

Detractors would argue the underlying sociocultural rules and actions in real life can be best perceived and interpreted through their respective traditions. Of course, there is so much conflict between the traditions that "communication theory, in all likelihood, will never achieve a final, unified form" (Craig, 1998, p. 123). What this means is the health communication scholar has a HUGE toolbox of toys to play with. Phenomenology asserts communication comes from interaction with others. However, it fails to realize our understanding is shaped by constant communication interpersonally and interpersonally (i.e. Consciously and subconsciously). Human relationships need not be authentic to perpetuate societal learning. Think about how you felt when… (*spoiler alert)* … you found out Darth Vader was Luke's Father? "No matter how fantastical, extraordinary and imaginary the characters, the situations and the stories that people engage with are, the impact of these fictional experiences can be extremely relevant for people's daily life." (Schiavone, Reijnders, & Boross, 2019, p. 131). Thus, even fictive parasocial interactions are woven into our current social reality, which can change a culture. The sociopsychological traditions downplays sociocultural theory as flighty and untestable. Those scholars are correct, but, then again, society is in constant flux and recreation of new social order with each interaction. In other words, even though there is a tinge of psychology behind each communication act, the act itself is for order and mean-making. To make progress, we cannot rely on past traditions. We must "create new traditions of communication theory and new ways of schematizing the field; and apply communication theory by engaging it with practical metadiscourse on communication problems" (Craig, 1998, p. 149).

Intrapersonal narratives are possible through the idea of imagined interactions. Imagined Interactions (II) refer to a process of social cognition that allows actors to imagine themselves in anticipated or recently experienced interaction with others (Honeycutt, Zagacki, & Edwards, 1989). IIs allow people to identify self and others involved in the communication act. Whether the person(s) involved in the actual conversation exist in reality or in imagination is inconsequential. The point of II is to use its core tenets to have communication interactions with other people, whoever they may

be. While the actor is the director and producer of these scenes, the key point is that a narrative is taking place. The ability to self-produce and self-edit the inner narrative can help a person who lacks functional ability in understanding reality begin the process to create what is real (Honeycutt & Ford, 1999). In other words, people play out in their minds to prepare for upcoming conversations with real people (Honeycutt, 1990). While all evidence is anecdotal and not empirically supported, it is reasonable to assume that due to stigma, people with a hidden mental illness might turn to II to cope.

The more complete narrative includes verbal, nonverbal, and intrapersonal thoughts for each person in a communicative act. The chosen words reflect an emotional state, or lack thereof, for each person. Nonverbal provides information through visual or auditory clues (e.g., shrugged shoulders, sighing, shaking head, etc.). Knowing the intrapersonal communication leads to a richer understanding of the parties in the communication act. Imagine being able to see a bubble pop out above someone revealing their inner thoughts? While this could be humorous at times, the conversation would shift with each bubble. Narratives can take any form- spoken, written, or intrapersonal.

The actual conversation is inconsequential when viewed in quantum physics, which allows things to exist in the mind regardless of time and place. This exists due to the human ability to move across "temporal distances and space" such as done during imagined interactions (Wendt, 2015, 129). This is possible due to the senses, which create neural pathways in the brain for easier future recall. The mind operates all hours of the day to make sense of raw data collected by the senses. This information is transferred to long-term memory implicitly or explicitly. Implicit memories are usually nonconscious and related to sensory-laden emotions (Hall, 1998). One example would be a person smelling cinnamon and being transported, in the mind, to a time 50 years previously when he was six and eating fresh cinnamon rolls made by his long-deceased grandmother. Thus, people can interact with situations days, months, and even years later as if the event occurred in the present moment.

"We become more interested in what people are creating together than in what each person is doing. This approach shifts the focus to patterns of interaction, their impact on the embodied brain, and offers differing notions regarding how we might address the issue" (Parrish-Sprowl, 2013, p 265). Communication complex applies to all conversations, real

or otherwise. By looking at the patterns of speech, one can find the interaction pattern and understand the communication process through the narrative produced. This is useful in mentally ill patients who may have lucid and non-lucid moments. The combination of both provide a better insight into the overall condition.

The question, then, is of normalcy in the mentally ill patient. As with implicit memory, "definitions of normal and abnormal can be highly contingent on time and place. They can rise and fall depending on the historical moment or cultural setting" (Smoller, 2012, p. 27). For example, Victorian age doctors took a biomedical approach and looked only at physiological symptoms while disregarding textual writings of the afflicted (Cayleff, 1998). Thus, a doctor could not fully diagnose nor treat someone with mental illness because 1) they lacked the holistic and complete narrative of the illness provided through personal journals, etc., and 2) they held firm to the belief that a "woman's physiology enfeebled her nerves." (Cayleff, 1998, p. 1200). Thus, there is a need to explore those marginalized narratives to understand the hidden illness, even if the account may be fictionalized because, in the mind of the mentally ill, fiction is based on reality at times.

Metaphors are present are in words we say, words we write, songs we sing; and stories we narrate. Metaphors "allow us to comprehend one aspect of a concept in terms of another" (Lakoff & Johnson, 2008, p. 10). Metaphors are highly contextual and unique to person and place with meanings changing with every interaction. Thus, it becomes difficult to interpret metaphors in texts or spoken word due to implicit bias of the researcher's firsthand experiences. However, metaphors provide a baseline to understanding the thoughts and, by applying the ideas of quantum physics, allows movement back and forth in time/place to experience through the other. What must not be forgotten is "science and narrative, the quantitative and qualitative, are not competitors but represent a complementary duality, as intimately connected as the two sides of the cerebral cortex. Narrative preserves individuality, distinctiveness and context, whereas quantitative methods and evidence-based guidelines offer a solid foundation for what is reliably and generally correct" (Roberts, 2000, p. 440). Health Communication researchers, then, are armed to examine any form of communication, whether written, spoken, or in the mind only as imagination as interdisciplinary tools are employed.

Chapter Two: Communication and EMS Culture

In the previous chapter, there was a brief mention of the need for cultural understanding in communication research. This chapter has a deeper exploration of culture and communication. A discussion of culture is warranted in the literature review to understand EMS and its place in the larger medical sphere. There are cursory descriptions in previous literature; however, there is no deep exploration nor discussion of EMS culture. First, culture will be defined. Next, Emergency Medical Service history, training, and traditions are discussed. Finally, I will discuss how communication shapes the culture of EMS.

Communication offers a unique forum for cultural studies as all people communicate. There are divers ways in which people communicate. Understanding communicative acts and patterns is incumbent to avoid ending up in the tribal stew pot like in the old Bugs Bunny cartoons. To avoid the pot, communication researchers need to explore how, where, what, and why people communicate offers in a culture. In the late 1960s and early 1970s, Gerry Philipsen interviewed people in a Chicago neighborhood. He proposed that each culture has distinct socially constructed communication patterns (Philipsen, 1975). This makes sense as culture is a “complex whole which includes knowledge, belief, arts, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.” (Tylor (1871, p. 1). Hofstede (1984) offered an expanded definition when he wrote:

> Culture consists of the patterns of thinking that parents transfer to their children, teachers to their students, friends to their friends, leaders to their followers, and followers to their leaders. Culture is reflected in the meanings people attach to various aspects of life; their way of looking at the world and their role in it; in their values, that is, in what they consider as "good" and as "evil"; in their collective beliefs, what they consider as "true" and as "false"; in their artistic expressions, what they consider as "beautiful" and as "ugly". Culture, although basically resident in people's minds, becomes crystallized in the institutions and tangible products of a society, which reinforce the mental programmes (sic) in their turn. (p. 82)

After World War II, American businesses desired international expansion into Japan, China, and other Eastern nations. These companies wanted to understand business practices and cultures to effectively expand into those foreign markets. Since limited cultural studies existed, sociologists were sent and found “cultural differences in matters

concerning the language of time, of space, of material possessions, of friendship patterns, and of agreements" (Hall, 1960, p. 88). At the time, this was groundbreaking research, except the broad generalized classifications and categories of these studies lead to stereotyping of the new cultures for years to come.

Normally, one would avoid stereotyping; however, it serves a purpose during initial exploration when properly applied. Norberg and Isaksson (2010) explained further:

> Stereotypes are a starting point. If not used, the time to know a person (or culture) could takes longer. In order to avoid forming of prejudice new facts should be noted and should permit to change first impressions. The crucial thing is not to condemn people; not to have prejudices, but instead to be well informed. (p. 101)

Stereotyping allows for a quicker understanding of the subjects to reach a base description of a culture. Once in the field, communication researchers begin to: 1) observe the social interactions (i.e. spoken words, public performances, private conversations), and 2) classify those interactions to understand the culture (Haring, 1949). Observation combined with prior research, researchers can then "take into account the social meaning of differences between people in terms normative and behavioural (sic) content of their actions" (Oakes, 1996, p.102). In the end, stereotypes are replaced by data. From these initial assumptions, researchers more ably navigate the shallow cultural shores understanding deepness lies in the vastness of the limnological ecology. In other words, one begins to swim away from shore and dive deeper into the cultural ocean.

This study offers a unique perspective different from other EMS studies. Unlike researchers who lack funding to spend the months/years in a culture, I am a participant observer who worked in EMS from 1997-2011. I participated in the customs, rituals, and practices. This is far different than a researcher who spent three months reading literature then rode with an EMS crew for two weeks. This is my feeble attempt to emulate Philipsen's Teamsterville.

EMS as a subculture in Medicine

It is not a stretch to claim the medical culture is learned. Medical professionals (i.e., doctors, nurses, and EMS personnel) are taught in classrooms and clinical settings. Basic skills (e.g.- patient assessment, vital signs, personal protective equipment, CPR) and advanced skills (e.g.- aseptic IV techniques, intubation, Advanced Cardiac Life Support)

are the same across the medical profession. Beyond skills, doctors, nurses, and EMS personnel share a first language, which allows for coordinated patient care. This common language includes anatomy (e.g. clavicle, femur, dorsal, caudal), skills (e.g. Intravenous therapy, intubation, defibrillation), or signs/symptoms/conditions (e.g. Hypoxia, cerebrovascular accident, arrythmia). There are many other similarities between the different disciplines within the medical profession; however, subcultures emerge as the scopes of practice, workplace environments, and skill sets are compared.

As studies in EMS culture are limited, this study will combine elements of previous cultural studies by Hofstede and Nieto. Geert Hofstede, Professor Emeritus of Organizational Anthropology, and International Management at Maastricht University in the Netherlands is well known for his intercultural exploration of groups and organizations. In the 1970s, Hofstede collected data from over 100,000 surveys from IBM international employees. While analyzing this data, Hofstede noticed patterns of socialization skills across the data set. He proposed learning is subconscious and occurs at a collective level, which is:

> The collective programming of the mind which distinguishes the members of one group or society from those of another. The collective level is where most or all of our mental programming is learned, which is already shown by the fact that we share it with people who went through the same learning process but do not have the same genes. (18)

In other words, this level is where most people in a culture have the most in common. Hofstede (1984) used Individualism, Power Distance, and Uncertainty Avoidance as key points when defining a culture.

Individualism vs Collectivism is the degree to which a person in culture takes care of himself and his family first before others. The opposite would be putting the needs of others first. For our study, we will examine how paramedics achieves one, both, or neither in their lives.

Power Distance measures the degree to which inequality exists in a society between wealth and power, and how the members of that society accept the inequality. Power explores layers of hierarchy and how those levels interact with those above/below it.

Uncertainty Avoidance describes the comfort of members of the society have with uncertainty and ambiguity, and how members of that society create ways to deal with it

(i.e. - laws, stories, etc.). One consideration is how EMS personnel deal with uncertain situations encountered at work.

Nieto (2008) concluded that culture "is a human creation" (127) being "dynamic; multifaceted; embedded in context; influenced by social, economic, and political factors; created and socially constructed; learned; and dialectic" (Nieto, 2008, p. 130). The most pertinent for our study will be to look at the political and the learned factors within the paramedic culture.

Political factors influence culture by defining the hierarchies of power within the paramedic culture. These hierarchies affect the ability of paramedics to communicate and effectively perform the job. In 2009, the National Highway Traffic Safety Administration (NHTSA) "outlined the minimal terminal objectives for entry-level EMS personnel to achieve within the parameters outlined in the *National EMS Scope of Practice Model* "(1); however, each company can adapt the program to meet local needs. Thus, a State licensing agency controls what is taught, which directly effects paramedic cultural learning. The reason is because "culture is learned through interactions… It usually is not consciously taught, or consciously learned. That is why it seems so natural and effortless." (Nieto, 2008, p. 138). Thus, while the skills are taught in a classroom, we will look at learn the skills, values, rituals, and language of the culture through everyday practice.

History of EMS

The earliest known "paramedics" were of the Order of the Hospital of St. John of Jerusalem, which received "papal recognition as an order in 1113 by Pope Paschal II when the Order's Knight Hospitalers began aiding the pilgrims coming to Jerusalem" (Knight Hospitalers 2013, p. 2). The Order of St. John's was for the pilgrims. The Hospitalers provided care for thousands of people over the year. The Order continued and spread to Malta and Rhodes with the mission "to promote the relief of sickness and suffering without discrimination of race, gender, class, or creed in accordance with the second great principle of the Order, *Pro Utilitate Hominum* (For the Faith and In the Service of Humanity)" (Mission n.d.).

"Although modern EMS initially developed during Napoleon's time to aid injured soldiers, few major changes occurred in EMS until the 1960s." (Shah, 2006, p. 414). That is over 200 years!!! In 1966, National Academy of Science's report entitled *Accidental*

Death and Disability: The Neglected Disease of Modern Science (The White Paper), which "called for ambulance standards, State-level policies and regulations, and consistent ambulance services at the local level" (NHTSA 2009, p. 2). A few months later, the federal government stepped in to change the profession with the Highway Safety Act of 1966. Simpson (2013) states:

> Before the passage of the 1966 Highway Safety Act, ambulance service in America was disorganized and privately run; it varied widely in the quality of care provided en route to the hospital. Furthermore, the majority of mortician- and volunteer-run ambulance services in the United States had no uniform training standards for drivers or attendants" (p. 168).

For many rural communities, such as the one I grew up in, the funeral home operated ambulances frequently using the same units to transport deceased bodies to the funeral home. The point is that in the 1960s there was a lack or call for training for EMS. The changes in teaching did not begin large-scale until 1971 when the American Academy of Orthopedic Surgeons published *Emergency Care and Transportation of the Sick,* the first EMS textbook. (NHTSA 2009, p. 3). From this and other texts, civilians learn "how" to become EMS.

Organization Level in EMS

Some tenets of Structuration Theory (ST) relate to EMS on an organizational level. Poole and McPhee (2005) posited, "Structuration theory is the study of the system of *human practices"* (p. 174). The focus is on the observed practices within an organization-the meanings, the power, and the norms. In addition, ST allows consideration of time and space on the individual, group, organizational, and interorganizational levels simultaneously. In other words, a person may have multiple roles in and across the organizational spectrum. EMS personnel manage communicative acts on multiples level with each having a potentially different meaning. The bigger challenge is for the EMS personnel to navigate through all these correctly.

Training

In a letter to EMTs on their first day of class, Kelly Grayson, a 25-year EMS veteran, wrote:

> The reality of your profession isn't exciting rescues and cardiac arrest resuscitations twice a shift. Your reality will be dialysis transfers and people who can't poop. It will be toothaches at 3:00 a.m., and you'll have to

> maneuver your stretcher around five parked cars to get to the front door and weave your way through five able-bodied drivers to get to the patient with a complaint so minor you can't believe they called 911 for it. So why, if you're not going to save all that many lives, should you even bother? **You should bother because EMS is a calling. Even when you leave EMS, it never really leaves you**. (Grayson, 2018)

The current recommended skills and knowledge for EMTs and Paramedics are listed in the NHTSA's 2007 National EMS Scope of Practice Model. The reports states, "The Paramedic's scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies" (NHTSA 2007, p. 27). The paramedic student learns the skills and formal language of the paramedic culture in the classroom. The NHTSA 2009 standards call for extensive paramedic training to achieve "competency and knowledge in clinical behavior and judgments" (p. 7). The Texas Department of State Health Services is responsible for certifying paramedic education courses within the State of Texas. To become a Paramedic in Texas, one has completed a 140-hour EMT, a 160-hour EMT Intermediate, and finally, a 624-hour Paramedic course. (Texas Admin Code 157.32). Many local community colleges now offer an Associate of Applied Science in EMS, which takes six semesters to complete. The degree plan includes classes in patient assessment and airway management, emergency pharmacology, cardiology, medical emergencies, and 2 semesters of anatomy and physiology. (Tyler Junior College 2013). Paramedic must complete Advanced Cardiac Life Support (ACLS), Pre-Hospital Trauma (PHTLS), and Pediatric Advanced Life Support (PALS) or Pediatric Education for Pre-Hospital Providers (PEPP).

During the classroom phase, EMS learn patient assessment, diagnosing skills, treatment modalities, and advanced techniques, such as endotracheal intubation, intraosseous cannulation, and cardiac management. Margolis et al. (2009) concluded during the didactic phase "participants recognized that certification testing focuses on application, problem solving, and critical thinking rather than the simple recall of knowledge or information" (p. 509). The ability to "become involved in work that requires critical thinking and the ability to work without the guidance and direction of others" (Holborn, 2002, p. 90) that draws people to Emergency Medical Services. Hopefully, the training paramedics have a great preceptor who models the concept that "understanding

and managing the relational aspects of practice is directly linked to quality patient care." (Donelon, 2014, p. *xiv*). The goal of clinical to help EMS understand their place in the healthcare spectrum as an individual, as part of a crew/group, and as part of an EMS organization. Unfortunately, paramedics often fail to see their place within healthcare. This lack often causes conflict between paramedics and nurses. Owen, Hemming, and Brown (2009) found a lack of a common language as well as "a lack of awareness of each other's duties, responsibilities and problems" (p. 105).

Since paramedics will interact with nurses, it would be wise to teach how to EMS personnel how play in the hospital sandbox. The challenge is stopping the conflict before it starts. In other words, providers, whether paramedic or nurse, need to understand the other's role in healthcare. Hammond (2004) found, "Organizational factors, such as administrative segregation and differences in training, also contribute to the differences across the disciplines" (pp. 176). Montgomery (2005) stated:

> We have personal biases and attitudes that we have developed over the years. We have incorporated ideas, biases, and attitudes from our family, friends, teachers, and colleagues and have molded them into our own personal opinions, biases, and attitudes. As professionals, we need to be aware of these biases and attitudes and avoid letting them interfere with the development of positive home-school collaboration. (54)

It is through understanding the narratives discussed in Chapter 1 with the cultural studies discussed here that change can be made. This attempt is made during the didactic phase of learning the EMS practice.

The covert culture

While most calls are simple involving basic skills, instructors, who are practicing paramedics themselves, teach critical thinking skills and impart wisdom during the course. Beyond skills, they covertly indoctrinate students to EMS culture. I remember several tidbits of information from my own paramedic training. One instructor always said:

- There is a God, and you are not Him.
- Dead people do not breathe. Neither do dead cats.
- Kill Annie. Not the Mayor.

The "kill someone" reference should cause a flinch, but "killing" in EMS means someone dies who is having CPR performed on them. It does not matter whether case was futile at

the onset; it only matters that the paramedic was on the call. In the cultural vernacular, I killed many people during my career.

After completing the classroom portion, the EMS student "transfers the brain learning to the hands" (Personal interview with Frankie Jordan, 20-year Paramedic and my preceptor). During this phase, student paramedics ride along with field paramedics. The first step is learning the new EMS culture. The students have some clinical experience during the EMT training, but it does not expose the student to much beyond the basics. I started each preceptor shift the same as a normal day- wash the truck and count supplies. This is the introduction of the student into the new world. Of course, true to the paramedic hazing/practical joke tradition, I would always ask the student to find two fallopian tubes to put on the truck.

By doing this, I was issuing an invitation for the student to move from watcher to participant. The acculturation process occurs as first watching a new culture- the words, the relationships, the interactions- to classify and find meanings. (Haring, 1949). Fortunately, paramedic students have over 1000 clinical hours to hone their skills and learn the cultural norms of the paramedic world. I will use a few examples from my fourteen-year career as a paramedic to illustrate how there two skills are learned in the field.

I remember my first weekend of clinicals. I worked an overnight shift with an experienced medic. The first "rattle out of the box," or call, was a cardiac arrest. The medic began whooping and hollering, "Let's go get 'em boys! Bring 'em back from the jaws of death!" He then cranked up the radio to Mötley Crüe's "Shout at the Devil." Had I not had three years as an EMT, I might have been freaked out by this explosion of happiness over a pending death. On arrival, the medic let me "play." As I intubated the patient, the EMT connected the electrodes to the patient's chest. The monitor showed "V-fib," or ventricular fibrillation. I had just completed ACLS, so I knew the correct procedure, but I was a little scared. A normal person would advise to defibrillate. However, the medic shouted, "Light him up! Release the hounds of hell." I *lit him* (defibrillated at 200 joules), *shot the epi* (administered 1 mg epinephrine IV push), and, while the EMT began *pump and blow* (CPR), I *dropped the 7 at 21* (using direct visual laryngoscopy intubated the patient using a Mac 5 with the tube placed at 21 mm and verified breath sounds). We did a few more rounds of CPR, epi, and shocks before transporting the patient to the hospital.

Despite our efforts, the patient died. As we were cleaning our unit and preparing for the next call, the medic slaps me on the back and said, "Good job. But you killed him." This shocked me. I had never been accused of this before. I learned that "killing" is the medic terminology for someone who dies, even if the medic has no control over the situation medically. This is a brief example of some of the terminology a student must learn to make sense of the paramedic world.

Another shift, we were dispatched to a wreck. Enroute, we learned the car was on fire with the patient trapped inside. We arrived just before the fire department and watched the car burn. My preceptor handed me ammonia capsules and told me to hold them to my nose after the fire department doused the fire. We looked "look at the crispy critter." Somehow, by observing and smelling burnt flesh firsthand, I would learn how to be a better medic. After the call, we went to dinner at Kentucky Fried Chicken. This was my first introduction to true *gallows humor* (Kuipur 2012). "The function of humour in the emergency setting is to permit the individual to disengage from emotionally challenging emergency situations" (Scott, 2007, p. 353). This black humor not only serves to decrease psychological stress; it also increased social cohesion and support within the EMS community (Rowe & Regehr, 2010). The medic was modelling disconnection needed to function in the paramedic world. While these are my stories, it seems reasonable to assume countless student paramedics have had similar experiences of paramedic culture indoctrination.

The Written, Oral, and Mental Narratives

Narratives become important in the study of mental health in EMS populations. EMS personnel are a storytelling people, much like most people in high stress occupation (Tangherlini, 2000). After each call, EMS personnel complete a patient care report (PCR), where they document patient assessment, treatments given, procedures done, etc. EMS personnel use different memory types (i.e., individual, collaborative, professional) to construct the PCR (Angeli, 2015). EMS personnel **relive the call** at that moment. This bears repeating- THEY RELIVE THE CALL during the report writing process. They must work to make sense of the things they have experienced on the call.

The most common sense-making, sense-sharing tool is storytelling. Like medieval peoples who gathered round the bard as he told tales of other part of the kingdom, EMS

personnel talk relish in the non-isolated moments to share stories of slayed dragons their last meeting (Edwards, 2011). EMS personnel RELIVE THE CALL during these storytelling moments. The outward machismo hides the inward scared squire as emotion suppression is common in EMS personnel, which is an unhealthy coping mechanism to deal with the emotions inherent in the occupation.

Separating emotions allows EMS personnel to function professionally, but adversely affects other areas, such as interpersonal relationships if not checked (LeBlanc et al., 2011). The culturally induced maladaptive coping tool can lead to alexithymia, which is the inability to understand the connection between feelings and emotions. The outward orientation creates a robot with underlying emotions, but no constructive method to display them (Lanius, Paulsen & Corrigan, 2014; Thompson, 2009). Neurobiologically, the amygdala and hippocampal complex govern two independent memory systems that interact when emotion meets memory." (Phelps, 2004, p. 202). In other words, there is a wedge driven between and separating emotions from memories in the brain. The wedge grows over a career of repressed emotions. It is little wonder an estimated 35% of EMS personnel have undiagnosed alexithymia (Halpern, Maunder, Schwartz & Gurevich, 2012; Kirby, Shakespeare-Finch & Palk, 2011). As the alexithymia increases, alexithymics engage in increased risk-taking behaviors (Kano & Fukudo, 2013). Risk taking is associated with depression and PTSD.

As emotional suppression increases over the course of a career, interpersonal relationships suffer. Alexithymia could create a rift as EMS personnel do not understand the emotional state of their partners or themselves, which deepens the chasm. In most of these relationships, the partner is not in a high-stress occupation. The stress and emotions, while present in each, are different. It is difficult to compare a pizza delivery person not bringing extra parmesan cheese with his partner's stress and emotions after running a pediatric cardiac arrest. It is not that the partner does not want to understand, they simply cannot (Davidson & Moss, 2008). To explain, EMS personnel must RELIVE THE CALL.

#communicationfail

Communication as a discipline is woefully silent and underprepared to address many of the communication problems associated with mental health. Communication is descriptive in nature. The transmission framework makes communication quite

simple…too simple. In using this perspective, the researcher only has a few variables to consider- sender, message, and receiver. Channels, feedback, and noise were later added to the model. However, the transmission model deals only with the sending of the message. It seems descriptive and sterile. We look at what the speaker wore, how he spoke, how good were the visual aids, and more. A good example of the tradition is found in Cybernetics where the researcher looks to repair a broken system of communication rather than create a pristine environment.

If a communication problem arises, the act itself could be diagnosed and treated, much like EMS providing care for a person with exacerbation of Congestive Heart Failure. The transmission person assumes that the breakdown is in the line of communication or how the message is conveyed, which would lend itself to simple messages where meanings are not as important as the message. In other words, it is much like the algorithmic approach. A situation occurs, and a decision must be made- choose A or B- which leads to the next choice or so on. By analyzing each choice, we can create a better message.

An example would be in the case of a tornado. The senders need the receiver to clearly understand the impending danger and seek shelter. There is limited time for action. The message, "TORNADO coming. Seek shelter!!!", just needs to be delivered to the audience….no Canon needed. Find the best channels to reach the audience- radio, Facebook, text message, Twitter, television, telephone, "tele-woman," etc. and deliver the message.

The simplicity of the model shows it lacks the power to analyze the key component of human communication- the HUMAN. The transmission model looks at only one side of communication at a time expecting a solution from "fixing" the sender, the message, or the receiver without acknowledging that ALL may not understand each other at all. Here's the rub, Craig (1999) states:

> The constitutive model does not tell us what communication really is, but rather implies that communication can be constituted symbolically (in and through communication, of course) in many different ways. (p. 127)

Thus, a transmission model becomes a good starting point within the constitutive framework.

Once we go beyond the basics, we need to find the best ways to deliver the meaning of the message, which can only be delivered through constitutive framework. The earlier

example of the tornado warning would be, “Tornado coming is 5 miles from your house. Seek shelter NOW, or you will die!!!” If this weather person said this…I think most folks would listen as they understand the implications/meanings of the message and not want to die.

The benefit of the constitutive framework is the applicability to every realm of communication- rhetoric, socio-cultural, psycho-social, or critical cultural. Thus, the areas can and should “talk” with each other to increase the communicative effort. Another key element of the constitutive model is that communication is considered the cornerstone of sociality. The bonus is that we can use the transmission model within the constitutive framework without fear of encroachment.

#healthcommunicationWIN

It is only when communication scholars move beyond communication that communication can affect communication. In this, communication moves from descriptive and moves toward prescriptive. Communication becomes a part of the larger picture as health communicators “informed by the traditions of their field have opportunities to move beyond productive fragmentation and contribute something more to interdisciplinary studies.” (Craig, 1988, p. 153). As a health communicator, I am no longer stifled in the quest to understand mental health in EMS personnel. The interdisciplinary approach encourages this paramedic to combine his applied skills and communication theories with neurobiology, psychology, and sociology to find answers to mental health questions. Currently the health communication in mental health, especially emotions and PTSD in Emergency personnel, is barren as the Sahara Desert.

Health communication scholarship cannot reverse nor change mental health. However, through it a different conversation is started. This conversation allows for introduction of different disciplines using the Communication Complex model. Sociology would explore the societal structures (i.e., stigma, job-related emotional suppression) preventing access for EMS personnel. Another applicable frame is neurobiology where the memories, emotions, and thought influence mental health. Psychology allows the researcher to find the moments when/where stressors occurred and the responses to the stressors. The researcher has an objective and informed view of the mental health episode. Here in this moment, the researcher can understand the narrative told. It is through teaching

others how to find the hidden narrative that real and effective changes can be made through health communication. Hopefully, this will lots of money to taxpayers because my brother's medical team will be enabled to find the right combinations of messages and support structures to increase medication adherence, and thereby, decreasing his psychotic mental health crisis episodes.

Chapter Three: Trauma and Health Care Providers

He was a middle age male. He lived in a nice house in a good neighborhood with a smoking hot wife and adorable children. Although I did not know him personally, we had met once or twice at the local café as my partner and I were eating breakfast. Late one night, he decided to end it all. He called 9-1-1. Steeled by whiskey and pills, he placed a shotgun to his mouth… but flinched just as he pulled the trigger.

We smelled gun powder and pepper spray as we neared the door. We heard the deputies yelling, "Get down. Get down on the ground. Get down." He had been pepper sprayed 4 times without effect. He was running around the living room screaming and fighting the police. The room was a horror movie slaughterhouse scene. I felt a wet drop on my cheek when I entered the room. I looked up to see a splattered mass of hair, bone, and blood. He had blown off his bottom jaw. His tongue flapped loosely as bark-coughed and gagged on his own blood.

I was the biggest person in the room. I ran and tackled him. My skin and his melded together as he wiggled his blood-soaked body in my arms. Pepper spray infected my eyes. I was covered in a sloppy, wet mixture of blood and whiskey vomit with a dying man on top of me. Screeching… flapping arms… then moaning…. then whimpering as I bear-hugged him into unconsciousness so we could work to save his life.

I awoke panting, heart racing, and sweating. My wife said I was grunting and screaming in my sleep. On Sunday, July 23, 2017, I was transported back to late 1999…. he was sitting in my brain for 18 years waiting for the right time to visit. My head throbbed as I tried to make sense of what I seen, smelled, tasted, and felt in my dream.

Emergency Medical Service (EMS) personnel see critically ill, nearly dead, and dead bodies during their careers. The very nature of the job creates stress during calls and the waking nightmares triggered by a sense. Most stress ends when the call is over; the latter never ends.

With its start in health campaigns and messages, health communication has transformed into patient-provider communication, chronic illness, and interpersonal communication. Health Communication could offer a unique platform for researching and discussing mental health, but it does not. Health Communication, as a field, is only a few years old. Communication becomes holistic, complete and allows better understanding of the emotions in communication when biology, psychology, and other disciplines are added. One can explore the challenging aspects in EMS, such as suppressed emotions as a job-regulation function or job-culture (Deason, 2016). Unfortunately, health communication has added few publications in the emotional studies realm over the past ten years.

Communication Complex and Health Communication

Enter Communication Complex (CC) into the health communication research arena. Communication Complex is different from other communication research as it allows an interdisciplinary approach to the subject. CC relies on the idea of quantum consciousness, where "the brain is capable of sustaining coherent quantum states where consciousness is inherent in the very structure of matter" (Wendt, 2105, 92). This seems a strange start to communication. However, the transmission model is built upon the receiver receiving the message, which is sensory-related. Hearing cannot be all that happens in order communicate effectively.

One must, according to the HURIER model of listening, "recognize different barriers to listening and learning how to overcome each one to improve communication" (Brownell, 1987, p. 66). In this model, the receiver hears first then understands, remembers, interprets, and evaluates messages before respond. The polysensory, quantum mind processes the signal in nanoseconds by searching the subconscious memory and the active present environment for correlations (Doidge, 2007). This may explain why the words strike a chord and instantly trigger an emotional response without having direct meaning to the triggered experience. For example, a military veteran hears a loud bang, which startles him. He flashes back to the war and has an emotional meltdown. One would question if this is communication.

On the surface, it is not; the episode would fall into psychology or psychiatry. The idea that the brain is quantum means "what we do in the present is instantly correlated with what happened in the past" (Wendt, 2014, p. 56). The response required communication on the subconscious level. Thus, the normal means of communicating with self and others must change to effectively communicate with the incommunicable. Communicators need "to include developing self-awareness and the capacity to listen to the whole body, as well learning a range of practices that evoke effective conversational patterns." (Parrish-Sprowl, 2014, p. 212). This change calls for an interdisciplinary approach to break the barriers of the mind. The challenge in health communication is finding those scholars who speak more than one discipline fluently. By adding knowledge from other disciplines, we, as health communicators, can effectively study the communication act.

Of course, there is one more challenge to effectively studying communication, especially with the Emergency Medical Service population. It is the same challenge experienced by anthropologists- being an outsider. Even though they try to keep a neutral attitude, the researcher wrong conclusions may be reached about a culture, which may lead to negative stereotyping. Burtt (1968) believed it was "our underlying philosophical presuppositions" (p. 674) that prevent us from understanding another culture. Norberg and Isaksson (2010) concluded:

> Stereotypes are the starting point. If individuals do not use stereotyping, the time to know a person could takes longer. To avoid forming of prejudice new facts should be noted and should permit to change first impressions. The crucial thing is not to condemn people; not to have prejudices, but instead to be well informed. (p. 101)

Thus, stereotypes, when acknowledged, show the researcher where additional knowledge is needed to understand the culture.

Researcher within the Researched?

It is easy to say the EMS culture is learned. However, we must examine how it is learned. For this section, we will focus on paramedics as they have the highest training and, thus, the deepest roots into the EMS world. First, we will examine the classroom and laboratory experience before moving into what the paramedic learns while working the "streets."

Paramedic students learn the skills and formal language of the paramedic culture in the classroom. The 2009 National Highway Traffic Safety Administration EMS standards call for extensive paramedic training to achieve "competency and knowledge in clinical behavior and judgments" (p. 7). However, each state handles certifying paramedic education courses in their respective state. To become a Paramedic in Texas, one has completed a 140-hour EMT, a 160-hour EMT Intermediate, and finally, a 624-hour Paramedic course. (Texas Admin Code 157.32). The process takes around two years to complete, and if attending a college, the trainee completes an A.A.S in Paramedicine Science.

During this phase, EMS personnel learn patient assessment, diagnosing skills, treatment modalities, and advanced techniques, such as endotracheal intubation, intraosseous cannulation, and cardiac management. In the didactic phase "participants

recognized that certification testing focuses on application, problem solving, and critical thinking rather than the simple recall of knowledge or information" (Margolis et al., 2009, p. 509). Instructors, who are practicing EMS personnel themselves, teach these critical thinking skills and impart wisdom during the course. Beyond skills, they instruct covertly on how to become a paramedic. I remember several tidbits of information from my own paramedic training. Jimmy Hare, a 20-year veteran, and Jackie Peterson, a 20-year veteran, repeatedly told our paramedic class:

- There is a God, and you are not Him.
- Practice like it is real in here because it is easier to kill the manikin here in class than kill the mayor out there.
- Dead people do not breathe. Neither do dead cats. (I never understood the cat reference)

The callousness of the "kill someone" reference might confuse a non-native researcher, but "killing" in EMS means someone dies while in the care of the paramedic. It does not matter whether case was futile at the onset; it only matters that the paramedic was on the call. I killed many people during my career.

Once the student has completed the training, they must pass the National Registry Examination before actively practicing as Paramedic. The new medic is placed with a preceptor, who teaches the specific protocols of that EMS service. The preceptor teaches students "what the public expects of them. In other words, the preceptor allowed the study to exercise as a medic only stepping in when needed to prevent harm and let the student learn how to make the critical diagnostic skills needed for a career" (Gurchiek 2011, p. 127) Once this additional training period is over, medics are given their own trucks to operate and a crew to supervise.

To function properly within the medical community, a Paramedic must learn and use the formal medical mother language. These are the terms used universally among medical professionals in the United States to describe medical conditions, medications, treatment modalities, etc. Some examples are *dyspnea, bradycardia, Transient Ischemia Attack, COPD, rales, rhonchi, defibrillation, CPR, rocuronium,* and *albuterol.* This is not an all-inclusive listing of all the terms, a brief glimpse of the mother language the Paramedic employs in writing patient care reports and conversing with other medical professionals, such as nurses and doctors.

Beyond the medical language, the paramedic culture has its own language, which is the informal language learned from other EMS personnel during what Tangherlini (2000) calls "storytelling (by) medics (to) impose order on what are essentially unordered events" (p. 47). These sessions are spontaneous and occur any time two or more medics gather, which could be in the back of truck during truck check out in the morning or at midnight in the ER driveway after a bad call. It is during these storytelling sessions that EMS personnel engage in *gallows humor* (Rowe and Regehr, 2010; Kuiper, 2012). These sessions teach new EMS personnel the language of the paramedic.

EMS personnel employ colorful language outside of earshot of the patient and patient's family (*hopefully*). One of the most interesting subjects of conversation is death. Dead and dying patients are described as g*one to meet Jesus, cancel Christmas, FTD* (Fixing to Die), c*ircling the drain, no more birthdays, and gone to Chicago.* Burn victims became *crispy critters* or *fried okra.* The elderly nursing home transfer patients are *gomer totes* and *tater tots.* People suffering from breathing problems (i.e., COPD, emphysema, CHF) are *pink puffers* and *blue bloaters.* There are many more examples of the paramedic language; however, these show the backstage informal language of the EMS.

In addition to learning the language during these sessions, cultural taboos and superstitions are taught. There are only two taboo subjects no paramedic will make fun of or create obscene words about- pediatric death and child abuse. Violation of it results in instant rebuke from anyone overhearing and even ostracism for a while. Of the many superstitions, the one that most stands out is not saying "quiet." It is believed if the "q" word is spoken, all hell will break loose; so, any violation will result in a tongue-lashing from nearby co-workers. My preceptor told me, "Death comes in 3s." (Personal conversation with Frankie Jordan). I saw it come to fruition repeatedly over my career. There are myriad other superstitions in the culture, but these suffice to show the practice.

As shown, the EMS culture is bigger than a non-native researcher would expect. Once again, the health communication researcher may break down some of the walls to collect data, but the richness and depth of the data are lost. Thus, the correct interpretations lead to incorrect programs and messaging. This difference between this study is the researcher IS a paramedic and speaks the language.

Emotions are NOT good in EMS

As shown, EMS personnel are trained in many aspects of the job culturally. How do they learn to deal with the emotions of the call? To understand, we must discuss how they deal with uncertainty of the profession.

Uncertainty Avoidance. In the general population, people avoid situations that have potential to put them in harm's way. Paramedics are the same as the general population and do not like uncertainty. In EMS, avoiding harm to the medic is a top priority; however, due to the nature of the business, that is not always possible. Uncertainty is always present in the field on every call; however, paramedics can do things to lessen the uncertainty.

To reduce uncertainty anxiety, paramedics are creatures of habit. Every morning at shift change. Crews count every item in the truck from ice packs to bandages to IV catheters to ensure proper quantities on the unit. Equipment, such as glucometer, cardiac monitor, oxygen tanks, etc., is tested for functionality. Finally, unit fuel and fluid levels are checked. This routine reduces uncertainty and anxiety related to necessary supplies; however, the medic cannot control what happens on calls.

Not knowing what types of calls, one will encounter during the day creates anxiety in the paramedic. Some companies assign specific medical and trauma protocol to study each shift. Over 3-4 months, EMS personnel would review the 50-60 protocols. By knowing the proper protocols and treatment modalities, uncertainty was reduced because the response to the various etiologies and patient presentations became innate. However, the reduction in anxiety through constant hypervigilance and preparation creates a maladaptive hyperaroused state, which is discussed later.

The first thing I remember being taught in paramedic class was, "A dead paramedic is no good. Be safe." (Personal recollection of Jimmy Hare, Instructor). The admonition to be safe rings trues especially in emergency driving as "ambulances are far more likely to be involved in four-way intersection crashes, angled collisions, and collisions at traffic signals when compared with similar-sized vehicles" (Slattery & Silver, 2009, p. 291). Knowing this fact, paramedics are wary of all intersections, and, yes, sometimes, they will creep through a green light intersection for their own safety. Once on scene, the paramedic ensures the unit is parked for easy scene departure. While walking towards a scene/house, EMS crews constantly scan for hidden dangers that could harm them. These are the steps

a medic takes to reduce uncertainty. However, much like the drive to innately know the protocols, the constant hypervigilance creates a hyperaroused animal incapable of uncertainty reduction. This concept is discussed in Chapter 3.

Paramedics take equipment to the patient on every call to be prepared for a worst-case scenario on each call. For example, a simple "sick" call could be a cardiac arrest. This results in lugging heavy (50 extra of equipment) and often unneeded equipment, but from a personal experience when this scenario happened, it made the difference between life and death. By reducing uncertainty, EMS personnel can focus on patient care. But how does this constant vigilance and preparation affect emotions?

Emotions in EMS personnel. EMS personnel cannot control variables of a call. However, they incessantly work to control themselves and control their emotions. This fits within the Biomedical/Cybernetic practice of medicine discussed in the theory section. By removing humanity, EMS personnel focus on symptoms and begin treatment. All the preparation to reduce uncertainty pay off and emotions are repressed while providing patient care. This is possible through double-face emotion management where EMS personnel acknowledge, but quell, their internal emotions to provide patient care (Tracy, 1998). This is mandatory to treat patients and is learned as part of cultural indoctrination (LeBlanc et al., 2011). This job-learned emotional suppression could be a cause of alexithymia, which leads to increased incidents of PTSD.

Herein lies the power of health communication using Communication Complex. The researcher can explore the emotions that existed before, during, and after a call. By understanding the implicit and explicit demands of the EMS world, the health communication researcher can begin to link emotions and emotion regulation to possible Posttraumatic Stress Disorder (PTSD). The next section focuses on the history, diagnosis, and other factors of PTSD.

Posttraumatic Stress Disorder (PTSD)

As stated previously, Communication Complex allows for multiple approaches to understanding communication. The health communication scholar must be aware of possible diagnoses in their study populations. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5)* lists Posttraumatic Stress Disorder (PTSD) in the Trauma- and Stressor-related disorders section. Disorders in this section "include disorders

in which exposure to a traumatic or stressful even is listed explicitly as a diagnosis criterion" (APA 2013a, 265). However, PTSD was not always considered trauma related.

The "*DSM-II* contained no specific listing for a psychiatric disorder produced by combat because the writers had no first-hand experience with war neurosis" (Scott 1990, 297). Without a good diagnosis and understanding of trauma effects, psychiatrists simply told veterans to get over it. This may be one reason that 20 combats veterans commit suicide each day (Department of Veteran Affairs, 2016). It was not until the late 1970s when Shatan and others "worked consciously and deliberately" (Scott 1990, p. 308) to get PTSD placed in the *DSM-III* as a specific disorder. The addition of PTSD into the *DSM-III* was a start; however, patients were "required to have symptoms present for at least 30 days without clinically significant spontaneous recovery" (Marshall, Spitzer, & Liebowitz 1999, p. 1681). Still, PTSD was classified as anxiety. It was not until after 1993, when studies on combat veterans showed PTSD was trauma related versus fear or anxiety (Zimering, Caddell, Fairbank & Keane, 1993), that PTSD was moved from the anxiety in the *DSM-IV-TR* to its current place in *DSM-5*.

The *DSM-5* shifted its focus to the *why* instead of the what. The *DSM-5* "pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal." (APA 2013b, n.p.). With the focus change, clinicians could explore root causes, ongoing symptoms, AND coping mechanisms.

Diagnostic criteria of PTSD. With the change in focus, clinicians had more tools in understanding the process of PTSD. They realized that onset was not always immediate in nature. Thus, the American Psychiatric Association added three symptom types to the PTSD diagnosis, which, according to the *DSM-5* are acute, chronic, or delayed expression. *Acute* is for symptom duration of less than three months. *Chronic* is the specifier for symptoms lasting over three months. *Delayed expression* reflects psychiatrist "recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria" (APA 2013a, p. 276). The *DSM-5* recognized that after experiencing a traumatic event, John Q. Citizen could have resolving acute symptom, but then experience long-lasting effects starting 6 months or later after the event. This increased onset latitude in diagnosing creates a challenge for a clinician.

Even with the increase in symptom onset/duration criteria, the common component in any PTSD diagnosis is the person must have been exposed to a traumatic event (APA 2013a). The exposure may result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event.
- witnesses the traumatic event in person.
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental).
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic *event.* (APA 2013b, n.p.)

EMS personnel do not routinely see the exact moment when accidents occur. However, they do see the after-effects and witness critical patients become more unstable. The key to diagnosing PTSD in EMS personnel is the repeated exposure criteria.

Critical Incidents. These are calls that "surpass normal coping methods' or 'cases charged with emotion'" (Donnelly & Bennett, 2014, p. 1). These critical incidents are an accepted part of occupational hazards associated with EMS.

Repeated Exposure. EMS personnel experience trauma time-after-time over days, months, or years. Beaton (1998) found "77% of medics study had, in the previous six months, been exposed to a full-arrest CPR and 44% has witnessed a full-arrest CPR with family members present" (p. 824). Regehr et al (2002) found:

> **All the participants** indicated that that they had been exposed to at least one critical event on the job. These events included violence against themselves (69.8%), personal situations viewed as near death (55.8%), line-of-duty death of colleagues (27.9%), multiple casualties (90.7%), death of patients in their care (84.95%), and death of child (84.9%). (p. 995).

Through autoethnography, Deason (2014) and De La Garza (2011) showed how repeated exposure affected their Emergency Services career and their personal lives. Sides (2011) recounts the story of a first responder at a horrific plane crash site and how that episode affected his life. These three accounts represent the thousands of untold stories of exposures EMS personnel experience over a career. With that possibilities of exposure as shown above, one would think all EMS personnel would develop PTSD. Yet, Donnelly (2012) found only 6.4% of the 12,000 responders in her study experienced PTSD

symptoms, which she was surprised the number was so low. To understand why the report is low, one must understand PTSD.

PTSD Symptoms. The key to a correct diagnosis, as discussed in the previous section, is recurrent, involuntary symptoms over a course of time, whether days, months, or weeks after a traumatic exposure. EMS personnel have memories, dreams, or flashbacks where they live the calls repeatedly (APA 2013a). A flashback is:

> A type of memory that you experience as markedly different from those memories of the event that you can retrieve at will. The difference might be a marked sense of a reliving of the traumatic experience(s). Some report complete reliving, whereas others report more momentary or partial reliving of perhaps just one aspect of the original experience. For some, flashback memories take them by surprise or swamp their mind. Finally, some report a sense of time-distortion and, for example, react to the flashback memory as though it was an event that was happening in the present. (Hellawell & Brewin, 2002, p. 1150)

Flashbacks, it seems, reinforce the communication complex notions of time and space. As discussed in the mental health section, EMS personnel may develop alexithymia, which is an emotional disconnect leaving them unable to analyze emotions and feelings. Flashbacks are real in the mind, which means EMS personnel relive an experience which they cannot emotionally comprehend. Thus, EMS personnel could develop avoidance of the stimuli or dissociative amnesia about the event (APA 2013b). For example, on January 24, 2010, I was involved in an ambulance rollover. While not injured, I have limited recollection of event over the next two days. My wife has told about things I said or did during the three days off, but I cannot recall anything.

The final symptom category would be “alteration in arousal and reactivity, which include irritable behavior, reckless or destructive self-behavior, hypervigilance, and sleep disturbances (i.e. nightmares)” (APA 2013a, p. 272). Hypervigilance is manifest many times in the section about uncertainty reduction. It is through constant awareness EMS personnel work to control emotions. The most common reckless or destructive behavior in EMS populations is drug/alcohol abuse. Meyer et al. (2012) found a strong correlation between alcohol abuse and PTSD among firefighter populations. Extrapolated this finding makes sense in EMS population as both share similar high-stress ratings.

Stigma and PTSD. There are several instruments to establish if a provider has or is prone to PTSD. What they do not measure is EMS attitude about PTSD or mental illness. Many

EMS personnel fear being labelled, abandoned, or ostracized if they seek help (Marin, 2002). While I usually rely on firsthand experiences from my EMS career, I turn to an interview with two confidential EMS personnel, who asked to still be anonymous. Jack, an educator and 25-year Paramedic, and Jill, a 10-year veteran, both reacted negatively when I asked if they would want a partner that had been diagnosed with PTSD. Thus, a stigma, or "an attribute that is deeply discrediting" (Goffman, 1963, p. 13), is attached to PTSD. Knowing the outward expression of distrust and stigmatization from other EMS personnel, there is no reasonable chance that any EMS personnel diagnosed with PTSD would want to share their diagnosis. As shown earlier, this creates a world of loneliness interpersonally. Now, there is a potential for increased intrapersonal effects of PTSD as they internalize the negative belief resulting in self-stigmatization (Greene-Shortridge, Britt& Castro, 2007; Mishra, Goebert, Char, Dukes, & Ahmed, 2010). Ultimately, "the perception of stigma may serve to deter Medics from seeking treatment. Though Medics may have better access to care because of their proximity and relationships to health care resources and providers." (Chapman, 2014, p. 22). The EMS world is vicious and mean, which would account for such short career life.

What is a Health Communication Scholar to do?

Multiple Comprehensive searches of communication databases revealed no published communication studies combining EMS personnel AND help seeking, stigma, alexithymia, or PTSD. "Considering the overall prevalence of PTSD reported 20% in emergency work vs 5% in the general population, it is imperative to develop strategies to prevent and treat mental health problems" (Hegg et al, 2013, p.5). Invisible etiologies, such as suicidal ideation, or thinking of a detailed plan to commit suicide, have reached a critical level among EMS providers with 37% reporting suicide contemplation as well as 6.6% reporting suicide attempts (Newland et al, 2015; Nordqvist, 2016). Researchers have found a correlation between multiple exposure to suicides and increase suicidal ideation (van de Venne, Cerel, Moore & Maple, 2017). A six-year (2009-2015) retrospective study found EMS personnel have significantly higher suicides rates than the public (Vigil et al, 2019). This is unacceptable… and health communicators can make a difference.

Epilogue to a nightmare

I want the dream time nightmare machine to stop. I want the triggers that leave me crying in a puddled mess in my closet for days to stop. I want to stop and smell the roses without remembering the ejected passenger impaled on a fence next to rose bushes. I want to eat a juicy steak without remembering the man who choked to death on steak hours after he found out his aunt (the one I did CPR on) died. I want to hear the birds sing without remembering the man crushed to oblivion by a miscut tree his friend was felling. I want to be able to live like normal people- like people who do not want to end it all. I do not mind the memories. I do mind the control they have over me because I have no control of my mind. I want THAT world to stop controlling THIS world.

Chapter Four: Finding EMS Communication

> Today's paramedic must not only demonstrate extensive clinical knowledge and skills for paramedic practice, but must also demonstrate **professionalism** throughout their daily lives, both on and off duty. (Lloyd-Jones, 2014, p. 4)

Professionalism is a nebulous concept. Formally, Merriam-Webster defines professionalism as "the competence or skill expected of a professional." Lloyd-Jones's call for professionalism is one of the first lessons students learn as they work toward their Emergency Medical Service (EMS) certification. Scott Miles, a 20+ year paramedic and EMS instructor, defined professionalism in my paramedic class one day thusly, "Be nice to everyone. Don't kill the patient." The chasm in two definitions leaves one to wonder what EMS professionalism is.

The profession is taught in two phases- classroom and field work. First, instructors use the classroom phase to teach EMS personnel "critical thinking and to work without the guidance and direction of others" (Holborn, 2012, p. 90). Two common textbooks are Lloyd-Jones' 500-page *Fundamentals of Paramedic Practice: A Systems Approach* (2014) or the 1760-page *Mosby's Paramedic Textbook* (2014). Textbooks have chapters covering anatomy and physiology, pharmacology, patient assessment, medical emergencies, shock and trauma, etc. As discussed previously, this part of training requires two to four years as EMS personnel complete an Associate of Applied Science (AAS) or Bachelors in Paramedicine (BS). Beyond textbooks, EMS personnel receive specialized training, such as advanced cardiac life support (ACLS), pediatric advanced life support (PALS), advanced trauma life support (ATLS), and emergency vehicle operations (EVOC). After completing the classroom skills training of each certification level, EMS personnel are released to practice those skills in the field. EMTs practice basic skills; Advanced EMTs and Paramedics practice advanced skills. Both practice patient assessment, diagnosis, and treatment under the watchful eye of a preceptor. Calls are reviewed. Skills are reviewed. Everything is reviewed, except the much-needed ability "to recognize and discuss the emotion work inherent in their work and the signs and symptoms of stress" (Williams, 2013, p. 517). It is missing in the classroom (1000 hours) and in field preceptorship (600-800 hours). Thus, while many EMS personnel have excellent patient-related skills, they may lack intrapersonal skill needed for self-care.

There is no chapter in the textbooks discussing the need to maintain emotional distance to do their job effectively (LeBlanc, Regehr, Birze, King, Scott, MacDonald, & Tavares, 2011). Often, EMS personnel balance outward professionalism with emotions. The ability to split the two competing forces is called double-face emotion management, or the ability to "manage the emotions of two parties at the same time—those of the self and those of the (patient)." (Tracy & Tracy, 1998, p. 407). Self-regulation and emotional suppression increase stress as EMS personnel "use emotional detachment from the patients and their families to protect themselves from difficult events that might have stirred them emotionally" (Avraham, Goldblatt &Yafe, 2014, p. 202). Solitude increases because "the EMS profession is unique in the health professions in that for the duration of their clinical practice paramedics work in isolation" (Edwards, 2011, 81). In other words, there is little direct supervision of work and decreased interaction with other professionals, especially in rural areas.

Solitude is great if building a Fortress for Superman; however, isolation means EMS, and particularly a paramedic, will work a cardiac arrest alone in the back of a bullet hurtling down the highway at 80 miles per hour. A hospital cardiac arrest team responds with 8-10 personnel within minutes. Even though there may be an EMT partner, the gap in experience limits the EMT's ability to aid the paramedic in negotiating the emotions from the call. While not intentional, "this partner negative interaction and (lack of) partner emotional support have significant direct effects on psychological distress" (Cox, Buhr, Owen & Davidson, 2016, p. 313). The separateness of the profession increases stress in paramedics as they have limited additional support after a critical incident, and many leave the profession for this reason (Chapman, Blau, Pred & Lopez, 2009). The problem is that "once individuals are lonely and disconnected, they are at greater risk for becoming even more disconnected" (Levin, 2012, p. 253). Social support may not be available to EMS personnel, Clohessy and Ehlers (1999) found:

> It is not surprising given that they are skilled individuals who often work under conditions of extreme stress, witnessing many distressing scenes, and whose performance under such conditions may literally mean the difference between life and death. A substantial subgroup of emergency workers may need support in dealing with the traumatic events witnessed on duty. **Time pressure and a job culture that emphasizes distancing oneself from emotional reactions make it unlikely that they will find adequate**

> **support at work if they experience difficulties.** It is noteworthy in this context that the most common symptoms reported included estrangement from others and irritability. (p. 262)

Unfortunately, this emotional distancing is needed for EMS to perform their jobs. Previous chapters of this dissertation have explained why/how/when/where EMS avoid these emotions. Emotional disconnecting creates dissonance as "paramedics perceived their health and safety to be primary concerns when responding… (but) these concerns were often reported to be negated by their desire to fulfill their professional responsibilities" (Smith, Morgans, Qureshi, Burkle & Archer, 2009, p. 24). Often, as in mass casualty and disaster responses, the balance between personal safety and public safety is completely waived as EMS feel duty to act. Due to nature of the profession as the first step in the medical chain, EMS personnel experience critical incidents at greater rates than other medical professionals (i.e., doctors and nurses).

Critical Incidents and Mental Health

On June 24, 2002, at 9:30 am, Ernest Carter, a charter bus driver with critical levels of cocaine and valium coursing through his veins, "slammed (the bus) into a concrete bridge support" (KCBD, 2002, see Picture 4.1). Fifty-one souls were on board. The scene was war field scattered with death and chaos. The first-in unit had a paramedic and his EMS partner… 2 people for 51 patients. The crew sorted bodies- living and dead- ALONE until additional help arrived 18 minutes later. I was on-duty 90 miles away; I did not respond; I heard the radio traffic.

Picture 4.1 Terrell Bus Wreck courtesy of KCDB

On Friday, August 13, 2010, the on-coming EMS crew walked into their station. A truck generator had been left running overnight accidentally. Casey Steenland (see Picture 4.2) died from carbon monoxide poisoning; her partners, Daniel Gaona and Ron Masten were unconscious. One of the crew trying to provide aid was overcome leaving 1 paramedic

Picture 4.2 Casey Steenland Courtesy of The Marshall News Messenger

with 4 patients. ALONE until the next units arrived an eternity later. I was on-duty 60 miles away; I did not respond; I heard the radio traffic.

These are critical incidents "surpassing normal coping methods or (are) cases charged with emotion" (Donnelly & Bennett 2014, 1). EMS personnel will experience at least one incident per year of EMS service; it is reasonable to assume this number is significantly higher (Regehr, Goldberg, Glancy & Knott, 2002). Cardiac arrest seems to be the most prevalent as "seventy-seven percent (77%) of medics had, in the previous six months, been exposed to a full-arrest CPR and 44% witnessed a full-arrest CPR with family members present" (Beaton, 1998, p. 824). Other examples of critical incidents are CPR on adult or pediatric patients, mass casualty incidents (4 or more patients), and motor vehicle collisions where patient(s) have multi-system trauma and other severe injuries.

EMS are alone on-scene, enroute to the hospital, and return to service. Alone to process the call. Aloneness is one reason critical incidents have been linked to increased burn out and negative psychosocial outcomes (Cicognani, Pietrantoni, Palestini & Prati, 2009). This may be due to, as described above, emotional distancing and suppression. However, there is a bigger problem. Many EMS companies are short-staffed meaning employees are forced to work more shifts or longer shifts (Edwards, 2019). For example:

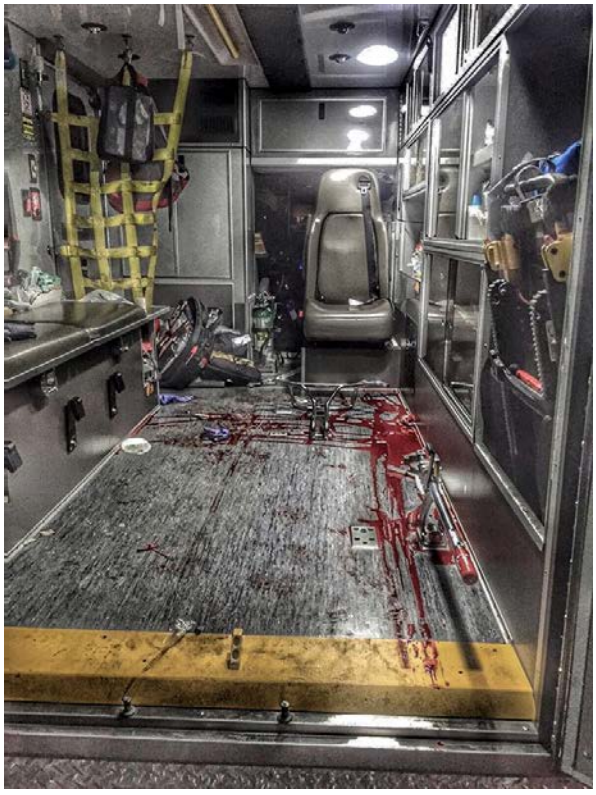
> Michael Flynn, a 15-year paramedic in the Atlanta area, said many of his peers depend on caffeine to stay awake because they have to push themselves to work many hours. Many don't talk about the emotional toll of the job because it is not a welcome topic of conversation. There's a lot of 'talk' about mental health but it's closer to what you see in the military. You really don't talk about it." (Benard, 2019)

Furthermore, some states, such as Texas, have sanctions, including revoking certification, if EMS leave their duty stations without relief (*Texas Administrative Code* Ch. 157). With longer hours on-duty, EMS are at increased risk of occupational fatigue and depression due to poor sleep conditions (Courtney, Francis & Paxton, 2010). Low control of emotional control of calls and low supervisor support increase work stress and depression in EMS personnel (Regehr & Millar, 2007). The lower social support and job stress can create comorbid lead to increased hypertension and cardiac problems in EMS personnel (Bigham, Jensen, Tavares, Drennan, Saleem, Dainty & Munro, 2014). It is no wonder the average EMS career has dropped from 6.5 years in 2011 to 4 years in 2016 (Davis, L, 2011 as quoted in JEMS, 2017; Paschal, 2016)

The Michael Flynn quote highlights a bigger EMS issue where mental health is exiled and internal displacement abound as EMS are left to make sense in/of their worlds. EMS become Internally Displaced Peoples (IDP). The United Nations Refugee Agency states:

> **Internally displaced people (IDPs) have not crossed a border to find safety. Unlike refugees, they are on the run at home.** IDPs stay within their own country and remain under the protection of its government, even if that government is the reason for their displacement. They often move to areas where it is difficult for us to deliver humanitarian assistance and as a result, these people are among the most vulnerable in the world. (UNHCR, n.d.)

While this is a stretch to compare EMS to those form war-ravaged areas, the notion is that EMS are forced to flee from the world of emotions and emotional care. Hence, EMS collective well-being, or "emotional and cognitive evaluations of (peoples') lives" is ignored (VanderWeele, Hawkley, & Cacioppo 2012, p. 777). Emotion may be overwhelming after these critical incidents. Needing to release and lacking social support creates a tension state in EMS. Sessions with a trained professional would be optimal; however, most "counselling" sessions take place amongst other paramedics in the ER parking lot. With an empathetic-ish audience gathered, EMS personnel share the gruesome details of the call. (See Picture 4.3). The medic performs before a "Been there, done that, got the t-shirt" audience. These storytelling sessions "allow EMS personnel a high degree of control over events that were often out of their control when they were happening" (Tangherlini, 2000, p. 47). In other words, EMS attempt to make sense of the call. This could be the beginning of emotional



Picture 4.3 After a BAD call Photo courtesy of Paramedics on Facebook

management, but these sessions quickly turn as the one-upmanship leads to “gallows humor” with darker and darker stories (Kuipur 2012).

Normally seen as self-destructive behavior, “the function of humour (sic), and in particular of using humorous descriptors in the emergency setting, is to permit the individual to disengage from emotionally challenging emergency situations” (Scott, 2007, p. 353). This makes sense as EMS need to decompress after a critical incident. Seeing dead bodies takes a toll. Even though this humor is misunderstood by outsiders, black humor works to decrease stress in the provider (Rowe & Regehr, 2010). But this same release can induce alexithymia and dyscommunication as the provider becomes disengaged emotionally from family, friends, coworkers, and self (Deason, 2014).

As mentioned previously, EMS personnel develop the double-face management for emotions. This occurs because of the initial EMS training courses, where EMS personnel are taught to separate feelings from the call through avoidance (Deason, 2016). One emotional management tool is sublimation, which occurs when people attempt to modify or shift an emotion into something socially acceptable. When the person attempts to sublimate emotions, it potentially creates negative psychological effects and changes in the communication process. EMS may have difficulty with the emotions from the calls and choose to suppress those emotions as a function of job-related emotional suppression (Watsell, 2002). Thus, learning to suppress emotions is a learned activity, and unfortunate survival skill, within EMS cultures (Panayiotou, Leonidou, Constantinou, Hart, Rinehart, Sy & Björgvinsson, 2015).

One possible negative effect of job-related emotion suppression is alexithymia, which is “a personality style with concrete and externally oriented cognitive style and difficulty coping with emotionally stressful situations” (Cozolino, 2014, p. 21). However, “alexithymia is not a diagnosis, but a construct useful for characterizing patients who seem not to understand the feelings they obviously experience, patients who seem to lack the words to describe these feelings to others” (Muller 2000, 1). Alexithymia, which affects 35% of EMS personnel, is a maladaptive coping strategy leading to negative growth and is an early indicator correlated to increased PTSD (Halpern, Maunder, Schwartz & Gurevich, 2012; Kirby, Shakespeare-Finch & Palk, 2011). The key point is that alexithymia may occur when past and present collide due to a sensory stimulation, and EMS personnel are

unable to process the underlying feelings and emotions. Therefore, alexithymia is believed to be an early indicator of PTSD and future mental health challenges.

Lacking a model of a PTSD progression, Deason (2016) created a crude model (see Appendix A) to illustrate possible contributing factors of alexithymia and PTSD progression. The variables represent the different elements of EMS. Based on the previous research, it is reasonable to assume there is a correlation between length of service and exposure to critical incidents; in other words, the length of service equates to more "bad stuff" seen. What this model allows is a preliminary framework for exploring the communication patterns in EMS personnel.

The Job Demands-Resources (JD-R, see Table 2) model shows the relationship between job demands, job resources, and strain (Bakker & Demerouti, 2007). The JD-R allows a researcher, regardless of profession examined, to classify specific job-related risks into one of two categories- Job Demands or Job Resources. "The JD-R model proposes that the interaction between job demands and job resources is important for the development of job strain and motivation as well." (Bakker & Demerouti, 2007, p. 314). By using this model to frame the study, it becomes easier to investigate the effects of storytelling function among EMS personnel. Using written EMS narratives from the Code Green website, Deason and Park (2017) applied the JD-R model to identify job strains in the EMS profession (Deason & Park, 2017).

One group that has received little attention in communication research is Emergency Medical Service providers. The National Association of Emergency Medical Technicians estimates there are 840,000 EMTs and Paramedics practicing in the United States. There are many paramedic studies; however, there are limited studies combining EMS AND communication. Even more limited, and nonexistent, is a study combining EMS, health communication, and mental health. The core of the present study is how collisions of past emotions and present reality affect provider communication and mental health. This study is unique in that it uses storytelling as the explorative tool to measure job demands, job resources, and strain or motivation.

Regehr et al. (2002) explained that due to "work rotation and extended time off, great cynicism often occurs within the organization towards paramedics who take time off for psychological injury" (p. 957). The mind does not take time off and may relive calls

anytime. Moreover, this limited time off and repeated exposures do not allow for adequate decompression between shifts (Courtney, Francis & Paxton, 2010). It is storytelling is used to cope with emotions. I can offer my experience presently to attest to the fact of the ridicule placed on individuals who openly confess having psychological problems. Thus, as Donnelly (2012) concluded, social pressure and support discourages from accurately reporting symptoms. In other words, EMS may have mental health diagnoses (i.e., alexithymia, depression, PTSD), yet remain silent for fear of retribution from co-workers (socially) AND the company (administratively).

#AllMethodsMatter #exceptthosethatdont

Many communication traditions, especially cybernetics and rhetoric, rely on the transmission model, or Sender-Message-Receiver, of communication. This over simplistic view does not account for things beyond the surface. "Moving from a communication simple to a Communication Complex approach opens our thinking to strategic and programmatic possibilities that place public health professionals in a better position to meet the challenges faced around the world." (Parrish-Sprowl, 2013, p.3). Theoretically, the study is framed around Communication Complex (CC). CC is suited for exploring mental health and EMS communication. CC provides the most insight into how, why, and where communication takes place by using its complexly simple metaframework incorporating biology, psychology, sociology, communication, and more.

There is something in the EMS world creating communication difficulties that cannot be derived from mere observation. How can I as a researcher find the deeper causes of communication changes and mental health in EMS? The complexly simple answer is storytelling. Storytelling is not new nor is its study. Using a CMM-ish platform, researchers can dissect the stories EMS personnel tell each other. Pearce and Pearce (1998) state, "we are, individually and as members of various social groups, different because we communicate differently… to 'do' CMM work consists of entering into patterns of communication as a participant with a commitment to improve them." (p.171). For this very reason, I chose to include autoethnography as part of my dissertation- I am a paramedic. I cannot remove myself from that world as it lives in my mind daily. Even though I physically left EMS in 2011, my legacy did not. When I returned to Texas for the holidays, I visited the local station. One participant stated, "I know you. You are the Sprite

can guy from the training video." (*See Chapter 7 (IN)to the Ditch*). From a social constructionist standpoint, "the meaning of an act is not finished when the act is performed, it depends on the way it is moved toward completion by the subsequent acts of others." (Pearce & Pearce, 1998, p. 179). My wreck had moved from a personal story of why I left EMS to study health communication and mental health issues to a safety briefing years later. Both are true, but incomplete without the other. I am sure there are multiple descriptions of the accident narrative/story, especially from the truck driver who ran us off the road, the driver behind us who witnessed the wreck, the responding EMS crew, the dispatcher trying to get more information from me about the wreck, my wife, my son…possibly even the worm whose dirt home was plowed through. "By fostering multiple descriptions of situation, the diversity of narratives to describe a situation is enhanced which keeps alive the resources for elaboration and transformation." (Barge, 2004, p. 191)

The world is not replicable nor utopian, which for a social constructionist presents unique challenges. However, a real world emerges when I, as a paramedic/scholar, engage with other embodied persons to understand the how EMS personnel communicate. (Cronen, 1995). Communication, like EMS work, is messy. It is through this discovery we learn EMS personnel are covered in blood, vomit, and other bodily fluids daily. It is in the messiness of THAT moment that one begins to understand "engaging a context, complete with the shock and messiness that accompanies the happenstance of concrete social situations, (can one begin) clarifying moral issues and problems." (Tracy, 2007, p. 107). In other words, researchers begin to understand WHAT communication means to EMS personnel. Scientific theory has incomplete answers; normative theory has incomplete answers. The incompleteness of lived experience as isolated experiences and not as a whole is where the reason for exploring the problem level of lived experience (Craig & Tracy, 1995). Thus, it is only through the marriage of science and normative theories that answers can be achieved.

Grounded Practical Theory when combined with the CC framework offers the best solution. Craig and Tracy (1995) offer the first description of practical theory stating:

> Scientific theory is concerned with what is, not with what ought to be; the goal of scientific theory is to discover general explanations of phenomena that increase our ability to understand, predict, and control events.

> Normative theory, in contrast, is centrally concerned with what ought to be; it seeks to articulate normative ideals by which to guide the conduct and criticism of practice (p. 249).

Grounded Practical Theory makes the most sense to isolate, analyze, and create new communication within this community. GPT mimics a paramedic's ability to combine scientific observation of a patient's vital signs, signs, and symptoms with the patient's narrative of the episode. GPT looks not at the quantity but the quality of the communication (Muller, 2014). It encourages the researcher to embrace messiness (Tracy, 2009). Practical theory involves embodied persons elaborating their abilities to explore, make sense of, and engage the uniqueness of their lived experience at moments in time and to cocreate with others forms of communication that facilitate the emergence of new possibilities for action. (Barge, 2001). Practical theory allows one to map communication and its struggles, reflect on how theory and practice interact, then create useful descriptions to transform communication—and hopefully, the world of EMS (Barge & Craig, 2009).

There are many ways to embrace the world of EMS communication. "Ethnographers translate the details of one culture for an audience usually unfamiliar with that culture." (Ellingson, 2009, p.131). When this happens, people begin to see the effects of interaction between cultures called *globalization*. Interestingly "globalization creates a practical need for everyone to understand the political discourse of other nations because it is quite likely that their country will become engaged with another country, with understanding of each other needed to create functional civil societies." (Parrish-Sprowl, 2009, p. 267). The EMS culture, as shown in chapter 2 of this dissertation, shows EMS personnel become citizens of a different nation when they enter the career. The difficulty in communication arises as EMS personnel move between the real world and the EMS world. They have dual citizenship, but liminality puts them not in one world nor the other. It is the moments where the two worlds that this dissertation hopes to land and stake a claim.

Due to the nature of the occupation, Emergency Medical Service personnel (EMS) are exposed to critical incidents at greater rates than other medical professionals (Beaton, 1998; Regehr, Goldberg, Glancy & Knott, 2002). These critical incidents "surpass normal coping methods or (are) cases charged with emotion" (Donnelly & Bennett 2014, p. 1). Some common examples of critical incidents are CPR on adult or pediatric patients, mass

casualty incidents (4 or more patients), and motor vehicle collisions where patient(s) have multi-system trauma.

After these critical calls, EMS personnel have multiple conversations with themselves (interpersonally) and other EMS personnel (interpersonally) (Parrish-Sprowl, 2014). These internal and external conversations create emotions and emotional states in people that is unacceptable (Parrish-Sprowl, 2013). These are called perturbations within and must be resolved to keep positive mental health.

One cultural way EMS personnel deal with these perturbations is through storytelling. It is through the humorously strange and dark tales people new to EMS are indoctrinated and taught new medics the hidden cultural norms of paramedicine (Kuiper, 2012; Rowe and Regehr, 2010, Tangherlini, 2000). The EMS culture is within yet without the medical culture (Deason, 2014). How does CC help a health communication scholar understand the EMS culture?

"Communication complex shifts our attention to the pattern that is created when people talk. The pattern offers a much richer unit of analysis for improving communication. We become more interested in what people are creating together than in what each person is doing" (Parrish-Sprowl, 2013, p. 5). CC allows the scholar to delve deeper into the enacted communication of EMS personnel storytelling.

From a neurobiological perspective, the brain relies on neural inputs to make sense of reality around it. However, the brain "is polysensory (in that) all our sense receptors translate different kinds of energy from the external world, no matter what the source, into electrical patterns that are sent down our nerves" (Doidge, 2007, p. 18). Our senses, then, are linked to the neural networks in the brain. Furthermore, the neural coding that occurs in these neural networks allows the brain to interact with the present environment at the same time the environment is interacting with the senses (Northoff, 2010). Thus, the brain can obtain and process information while simultaneously creating new neural pathways.

The idea of senses creating neural pathways in intrinsic to emotion recall and creation of cultural identity. The brain is not linear. All the neural pathways link to different memories created through the above interaction process. This process creates a "temporal non-locality (where) correlations can occur between events separated in time" (Wendt, 2015, p. 54). In simpler terms, the brain links senses to past events. For example,

a person smells a certain perfume and remembers his long-deceased grandmother. In that moment, he is transported back to her kitchen 50 years earlier. He experiences total recall of events of that happy time in his childhood. "What we do in the present is instantly correlated with what happened in our past" (Wendt, 2015, p. 56). Thus, to our point of temporal non-locality and emotional recall, the person is experiencing the smell TODAY yet remembering the smell 50 years prior. It is this ability to cross years instantly that allows for present manipulation of reality while adhering to the social stability of by gone times.

Consciousness occurs when something is experienced through the senses and a neural network is established (Wendt, 2015). It is through these experiences individuals form relational patterns where "multiple conversations shape and are shaped by the actions of themselves and others" (Parrish-Sprowl, 2014, p. 212) irrelevant of time and place. The brain, then, changes its structure with each interaction (Doidge, 2007). With CC, attention is shifted "to the pattern that is created when people talk" (Parrish-Sprowl, 2013, p. 4). The shifting patterns inherently affect social order.

The reason CC resides as a sociocultural model is the interactions are what create society. Our senses become part of the social reality. Everyday conversations and actions move into the culture as ideas are spread from person to person. While this seems like Symbolic Convergence discussed earlier, it is different as the communication acts work to define society. Interestingly, "it is only about 5% of our life that is run with our conscious creative mind, while 95% of our life is actually coming from the programs in the subconscious mind." (Lipton & Buczynski, n.d. p. 19). In other words, daily communication runs as a background program processing data twenty-four hour per day. CC looks for outward manifestations of the subconscious that express themselves in conversations.

Detractors would argue the underlying sociocultural rules and actions in real life can be best perceived and interpreted through their respective traditions. Of course, there is so much conflict between the traditions that "communication theory, in all likelihood, will never achieve a final, unified form" (Craig, 1998, p. 123). What this means is the health communication scholar has a HUGE toolbox of toys to play with. Phenomenology asserts communication comes from interaction with others. However, it fails to realize our

understanding is shaped by constant communication interpersonally and intrapersonally (i.e. Consciously and subconsciously). Human relationships need not be authentic to perpetuate societal learning. The sociopsychological traditions downplays sociocultural theory as flighty and untestable. Those scholars are correct, but, then again, society is in constant flux and recreation of new social order with each interaction. In other words, even though there is a tinge of psychology behind each communication act, the act itself is more for order and mean-making.

The brain uses sense receptors to translate the into electrical patterns (Doidge, 2007). Unlike the transmission model of communication, CC allows the brain to process incoming and outgoing information simultaneously. The brain may associate a sense with the stored information, which can act as trigger in the future to release the information. This is important when discussing emotions as neural pathways link to different memories created through the interaction of senses and impulses. This process creates a "temporal non-locality (where) correlations can occur between events separated in time" (Wendt, 2015, p. 54). In simpler terms, the brain links senses to past events. This seems to imply that emotions are conditioned responses to stimuli, much like Pavlov's dogs. However, the human brain can create multiple realities and answers each the same yet different based on present context, yet no create a conflicted reality (Buchanan, 2011). This explains why some people can mirror others' actions and emotions (i.e., have sympathy) (Bråten, 2007). For this study, we assume there is attempted job-related emotional suppression during a critical incident to properly function, yet, the brain will still process the information and store subconsciously. The problem explored is how the memory recall occurs unconsciously and quite suddenly when a sense is triggered.

The easiest way to identify potential triggers and problems areas is through a quantitative exploration of the Factors of Alexithymia model (see Table 1). The researchers can identify, for example, the correlation between length of service and exposure to critical incidents on the prevalence of alexithymia and PTSD. The JD-R model is useful in identifying exact social supports, physical demands, etc. However, one thing missing is the humanness and participant explanations of why those are important. While other methods could be used, the qualitative methods of autoethnography and interviews provide the richest meanings.

Few researchers have actual experience in the research field. However, the field notes and interviews help the researcher "make sense of the context and build larger knowledge claims about the culture" (Tracy, 2012, p. 3). Thus, the researcher can describe the "actor's point of view in a context-text specific situation" (Tracy, 2012, p. 23). Most research removes the writer completely producing an almost sterile, clinical setting for the reader. This is good for presenting facts that can be empirically deciphered; however, "readers are not encouraged to see and feel the struggles and emotions of the research participants. Normally, we deprive them of an opportunity to care about the particular people whose struggles nourish the researcher's hunger for truth" (Bochner, 2012, p. 159). Humanness is missing in most academic writing, and readers need some feeling to connect and understand the subject.

To make progress, we cannot rely on past traditions. We must "create new traditions of communication theory and new ways of schematizing the field; and apply communication theory by engaging it with practical metadiscourse on communication problems" (Craig, 1998, p. 149).

A Researcher's Paradise: Etically Emic Exploration Extravaganza

I deliberately chose the term etically emic approach as I envisioned this dissertation as mixed methods; however, I did not realize this meant QUANTITATIVE AND QUALITATIVE methods. *I can do drug calculations like a maniac... on a call I needed to give 5 milligrams per kilogram of a certain medication to a patient. I could have had a carnival weight guesser job because in the day, I could get within 2 pounds. The patient weighed around 250 pounds… um...this is not kilograms. Well... divide 250 by 2 and subtract 10 percent… bam… weight in kilograms- 113 x 5= 565 mg. Medicine is 25 milligrams per milliliters… so… 22 milliliters. Quick easy med calc at 2 AM. All day…. every day. It was that easy.* But this quant thing…*as the great philosopher Ariana Grande sings, "Thank you, next!"* It was back to square one trying to figure out how to explore how the bad things EMS see shape their communication patterns.

This dissertation has a novel design. No, seriously, I want it to read like a novel instead of boring academic speak. However, I need to move to that realm for a while to make this sucker sound credible. Since the topic is EMS, my lived experiences are *insert academic word of your choice (*germane, appurtenant, ad rem). Lived experience is an

acceptable lens to use. I have not hidden the underlying bias I have a participant observer in this dissertation, but the strength of these experiences come in my autoethnography. I will discuss AE as a method later. However, I needed to buffer me with something else. Surely, though, my experience was not unique. Other EMS have had to have had similar experiences and thoughts as me…, I am not a unicorn. With mixed methods off the table, I looked for an approach to this project to foreground both participant groups. We had similarly different experiences in EMS at the same times in different place, yet the end was maladaptive coping and PTSD for BOTH!!!

The challenge as a researcher is the miniscule amount of research in communication, mental health, and EMS. Most of the literature is translated from other disciplines. For example, business management addresses the conundrum of no research perfectly. Punnett, Ford, Galperin, and Lituchy (2017) state:

> Where little empirical research has been done, emic research is critical. We need to know how people in under-researched places view the constructs of interest; otherwise, researchers impose a particular view, developed elsewhere. While valuable, knowledge based on emic research alone often does not allow for statistical comparisons among groups. In order to more clearly understand how groups are similar or different, etic research across groups is also necessary. (p. 4)

This is the piece missing in EMS studies. It was by outsiders (etic) imposing a scholarly voice. In the introduction, I called for you to be my partner in this messy journey. The literature has shown EMS tend to repress emotions, have maladaptive coping mechanisms, and want to die. Light bulbs lit when I discovered "pluralism mirrors the human experience, both are messy. Highlighting transparency in the use of reflexive research practices could strengthen the use of pluralism when researching sensitive topics." (Dempsey et al, 2019, p. 3). In other words, pluralism promotes using multiple methods research (MMMR) design ''of two or more studies using different methods, which address the same research question or different parts of the same research question or different parts of the same research question or programmatic goal'' (Morse, 2015, p. 210). Combining AE and ethnography seemed appropriate as I see "everything as data, look emergence of categories, relationships, theory, and research design, and constantly compare different analysis when researching" (Johnson & Walsh, 2019, p. 3). Ultimately, the strength of using a multimethod approach in qualitative research comes when "considering how each

method works with the other(s), it also offers a way of thinking about how different worldviews may be brought to bear on the same research question to generate alternative understandings to move forward in unanticipated ways." (Shaw & Hiles, 2017, p. 239).

What makes this study more novel is the concurrent design where events occurring AE and ethnography seemed appropriate as I see "everything as data, look emergence of categories, relationships, theory, and research design, and constantly compare different analysis when researching" (Johnson & Walsh, 2019, p. 3). The strength of using a multimethod approach in qualitative research comes when "considering how each near the same time are used as data (Hesse-Biber, Rodriguez, & Frost, 2015). *But wait there's more…* This study uses a participatory action research (PAR) approach which "is concerned with research‐participant interactions, obtaining sound data, and engaging in ethical behavior. The method adds that we must also bring about some *action* through our research to improve our communities and the world." (Olson & Jason, 2015, p. 395). Thus, an etically emic concurrent participant action research multimethod approach is the approach needed to answer the how experiences shape EMS communication.

The Researched: Ethnography as a Method

"Ethnography (gives a) full description of a specific world rather than a specific segment, (but) a potential problem is seeing data everywhere, gathering everything, but the unconnected data creates a study with low-level description" (Charmaz & Mitchell, 2011, p. 161). Furthermore, "The ethnographer participates, overtly or covertly, in people's daily lives for an extended Period of time, watching what happens, listening to what is said, ,asking questions; in fact collecting whatever data are available to throw light on the issues" (Hammersley & Atkinson, 1983, p. 2). Ethnography is exciting because I have lived experience in EMS; however, it demands even those entrenched in the culture "to treat this as 'anthropologically strange', in an effort to make explicit the presuppositions he or she takes for granted as a culture member. In this way, the culture can be turned into an object available for study." (Hammersley & Atkinson, 2007, p. 9). In other words, this study CAN be etically emic!!!

The literature review chapters give the needed background to inform the ethnographer about the communication (Ch 1), EMS (Ch. 2), and trauma/mental health (Ch. 3). The broad scope could create a huge dissertation which I would never complete.

However, I employed Knoblauch (2005) notion of focused ethnography where observation is supported by technology, such as voice recording and transcription. Finally, the focused ethnography "still addresses the emic perspective of the natives' point of view, yet in a very specific sense. It only aims at certain elements of (partly embodied) knowledge relevant to the activity on which the study focuses." (Knoblauch, 2005, p. 10). Thus, a focused ethnography is informed by a primary survey of symptoms and can move to specific etiologies and distresses addressed by a secondary survey. In this case, I can discuss EMS, mental health, and communication…and this study can be etically emic!!!

The Researcher: Autoethnography as a Method

Autoethnography (AE) is a unique ethnographic method of gaining knowledge of a population. AE is an ethnographic study of one. Many scholars dismiss AE as navel gazing and not rigorous enough for academic consideration. However, AE is where the researcher interacts and "enters the participants' world to collect data and literally becomes the instrument when analyzing it" (Devers & Robinson, 2002, p. 241). Autoethnography is a journey into self and connecting that self to the reader to make sense together. AE declinicalizes the story and make the writer part of the story, which connects better with the reader (Doty, 2012).

By choosing to make himself the subject of his monograph, "The Critical Life," Pelias (2002) opens himself up to criticism from the outside as he describes his criticism of other during the course one day. Unlike traditional scholarship, autoethnography readers feel they "have choices about what positions to take in a story, that what they are reading rings true to their experiences in the world (or, if not, that there are reasonable explanations why not), and that they come to know the characters." (Berger, 2001, p. 514).

In AE, the ethnographer is the chief character and the star. "Autoethnographers look for reflexivity, impactfulness, aesthetic merit, substantive contribution and degree to which the text clarifies a lived reality… (through) the level of detail or "thick description," in the complexity of the writing and the emotional credibility and honesty of the author." (Dumitrica, 2010, p. 29). Furthermore, the honesty includes the true self (i.e., the good, the bad, the ugly- *insert whistle here*) (Tamas, 2008). The challenge is that the author's reality biases the told story. Therefore, autoethnography is not widely accepted by the academic world- the truth rests in the author. Bochner (2012) submits work should be

verified. In EMS, the easiest way to verify is to check for the paramedic's name listed on the patient care form filed with every run. Thus, we can tell if the writer is truthful in his storytelling. A former partner said, "Trust but verify."

Another benefit of AE is "it can be therapeutic for the storyteller to work through difficult times, events and issues in his/her own life in the development of a preferred identity" (Grant & Zeeman, 2012, p.2). However, therapy is psychological- not communication. Therefore, the story is only half; how the facts affected my feelings make up the other half. Carolyn Ellis is considered one of the founders of modern AE. About AE, Ellis (1999) wrote:

> Honest autoethnographic exploration generates a lot of fears and doubts- and emotional pain. Just when you think you can't stand the pain anymore, well, that's when the real work has only begun. Then there's the vulnerability of revealing yourself, not being able to take back what you've written or having any control over how readers interpret it. It's hard not to feel your life is being critiqued as well as your work. It can be humiliating. (p. 696)

Autoethnography, then, is a valuable tool when the researcher is trying to explain the deepness of a subject where traditional qualitative inquiry could not scratch the theoretical surface. It is deeply personal and uncomfortable, yet, the uncomfortableness is useful to bring to light marginalized populations.

The difference between AE and autobiography is the writer tries to find the deeper meanings in the work. Often, the writer must examine his feelings and observations while researching. AE requires much research before embarking on the journey to discovery self better. It is through gazing at one's own navel that I, then, can move to other methods to help inform (e.g.- interviews, surveys, etc.). From these methods, I look at different theories that help inform and explain the research. This first step is well-documented to ensure adequate room for reflection.

Mimesis, or reflection, is the first step. In the phase I examine the results of what I have found in the research. I try to find patterns or categories that have moved me during the research. I think about why those are the most important to me. I can use any theory to explain. Most often I use an iterative approach to go in and out of the data to identify meta-themes and use Communication Complex to order them before moving to the next step.

Poiesis, or meaning, is the most challenging to me. In finding the meanings, I must address my OWN biases first and how those effect my worldview. Reflection answers the "is it there" question. As autoethnographer, I must the links between my life, the research, and the theories. I must consider these as I write.

Kinesis, or movement/change, is the third principle of Autoethnography. This is the step where the writer tries to create MOVEMENT in the reader. By addressing the topic with personal stories and ideas combined with theory, the writer works to right the wrongs in the world.

As a paramedic, I cannot separate myself easily from my former world. I am an Internally Displaced Person. AE allows me to explore HOW the things I saw and did affected my communication…and made sense of that world. AE becomes cathartic NOT therapeutic as questions are answered. My AE gives a deeper look into a field that an outside researcher might understand. I know the culture and the language, which allows greater sense-making and adds MY voice to the research. It is not a gaze upon my navel; it is an unflinching stare into the abyss of my broken and troubled soul.

Doing It My Way

Once I decided on using ethnography and autoethnography, I obtained Indiana University Institutional Review Board approval for research involving human subjects. I used my known Facebook contacts to recruit EMS personnel. After recruiting participants, I conducted semi structured interviews using the IRB approved interview guide. Interviews were recorded, transcribed, and checked for accuracy.

Participants. As this dissertation is multimethod, there will be two participant groups in two separate studies. The groups are:

1. EMS personnel, ages 18+, with at least three years EMS experience. The rationale is participants should have experienced multiple critical calls from which to draw.
2. The author.

Data Collection. Study 1: Interviews with other EMS personnel are needed to understand the communication process more fully. "Interviews are conversations with a purpose" (Tracy, 2012, p. 138). As shown previously, EMS personnel are storytellers. A structured interview uses a prescribed script or set of questions from which there is no deviance. A

narrow scope of questioning would not fit a study of storytelling. Semi-structured interviews will allow "an adequate sample size that permits-by virtue of not being too large- the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in a new and richly textured understanding of experience" (Sandelowski, 1995, p. 183).The semi-structured interview allows the researcher a chance to ask clarifying questions, probing questions, etc. as the circumstances dictate. This freedom mimics the freedom felt by EMS personnel to act on changing patient conditions.

Data Collection Study 2: Autoethnographic data collection will be from personal journals kept during my EMS career. I will use the interview guide for a self-interview to gain further details of events.

Data analysis. By choosing an emic approach, the research "represents the participants and their viewpoints, and focus on the setting and its participants in terms that the researcher brings to the study" (Schutt, 2015, p. 322). One reason is the primary researcher worked in EMS for fourteen years yet is a communication scholar. This allows deeper analysis from participant observer perspective.

A narrative analysis "puts together the "big picture" about experiences or events as the participants understand them" (Schutt, 2015, 339). A narrative approach allows us to investigate meta-themes across multiple interviews as well as the overlapping ideas within each interview.

Not a conclusion but a START

"People with social ties and relationships had lower mortality rates than people without such ties" (Berkman & Syme, 1979, p. 200). The literature shows EMS have mental health challenges. The literature shows EMS personnel engage in storytelling. The literature is lacking a participant/observer/scholar to decipher the EMS world. The literature does not show the affect of critical incidents on EMS communication patterns. This dissertation is the entrance to the rabbit hole.

Chapter Five: *Coloring Outside the Lines:* Tales of a Dyscommuniholic

Hi! My name is Aaron, and I am a *dyscommuniholic*.

Listen to my story from a time long, long, ago in land far, far away. Once upon a time, before I began my academic journey, I was a Paramedic. The widow's mite was more than my pay. We were told, "There is a God. You are NOT Him!" Except I made god-level choices about life and death. Somewhere in the too frequent battle against the clutches of death, I lost my soul. Listen, my children, to this tale of ghosts, demons, and dragons.

In a dimly lighted back room, as the moon was rising, soft chanting:

> You're clear. I'm clear.
> Shock. Shock. Shock.
> Crack the chest.
> And crack again.
> Pump and blow
> Pump and blow
>
> Put some epi down the tube
> Pump and blow
> Pump and blow.
> Shock once more and CPR
> Not too fast...not too slow
> Pump and blow
> Pump and blow
> Drop the tube and off we'll go
> Pump and blow
> Pump and blow

The cult was conjuring the Ventricular Fibrillation algorithm from Advanced Cardiac Life Support. It was a long day had been filled with scenario after scenario. We, the sorcerers of life and death, shot lightening and slew the dragons. We used our newly found necromancing craft to raise the dead to life and curse the demons back to hell. The great mage taught us one final lesson. Alas, poor Yorick, was by the River Styx and the ferryman was near. We discussed protocols, Do Not Resuscitate, Advanced Directives, and signs indicating death (i.e. dependent lividity, trauma incompatible with life, decomposition). These should make the decision to terminate resuscitation easier. The operative word is "should." We clinically discussed death. We never discussed HOW we should feel. EMS personnel are humans with emotions. Expressing emotions can make

the career difficult as other EMS may ridicule or harass. I, like most EMS, learned emotional suppression on duty but not how to clock out when leaving the station (Deason & Park, 2016). Too often this switched-offedness leads to increased marital problems, health problems, drug and alcohol abuse, and suicide. These are some of the problems leading to a state of *dyscommunication* within the EMS culture.

Miscommunication or *dyscommunication?*

This is going to be a weird journey for a second. Please bear with me as I an unorthodox approach. In a previous chapter, I juxtaposed a formal definition against the EMS interpretation of professionalism. In this case, I am using the dictionary term versus a medical dictionary to explain the difference between miscommunication and *dyscommunication.*

According to *Webster's Third International Dictionary,* the prefix *mis-* indicates "wrong or incorrect" (Gove, 2002, p. 1422). Miscommunication is a communication act and can be corrected, hopefully, with limited consequences. I could forget to tell my wife about a late meeting, and the kids are left at school. It happens and is complete in one episode. The prefix *dys-* means "abnormal or difficult" (Gove, 2002, p. 711). In medicine *dys-* is **sign** of an underlying chronic, prolonged, diagnosable, and treatable condition, such as Chronic Obstructive Pulmonary Disease (COPD). *Dyspnea,* or difficulty breathing, is a common **sign** in medical emergencies. I had an arsenal of different treatment protocols based on my presumptive diagnosis. Albuterol via nebulizer for asthma. Diphenhydramine or Epinephrine for anaphylaxis. Lasix and oxygen for congestive heart failure. Nitroglycerin and oxygen for myocardial infarction. My job was to treat the patients' presenting signs and symptoms…not the underlying conditions. In 20- 60 minutes I could not counteract a lifetime of bad life choices (e.g.- smoking, drug abuse, eating 6 pounds of fried catfish every weekend at the $8.99 all-you-can-eat buffet) nor a loss in the genetic lottery (e.g.- asthma, allergies).

The difference between miscommunication and *dyscommunication* is affect, duration, and effect. EMS personnel are exposed to critical incidents discussed in previous. These exposures often create a state or condition of abnormal communication reaching into emotional, familial, interpersonal, mental, physical, psychological, occupational, relational, spiritual (and other -als, too). *Dyscommunication* is one sign of conditions

involving entire systems over time versus miscommunication's limited scope and reach. There are hundreds of thousands of EMS professionals around the globe. There are as many studies of EMS; however, these studies are by researchers with cursory knowledge of the EMS. A search yields no EMS voice in health communication. However, Petronio said, "Just because something is missing does not mean is needs to be researched." (2015, Personal recollection from lecture).

Qualitative EMS studies usually involve academics observing and interviewing EMS crews. These studies have produced great data and improved knowledge of EMS. Lacking substantive data and previous research to drive a study of mental health and communication in EMS, I need to find a lived experience to correlate with interviews. One great way to start inquiry is through autoethnography, which "confronts dominant forms of representation and power in an attempt to reclaim, through self-reflective response, representational spaces that have marginalized those of us at the borders" (Tierney, 1998, p. 66). AE is lived experience with theoretical foundations. It is a lamp to light the shadows of humanity. In this autoethnography, I reflect on *dyscommunication*.

An unflinching stare inward

I am in a minority because x^2, t-tests, ANOVA, U test, Kruskal-Wallis test do not connect me to the participants…even if P=*.000whatever*. Too often the written word is a sterile, clinical report for the reader. "Readers are not encouraged to see and feel the struggles and emotions of the research participants. [Traditional research methods] deprive them of an opportunity to care about the particular people whose struggles nourish the researcher's hunger for truth" (Bochner, 2012, p. 159) Traditional research may focus on the 99.98% who do activity x or live in city x. Participant data are useful, but individuals are missing. Who are the .02%? These anomalous outliers are left out; their stories are not heard. It becomes easy to marginalize these voiceless people.

Autoethnography (AE) "enters the participant's world to collect data; the participant become the instrument when analyzing it" (Devers & Robinson, 2002, p. 241). Autoethnography is a journey into *self* and connecting that self to the reader to make sense. AE is easier to read as the writing is part story, part theory. I am data, which connects him to the reader (Doty, 2012). The data analysis moves from impersonal they/them to I/me. AE is freeing as writers "want you to take what they have done and engage with it,

allowing yourselves, perhaps even forcing yourselves, to consider the ways in which their stories relate to your life and to find in this conversation the truth about yourself." (Ellis & Bochner, 2017, p. vii)

In "The Critical Life", Ron Pelias (2000) details the events of one day in his life as a critic of others. Yet, in revealing his own critical eye, he opens himself up to criticism from the outside, which gave his readers a chance to reach their own conclusions about his actions during the day. On "The Critical Life," Berger (2001) wrote:

> Readers must feel that they have choices about what positions to take in a story, that what they are reading rings true to their experiences in the world (or, if not, that there are reasonable explanations why not), and that they come to know the characters. (514)

In autoethnography, the ethnographer is the chief character and the star where:

> Instead of looking for validity, reliability, and generalizability, autoethnographers look for reflexivity, impactfulness, aesthetic merit, substantive contribution, and degree to which the text clarifies a lived reality (Holt 2003). The merit of such a piece lies in the level of detail or "thick description", in the complexity of the writing and **the emotional credibility and honesty of the author**. (29)

AE is seen as navel gazing and not widely accepted by the academic world as writers could downplay certain qualities. An autoethnographer relies and reflection and meaning making as discussed in chapter 4. Thick description in AE comes when I present myself truly with all my flaws with verifiable stories (Bochner, 2012; Tamas, 2008). In EMS, the easiest way to verify is to check for the paramedic's name listed on the patient care form filed with every run. Another example of how to verify would be, if a person writes about how he ran in the 2013 Boston Marathon, registration information could be verified as well as his approximate checkpoint time to verify his whereabouts when the first bomb exploded 4 hour, 9 minutes, 44 seconds into the race. It's easy to tell if I'm fibbing. A former partner said, "Trust but verify."

Storytelling "can be therapeutic for the storyteller to work through difficult times, events and issues in his/her own life in the development of a preferred identity" (Grant & Zeeman, 2012, p.2). Knowing that communication is not an isolated event, the stories are only half of my story of *dyscommunication.* How the facts affected my emotions and my

feelings make up the other half. Bochner and Ellis (2000) wrote:

> Honest autoethnographic exploration generates a lot of fears and doubts- and emotional pain. Just when you think you can't stand the pain anymore, well, that's when the real work has only begun. Then there's the vulnerability of revealing yourself, not being able to take back what you've written or having any control over how readers interpret it. It's hard not to feel your life is being critiqued as well as your work. It can be humiliating. (738)

Autoethnography has been my hardest academic venture as I openly share with the world my struggles with depression, self-loathing, and PTSD. The fear comes from the possible judgment from peer academics and honest self-evaluations. Some incidents are humorous. Some I tried to bury and forget as they caused pain and inner turmoil as I try to make sense of them. Some only haunt in frequent nightmares. When I do AE, I found myself going back onto the road of *dyscommunication* I had as medic- the road I hope to never see again.

Using a narrative ethnography, or autoethnography, I will try to make sense of how the EMS profession affected my communications over the course of my career. Through reflection, I hope to understand how my own *dyscommunication* affected my life, and how others can use the experience, including non-paramedics, to overcome their own communication problems.

The training and life of a Paramedic

Since I have written about EMS evolution and EMS culture in previous chapters, this section is what I learned during my career. The modern practice of paramedicine in the US began in the 1950s when "the American College of Surgeons developed the first training courses in EMS" (NHSTA, 2009, p. 2) where students were taught the bare basics and mostly were just "ambulance drivers." From there, each state devised its own standards in training and licensing. It was not until the National Academy of Science "released *The White Paper* in 1966 describing deficiencies in prehospital care" (NHTSA 2009, p. 2) that prompted the National Highway Traffic Safety Administration to create a National Standard Curricula. Over the ensuing years, the NHTSA revised until its current incarnation as the 2007 National EMS Scope of Practice.

Long and arduous are the best words I can find to explain the process to become a Paramedic. I worked three years as an EMT-Basic before completing the six-month Advanced EMT course in 2000. My Paramedic course was an intensive eighteen-month program covering diagnostic skills, medication usage, and lifesaving techniques. We

learned disease processes, anatomy and physiology, cardiology, pharmacology, and traumatology. We never learned good patient-provider communication other than, as one instructor stated, “Be empathetic.” This lack of teaching communication skills enables and promulgates a culture of paramedic *dyscommunication.*

This seems like a stretch to blame *dyscommunication* on a lack of training in empathy and empathetic language. In class, we ran through so many scenarios and drills. During the first training scenarios, we were exposed to the fact that some patients die no matter if correct treatment modalities are used. We killed the hell out of Resusci-Annie. Our instructors would stand over us and yell at us like families would on scene. This exposure is supposed to help us deal with the stress of being a paramedic. One instructor told me, “It’s better to kill the manikin in here than the city mayor out there.” (*Personal note- have done both, and he was right.)* The goal was to remove self from the call. In other words, remove my humanness while in the throes of battle. It is during the review of these scenarios that medics learn the foundations of *dyscommunication* in EMS. I could diagnose and treat better than some doctors, but I never learned emotional communication with patients and families.

A requirement for our class was to be an Advanced EMT. This was a benefit as we were able to practice skills sooner in the field. We started our clinicals at month 2 rather than month 9 in a traditional EMT to Medic program. We had longer to complete 1600 hours of field internship (800 ambulance/800 emergency room). This was awesome for me as I was working 96 hours per week in addition to study, clinicals, and class. I thought 1600 was crazy considering I had just completed 800 hours in my AEMT class. But what I came to realize, it was more about the experience gained during those hours that made me a better clinician (Margolis, 2009). Our instructors made us do at least half of EMS in the city and ER clinicals at the level 1 trauma center.

We were assigned a preceptor during clinicals. Our preceptors became instrumental in providing guided experience and a frame wherein to use the knowledge gained. One of my favorite preceptors said, “I am here to let you play, but keep you from doing stupid shit.” In ER and field settings, we discussed the patient afterwards finding areas of improvement. The preceptor asked how I arrived at the diagnosis and treatment plan. The first time it freaked me out. I felt like I had missed something important.

Honestly, he was trying to get me to think about choices and understand the potential outcomes. He was helping me create rationales that would stand up in court. The review is clinical and sterile, much like traditional research. Emotional distance is needed to allow EMS to do function effectively *during the call* (LeBlanc, 2011). My instructor told me, "Emotions cloud judgment. You have to treat what's going on, not who is on the cot." (Personal recollection). My preceptors never taught emotion management (Williams, 2012). Unlike today's EMS students, I was not taught:

> Loss, grief, shock, depression, anxiety, self-harm, and skills like breaking bad news, listening, empathy, self- awareness must be incorporated to enable a holistic perspective and the care of people rather than conditions. The support needed by the student paramedic must include recognition and discussion of the emotion work inherent in their work and the signs and symptoms of stress. (Williams, 2012, p. 6)

Except…emotions cloud judgment. Emotions kill patients. It does not matter how I feel. My job was to save lives. To paraphrase Tom Hanks' character in A League of their Own, "There is no crying in EMS." Emotions and communication are not addressed leaving many to fall into the *dyscommunication.*

Even though paramedicine has become more accepted as a practice, PTSD and other stressors cause *dyscommunication* for practicing EMS personnel. As many as 77% of medics had been "exposed to a full-arrest CPR and 44% has witnessed a full-arrest CPR with family members present" (Beaton, 1998, p. 824). Paramedics on shiftwork are at increased risk of occupational fatigue and depression due to poor sleep conditions (Courtney, 2010). Psychologists all agree that stress is factor, but none address ways to fix the paramedic *dyscommunication* (Lowery 2005; Minzo 2006; Hackland 2007, Porter & Johnson 2009, Prati 2011, Donnelly 2012, Halpern 2012). With long hours, job stress, emotional distress, and the constant possibility of a line of duty death, the average EMS career is less than seven years (Edwards, 2008; Chapman, 2009). The EMS adage is "there are no old paramedics." Not exactly earth-shattering news there.

***Dyscommunication* is…**

EMS see bad shit should be the title of my dissertation. I saw so many dreadful things, but I bottled them up. I lost my humanity…maybe not humanity, but I lost my humanness. Clinicals never taught me to diagnose and treat my critical emotional stress points (Halpern, 2012). The plus side is I have PTSD now. I did learn how to tell stories

of my experiences, especially after bad calls. I lost my humanness as I began speaking the EMS native language. It blew off stress, but never emotions. This crudeness calls a burned person a "crispy critter," a nursing home patient being "a gomer tote," or to "cancel Christmas" after a cardiac arrest patient died. I sent the lightning (defibrillated), gave the juice (epinephrine), and dropped the 8-0 (intubated) on a bajillion patients. Oh my gosh, I could author a book about all the names we had for patients and patient conditions. This language is called *gallows humor* (Kuiper, 2012). "The function of humour (sic), and in particular of using humorous descriptors in the emergency setting, is to permit the individual to disengage from emotionally challenging emergency situations" (Scott, 2007, p. 353). Thus, black humor serves to decrease psychological stress and increase social cohesion and support within the EMS community (Rowe, 2010) …. except it doesn't.

Alleviating stress within the profession is good, but, too often, EMS are not taught how to talk at home which creates *dyscommunication* with the medic's family. One of the biggest challenges for medics is not the patient, but finding a way to communicate with their spouse and families effectively. When I had a bad call, I couldn't find words to describe how I felt to my wife. I could talk about the call all day. Quality Assurance is EASY; Quality Life is NOT. "Giving EMS family members the opportunity to communicate about their emotional reactions to their stressful jobs as well as making a concerted effort to communicate about family and household responsibilities is central" to creating a better work-family fit (Roth, 2012, p. 467). Here is the rub; the family may not comprehend fully what "a day at the office" means for a paramedic. Nowhere in the educational process is the family added to the equation. Wives and children are not given an orientation to the culture and, thus, are oblivious to the inner turmoil of the paramedic. This lack of understanding between paramedics and their families adds to the paramedic cultural *dyscommunication.*

All the academic talk is great, but without the tales of a paramedic life, we cannot you about my *dyscommunication.* While I cannot recall each call I ran in my career, the following show my path and journey towards *dyscommunication*. Some are funny and unbelievable. Others are horrid, harsh, and ugly. For confidentiality purposes, and within bounds of autoethnographic writing, I have changed some identifiers to protect patients and other medics. In the spirit of disclosure, I think most of these are true, but so many

memories have fused together to create things that NEVER happened. But the experiences in themselves are true-ish. In previous autoethnographies I left out graphic details out of the stories as I cannot do full justice to them in writing. To understand my lived experience and how it shaped my communication, I am not in these tales! Yes, I saw brains, sliced off heads, and splayed open stomachs oozing guts just like the movies. Understand, I saw it then…and still see all of them today when I close my eyes.

This is where we leave off the literature and scholarship to explore my journey through the paramedic culture and its *dyscommunicative* state. The following stories show the spiral down towards *dyscommunication*, and finally how I "got better."

Tales and "Tells" of *Dyscommunication*

My parents were both nurses, so hospitals were not new to me. I spent countless hours in the ICU with my mother late at night discussing medical stuff. I spent time with my father on the floor and asked questions while he charted. This is how I lived my teenage years. However, I was 25 and needed 40 EMS clinical hours to complete my EMT-Basic course.

I worked as a dispatcher for a local private EMS service. I knew the crews and was looking forward to putting the knowledge to use. I was 20 minutes early to that first clinical. "Beaner" and "Happy" were the medics on duty with "Sunshine" leading the transfer truck. We began checking supplies for state-mandated par levels. We had completed 6 of 12 cabinets when Beaner started yelling at "Spaz". "How could lose those tubes. You (pointing to me) help him find them." The EMT quickly replied that he had no idea. I started digging through all the other cabinets looking for "Fallopian tubes." I was as EMT student and had not been introduced to this equipment; so, I was sent on a quest to find Beaner's missing fallopian tubes. I walked to the supply room and asked Happy (a male) if he was missing fallopian tubes on his truck. He suggested asking Sunshine. She had them on her truck, but they were locked away. She suggested I ask the "Puddles", the Director of Operations (a male) or Mama J, the owner (a female), if they knew. Puddles almost swallowed his Skoal laughing and sent me further up the chain. Mama laughed her head off and sent me out of the office, but not before offering a lesson in female anatomy. I had just been introduced to, or hazed, the EMS culture. Beaner, Spaz, Happy, Sunshine, Puddles, and Mama J were all in it together.

A few days later, I had my first hospital emergency room clinical. As I was walking in the door, the loudspeaker announced a Code 44. From class, I knew this was a cardiac arrest. I needed to do CPR for a clinical check off and ran to the room. This was first real dead person I had seen in EMS. The nurse cut open her shirt and bra…her breasts were the size of a small island and flopped wildly at her side. The nurse shouted, "Quit ogling and help me corral these things." I quickly grabbed the patient's left breast and held it in my hand. I had never touched a breast before in my life. They said I was smiling. The ER doctor just looked over at me and laughed as I just stood there holding the dead woman's boob in my hand; they were supple, huge…and still warm…

I passed my state certification test and was assigned to a transfer truck. This unit was responsible for transporting the noncritical patients everywhere. This unit did 8-12 noncritical transfers per 24-hour shift where the MICU (or medic unit) only ran 2-3 emergencies. I thought I was getting hosed. The green EMT hired at the same time didn't have to do any transfer duties. After a month, I complained one day to the supervisor. He yelled, "You haven't earned the right to take care of real patients. Get the fuck out of here you newbie fuckface rookie." Lesson learned.

Two months later, I had enough experience to be paired with a Paramedic on a "real" truck- no more transfer jockey for me. Our first call was a transfer. Seriously??? I had paid my dues on that hated transfer truck. When we got back, the supervisor asked, "Hey fuckface, how'd you like THAT call??" We did 4 more non-emergency transfers that shift. My medic did not ride a single call over the next three weeks as we mysteriously caught EVERY transfer. Later, I learned (from Spaz) Happy had told Beaner (the supervisor) to give our truck all the transfers since I knew how to do that paperwork. It was hard to be happy when getting screwed over, but I was forced to keep it all in. I was broken.

After a week or so, Happy decided I had been punished enough. We entered the regular 911 rotation. The heavens opened, and God smiled down on me as someone woke up dead and called 911. I FINALLY got to use the woo-woos (lights and siren). The address was 2 miles from my house. The wife worked as an aide at the local nursing home. I had seen the patient around town several times. I knew his kids. Enroute, my partner was telling what he wanted done. I had been in EMS 1 year but had never worked a cardiac

arrest before. I oversaw pump and blow (CPR) and connecting the monitor. I could do that; I was eager to please Happy. My joy turned to ugh as we found a very naked male wedged sideways in the very narrow space between the bed and wall. At least I didn't have to strip and flip him. As the EMT, it was my job to manhandle the very wrinkled, fat, and cold 300-pound man. I have never felt cold like that before…He was VERY dead. The wife said he had 2 previous heart attacks. The medic curtly said, "Third time's a charm." We left him dead on the floor with a smile still on his face. My medic "prayed" in the truck, "Dear God, please let me die like that. Amen." The next two shifts, we worked two additional cardiac arrests. Both, like the first code, were cold, wrinkly naked males who died while "playing hide the sausage" *(the medic's words, not mine*).

I began losing humanness after those calls. I could work a call with someone's guts splayed open then go eat dinner without flinching. I did not realize I was losing touch with sensitivity until my first *dyscommunication* episode a few months later. Mama J moved me BACK to the transfer truck. We were taking a stage 4 lung cancer patient across town for radiation treatment. He was weak and frail He mentioned that his radiation had been on hold a few days because he had had a small heart attack in the oncology unit. Without thinking, I spurted out, "Ouch! Double whammy!" His wife in the front seat heard. I heard my partner groan. The patient died 3 days later. I am an ASS!!!

What I had not noticed was that during those 2 years with that company, I began a slow spiral downward. It was not one incident. It was hundreds of calls. Previous chapters have shown the link between neural pathways, senses, and emotions. I was dumbfounded when I found the following:

> Emotionality in men is prohibited and policed by both other boys and men and by girls and women, leaving individual males with little choice but to suppress emotions and behaviours that may be deemed as weak. (Patton & Joubert, 2016, p. 19)

This notion adds to idea of a causal link between EMS job-related emotional suppression and *dyscommunication.* Furthermore, Griffiths (1997), a noted Emotion Philosopher at University of Otaga, New Zealand, proposed:

> Moods and emotions are plausibly neurochemical states, which act to modify the activity of broad areas of the central nervous system. If this is how the neuroscientific picture turns out, then their action would be precisely to modify the probability of transitions between a given input, internal states, and output.

> Very simply, suppose that under certain conditions, the presentation of a spider has a high probability of triggering the fear affect program. The effect of depression would be to inhibit the depolarization of neurons in the pathway subserving that response and thus to alter the transition probability between the presentation and the fear response. The implementation level description of moods explains why moods function like higher-order states. **Emotions are implemented by neural states. A mood state is a neurochemical condition which modifies the propensities of one neural event to bring about another.** It thus alters the functional description realized by the affect-program system. Its effects may be diffuse, affecting the whole system, or specific, affecting the various emotional responses differently. (pp. 254-255)

In short, sensorily based stimuli create powerful emotions creating a neural pathway of seared memories. The body reacts physiologically and functionally to preserve system integrity. Within Communication Complex, these are perturbations. I subverted my body's natural reaction to emotions and other stimuli causing decreased mental health. An interesting side effect is that I have suppressed olfactory sensation. I do not smell good. I am not ticklish either…

I ultimately left that company because 1) I was getting paid less than $4 per hour, 2) the owner was a crazy old tyrant who hired horrible supervisors, 3) there was no possibility of advancement since it was a private company with only four ambulances, and 4) Ms. J was a crazy bitch who demanded we detail her car and her friends' cars. These factors are key reasons EMS personnel leave even when they have a great desire to serve others (Blau & Chapman, 2011, Edwards, 2008). Except I did not leave EMS…yet. I changed companies and started Paramedic class.

I had been working a rural station (average 3 calls per shift) but had changed to working in Tyler, population 85000. I worked the weekend overnight 1700- 0900 shift to accommodate my school schedule. We ran around 60 calls every Friday, Saturday, and Sunday. Since our unit was the only one on duty between 4:00 – 7:00 am, we had more cardiac arrests, overdoses, shootings, stabbings, and wrecks than a theater has popcorn. One skill I had to master was endotracheal intubation. We worked at least fifteen cardiac arrests and ground checked another dozen in the first two months. Ground check, aka dead on arrived, meant the patient had dependent lividity, rigor mortis, a DNR, and other signs of death. Lots of paperwork; no playing; no fun at all. Why did they have to wait so long to call when they died? Working consisted of CPR, cardiac meds, rhythm analysis… everything I learned in school. It was exhilarating!!! I got to play in the city. I brought the

lightning!!! To feel the body jump with the shock…and the smell of burning flesh from all its power…. AMAZING!!!!!!! They all died…but I had some fun playing and bragging to my classmates about how many people we had killed the previous shifts.
The combination of sleep deprivation, too much caffeine, school stress, and no time off created perfect storm conditions for *dyscommunication* to flourish.

We had a LOOOOONNNNGGGG weekend. At 0200 on Monday morning, we ran our 93rd call of the weekend. We ran lights and sirens across town for an unknown hemorrhage. Usually these calls were awesome…and the back of our unit resembled slaughterhouse rather than an ambulance. YIPPPEEEE! We arrived at the house expecting blood and guts. A 25-year-old male casually walked out of the house as we pulled up. He was the patient. No blood…no nothing. He knew he was dying because WebMD told him so. I began asking questions about his signs and symptoms, which included blood streaks on his poop for 2 weeks and an itchy butthole. I knew the diagnosis. My partner knew the diagnosis. The six firefighters who had been summoned to assist with the person near death knew the diagnosis. I hadn't slept in 40 hours. I hadn't eaten since in over 24 hours. I hadn't bathed since Friday. I spilled Dr Pepper on my uniform on the way over. I was tired, hungry stinky, wet…and pissed. I was pissed because the jack wagon had called 911 for freaking hemorrhoids. I was tired…and slightly irritable at this point, which is no excuse…. but… I erupted, "You brainless motherfucking fuck. You have fucking hemorrhoids. Walk your fucktard itchy ass over to the Walgreen and get something other than a banana to shove up your stupid bitch ass!" His jaw gaped open. My partner's jaw opened. A huge woof came as all 6 firefighters' mouths hit the pavement. I skipped back to the truck and cheerfully told dispatch, "No ambulance needed. Back in service!" Scene time was 45 seconds…and I didn't even get a patient refusal form. I relegated him to the ranks of nothingness of the No Patient Contact realm. Did he have emergency? Not really, but I knew something was not right in me. I blamed it on being tired, hungry, and stanky. The stress was building, but I never saw what would happen next when work crossed into homelife.

For the two years I was in AEMT and Paramedic classes, I usually added a 24-hour shift on Tuesday and/or Thursday each week to my weekend 16-hour shifts for around 100 hours per week. I was in class or clinical rotations another 30 hours. Most week I was

home Monday afternoon and Friday mornings. I was home to sleep between shifts. We never argued, but only because we never talked. She was content to get that $2500 paycheck every other Friday. I was content not having to talk to her. I was married to her on paper only. In 2001, after two years of school, I became a "real" paramedic after passing both the Texas Licensed Paramedic examination and the National Registry Paramedic examination on the first try each.

I became a god, and my communication began to change, going slowly downward. Not only did this cause great stress on my body, it began a greater *dyscommunication* with my wife. EMS and the quest to become paramedic was my mistress. My wife had her own affair during this time. She was lonely and miserable. She found comfort in the bottle and became an alcoholic. She was in this condition four years before I was home long enough to realize it. She should have divorced me, and I would not have blamed her. I was burned out in my job…and my marriage, too. Part of the reason may be:

> Individuals who are **more burned out at work may have a diminished capacity to engage interpersonally at home**, **thereby impairing adjustment on the dyadic level**. Current findings also suggest that the examination of individuals' coping responses in isolation is insufficient when explaining outcomes on the dyadic level. Supporting previous studies that have documented the importance of a spouse's response to one's coping effectiveness (Holtzman et al., 2004; Holtzman & DeLongis, 2007), it was observed in Study 3 that rumination and withdrawal interacted to exacerbate marital tension for both partners. **On days when paramedics engaged in more rumination, the impact on marital tension worsened if spouses withdrew from the relationship**. (King, 2013, p. 117)

I could not explain to my wife the very things that were killing me emotionally. We had tons of money and stuff without emotions. I had learned to suppress emotions as means of survival in EMS, but I was lonely. In his groundbreaking study, Pieters (2013) found:

> Materialism and loneliness form a self-perpetuating cycle with vicious and virtuous sides. Materialism was associated with an increase in loneliness over time, and loneliness was associated with an increase in materialism over time, and this latter effect was notably stronger. (p. 627)

This makes sense to me in 2020 as an aha moment, but it never occurred to me 20 years ago when I was in the trenches. Lonely people have "poorer sleep quality, longer sleep latency (falling asleep), longer perceived sleep duration, and greater daytime dysfunction due to sleepiness than did nonlonely individuals. Thus, a pathway by which

loneliness may affect health is via diminished restorative processes." (Hawkley & Cacioppo, 2003, p. 103). Loneliness, sleep deprivation, compassion fatigue, mental health…. everything becomes tied up in cyclone of self-destructive *dyscommunication*.

After a string of 3 LEO/EMS/Fire suicides in Tamp Bay region in 2019, Pasco County Sheriff Chris Nocco and Jacksonville Sheriff's Office EAP Counselor Tina Jaeckel stated in interviews with *Tampa Bay Times,*

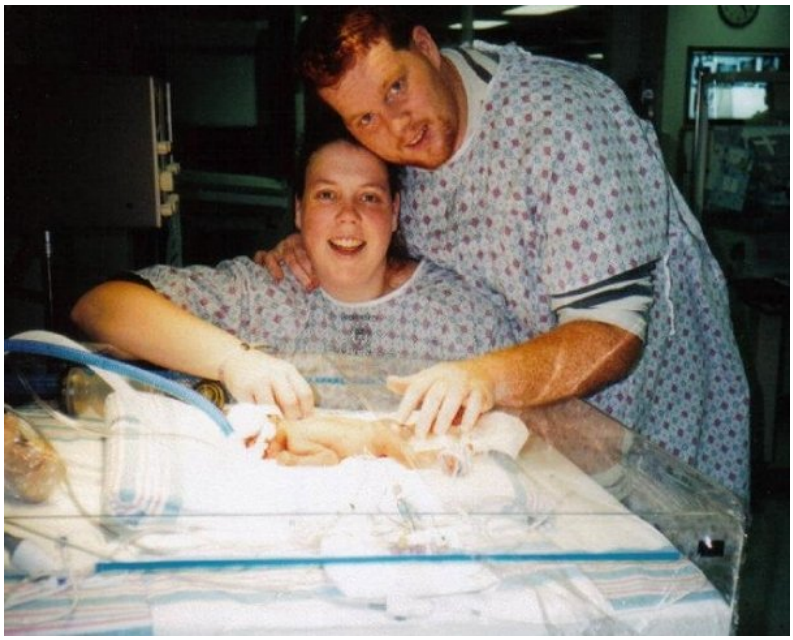
> Law enforcement can also produce a culture where officers may not seek help for mental health issues because it can be seen as a weakness. Nocco echoed that sentiment. He said law enforcement officers must become more open about their struggles and start address on-the-job mental health issues such as post-traumatic stress disorder. "**It's very hard to change the culture**," the sheriff said, "**where people are told to suck it up**." (Taylor, 2019, n.p.)

The suck it up culture exists in EMS as discussed in previous chapters. I was burned out…and about to explode. We brought in a patient in mild respiratory distress to the local ER. When the nurse asked why I brought the patient there, I shouted, "I thought the little red sign meant there was a nursey-poo here… *cough cuntfacebitch cough."* In my defense, she had lodged 36 complaints to my supervisor about "serious" infractions, such as my shirt was untucked after working a cardiac arrest, leaving our truck running outside the ER when it was 25 degrees outside, and, my favorite, not calling in a patient report for a patient being directly admitted to the floor. She was a big old bitch… and needed to know it right then!

During my two-week company sponsored (and unpaid) "vacation," management found a slot closer than a 300-mile roundtrip from home. I was given the "opportunity" to spend some quality time with the BHC (Behavioral Health Center) counselor. I should have used this chance to address my *dyscommunication* and find a healthy outlet. The counselor had "awareness of the role of organisational and cultural factors (in EMS) but did not realize that clinical models of PTSD are of limited use in understanding risk/ resilience factors in the emergency service worker population." (Evans, 2012, p. 113). So, I easily played a game where I blamed everyone else for these bad feelings inside. The nurse really was a big old bitty… but I should not have told that to her face… I was not ready for the next phase where dark *dyscommunication* spewed to create a downward pattern lasting year beyond the end of my career.

Dyscommunication is a dark bastard from a harlot mother

My wife and I always wanted a large family. We were excited in 1998 when we found out we were pregnant a few months after getting married. Our joy was short-lived. At week 25, Justin Blake Deason was born at 6:33 am, December 1, 1998 in Shreveport, Louisiana. I was on-duty 90 miles away when I got the call. We were escorted to the Neonatal Intensive Care Unit 6 hours later. Our little boy was intubated, had a chest tube for a tension pneumothorax from intubation, 2 IVs, and several tubes I had never seen before. It was a nightmare. We could not hold him… and due to elevated heartrate near 400 bpm with touch, the first 24 days were spent staring at him (see Picture 5.1) We got to hold him for the first time on Christmas Day. During those 83 days, we only were able to visit every 3 days for a few hours when I was off duty. We decided a small family was a good thing.



Picture 5.1 Mary and I in LSU-Shreveport NICU with our preemie Justin, Dec 1998

A year later, we were dispatched to a cardiac arrest. No big deal. I had worked many cardiac arrests. This time was different. The first responder ran to our unit in the driveway while performing CPR on a 4-month-old infant. He was a twin. He was pulseless, apneic, and unresponsive. He had full rigor mortis and lividity. He was cold and blue. He was dead DEAD not just regular dead. He had been dead all night. There was nothing to do to save him. I had to tell the parents their child was dead. I think this was one of the few calls that rattled me. My own son was just a few months older than this angel. I called home to hear my son breathe…and realized, we wanted more children… eventually.

After years of fear, we began trying again. Within a few months we were pregnant again. We were excited to have another addition to our family. We knew it was a girl (even though we not far enough). Due to the previous high-risk pregnancy, we went to the doctor every week. Everything was progressing as it should. Mary was excited…and we began dreaming of her wedding, grandchildren, and everything else little girls should be and do. I was 45 hours into a scheduled 48-hour shift when Mary called me. She was sobbing uncontrollably. We were eight weeks into the pregnancy. She started spotting earlier in the day and had just begun bleeding. She was cramping with severe back pain. Symptoms and signs collected, my presumptive diagnosis for the patient could only be one thing- a miscarriage. I told her curtly the embryo was dead. I promptly went back to sleep; I was tired. Seriously, I hung up on my wife; she was miscarrying alone. At shift change three hours later, her sister drove her the 30 miles to me. It was just a miscarriage- 10-15% of pregnancies end in miscarriage. It happened all the time, especially in the first trimester. I did not understand why she was upset for a common pregnancy problem. I drove the speed limit to the hospital. I was tempted to call a patient report into the emergency room to let them know I was fifteen minutes out, even though I was transporting by private vehicle and not an ambulance. My wife later commented that I was so emotionally removed that she was like just another patient. Emotional suppression, as discussed previously, is one job-regulated function I did not turn off…even with my own miscarrying wife. It is easy to see how the key determinants of emotions are socioculturally driven (Thoits, 1989). I learned emotional suppression at work. I was ALWAYS on duty even when not at work…and *dyscommunication* was born instead of a healthy baby girl. I am *dyscommuniholic. Dyscommunication* is the dark bastard of a harlot mother.

Kool-Aid, peanut butter, and Ms. Jones

Late one night, we were called to the north-side Whataburger. It was in the rough part of town. As we were woo-wooing across town, 15 police cars screamed by us. We arrived at a throng of wailing banshees gathered around a body in the Whataburger driveway. The late teenaged African American male lay in a pool of blood. The monitor showed asystole…. the flat line showed he was dead. We knew it. The police knew it. The crowd knew, which set them off from a normal "lordy, lordy, lordy" to *tachylordia* where they are shouting "Lordy" much faster. They were getting more agitated by the

second... screaming at us to do something, or ELSE. We kindly obliged knowing he was still dead, and no matter how much we did or did not do- he was still dead…but we still going to try. He had a gaping chasm where his lung used to be. We began CPR. We tried to plug the holes in his chest. We started a large bore IV to replace the blood on the driveway. Every chest compression spewed a paler and paler red Kool-Aid on the floor of the ambulance. Every compression shot blood out of his mouth like Old Faithful. Blood spatters covered my uniform. I was going to have to change AGAIN after having been puked on earlier in the shift. Now, I had nursing home chipped beef AND Kool-Aid in my boots. The kid had been shot close range with a 12-guage shotgun over a pair of sunglasses.

I have talked about mental health and communication throughout my dissertation. What is missing is down time between shifts in EMS. The closest literature comes from the military. Both EMS and military experience critical incidents (in different forms obviously). The average single military deployment time is 7.7 months; those with multiple deployments average 16.9 months total. This time between deployments/shift is called dwell time. The average military dwell time between deployments is 21 months ((MacGregor, Han, Doughtery & Galameau, 2012; National Research Council, 2013). Military personnel have time to resume non-combat operations, demobilize their units, seek mental health counseling, and return to a normal-ish life with their families. EMS personnel have different deployment schedules. The most common are rotating 12-hour shifts (2on/ 2off/ 3on/ 2off/ 2on/ 3off); 24-48 (24 hours on/48 hours off), and 48-96 (48 hours on/96 hours off). EMS have no dwell time; no time to disengage. Having time to decompress is important as "the risk of suicidal attempt increased as dwell time decreased, highlighting that this period of rest, recovery, and preparation between deployments has an important protective role." (Ursano et al, 2018, p. 601). EMS have the same stressors as military… the difference is time. Using the previous call as an example, we ran 4 more calls that shift…and got off 2 hours late but were expected to be back on duty in 6 hours at 1700 for another 16-hour shift. Managers don't work weekends. Counselors don't work weekends. We had no resources… no help to process that call. No wonder PTSD, suicidal ideation, alcoholism, and drug abuse run rampant in EMS…. But for then…we were back in the saddle again.

I honestly have no idea about the chronology of everything I have shared. These calls that live in my head and play in my dreams "are pure recollection, or the associative occurrence of a representation of past experiences" (Moore, 1996, 38). It is in the act of pulling all the isolated experiences together into a whole that one begins to see time is irrelevant and has no backward boundary quantumly. It is easy to see how the calls meld together in a never-ending symphony of horror…because time does not exist (Wendt, 2013). A few more tales until story time is over.

All we were given was that car was in the ditch about 20 miles outside of town. While enroute, dispatch advised that the helo launched per scene command, and CPR was in progress for one of our two patients. We had to maneuver through the lengthy line of traffic. We saw the car perpendicular to the highway resting near a culvert; it had flipped with heavy roof damage. The scene was a hotbed of activity with local volunteer fire personnel swarming the vehicle and a horde of looky-loos (people from blocked cars) gawking at the scene. Fire ran to us and gave a quick assessment. 2 patients- a mother and 4-year-old daughter. The mother was trapped in the car in serious condition. The daughter was partially ejected and moved the ground by bystanders. My partner went to car; I went to child. CPR was still in progress by bystanders. She had blood all over her face and body with blood pooling on the ground under her head. I was about to start patient assessment and noticed ants crawling on her head. We had to move her. Fire came over to help me with the move. They secured her body; I maintained C-spine precautions due to mechanism of injury. I could feel a cold wetness of blood as we lifted. Suddenly, the coldness turned into warm peanut butter as my hands slipped in her skull. With the mother watching, I contacted medical control to "call it" determining asystole and trauma incompatible with life (being ejected and having brain matter leaking from the huge hole in her skull) made further attempts futile. I watched the mother's eyes flinch in horror as we placed the sheet over her baby. She was trapped and could not even hold her baby one last time. the banshees wailed. We later found out a driver in her lane had illegally passed on a hill and had run her off the road. Her only fault was taking her daughter into town to get an ice cream cone for going potty in the big girl toilet. Every time I make a peanut butter and jelly sandwich for my little girl, I feel her brain.

Before she was Ms. Jones, she was G-ma. My best friend, Tim and I went to her house a bazillion times as kids. She was the nicest little old woman, and She always had warm cookies and milk for us. She smoked like a freight train, 3-4 packs per day for 125 years. Today, she was coughing and having slight difficult breathing. Her grandson, who was my best friend since kindergarten, was at the house with her. We talked about the local football team as we loaded Ms. Jones on the cot. Oxygen helped. Monitor showed a slightly tachy NSR around 110. We rolled her outside and into the truck. As we lifted her, she smiled at me and in gasping breaths struggled to say, "I… don't…. feel…" then deafening SILENCE…No gurgles...no groans…no death thralls. Her eyes open staring at me. Her dead eyes stretching out to take my soul with her. My friend watched me kill his grandmother.

Call after call. Death after death. Sleepless night after sleepless night filled with nightmares. Even off-duty I was sleeping 3-4 hours per night. Day after day of repressed emotions and performing calmness. This "surface acting is very harmful to EMS professionals, leading to lower job satisfaction and decreased overall health." (Blau, Bentley, & Eggerichs-Purcell, 2012, 638). I was almost done. My marriage was almost over. My mental health and life happiness were gone. There's so much Kool-Aid, peanut butter, and Ms. Jones in my life.

A body count like a Rambo movie

Late one night, I was working overtime at an outlying station. We were the second unit dispatched to a two car MVC. Radio traffic indicated massive damage to the vehicles and several bodies in the road. MULTIPLE WHAT??? We stepped it up from 70 to 95 mph. We were a fiery chariot racing to battle. We were 30 seconds behind the first in. They were coming in from the South, so they got the pickup truck and bodies. We got the minivan 100 feet away on the North. Our duty was to triage the occupants. The driver and front seat passenger were unrestrained. The windshield had two perfect head indentions filled with blood, hair, and brains. The driver was crumpled under the steering wheel. The front passenger was upside down with her head wedged between the seat and the transmission shift; her severed left arm hung out the shattered side window. We used the triage discussed in Chapter 1 to detach ourselves from the horrible decisions we were

forced to make. Despite the chaos of the scene, in the eerie stillness I could hear my partner's heartbeat as the body count moved to 2.

Thanks to adrenaline coursing through our veins, we attacked the side door of that Astro van. After minutes of tugging and cursing, we entered the middle row war field of more mangled bodies. *I could hear the Count from Sesame Street counting dead bodies for me… one ahah... two...ahaha… three ahaha... four. Ahaha… yes, four lovely dead bodies.* but heard a soft moan somewhere in the vehicle. I had to hold and maneuver through the dead bodies as we looked. We found two toddlers on the floor- just under their grandmother. Both children had massive injuries. Both died later that night. The wreck happened just under a blinking caution light. (I sometimes freak when I see blinking yellow lights).

Around midnight, we dispatched to a stabbing. A dispute between two drunken friends had escalated. We found the patient prone on the ground. We removed the shirt and found three knife wounds on the chest. One was supraclavicular. One was left lateral around the fifth intercostal space. The final was midsternal. He was asystole, but warm. In class, the instructor always said, "They ain't dead til they're cold and dead." So, we worked him. The ER doctor called the code about 28 seconds after arrival. Police were there and took pictures. It took an hour to finish paperwork and clean the lake of blood from the truck. I heard the doctor shout, "Cool. You've got to check this out." I ran into the code room where the dead body lay. Before I could ask what was going on, she grabbed my finger and stuck it in the side wound. "That's his heart!!!" There was only one thing to do… I shouted for my partner to come in and feel it. Pure awesomeness.

We were dispatched to another MVC. Over the county radio, we heard the vehicle was on fire, and witnesses confirmed the patient was still trapped and screaming as he burned in the car. On arrival, the car was completely engulfed. There was nothing we could do, but hope the other unit coming out to gawk was bringing marshmallows to the bonfire. He was a crispy critter. As the funeral home only had one person on duty that night, we stayed to help extricate the charred remains. The burned corpse stuck to the springs in the seat. Removing would take a little force. I got leg duty and attempted to pull. The victim was still lodged; all I did was remove a huge chuck of leg meat. "Aww…medium rare. Just how I like it. Anyone got sauce?" Everyone laughed.

It was a slow day at work, so we decided to do "trauma" training. In honor of Saw VI, which was being released soon, we had a "Saw-a-thon." We watched all five movies that day. We laughed and laughed and laughed some more. We told war stories about how we had seen worse on calls. At one point, we even pulled out our cell phones and started showing each other pictures we had taken of the dead from other calls. I think I had become fully enmeshed into the paramedic culture and its *dyscommunication.*

I witnessed too many people take their last breath. All told, I know I "killed" many people in my career. I saw death all the time. With all those chances to play god, I only "saved" one cardiac arrest. Upon regaining consciousness, she was pissed and started cursing me (and later filed a complaint with the Company for ruining her good shirt and breaking three ribs). On a side note, it was my birthday. So, I got cake and my only "save" that day.

It…

On January 24, 2010, at 1:37 pm, an 18-wheel driver decided to text and drive. At 1:38pm, he swerved into oncoming traffic and forced a vehicle to run off into the ditch. The vehicle flipped over.

A bystander bent over and asked the occupants, "Do you need an ambulance?"

They did not. They only had a bump or two. They managed to climb out of the wreck. The passenger stood near the roadway shaking as he called his wife.

"Mary Lee, I am fine…"

At age 37, I cried for the first time in my adult life and fell in a sobbing heap to the ground on the side of a country road.

.

.

.

I ugly cried…

Making sense of It

Trying to find meaning in all these stories is challenging. All my tales- told and untold illustrate a downward decline or "line of action to move automatically from one specific activity to another" (Mezirow, 1997, 5). The linkage is there when seen as a whole. In other words, I created a habit of *dyscommunication.* Much like smoking and other unhealthy habits that lead to a lifetime of disease, I did not see the problems caused by my horrid communication habits until it was chronic part of my life. I see how from the very beginning of my EMS, when I held the dead lady's boob in my hand, I headed down the road of *dyscommunication*. I learned gallows humor from the experienced medics I worked with (See Picture 5.2). Honestly, who in their right mind jokes about holding a dead man's burnt leg meat in the hand? I learned how to speak and act like a paramedic; I became a real-life paramedic. I learned how to keep ME out of the communication equation by becoming insensitive with my patients and not really listening to myself or them. I had a failing marriage heading towards divorce. I did all those things the researchers said I was going to do. I became the paramedic the researchers said I was destined to become. De la Garza (2011) concludes, "Paramedics, too, often lose their faith, their families, and a sense of who they are. The dark and negative events they face in the performance of their duties eventually take their toll on the human body and on the human spirit." (p. 224). Some turn to alcohol. Some turn to drugs. I became a *dyscommuniholic*, and in doing so, became a quantifiable statistic. I talked and acted like a god. No, I was GOD and finally reached the apex of *dyscommunication.*

Picture 5.2 Courtesy of Arrogant Pricks of EMS

I was patient and paramedic that day. But when other EMS personnel arrived, I entered a liminal space, being neither patient nor paramedic. Kelly (2008) wrote, "Liminal spaces are between cultural states, making them an in-between place, a non-place. In this space, initiates are between social roles, cultural expectations, and status." (p. 337). I had a chance to negotiate my future career and communication states- get better (posttraumatic growth) or get worse (severe PTSD).

Most of the time people tend to focus on PTSD as the only option. Everyone will have posttraumatic stress after something bad. The "D" comes when the PTS is not addressed effectively. The goal is to achieve Post-Traumatic Growth (PTG) which uses "problem-focused coping, positive event perspectives, and working through feelings" (Scheuttler and Boals, 2011, p. 190). I had to make sense of this new place I was at in life to get better. Chopko (2009) wrote:

> During the process of posttraumatic growth, basic assumptions held before the traumatic experience are abandoned as attempts to build new schémas, goals, and meaning are made. This occurs because prior basic assumptions cannot accommodate the new reality presented by the traumatic experience; thus, new goals and worldviews are formulated to compensate for the change in perspectives. (p. 371)

In other words, I had to make sense of a new reality and find a place to grow. Liminality is a great space. Because I no longer knew myself, I had to refine and redefine who Aaron Deason is. The process hurt my soul. As I researched early in grad school, I came across Tedeschi *et al.* (1998), they wrote:

> A variety of cognitive changes regarding fundamental questions about life such as why it is important, what one can expect of it, what contribution one can make, and whether an individual life is important and meaningful, are affected by trauma. (p. 13)

When other EMS personnel made jokes about my wreck, I realized how my *dyscommunication* caused undue pain and distress to patients notwithstanding having the skills to save their lives. I saw that I lacked every facet of niceness and politeness that civilized human beings should have. I wanted to change my *dyscommunication.* O tried to find ways to address the stress and create a better communication pattern. I tried walking. I tried talking to the REAL God, who I had forgotten was not me. I tried everything during that climb uphill on my life roller coaster.

One year to the day after the accident, I quit EMS and walked away forever. The strange part is that I kept my certification current until 2017. Do I still have problems with *dyscommunication* even though years removed from EMS? Yes. Interestingly, like Chatham-Carpenter (2010) who "felt a strong pull to go back to anorexia, as (she) immersed (herself) in the research" (p. 1), as I read thousands of articles, reflect on my paramedic life, and write this dissertation, my dear, sweet wife can testify I slid back a little. You see, I am a recovering *dyscommuniholic*.

Chapter Six: (IN)to the Ditch: Ten Seconds that Saved my Life

You have a lot of time to think about things when you're upside down in a ditch. *And most of that stuff don't really matter!*

But I have gotten way ahead of myself. I need to start at the beginning. I never intended to become a Paramedic. This whole adventure started when my friend invited me to join the Gilmer Volunteer Fire Department back in '94. For the next two years, I continued to play firefighter and first responder. Around Christmas 1996, we responded to a wreck with EMS. There were 25 patients and only two ambulances. I responded with the volunteer fire department. They needed help. Being an Eagle Scout, I knew how to bandage and provide basic first aid. The medic, who had three critical patients, threw me some supplies, and said to get busy. I did. I loved it. I realized helping others was fun. Helping others is one reason people join EMS (Chapman, Blau, Pred, & Lopez, 2009; Holborn, 2002), which I did when the next EMT class began in February 1997.

January 24, 2010, started out as normal as going to work on a Sunday could be. I was excited because instead of a 48-hour shift, I only had to work 24 hours. A normal EMS shift rotation is twenty-four hours on duty followed by forty-eight hours off duty. This schedule was another reason I loved EMS. However, at the time the company was short-staffed; so, a shift was 48 on- 24 off. Mandated long hour shifts are one of the down sides to otherwise awesome job (Edwards, 2008). I looked forward to a "normal" shift on the ambulance, because on the previous shift several tornados had hit East Texas- Waskom, Noonday, Whitehouse, and Harleton were the closest to us. We ran eight calls that shift…six during the torrent. I had enjoyed my day off, but really needed to go back to work to rest…*Sundays at work meant no calls and lots of nap time.*

I woke up at 0457- three minutes ahead of the alarm. I fired up the computer and checked the obituaries. I always did it back then… *I had seen many of my emergency friends die…one from cancer, two in off-duty motor vehicle accidents, and one in the line of duty- Trooper Todd Holmes. After each death, I planned my funeral. My poor wife endured the full process and often just shook her head… how our marriage ever survived those years I will never know. To this day, when I think about my time in EMS and when I talk about it, my thoughts become more erratic than a fat kid with ADHD in a candy store on a sugar high… Oh yes… the funeral plans… Bagpipers and drums leading the*

procession. My beloved Boy Scout Troop would form the honor guard, and my EMS and Fire buddies would be the pall bearers. I figured I would die in the line of duty because I was working 96- 120 hours per week. Music would be Queen's Another One Bites the Dust and AC/DC's Highway to Hell… ETMC Air One and Mother Frances Flight for Life would hover overhead as the slow, silent mile-long procession of fire trucks, ambulances, and police cruisers drove to the cemetery. The pipes wailing Amazing Grace as I was carried from the hearse to the gravesite. The final call over the radio and the bell ringing…it was going to be awesome…a scene straight from the movies…

I did not understand at the time that thoughts of death and planning are NOT normal. But I had seen LOTS of death. Since I lived in the area where I worked, I saw the scenes every day. I saw the people whose loved ones I had performed CPR. I saw…and saw….and saw… It was bad enough the I saw them physically; I saw the dead in my dreams, too. I did not understand nightmares and flashbacks are PTSD signs (American Psychiatric Association, 2013a) … but I was about to in a BIG way…

I got my gear ready and food packed for the day. Kissed my sleeping wife on the head and left for the shift…*I always kissed her before I left. Even though we had some marital issues at the time- due to the long hours at work and the huge stress it was on our time together- I just did it…whether she was awake or not. One last kiss- because I never knew when or if the next would come…*

"The Green Turd"- my 1995 Subaru Legacy Outback Wagon- was in fine form, as usual, and wouldn't start that morning. The battery was dead…*Only 38 minutes into my day…good grief…* I drove the van around and got the car started easily enough…. *Maybe one day I would spend a little bit of all that money I was busy earning to fix the damn thing…* It took a few minutes to get her blowing and going. It was a 23-minute drive to work. The only redeeming thing about the "Green Turd" was the Alpine stereo system in it. I cranked it up and was jamming to opera and show tunes on the way to work… *I was about five miles down the road when I got a page from Dispatch... I had a special ringtone for them- the klaxon alarm from the TV show Emergency…I looked down because at that time of day it had to be important…Yes, I was driving and texting… and yes, I ended up running off the road and down into the ditch.* After a lot of cursing and swerving, I

managed to get the car back on the road. I promised to never look at texts from anyone while driving, especially Dispatch.

After the above incident, my heart rate had just gotten back into the under 7,000 beats per minute range when I saw it…*a huge wild hog in the road. Seriously??? Was this a "try to kill Aaron" day? I had heard that anti-lock brakes don't lock up…but the amount of smoke produced from skidding and swerving that would've killed mosquitos in five counties says differently. I ended up in the ditch for the second time in less than 10 minutes. This day was not getting any better…*

Even with everything that happened, I still made it to work on time. After washing our brand new $150,000 ambulance, we settled in for our Sunday morning routine. We counted <u>every</u> supply in our unit- every medication, every bandage, every intubation tube…*every everything* …then we had to ensure each had not expired. If that was not fun enough, then we had to do the same for the stock room, too…*I think we had over 10,000 items to check and each had to be 100% correct with inventory control numbers sent out by the main office- called "par level"…if not, we had to fill out quadruplicate requisitions for replacements and complete a discrepancy log and get them taken care of before our shift was over- which eventually meant a trip to Tyler. Good grief… it was so NOT worth the $11.24 per hour I was getting paid. It was so slow and tedious…and all I wanted to do was take a stinking nap. And of course, during the process, we found three out of date medications and six more needing to be brought up to correct par level* … Four and a half hours later at 1130, it was finally naptime…

Exactly eleven minutes later…*just as I had gotten my boots off and relaxed.*..the emergency alarm sounded. "Dispatch, 3718. We have a priority A heart problem at…. *I don't remember where it was…I was unhappy. This was freaking Sunday people…go to church and get Jesus in your life! Leave me alone. All I wanted was some peace and a nap…*

And just like that- from sleeping-ish to running full bore in 1.3 seconds…and out the door we went to save a life. The patient was suffering chest pains…*We had the sirens blaring as we drove through town. I was looking down just as my partner cursed…some jay hole had pulled out in front of us…EXCUSE ME…We ran onto the shoulder of the road...I was in a ditch for the third time today…I was not having fun…and to top it off, I*

recognized the car as a local preacher…wait, shouldn't he be in Church preaching…but I still prayed for forgiveness for cursing at the fella…

The patient was having cardiac problems. It was just enough that going to the local emergency room made no sense. He would end up in Tyler anyways; so, the 53-mile trek to Tyler was in my future…*I was beginning to realize that there would be NO nap for me that day.* I remember the patient being pleasant …*for being in a lot of pain.* He was at a "7" on the pain scale… *"0" being pain-free and "10" being the worst pain you could imagine in your life…we always said it like that, too.* We treated him according to the cardiac protocols and got his pain down to a "0." We dropped him off at Mother Frances ER in Tyler. Then, I trudged downstairs to the pharmacy to get the supplies that were missing from our station. *I hated pharmacy trips…those people were slower than a slug in salt. A quick day down there "in the dungeon" as we called it was around forty-five minutes...*To my delight, it only took ten minutes to complete the task, and we were headed back to our station in Winnsboro…. *Yippee!!! I might even get the nap in today.* I worked on the paperwork for the call as we travelled home.

I remember passing by Tyler State Park on FM 14*...but the next six minutes are kind of a blur...* My EMT, Bill, was driving so I could complete paperwork. *The only reason I know the rest of this story is thanks to the in-truck camera system…Actually, it only captured thirty seconds- fifteen before and fifteen after…*

We topped a hill…*did Bill just say, "Oh shit?"…yes….yes, he did… oh my God there is an 18 wheeler in our lane… Bill jerking the wheel to the right… we missed the big rig…the ambulance started to shimmy…Bill was off the shoulder…correcting…back on pavement…wait, this doesn't feel right…the truck is shooting across the road at an angle… this isn't right at all...*Time slowed… *a ditch…oh mother of ….*

The world slowly turned around as we spun out of control… *The ground reached up and grabbed us…the ground is out my window and coming closer…we are crashing??? I am going to die…* and peace came. This was how it was going to end. I closed my eyes as we hit the embankment and slowly flipped over on our side. I remember being jerked around the cab of the ambulance and seeing stars, but that is all I know about what happened.

Wait…I am alive??? Quick check… You are a Paramedic... who is you? Am I talking to myself in third person? Aaron…come on man…get it together… GET IT TOGETHER… deep breath… better now…quick trauma assessment... fingers moving- check… feet moving- check… no neck pain- check… head…uhm…feel liquid…oh crap…head trauma? I slowly brought my hand down expecting to be covered in blood…it was just wet…no blood … (I found out through watching the video that it was Sprite from the can I had been holding in my hand and crushed as we flipped)…*I cursed the pharmacy people for being fast. They had ruined my nap…*

My partner was dazed and confused. We looked at each other...*You ok? Yeah, you?* Bill was in his seat belt. He almost took off the restraint until he realized he was going to fall 5 feet down onto me. We were staring out the front windshield. *In shock I think*… when a passing motorist who had seen the wreck ran to the front of our ambulance. She turned her torso a complete 90 degrees, so she could look us in the eye…and VERY SLOWLY shouted to us. Now, remember, we are turned over in a ditch in a freaking ambulance… "DO…YOU…NEED…AN….AM- BUUU- LANCE????" *I am not sure if we gave her a thumbs up or a middle finger, but she got the message that <u>WE</u> were 9-1-1.*

I grabbed the truck radio. "3718, Dispatch …Emergency traffic…" No REPLY… A Canton truck was trying to get directions to a call…

"3718, DISPATCH…EMERGENCY TRAFFIC…10-4 GOOD *(I might have said a curse worse word or three here- I blame shock- at least that is what my boss told the FCC people)* BUDDY…EMERGENCY TRAFFIC…"

I was screaming at the top of my lungs because no one was answering. 10-4 Good Buddy was our secret code word for true emergency…*I had been practicing saying it for the past year and a half…waiting for the precise moment I knew it would be appropriate to use…and dammit, the freaking Canton crew would not shut up… they were pissing me off… even worse, I was finally horizontal but it did not involve me getting that nap…* Apparently anger is the first sign of shock…

On the third time, someone answered me... "Go ahead 3718."

"We have been in a wreck." There was complete silence on the other end for an eternity.

"Where are you?"

"IN A DITCH!" …more silence from Dispatch…

"Ok Sir…Where?"

"On the side of the road…." *Ok…maybe I was in A LOT of shock right then…*umm... between Tyler and Winnsboro? I think???"

"Ok... Try to find out where you are." …*Seriously???*

The next part of the conversation might have been in my head...or I might have said it over the radio. Not sure… *You have a freaking tracker on our truck…YOU find us!!!*

Bill is now in the real world and seriously freaking out. He wanted out. The only way for him to get out was through the top. I unbuckled my seatbelt and turned so my back was against the passenger side window. I pushed my feet up to him and steadied him as he unfastened his belt. I then pushed him out through the driver's side door he had opened. He crawled out the top and jumped down to the ground. I felt secure and safe inside…so I just sat there. He was screaming from outside for me to get out...*No, I am fine here. Safe… Nice and safe…You've done enough…I am fine!* There was no way I was going to make it out the top. I would wait for the JAWS to cut me out.

"AARON…. CRAWL OUT THROUGH THE BACK…" *I had not thought of this. Even though he had just tried to kill me, he made sense…* So, I managed to wiggle…*and I ain't no small fellow…* through the small opening and into the back of the unit. I freaked out a little. I saw the cot crunched against the Paramedic seat…*the seat I had been in just an hour ago…* The force of the wreck had broken several welds on the cot and had also broken it loose from the mounting bracket. I saw the monitor, which I had secured in its holder before leaving the ER, partially inserted in the seat where I had been sitting just an hour prior…*it had ripped off half of the foam padding on <u>MY</u> seat…Wait…if me and the patient had been back here, we would both hurt… fuck that, I would be DEAD!!!*...I went back into shock and just sat there in the pile of supplies that had spewed out from the compartments. *A sobbing mess of a paramedic sitting in a pile of bandages and gauze pads...*

I had seen all the other serious stuff during my career. I had seen child die; I had patients die in my arms; I saw blood; I saw guts. But it had always been someone else…not me. I could deal/avoid the feelings with someone else…. But it was me this time. I was a statistic now. One of the 55% of EMS personnel who had a very real and near-death experience (Regehr, Goldberg, Glancy, & Knott, 2002). The laugh it off approach was not going to work this time (LeBlanc et al., 2011).

Bill screaming at me again. I came around to this world again and weaved through the explosion of my truck…*I chuckled because someone was going to inventory that mess and it wasn't me!!!*

I sat down on the side of the ditch beside my wrecked ambulance for a few minutes…and cried. Then, I had to call my wife…I was choking, coughing, and crying as she answered.

"Hey Mary…. I am okay…"

All I heard was crying on the other end…*I never want to have that conversation again in my life.* It was then that I knew my days were numbered in EMS. One year to the day, I walked away from EMS forever, like many others before and since have done (Blau & Chapman, 2011). I am not afraid to die anymore. I do not look at the obituaries anymore. I have not planned my funeral anymore. I have not done a lot of things I did before I "died" that day. I HAVE done a lot of things I never did before I "died" that day.

Like I said in the beginning…you have a lot of time to think about things when you are upside down in a ditch...except some stuff REALLY does matter.

Chapter Seven: A (_____) Rises from the Ashes

When I die no one should be surprised. I think everyone knows I fight depression, PTSD, and suicidal ideation EVERY DAY OF MY LIFE…. When I did my PhD program exit interview, I explained my mental health issues to the Grad Director, Department Chair, and Public Speaking Director… but I don't think they take me seriously because I look happy on the outside. Only sad people are depressed.

I hope my wife understands how much I love her but cannot deal with feeling dead inside. This has been a simmering darkness and emptiness in my soul for too many years.

Don't get me wrong, there have been moments of happiness. The trip to Chicago to celebrate the adoption of the Littles. I love the happiness in my children's eyes as they sang Happy Birthday to celebrate my 46th birthday. The joy of my kids splashing in mud puddles and throwing snowballs. These small moments do not make happiness enduring to my soulless shell.

The only reason I am not dead today is because I haven't found the right way to die. And somehow my mind always interferes with my inevitable demise. I want to die. Lethal dose of Tylenol is 40 grams (less than 1 bottle) and some alcohol to create irreversible liver damage, but as I watched Charlie bloat and eventually drown in his own body fluids, I knew this is too long and painful. I had access to versed and norcuron… two of the drugs used in lethal injection…quick and easy. I drove fast and didn't wear a seat belt off duty… there were so many curves and trees on the way home…75 mph should be enough to do it. If you look at my google search today, I was estimating how many floors I would need to fall based on 460 pounds. It is not as many as I thought… 4-5 should be good enough. Trazadone is around 4.5 micrograms/liter. I have a bottle of 30 in the cabinet. I drive a 1999 Subaru with a broken exhaust. 2000 mg Trazadone to get me sleepy…drive to a secluded spot…drape the tarp in the shed over exhaust… it shouldn't take more than 10 minutes. I found a 12-gauge shotgun for around $50 on Craigslist…Shells are inexpensive at Walmart and Indy Gun Shop. Except I tasted a metal barrel in my mouth years ago…when I was sad but still had a soul. My new fixation is carbon monoxide. I can buy a HUGE bottle at the local welding supply for … pure CO takes about 5 seconds… Each day the list grows bigger and bigger….

I cannot focus…I see Charlie. I see Carly….it is my fault she died on January 29th overdoing on drugs and alcohol- she was alive on January 24 when I yelled and cursed her out. I see the dead of years every night in my nightmares. They reach out greeting me... I couldn't save them…maybe they can save me? I see the brains of the ejected 4-year-old girl on my gloved hands as we pronounce her dead on the side of the road in front of her mother who is still trapped in the car. I see the bruises on a battered

wife. I see a great man, who I had known for 30 years, slowly die and decay into a shell as he loses a battle with cancer. I see the sheet I covered my best friend with no longer rise and fall with his breath as I help load him onto the funeral home gurney. I see the crowds of fellow academic classmates mocking and laughing behind hands …knowing I am not invited nor welcomed. Colors, once vibrant, fade as the black mist slowly grows in my soul. I see a liar in mirror every day. I see everything yet nothing...but death.

I cannot focus… I hear the church lessons about happiness…I hear myself teaching those lessons to other… knowing I am not and will soon be dead. I hear the songs of my mother. I hear the warm voice of my wife. I hear the laughter of my children. I hear my students asking guidance or help… I hope I gave them good answers. I hear the voices of faculty…you are no good they say…your research is not good enough…you are not smart or academic enough. Music is playing in my headphones as I write this note. It is the only thing I can control in my life. If I play it loud enough maybe it drowns out the screams of the families I had to tell their loved one died. Maybe she won't ask me again if she is going to die… maybe it will drown out me telling her yes. I hear the screams of a child trying to wake her dead mother on Christmas day. I hear the siren…and flinch. Which ghost will visit me tonight? Everything is noise now. I hear a liar telling everyone he is okay. I hear everything yet nothing… but death

I cannot focus…I cannot smell the flowers blooming on campus. I cannot smell my wife's perfume. I cannot smell a good brisket. I cannot smell the dandelions my children pick for me. I cannot smell joy or happiness. I can smell sepsis. Today, I smelled diesel fumes from a truck idling as the crew placed a new sign at Ivy Tech. I smelled his burned flesh. I smelled the blood shooting out of his chest with every chest compression. I smell me, the liar, as I try to cover my shame somehow thinking a shower will wash the filth from my soul. I smell everything yet nothing… but death.

I cannot focus… Everything is dead. Everything is gone. Everything is tasteless and odorless. I know a good Christian should not feel this way, but, maybe in death, I am redeemed …I hope. (Author's suicide note, October, 2018).

I did not set out to become a zombie. I used to smell the roses. I remember the taste of lemonade. The gentle kiss of a breeze on my cheek during early spring is now a fleeting memory. My emotions, feelings, senses, and soul were slowly drained away over fourteen years providing care for the critically ill. I didn't mean to lose feelings or senses…or reality. Zombification, unlike the quickening in *Walking Dead*; is a slow, meandering hurricane building force until destroying everything at landfall. The difference is no one

sees the zombie storm until it has "past", and the zombie cannot perform *zombie-esqeness* publicly for fear of Darryl's crossbow. The constant rumination in *dyscommunication* lowers the cognitive, reasoning, and problem-solving skills in zombies (Afifi, Afifi, Merrill, Denes, & Davis, 2013). *Well, hell bells… I am damned by others for sharing or by self for repressing emotions.*

Oh, the Places You'll Go! … Except when you don't

I am the youngest of nine children. My father retired from 20 years military service when I was four; we moved to a small rural community. Our television broke shortly after we moved to Texas. Fortunately, our family's five-acre plot was surrounded by thousands of acres of dairy land, ponds, creeks, and woods to explore. We played Tarzan swinging tree to tree. We build forts in the woods. We had rock fights in the nearby gravel pit. We swam in those snake-infested creeks and ponds. The creek, though, was my favorite place to go because the water was always cold in the scorching Texas summers.

Picture 7.1 Kelsey Creek by Aaron Deason

When I started counseling in 2018, my therapist asked if I would try art stuff to help. Picture 7.1 is my attempt to illustrate the exact spot at Kelsey Creek. By creating a picture of the place, I could explore my emotions then…and now (Teroni, 2007). Oak trees and walls of briars crowded the banks, except in one place where the creek widened to 15 feet across and 3-5 feet deep. In this place, the trees thinned, but there were enough trees for shade as the breeze blew through the only open spot on the creek. Our place had a sandy bank and a few vines growing where we could swing into the water. It was the only place with no snakes. It was the only place with no poison ivy. It was the only place where we could be free from the cares of the world. It was my physical safe place in childhood and my emotional safe place as an adulthood. Art helped me find something to feel when I could not feel anymore (McNiff, 2019)

But, back to my awesome childhood…If the temperatures were too cold or raining, we moved the action inside to our 3200-square foot gymnasium where we jumped on the trampoline, played basketball, roller skated, and rode bicycles. After dinner, we sang songs around the piano, performed skits on the stage of our house, or sat on the front porch listening to my sister as the sun dropped. At night, we played kick the can, hide and seek, ghost in the graveyard, coons and hounds, and other games. On hot evenings, it was cooler outside than in; so, we would spread blankets on the front yard and gaze into our 360^{o} view of the universe. But most important; we had our family; we had love. I had everything a child needed or wanted. I was part of the 64.8% of Upshur County, Texas families with both parents present and married to each other (US Census, 1990). I was NOT a zombie then.

I was an honor student in high school, an Eagle, married with a career, awesome kids… everything. I was set in life to go so many places. *Oh! The Places You'll Go!* (Seuss, 1990) was published months before my high school graduation in May 1990. In January 1990, *Oh, the Places You'll Go!* was published. It was a strange graduation gift I did not understand at the time. When considering the previous discussion of the ebb and flow of mental health, the story has a different meaning. Consider the following stanzas:

> Oh! The places you'll go!
> You'll be on your way up!
> You'll be seeing great sights!
> You'll join the high fliers
> who soar to high heights.
> You won't lag behind, because you'll have the speed.
> You'll pass the whole gang and you'll soon take the lead.
> Wherever you fly, you'll be best of the best.
> Wherever you go, you will top all the rest.
>
> **Except when you don't.**
>
> Because, sometimes, you won't.
> I'm sorry to say so
> but, sadly, it's true
> that Bang-ups
> and Hang-ups
> can happen to you.
> You can get all hung up
> in a prickly perch.
> And your gang will fly on.

You'll be left in a Lurch.
You'll come down from the Lurch
with an unpleasant bump.
And the chances are, then,
that you'll be in a Slump.
And when you're in a Slump,
you're not in for much fun.
Un-slumping yourself
is not easily done. (Seuss, 1990)

The Zombie Apocalypse

Sunday, December 5, 1993, I was getting ready for church. The smoke I smelled made me think breakfast was ready. I went to the kitchen… it was not. Returning to my room, I looked out my bedroom window… my neighbor's house was on fire. There was not much I could do besides calling 911. I ran across the street. Canned food become missiles shot into the sky. More and more missiles launched as the fire grew. Neighbors and family showed up. No one saw Shumway. By the time the volunteer department arrived, the wooden house was fully involved. It took about an hour to control the blaze. The firefighters found him four feet from the back door. I saw his charred body. I saw the faces of his family. If I had called him an hour earlier about the Sunday School lesson…if I had looked out my window 10 minutes earlier…if had been a volunteer firefighter… if so many things…

May 24, 1994, I joined the local volunteer fire department because I wanted to help others and to drive fast while doing it (Blasi, 1999, See Picture 7.2). Like ninety-one percent (91%) of people choosing fire or EMS as a career, I was "action-oriented, risk-taking, very independent, very determined, and aggressive." (Holborn, 2002, p. 70). I was a 22 and bullet-proof. Plus, chicks dig the handsome dude standing on the middle engine under the "T". Dude…those years (1994-2009) were awesome…except maybe the bad calls…but I am getting ahead of myself.

Picture 7.2 Gilmer Fire Department, 1996 Courtesy of Aaron Deason

November 12, 1994, I was one of the first responders on scene. I recognized the car…a fellow firefighter and a friend from high school…only a few months younger. He was many things to many people- a father, a son, a husband, a friend- before driver collided with him. Donny was the first newly dead body I ever saw. No blood. No gore. Nothing. Just death. cold. pale. dry. death. His wide-open lifeless eyes sucking at my soul to replace the one just lost. I flinched…determined to NEVER do that again! I vowed to control my emotions.

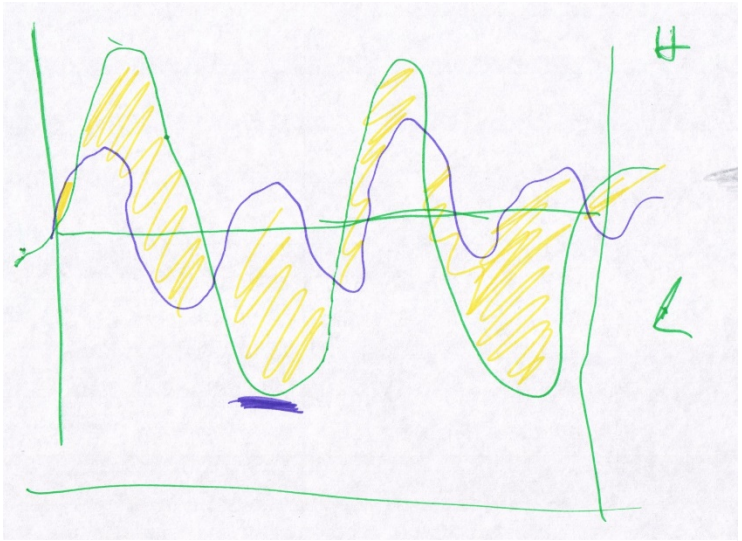
While writing the initial Tales of a *Dyscommuniholic* (Deason, 2014), I explored how EMS affected me. Chapter 5 of this dissertation is a deeper autoethnographic probe into my emotionless self. It was through these I discovered *dyscommunication*. I realized:

> Emotions can be regulated, controlled, or shaped, not only in their external display, but also in their experiential aspect. When this happens, **the quality of spontaneity is lost** and, with it, the capacity of emotion to naturally reflect specific motives and concerns. At this point questions about sincerity and about the meaning of emotions arise. What can be trusted and taken for granted in animals and young children, is approached with skepticism in cultivated adults. **The very person who experiences the emotion sometimes wonders about its real meaning.** (Blasi,1999, p. 12-13, emphasis added)

I had moments of…weird things in my heart or mind. It might have been joy; it could have been the 3-day old tamales I had for dinner. See, the problem is…I was OUT of EMS when I wrote the original Tales. My EMS life was controlled by algorithm after algorithm…there were no surprises… ever. I suppressed emotions. Seriously, I quashed them immediately. I did not see the utility in emotions. There was no use for them. Surely, mine is not the only truth. Had other EMS people had similar experiences as mine?

In 2017, Daniel Park, a Health Communication PhD colleague, and I embarked on a journey to identify metaphors found in written narratives from the Code Green Campaign website for a class assignment. This site published EMS stories about critical incidents. We used the Job Demands-Resources Model (Bakker & Demouttti, 2008) to find job demands, job resources, and job strains in the EMS field. Metaphorically, we found a correlation between high demand, low resources, and strain. (Deason & Park, 2017). We identified correlations creating a state where mental health could be influenced. One interesting result was the denial, at first, of the effect. Most wrote a variation of "*I'm fine.*" It was eye opening to see other responders writing about their lives. To see they had challenges, too, was a Balm of Gilead. I did not reach for it…yet. I was not ready to quit being a zombie. I was on Zoloft…and denial.

In retrospect, the zombie was not new. My therapist in Indiana, bless her heart, tried to help me understand. There are differences in the highs and lows for "normal patients" and "mentally ill patients." (See Picture 7.3). As stated in Chapter 1, all people have mental health. The purple line shows the "normal"; The green line represents those with mental illness. The swings from high to low are present for both, but this normal group can maintain proximity homeostasis (Pickering, 2002).



Picture 7.3 My Therapist's Explanation of My Mental Health Swings Courtesy of IUPUI Counseling Center

There is a huge yellow gap those with mental illness cannot overcome alone. My normal was NOT normal. My maladaptive coping skills created a sea of HUGE waves and mood swings with few moments of homeostasis.

No one told me about the challenges with mental health and depression. I had seen, smelled, touched BAD stuff for years. The horrors connected with many neural networks, emotions, and senses (Wendt, 2014). I repressed those networks, emotions, and senses. By controlling/repressing these emotions, I "topped all the rest…except then I didn't" (Seuss, 1990). The constant attempt to control emotions created a soulless beast. As stated above, "***The very person who experiences the emotion sometimes wonders about its real meaning.***" (Blasi, 1999, pp. 12-13, emphasis added). One cause is the occupational emotion-regulation Daniel and I discovered in our Code Green study (Deason & Park, 2017). Apparently, zombies have no emotions… or have maladaptive ways to control emotional display.

The constant drive to control/monitor surroundings and emotions is called hypervigilance, or hyperarousal. This need to control creates anxiety as:

> Increasing fixations and doing so over a broader area is likely to increase the odds of finding a possible threat. Consistent with the previous interpretation however, it is possible that increasing fixations over a broader area may also decrease anxiety if no threat is found. In this sense, hypervigilance may be perceived by an individual as a behavior with few costs. If a threat is found, one is prepared to act; if a threat is not present, one can relax. (Kimble et al., 2014, p. 244)

Except, I did not relax as unfound threats found meant ones still lurking in the shadows. My entire existence was spent preparing for the threats. I know now it is irrational, but at the time, it was the only way I made sense of my world for my survival. The disruption and dissonance of constant monitoring created an uncontrollable homeostat.

EMS personnel, unlike many other health professions, are always on. The switch turns off when they leave the office at 5pm. I was taught to observe, diagnose, and treat…I was trained to act…NOW. Every person I met was a patient. I sized up veins in arms and hands. Always a quick head to toe for signs of distress. A cough is someone choking. I noticed the pursed-lip breathing. I knew response times for fire and EMS to wherever I was. I knew what I was going to do the moment they coded or quit breathing. I had catheters, iv supplies, bvms, ET tubes, intubation kit, nebulizers, and first round meds. I

always had an airway bag with oxygen in the car with me. I carried gloves in my back pocket. Many times, I had a radio near my person. Speed dial 1 on my phone was dispatch. I was always on. I was full throttle awake…and, if I slept, in my nightmares. Most nights I slept from exhaustion. I did not learn how to turn it off… I had years of being shocked and staying shocked. Interestingly, lab rats electrically shocked in the presence of a specific object tend to bury ANY unfamiliar objects in sawdust when introduced to the cage; the poor rats slept less and died earlier (Mikics, Baranyi, & Haller, 2008). My "on-ness" hypervigilance created a viscously vicious life where I became a lab rat burying emotion-causing object…. *drats!*

I was a hyperaroused emotion-burying rat in a profession of hyperaroused emotion-burying rats. The problem with hyperarousal and emotional suppression is "human affective resources are limited; prolonged intense arousal is physiologically debilitating." (Thoits, 1989, p. 337). People with comorbid depression and "those with more severe arousal symptoms demonstrate poorer recovery and more severe PTSD symptomology" (Schell, Marshall & Jaycox, 2004, p. 188) I had lived a 20 year lie created by emotional suppression…and all those things Daniel and I discovered in our study. I was the people. I had died years ago…then it got worse!!!

The first four years were financially good. I had my guaranteed $13000 from the University plus adjunct pay from teaching classes at a local community college. At the year 4 review, my contract was not renewed. I no longer had the meager funds from the University…or INSURANCE. The 4 adjunct classes were nowhere close to being enough to support a family. Like many students, I had a tough choice between food, rent, and medication. We ate and had a roof over our heads. I could not afford $18 for medication. My once dark world…grew darker…and darker…and darker…. and darker. I was alone. I could not un-slump myself. Every day I researched, ruminated, and wrote about the things I saw, smelled, touched, heard, and tasted. Every day was a trigger. I freefell through denial then anguish then despair. No one had shown me the sign above the emergency service gate I entered read, "*Lasciate ogne speranza, voi ch'intrate" ABANDON* **ALL HOPE YE WHO ENTER HERE** (Alighieri, 1472/2009, p. 18). I had no hope; the zombie longed to die.

Even though I had not run an EMS call in several years, the residual effects of were there. I had swapped EMS hypervigilance for an academic hypervigilance. I did not feel, smell, cry…nothing!!! Maybe, in death I could live. Suicidal ideation, or thinking of a detailed plan to commit suicide, among EMS personnel is thirty-seven percent, and almost 6.6% of EMS personnel attempt suicide (Newland, Barber, Rose, & Young, 2015; Nordqvist, 2016). Given these numbers… there no way I was going to "un-slump myself."

The zombie, though, did not look like a zombie. Depressed creatures do not look depressed. I was a functioning-ish zombie. I taught my classes. I even tried to write this dissertation. Inside my canker-filled body lived a dark soul. I met may of the DSM IV (APA, 2013) criteria for major depressive disorder. My symptoms were:

1. Irritated. Small things set me off.
2. Losing interest in previous activities. I did not want to play League of Legends or World of Warships
3. Tired perpetually with increased fatigue
4. Insomnia and sleeping around 4 hours per day. Not consecutively…just 4 in total
5. Eating… I didn't want Dr Pepper or Little Debbie's Oatmeal Crème Pies.
6. Hated myself
7. Lost concentration and could not think
8. Indecisive. I was like a woman who was asked to pick a restaurant.
9. Wanting to die. Having a plan

Nine of ten was better than my little league career batting average (*I had 1 hit and 3 walks in 4 YEARS)*. I longed for death as it was becoming the only way to stop the hurt. Too many times I prayed, "Dear God, please let me die." And when I thought he had forsaken me; a new thought was born each minute…and festered. On October 31, 2018, the zombie had a plan.

A (Zombie) into the Ashes

I went to campus on November 1 for help. My advisor had given me pep talks before and had talked me off the ledge. I needed that today…or else. The zombie lumbered down the long, cold, dimly lighted hall. Unlike the outside hall, the office was bright. He gave counsel, but still, I left the office encased in a vantablack cloak- the darkest black created by nanotubes to absorb all light and hope (GDN, 2014).

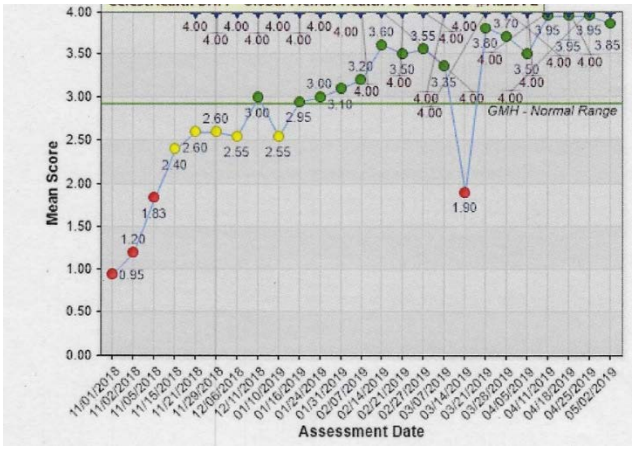
I fought through the blindly dark sunlight toward the Grad Office to find Prof. X. As we talked, I felt something wet on my cheek. *What the hell???* Reverting to paramedic

mode, I did a quick assessment. *Was I bleeding? I touched it… nope, not blood. It was a clear fluid? It was salty.* I remember hearing something about salty fluid exuding from eyes once… Professor X saw the one little drop and knew it was serious. The zombie moaned…and left the office. He stumbled across campus to his car on the 5th floor of the parking garage. It was parked near the wall. He looked over…this was not the first time he thought about jumping… he had promised Professor X he would do something first. A short drive across campus…

As the elevator opened, I sighed heavily. The weight of 1000 dead souls crushing my chest. The arrow pointed right. Like a man condemned to lethal injection, I trudged down the hall toward the door. The small, black sign read Counseling Center. I didn't want to go… but I was broken.

The receptionist handed me a tablet and pointed me to waiting area. I sat and stared at the screen. The CelestHealth Solution's *Behavioral Health Measure-43*® (BHM-43) appeared on the screen. The BHM-43 is a 43-item questionnaire used to assess well-being, symptoms, and life functioning. The website provides a richer explanation of these areas, which are:

- Well-Being Scale—Assesses the first of the three behavioral health phases to improve in treatment. Distress, emotional-wellbeing, life satisfaction, and energy/motivation are evaluated.
- Symptoms Scale—evaluates the major mental health syndromes including anxiety, bipolar disorder, depression, drug/alcohol abuse, hostility, obsessive-compulsive, eating disorder, psychoticism, sleep disturbance, somatization, suicidality, and risk of violence.
- Life Functioning Scale—measures life functioning in all the relevant areas--work, school, family, life enjoyment, intimate relationships, social relationships, sexual functioning, physical health, self-management, and money management. (CelestHealth Solutions, n.d.)



Picture 7.4 Deason Global Mental Health Report

The three-minute task took almost fifteen to complete. I could not focus. The initial data revealed a red and orange severely depressed, suicidal, sleepless, non-life functioning zombie (see Appendix B). My global mental health score was 0.95 on a 4-point scale, where 3 is normal (see Picture 7.4). I arrived at 4:55 pm, only minutes until closing time. I don't remember how many people questioned me. The next hours were a blur. Question after question… story after story…dry heave tear after dry heave tear (*I say dry heave because I wanted to cry, but my body wouldn't let me. Much like when retching and not vomiting.)* … silence after silence. I left at nearly 8:00 pm. During the process, someone had called my primary care physician to have my prescription refilled. It may have been me. It may have been them. It may have been Santa Claus.

That night, the zombie took his Zoloft… and for the first time in a long time… had a spark of hope.

A (Zombie-Phoenix) Rises from the Ashes

I would like to think it was at that moment the zombie died. Not yet. I was not prepared. According to legend, when a zombie-phoenix "feels its end approaching, it builds a nest with the finest aromatic woods, sets it on fire, and is consumed by the flames. From the pile of ashes, a Phoenix arises." (Garnet, n.d., as cited in Leafloor, 2019). In the academy, unlike in EMS, I was supposed to think a lot. The entire PhD process teaches quiet pondering moments. The biggest problem is "those who suffer from PTSD symptoms need help in replacing rumination and wishful thinking with imaginal exposure to facilitate emotional processing and change in meaning." (Clohessy & Ehlers, 1999, p. 262). I had tried everything to get rid of these thoughts… meditating… playing… singing… starving… binging… riding… praying. NOTHING. I had constant thoughts of suicide, self-doubt, depression, and more. While I performed outwardly, a lifetime of abnormal shiftwork on the ambulance and long study nights in grad school laid a foundation for chronic mental illness (Wang, Armstrong, Cairns, Key, & Travis, 2011). Rumination allowed the memories to resurface, and I sunk deeper into the sea of despair. My hope slowly dying as I plummeted in zombieland, and my impending death in the beginning starts to make sense as "life is not livable without hope." (Verhaeghe, van Zuuren, Defloor, Duijnstee, & Grypdonck, 2007, p. 738). But that was because I was trying to swim alone.

When I went swimming today, the lifeguard escorted me to the pool. The standard first question, "What brings you here today?" SILENCE… Our breaths in unison. Our sighs in unison. Our thoughts…not in unison. *How do I talk about wanting to die without being committed a facility? I had only had these thoughts in my head and had only verbalized them in my nightly UNANSWERED prayers to God. The constant nightmares keeping me from sleeping. The flashbacks and triggers keeping me from opening my eyes. HOW? What if she rejected me like everyone else I had ever talked with? I hated me. I wanted to die, but I didn't want to die. I was confused by everything. There was grass in zombieland. No sunshine. No flowers. No trees. Only the ghostly hiss from circling turkey vultures.* I would not admit anything aloud. I needed an object to blame for my feelings of self-loathing. If objects are the root of my angst, once removed I could be fixed. The crazy thing is I wanted to be healed…but I wanted an easy fix. Kind of like giving a patient nebulized albuterol for asthma. I chose EMS and school. Yes. Those two caused me the most stress. I had nightmares from PTSD. I felt bullied and shamed in the academy. *It happens, and everyone knows it. The power dynamics keep it covert and hidden while being openly displayed. How the hell do you think Bill Cosby, Harvey Weinstein, US Rep. John Conyers (D-MI), and other high-profile people got away with what he did for so long? Think about the power professors hold over their students. Yes, I would blame them. Nope, my fault at all. I was traumatized by them…and all the bad stuff from EMS.* Except, physically present objects are not necessary to have an emotional response as the emotions acknowledge values we are (or seem to) already be aware of. (Shargel, 2015; Müller, 2017). This made no sense considering all the good things in my life. Somehow, my values were involved??? Back to W*ebster's* for some help. A value is "the regard that something is held to deserve; the importance, worth, or usefulness of something." (Gove, 2002). She stared silently.

So, she let me stew and squirm for an eternity until I loudly, "I want to die." *I had a chance to lay it on everyone else and other stuff. I had failed miserably. The silence had gotten me. Her evil plot to break me had worked.* It was back on me at 39 seconds into counseling.

We decided NOT dying was a great first goal. The first sessions were spent trying to unpack my current life situation. I am glad I was going to therapy in 2018 instead of

1990. Back then they starting to realize Freud was incomplete. The field was in turmoil because

> Clinicians must currently try to understand and treat emotional disorders without the benefit of a reliable theory of normal emotions. Even at this early stage, several implications may prove helpful. The first is that we have bad feelings for good reasons. **Fear, anger, sadness, and loneliness are not abnormal, they are defenses that help us to deal with situations that decrease fitness**. In order to explain them, we should look first not to brain mechanisms or personality characteristics, but to **the current life situation** of the person experiencing this feeling. (Neese, 1990, p. 284)

The brain is polysensory using all the available senses to interact with the environment (Doidge, 2007; Northoff, 2010) It is through these sensory inputs the brain simulates what is happening in the present world. "(My) brain uses (my) past experiences to construct a hypothesis and compares it to the cacophony arriving from (my) senses." (Barrett, 2017, p. 27). So, my current situation was tied to those past experiences I had stuffed into a bottle.

I misunderstood an assignment one week. I thought she said to journal each time I had a suicidal thought. I was to ponder the provoking circumstances with each thought. Entertaining the suicidal thought instead of shewing it off my mind's stage created a much bigger problem and triggered MORE suicidal ideation (Morrison & O'Connor, 2008; Rodgers & Joiner, 2017; Smith, Alloy, & Abramson, 2006) . It was the most powerful and creative I had felt in 6 months. My goodness, the dam broke and flowed so fast that I barely had time to track them. I had 28 suicidal plans or thoughts in the first 4 hours. I stopped as the slow, fine falling graupel had turned into an avalanche threatening the tiny valley village of my susceptible mind. This might explain why there was so little progress on our November 15, 2018 visit (See Appendix C). While my global mental health score (GMH) has risen from 0.95 to 2.40, I still scored low on the depression sub-scale. I was supposed to focus on whether the thoughts were rational or irrational…. *Ooops!!! Rumination is bad…really, really, REALLY BAD for PTSD and suicidal ideation.*

In retrospect, I think working on the PTSD part was ineffective because I do not like emotions. I had been taught in medic school emotions kills patient; so, I had learned to repress them leading to *dyscommunication.* I am a very analytical person. I was trying to quantify sensorially an ethereal thought. "Emotions involve the subject who undergoes them in a distinct manner; however, they are not a representational claim about the

connections between emotions and the self." (Teroni, 2016, p. 450). In other words, emotions exist but aren't real or tied to me? *WTF? Emotions are baffling bastards like that. I couldn't do it.* Like so many times in my past, I chose to avoid emotions instead focusing on my present conditions of nightmares and suicidal ideation. Dead people don't breathe… or think… or feel emotions. *Maybe emotions would make more sense later…if I didn't kill myself first.* Emotions are fickle.

After the failed exercise, I needed to adjust my rudder. I knew sailing and navigation basics, but I was sailing in the deep, dark emotional waters now. I needed to understand the winds and the waves. My world was black and white. My mama taught me right is right even if no one else is doing it. I gave other people latitude without leniency for myself. I had too many irrational ideas about perfection. Using athletes in his study, Turner (2016) suggested:

> The development of irrational beliefs in athletes is likely to be driven by athlete socialization into competitive environments, while as human beings athletes have an innate tendency to develop irrational and rational beliefs. In fact, it is argued sport is especially **promoting of irrational beliefs especially through language**. (p. 12)

EMS, like athletes, are competitive against coworkers, nurses, themselves. As I asserted earlier, EMS is a learned culture where I heard and told stories. During the calls and story times, I developed an irrational thought system deflating self-esteem and self-compassion. I needed to be nicer to me as:

> Self-compassion predicted lower depression and anxiety, and these associations occurred independent of its covariance with self-esteem. Even more importantly, **self-compassion was incompatible with the irrational beliefs of self-worth and low frustration tolerance**, and multiple regression analyses demonstrated that self-compassion explained the positive linkages of self-esteem with these two irrationalities. (Stephenson, Watson, Chen, & Morris, 2018, p. 813).

EMS exacerbated my irrational black and white, self-loathing, chaotic, restless world (Passardi et al., 2018), but I was trying. "Individuals with PTSD may actively attempt to withhold the expression of emotions, which may contribute to restricted

emotional experience." (Roemer, Litz, Orsillo, & Wagner 2001, p. 154). Furthermore, PTSD symptoms are:

> Related to (a) reduced levels of clarity and awareness of emotion; (b) low levels of acceptance of negative emotions, higher levels of experiential avoidance, and higher levels of emotion suppression; (c) difficulties engaging in goal-directed behavior when distressed and high levels of impulse control difficulties; and (d) impaired use of functional emotion regulation strategies, including low levels of reappraisal. (Ehring & Quack, 2010, p. 594)

We conceded emotions.

The bigger challenge in my life at the time was nightmares, flashbacks, and other PTSD symptoms. Since I wasn't sleeping more than 4 hours per day, my therapist suggested an aggressive chemical-based treatment over the prolonged exposure for PTSD. She suggested *3,4-methylenedioxy-methamphetamine* (MDMA). MDMA sessions are longer (5-8 hours vs 45 minutes counseling sessions) and allow freer exploration of sensitive subjects (Amoroso & Workman, 2016). But…. MDMA is freaking Ecstasy. All I knew was ecstasy was a party-drug used to make getting into pants easier. What's worse than a rising phoenix? A horny zombie-phoenix. NO THANK YOU Miss Therapy person ma'am. *Dispatch told us turn left into a pasture and stop at the yellow fence on the far side of a 100-acre pasture. Ummm…. Ok… Sure enough, left and yellow fence... we unloaded our cot, monitor, backboard, airway bag, and trauma bag from the unit. Total weight was near 100 pounds. We followed the trail through the fence. The ground become softer and softer…and "slipperier" … the water rose…and rose…and rose. Pretty soon we were hip deep and carrying out cot and equipment shoulder high like the Marine Corps Body Bearers. Except, I am not a Marine…I was fat, out of shape…and slogging through a freaking marsh. We found him about a mile in. He was face-down. He was in camo and was HUGE. I can see why his father thought he was a hog. My partner said we should work him. HELL NO!!! How we gonna do CPR and carry his fat 400-pound ass out? It took almost 2 hours for the 10 firefighters and a swamp buggy to get him out. The coroner and funeral home patiently waited for us in the dry pasture. Bastards.* No thank you…I can fully remember that swamp without Ecstasy.

A (Phoenix) Rises from the Ashes

After a few sessions later, we began discussing mindfulness as it "emphasizes nonjudgmental acceptance of one's experience, including unwanted thoughts or emotions" (Lang, 2016, 42). Decreasing hyperarousal hinged on accepting flashbacks, nightmares, and sensory triggers as real (King et al., 2013). *I had no problem with that… in theory. The problem is my response and mental state. No sleep means no nightmares. But each day was a sensory explosion of triggers.* The memories are very real. The calls are very real. Memories are timestamp/GPS markers to help us locate a reality where objects are not needed for to exist in time (Wendt, 2014; Müller, 2017). This is a baffling concept. Here is what I took from the sessions: 1) I cannot control the memory or triggers and 2) I am not in danger from them NOW…m*y ambulance is not flipping…no family wailing after losing loved ones… Nothing!!!*...Even though I know the boogey man ain't gonna me, these past events created a derivative of fear called affect. Consider this:

> One of the extraordinary features of the human brain is the evolution of pathways and processes that carry the meaning and motivational force of fear and other emotions without the necessity of creating an emotional state. Emotional states are stressful and sometimes slow in onset and offset. Affect is fast and adaptive, shifting rapidly with attention and thought. (Slovic, 2004, p. 989)

I had never thought of fear affect. I do not fear anything because it stems from not being prepared for situations. *And I am always prepared. Remember the hypervigilance and hyperarousal… I am ALWAYS on! I have plans and scenarios 10-12 deep for everything. Dinner at a restaurant, evening at the movies, driving down any highway. Seriously, I knew the last cross street, and distance and direction from closest city. There are no surprises in my world*...**EVER**. Most people operate in an emotional state; however, as I have shown in these autoethnographies, I run affectively, which explains why I have oft-fluctuating heightened highs with abysmal lllloooooooowwwwwwssss.

People running on an affective drive experience "emotions that conflict with or run counter to evaluative judgement" (Brady, 2008, p. 413). These recalcitrant emotions are the perturbations in the communication patterns (Parrish-Sprowl, 2013). These perturbations come at "significant cognitive costs. Insofar as emotions involve mobilization of cognitive capacities to do with attention, memory, and reasoning." (Brady, 2008, p. 427). In other words, hyperaroused people spend massive amounts of mental

energy preparing for stuff that will never happen. *Well, fuck me and call me Sheila. This is hyperarousal. And I have lived the life since 1994…always on.* Hyperaroused people tend to have lower mental health. This could explain why 37% of EMS personnel have suicidal ideation and 7% attempt suicide (Newland et al., 2015; Nordqvist, 2016). The numbers are astounding, but due to self-report and stigmatization from coworkers, this number is grossly underreported (Marin, 2002; Mishra, Goebert, Char, Dukes, & Ahmed, 2010). While there is no national clearinghouse, the National Registry of Emergency Medical Technicians, which provides primary certification testing for 46 states, had 406,000 EMS personnel registered in 2018 (NREMT, 2018). Thirty-seven percent of 406,000 is almost 150,000 with suicidal ideation. If any other population had these suicidal ideation numbers… *I will wait for you to contemplate the enormity of this epidemic…*

Jeff Dill, a Retired Fire Captain and founder of Firefighter Behavioral Health Alliance, has the most complete list of documented emergency personnel suicides in the US. He been notified of and has confirmed 1300 suicides since 2010 (Dill, 2019). *The good news is that is only 130 per year…or one death every 2 days. We can spare an ambulance driver. One boss told me EMTs are a dime a dozen… so…who gives a flying f--- about EMS? Damned if you help. Damned if you don't…* When I talked to Jeff, he said only 30-40% of suicides are reported due to stigma. No one wants their loved one to be labeled as the sissy who couldn't handle a few bad calls.

I rise from the Ashes

The phoenix was scared to face emotions, but it did find adaptive coping techniques to manage PTSD. I guess things became better when I realized I could not control it like I have tried to control EVERYTHING in the past. Checklists do not work. I needed some latitude where I can have a difficult day without feeling guilty for a trigger. A groundbreaking study was done in 2009 combining for PTSD, depression, and interpersonal relations. PTSD may disrupt families and relationships temporarily; however, depression may create long-term relationship difficulties due to emotional numbing (Beck, Grant, Clapp, & Palyo, 2009). It was by examining these triggers that we were able to lessen the effects of PTSD…and suicidal ideation. It took months of weekly hour-long sessions to discover what worked…and didn't. (Wampole et al., 2010). It was not until I quit playing with my counselor and devoted energy to trying the techniques that I saw

improvement. *Don't get me wrong…I still had suicidal ideation ALL. THE. TIME. in the beginning. When I really tried the concepts, the ideation faded into the background and life became more tolerable-ish. I actually thought about happiness...and maybe finding it. Thus ended my fifth year of PhD stuff.*

The greatest change in my life occurred when I was hired as a Lecturer at regional university in South Texas. *I do not know if I can say it is the University of Houston-Victoria??? But, y'all…I was stoked to be going home...or at least a 5-hour drive versus 18 hours. I was close to my mama. I was excited to go to a land where people didn't put beans or noodles in their chili; where they understood the need for good chips and hot sauce; where there was a donut shop with kolaches on every corner; where people said Yes ma'am and No thank you, please to <u>everyone</u> not just the powerful; where people understood my accent and sayings; and, where I could… be me.* Another profound change came when I increased my Zoloft from100 mg to 200 mg. My depression became more manageable and allowed better sessions the final sessions in Indianapolis before the move. I began having more better days each month… and fewer triggers.

But I still had not risen from the ashes. Remember, the phoenix is mythical. It always dies; I was waiting for it to happen. *Hyperarousal is a little bastard like that*. It amplified my fatalism, which increased my depression (Sullivan, 2016*).* I rechecked everything and made so many contingency plans. Something bad was bound to happen… *Life could not be this good. Do not get me wrong, financially it was tough. I was an adjunct… last check was in May 2019. As new faculty…first check was October 2019. We were broke. And there were a few hiccups in our move. Our rental house had no working refrigerator. The owner was out of country; the leasing agent would not act without his approval. We had no way to effectively store perishable foods; so, we were forced to eat out every day for 3 weeks. We had not budgeted the extra $500. But other than that small challenge… the 1200-mile move was easy, and the kids loved being close to a beach.* During this time, the nightmares decreased. I was sleeping 6 hours per night. I was using the grounding methods learned in Indiana. I still avoided emotions…

Summer turned to Fall as school began. Work was fine. My marriage was better. *... the bubble burst as the phoenix fell like a meteor to the Earth. I needed to complete this dissertation… I had found ways to avoid it for a year… but it yelled at me the entire time.*

This thing is about me…even though I talk about other EMS people. THIS IS ME. But I did not know how to show people the difference between the effects of a career and the lasting affect where I am damaged emotionally and mentally. Self-doubt seeped in…fatalism began again… suicidal thoughts again... dammit… I thought I had it beat last year. I didn't…

I think my depression was more genetic than situational. This became evident several years when I created a genogram for my Sociology of Family Systems class. A genogram, which is a family tree, becomes useful in counseling as:

> The genogram has often been used to **record genetic information** about a patient. In addition, it has been found to be useful for recording in-formation about family structure and relationships. **Critical life events**, including births, deaths, marriages, divorces, **and major illnesses are readily identified**. (Sproul & Gallagher, 1982, p. 959)

I used the genogram to trace mental illness in my family. Gray is used to denote depression. My two biological brothers, two half-brothers, my father, my paternal uncle and aunt, my paternal grandfather, and most of my paternal male cousins have severe depression. There are suicide attempts and several suicides on my genogram. My genogram had more gray blips than the Goodyear blimp. I remember the conversations I had with my siblings and parents about mental health when I was constructing that genogram. It opened many discussions later about mental health. So, I came by depression naturally, but I do think emotional suppression exacerbated the situation just a tad. Maybe this is why medication helped for a while…

It had been about 6-8 months since my Zoloft increase when a new, deeper bout of depression began. This is not uncommon. When monotherapy for depression becomes ineffective, doctors often add medicines from different antidepressant categories. (Bauer et al, 2017). Zoloft is a Selective serotonin reuptake inhibitor (SSRI). I could cite and write a tome about SSRIs, but this dissertation is not that type of dissertation. Since I felt a significant change and deepening of my depressive symptoms, I explained the increased ideation to my new nurse practitioner, *in Texas, our Texas, all hail the mighty State…* and we decided to add a noradrenaline and dopamine reuptake inhibition medication (NDRI)- Wellbutrin- to my treatment. *I am writing this about 3 months into the new medication change. The combination helps me manage depression. I gave up hope of control years*

ago. When I mentioned the nightmares and PTSD symptoms, her ears perked. She suggested a specific counselor. *Great another counselor. My last one was great, but it didn't work for long…maybe 6 months.* The difference is this counselor specialized in PTSD in emergency service personnel (i.e.- Law Enforcement, Fire, and EMS). *Maybe the winds of fortune were finally blowing in my direction.*

"What brings you in today?"

"I want to die."

"Oh really…" …and stared. Then unloaded the magazine…

"What does it mean to die?"

Uh…

"What makes you want to die?

…um

"What will happen if you die?

…shit

"What is you plan?

…Greenland??

I hate my therapist. She called me out my bullshit. She challenged me on everything. I was in a horrible state that first session. I had a definite plan unlike the cry for help at the beginning of the chapter. I was close to a reality break…the closest I have been since 1997 when I had the barrel of a shotgun in my mouth. She peered into my soul… and realized how close to edge I was and walked out to sit with me.

"When?"

"Anytime if I have a chance…Why do you think we don't have guns in the house?" I was a moment away from a 5150, or Mental Health Warrant (Emergency Detention), which criteria according Chapter 573 of the Texas Health and Safety Code are:

> Sec.573.001.
> (a) A peace officer, without a warrant, may take a person into custody if the officer:
>
> (1) has reason to believe and does believe that:
>
> (A) the person is **mentally ill**; and
>
> (B) because of that mental illness there is a **substantial risk of serious harm to the person** or to **others unless the person is immediately restrained**; and

(2) believes that there is **not sufficient time to obtain a warrant** before taking the person into custody.

(b) A substantial risk of serious harm to the person or others under Subsection (a)(1)(B) may be demonstrated by:

(1) **the person's behavior**; or

(2) **evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty**.

(c) The peace officer may form the belief that the person meets the criteria for apprehension:

(1) **from a representation of a credible person**; or

(2) on the basis of the conduct of the apprehended person or the circumstances under which the apprehended person is found. (Apprehension by Peace Officer or Transportation for Emergency Detention by Guardian, 2017)

The thing is, I wanted to die. I had no fear of death and would welcome a respite from the internal turmoil. She let me go home. I promised not to kill myself…*yet.*

Sooooo…My crazy old self trying to die…here we were again. Weekly visits. Weekly challenges. weekly promises to not die. I think the difference was this time I wanted it to stick. I needed it to stick. I had the motivation this time, which is linked to higher therapeutic success (Sjögren, 2019). Apparently, I lacked the tools to change. I had an academic knowledge from my research, but like Karen who freaked out during each call… *seriously, she was panting and freaking EVERY call. You could hear it in her radio voice. She could make a splinter sound like a forest had fallen on the patient. My god…SHUT UP KAREN… it was a wonderful day when she moved to administration…* I lacked a practical ability to perform. What to do??? Explore emotions. I have blamed emotional suppression on the terrible things I saw on the ambulance. I WAS WRONG!!! Back to the wonderful childhood I talked about 20 pages ago…

Well, it turns out being the youngest of nine is tough than I thought (see Picture 7.5). A fourteen-year age range made it tougher. Well, I was clumsy and fell often. If I cried or whined, my older siblings would circle around me and chant, "Piiiiitttttttyyyy pppppaaaaaaarrrrttttttyyyyy….. ppppiiiiiiiittttttyyyy paaaarrrrttttttyyyy." Louder…and louder…and louder…rubbing my head as they circled. This torture continued for 30-60 seconds…. EVERY TIME!!! I love them… but those moments taught me to control and subdue emotions. I didn't cry when I fell. I kept it all in. When my brother sat on top of me and let spit drool out until it broke… my forehead covered in his spit. Time after time. I cannot count the number of times… but I did not react. No crying. No yelling…nothing. I don't have ticklish spots anymore. *Seriously, even my wife cannot tickle me…she has tried. If there she finds a spot, I can take a breath…and the sensation is gone. Another big one… nose hairs… my wife can mess with my nose hairs… for most people, it would cause undue displeasure… I take a breath…and sensation is GONE!!! I control it!!!* All that control has come at a cost. I have no emotions… *Okay, I have them…but I beat them into submission and create a shelf of glass emotion bottles. Things are great until sentinel events shake the shelf. Lacking skills, they manifest themselves as suicidal ideation and increased depression. Well, dang...*

Picture 7.5 Deason Family, October 1976

The affective consequence of emotional suppression includes "(a) clear decreases in emotion expressive behavior, (b) no change in negative emotion experience, and (c) clear increases in sympathetic nervous system activation that appear to be most reliable for measures of cardiovascular activation." (Richards & Gross, 1999, p. 1042). This makes explains my lack of expressive behavior, and why I could explode negatively so easily… negative emotions are not affected. Additionally, the suppression created a constant

anxious surveillance from childhood… as an adult manifest as hyperarousal! It finally has come full circle…

Epilogue: A (Diamond) Rises from the Ashes

January 24, 2020…*10 years after my ambulance wreck; 9 years after quitting my job in EMS… to the day…* I laughed and felt something. At 47, I was having to learn things a child knows. I was trying new emotional ice cream flavors every day. I still see no utility in emotions… but it is different.

I am going to die? Yes.

By suicide? No.

My wife, Mary, is a horrible person. When I die, she is going to turn my big old 480-pound self of cremated ashes into a passel of diamonds, so I can always watch over her. *Seriously... it's cheaper than you think… only $10K for 1 carat ORANGE diamond… her favorite!!! …and she can get it on a payment plan… bonus!!* I don't think my dark humor will go away. I think I will never completely recover. I am sure depression will always haunt me…. *but hopefully, the next episode won't be so bad… there will always be another episode…*

February 5, 2020… and I will shave my head bald time after time after time… (See Picture 7.6)

I am a *Dyscommuniholic!!!*

Picture 7.6 Shaved Heads, 2010- Feb 5,2020

Chapter Eight: Patient Assessment

Emergency Medical Service personnel experience bad things during their careers. This dissertation fills the gaping black hole in health communication research on mental health and affect in communication. My autoethnography chapter stand alone and have their own meaning making. Those reflections will be combined with this chapter's discussion of themes from the EMS personnel interview results.

Through snowballing, 10 EMS personnel were interviewed. The semi-structured interview used questions in Appendix C and lasted 30-60 minutes. Each interview was recorded; however, Medic 7's interview was corrupted when exported, and the data was not used in this study. The nine interviewees were Caucasian paramedics with 10-25 years of service (7 were males, 2 were females). Gender and service lengths were within current normal expectations for veteran EMS, which is predominately white males with 13.6 years of service (Crowe, Krebs, Cash, Rivard, Lincoln, & Panchal, 2019). The nine interviewees work in Texas (3), Georgia (2), Florida (1), Indiana (1), Kansas (1), and Missouri (1). Interviews were transcribed and reviewed for accuracy.

Analysis was completed using the National Registry of Emergency Medical Technicians Advanced Level Psychomotor Examination Patient Assessment- Medical Skills Sheet is in Appendix D. Correct patient assessment is a critical skill in EMS; the findings are recorded in a legal document called a patient care report. The patient assessment model combines Communication Complex and Grounded Practical Theory to allow deeper code searching. The first step was a primary survey for mentation, chief complaint, and life threats, such as apnea or uncontrolled bleeding. Step two was a secondary survey which includes history of present illness, past medical history, vital signs, and a secondary assessment focused on affected areas. This step is important as the medic to create a diagnosis and treatment plan based on findings. Step three was patient reassessment where vitals and responses to treatment are evaluated. The medic should complete a patient reassessment every 10 minutes on a stable patient and every 5 minutes on a critical patient. The patient reassessment allows the medic to trend vital signs and patient conditions enroute to the hospital. The trends enable the medic to adapt treatments to the patient needs.

The primary survey revealed themes consistent with the common EMS stressors shown on Possible Factors leading to Posttraumatic Stress Disorder in Appendix A. The secondary assessment revealed chief complaints of *emotions, senses,* and *support*. The patient reassessment showed changes over time in the chief complaints.

Primary Survey

As stated, the primary survey found critical life threats (themes) of types of calls, staffing shortages, length of service and skills development, and what makes EMS EMS. All patients discussed the emotions surrounding critical calls. The most common call evoking emotions involved pedis, or patients under 12 years old.

> Usually it's **a younger person**. If it's an older patient, it's OK... but the kid… this person had I would love to live. And that can get to you. I think those are **harder than ever**. –Medic 17

> If I had **a really bad pediatric** call, I would go home …but it was still I didn't **know how to cope with the emotions.** Maybe, that's why I do have PTSD. Medic 3

Another theme emerged surrounded staffing. Most expressed frustration due the perpetual lack of paramedics which caused mandatory overtime.

> The problem is you know you know when you're here **you don't know when you're going to go off** or leaving or whatever. Medic 17

> What's the good things about this company what can I say it's good about it? Well. There's a check you're going to get a check. We're going to check every two weeks. But **you won't be home to spend it**. Medic 2

> **I was working 120 hours a week**. Which is a hell of a paycheck. I'm working at a station that is a medic down. Doing a lot of 60-12s and 72-24s. Medic 1

> They was (sic) always saying we will gain new medics in a little bit. But **they were lying. Made people work too damn much and people quit.** So, we went from 15 short to 30 or so short. Medic 9

Common themes emerged as interviewees discussed length of service and abilities. All agreed that the time needed to become proficient was three to five years.

> **When I say zero** …he started off as EMT basic…went straight through paramedic school... didn't work as medic or an EMT. And he doesn't quite have the… I'm sitting here going (shrugs)… I'm keeping my mouth shut and **he's going to have to learn the hard way because he's not listening to me.** Medic 6

> **Three to five years**. That's the break-even point where they start going from to diagnosing and they have the skills and experience necessary to meet the next level. Medic 1

> I also do a lot of teaching a lot of side by side rides where new paramedics come and ride with me. We raised the bar we try. So, we kind of bring street paramedics and **we have anywhere between three and five years to the next level**. Medic 9

The final common theme was about the culture of EMS. These comments reflected how EMS described their EMS world.

> We **have our own language**. Oh yes we are. We have our own slang and you are being a paramedic. We have our own mentality. We have our own processes. Medic 6

> **That's what separates us from the rest of the world.** We're able to take things like that and put it out of our mind til the next time it's brought up. That's why we do what we do, and other people can't do it. Medic 9

> Dark humor is an internal defense. You do have it naturally…. And some of it you learn. But it's a natural way for your mind to cope with things. I think it very helpful
> But research says it's not good to talk like that… (laugh)…
> Who said that?
> (**BOTH)**…**Someone who has never been on a truck**!!!
> Medic 4 and Aaron

Secondary Survey

With the primary survey complete, the medic began the focused examination of the second survey. It is not uncommon to find multi-etiologies and complaints. True to a critical patient, the medic found three chief complaints: emotions, senses, and support.

Emotions. The initial chief complaint was emotions. Evidence of emotional suppression was discovered. Suppression came in military language, shelf and stuffing talk, and denial. The emotional suppression expressed itself through military language.

> **We are soldiers**. We need them to react and almost come like they are **fighting a war**… **go execute your** orders and. Just do it. Medic 5

> **We are road warriors**. You effect people's lives…literally their lives. Their physical or eternal or whatever... you're affecting that. You have to come with a smiley face no matter what the last call was. Medic 1

> The people who taught me were hardened They were battle hardened men from actual war as combat medics in Viet Nam. While I was working on

> medic, the people who taught me were ere 40s 50s. **We drilled and drilled**. We only executed the algorithms. Medic 3

> You like you're on your own. **A lot of anger about this battle**. It's pretty messed up. Medic 18

Another example of emotional suppression was found in shelf and stuffing talk. There were several variations. Medic 4 gave the most poignant example when talking about him being the medic on the call when his wife died of a heart attack at age 34.

> **I have emotions but I stuff them on a shelf**… It's a rough and tumble thing where you don't want anyone to see you have emotions, so you suck it up and pull the tough card around everyone.
> Do you cry?
> Yeah. When I had my wife die. That was a bad one.
> Your wife…?
> That's not something you see every day. **But I found a way to take that and put it up on a shelf**. It only comes back every once and a while. You have to. It's going to eat away, and you become a basket case. Medic 4

Emotional suppression presented in denial after the critical incidents. Every patient expressed similar sentiments after critical calls.

> I was fine then**. I am fine** now. I don't need to talk stuff like that. Medic 6

> We're good. Oh, absolutely **we're all fine**. we're absolutely fine. Medic 3

> The first thing he said the first thing he says I'm dealing with it he said I'm fine. **I'm fine.** I'm dealing with it…nothing I can't handle. Medic 1

> It was a call with college freshman. they were pledging and piled 14 into an SUV. And it went off the side of a mountain. The medic and her partner were first on scene and they were up in the mountains just outside of Chattanooga. They weren't in a place like Atlanta. No Helicopter there on the road or on the side of a mountain. Just two of them with 14 patients on the side of a mountain. It was a bad call. After the call I asked how she was**. I'm fine**. Medic 5

Senses. EMS personnel have sensory experiences on the job. All participants agreed seeing things is unsettling, but the sights are minimal compared to what they smell and hear. Smells come in several types of calls, such as death, blood, or gunpowder.

> I see stuff. But never say anything. I find ways to turn off. Put them off to the side…until someone asks about them. Smell. The way that rotting corpse smells like dead fish. **That is what I smell**. I use Vicks on some scenes. Medic 4

> **Blood has a smell that you can't not remember**. This was in a bar dive bar so there's beer… beer in the air…liquor in the air. Greasy food in the air. And now we've got perforated gut hanging out. **The nasty bloody gut smell**... Medic 9

> **You remember the ones where it had the permeating lingering smell** where there was massive amounts of gunfire. We've had a number of scenes. Soon after Katrina when we had the gangs that came from New Orleans and we had a gang war. There were a couple houses we went into had automatic weapons… they just unloaded massive clips into people inside these houses and the air was so thick with the gunpowder **it permeated everything**. Medic 2

> I mean I've had bigger and badder scenes since then with that same smell. But that one was **more than a smell; it was a presence**. Medic 3

While smells may unsettle and create deep memories, hearing is a bigger challenge for EMS personnel.

> I think most the most critical one that we deal with is not her child died and that that sound is a sound you feel here (pointing to heart) … Most people in the field will handle the blood and the guts and the smell. It's that **cry that hits them hardest**. Medic 6

> the most experienced people are not going to have a problem with what they're seeing or what they are smelling. They're going to have problems from that mother or their father… they remember what mama and daddy said. It's… it's that **primeval scream** and it's primeval. Medic 5

Support. In the focused exam, patients expressed negative support from administration, distrust of mental health professional, and lack of understanding from spouse/family. Positive support came from partners and family members in EMS.

Support from supervisors and administration was missing or deemed negative. The supervisor, who should be a first-line advocate, fails to deliver the needed support.

> The stress stuff on the job… I think people can deal with the stress stuff. I think everything else on top of it. You know when dispatchers that you know seem vindictive. Maybe management that uses shock and discipline when somebody does one bad thing on the east side. **I don't trust the bastards**. Medic 1

> In the cab where you're working if it (critical incident) happen the super can call a time out or are they just supposed to. **But it has always been, "Let's go to the next call."** Medic 9

> You still don't feel like there's that **help from the administration** Medic 17

> I didn't talk to my super because…**well, I didn't**. Medic 3

> We had six-week period with 11-12 supercritical calls… and medics having problems. It was a shit load. I ended up going to the operations manager and saying, "What the hell was going on? **When are you gonna help?**" Medic 5

Mental health has a negative stigma in EMS. Medic 4 explained, "We don't discuss things like PTSD. We all have it. It's a given. Even a new dude… he's got it, too." After critical incidents, EMS may be offered counseling (i.e. psychological or spiritual). However, the view of those counselors is negative.

> Public safety in general creates a **distrust for these therapists**, social workers… counselors always say we have a hero complex. Medic 6

> 100% of people in EMS have PTSD. If they do anything other than a wheelchair run, they have some kind. You can't get away from it. I've got it. **A shrink would say this guy is fucked up**. Medic 4

> You understand you need a psychologist… but they are like brain worms. We don't want them in our heads. **They don't understand us**. Medic 18

> **I don't think a chaplain should ever call me for anything**. I am just not that kind of person. I don't believe the same way other people do. I don't do religion. Medic 2

The patients agreed family is important and mostly positive; however, negative support came from spouses or family members not understanding the nature of EMS.

> She kinda knows this job. Well, she knows what I tell her. But **she doesn't understand** what it's like to go out and find the dead bodies in the highway. Medic 18

> You were taking your work home with you**. You don't let your family know**. It's something that happened at work. I'm trying… you know... how do I tell my kids about a kid? And I said well you tell them that I had a really bad day at work and there was a little boy or a little girl that died. They love me **but don't understand**. Medic 2

> I didn't share a lot with my wife. **She didn't understand**... and it builds because both of us don't know what is going on. She's being a bitch on my days off when I try to explain why I sit around. Medic 1

Positive support came from coworkers and other emergency personnel (i.e. police, fire). This exists partly due to the brotherhood between services.

> Putting emotions back is a little learned and a little natural. Certain people are born being able to handle certain things. You learn it…like basing your dinners off a bad run helps you grab a little bit of humor out of it. Helps you put it somewhere else. Like spaghetti bake for a cracked cranium. It's one of those things that helps you laugh it off and get it out of your head a little quicker. **My partners are good like tha**t. Medic 4

> **I have my dad who's an EMT,** so I talk to him. You know I have I have plenty of people that know what I'm talking. Medic 18

> **I'd rather have the guys at the (fire) station**. Another person in the same line of work is easier to talk to. The psychiatrists and psychologists have no idea what we see. They have no idea what we do. The guys that are THERE with you that's the best group of people to talk to after a critical incident. Medic 6

Patient Reassessment

A patient reassessment is vital to notice patient trends. Hopefully, the patient condition improves with treatment, but if not, the medic is prepared to follow protocols for further treatments. No significant changes were noted in senses.

> How do you deal with that? It never goes away. It takes 30 seconds to see something… and 30 years to forget. I talked to him and calls from 25 years ago. **It does not stop**. Medic 18

> You've seen it many times…different variations of it you know. That's one of the senses you have them because you see that, and you say **Well that reminds me of another call right.** Medic 3

Fortunately, improved patient condition was noted in emotion and support. While separated in the secondary assessment, emotion and support became more intertwined in the reassessment. Pre-incident training has increased awareness of and decreased stigma in seeking support. The training has become part of EMT classes and yearly continuing education sessions.

> One of the things that I've done is introduce as part of our program a 90-minute lecture discussion on simply understanding what stresses the three different kinds of stress in our lives and how we deal with establishing resiliency and simply establishing the fact that **it's okay to not be ok right**. Medic 5

> Medic 5 lead a discussion on stress and bad shit the other day in class. It's gonna happen. It always happens… but now I have some ways to deal with

establishing resiliency and simply establishing the fact **that it's okay to not be ok right**. Medic 6

Supervisors and managers have had to learn math… an understanding the base of that (the EMS) pyramid are people. If you want your people to be able to get back after these really horrible calls, you need to make sure that they think… that they have a bathroom break... that they have the opportunity to have a bite… to catch their breath. Medic 1

Maybe for yourself to be human reminding yourself that you are a normal person having **normal reactions to abnormal situations**. Medic 3

My advice to new paramedic classes to deal with that (critical incidents). **Don't be afraid to talk** to somebody because especially some older because if they can't help you directly, they probably know somebody who can. Medic 18

Awareness increased of emotional and mental health issues increased with the increases in pre-incident trainings. The awareness comes from understanding the signs and symptoms gathered in the primary and secondary patient surveys. The reassessment showed decreased stigma on mental health.

Because **I don't think every critical incident leads to PTSD**. And what I've found that too many in a row or that **too many without any intervention increases your likelihood** of developing PTSD because of repeated trauma**.** Medic 5

I think PTSD is such that it's kind of like…say autism. It is a spectrum. You know the basic things that we're covering with PTSD is such a vague subject. Medic 1

I see where the person is **chatty Cath**y. We're making stretcher and get truck back together, and they **suddenly are not happy. They don't want to talk about the call.** They don't want to talk about anything like that. And that gives me a heads up…. they're having a hard time sleeping. Medic 9

If they start losing interest in things they enjoy. One of my partners absolutely loves Pokémon. I said well what level are you? And he goes I just put down for a while. I just can't concentrate on it. OK. That is a marker to me right Medic 6

You can see the **difference between somebody who is in there hurting by how they communicate**. There is some stuff that is funny shit. They should be pee in their pants funny… and you know they get very very serious about stuff. Medic 9

> I mean it's been my experience the folks that are having the **greatest problems share the least and it's the quiet ones**. I mean there are all kinds of indications to be watching for. Medic 18

Support has changed since the secondary assessment. Management is offering more support after critical calls. Multi-agency critical incident teams have formed in larger cities. Finally, the macho attitude is decreasing.

> I ran a pedi arrest. By the time I got my report done, I **had a call from chaplain and my supervisor offering time to talk**. Medic 2

> I've been doing along and having a lot of success **in intervening before things get really bad is doing it defusing within 24 hours**. I can often alleviate issues before they become issues. Medic 3

> **Support is changing an awful lot, too**. We realized critical stress issues affect the three major agencies here. You know... fire, police, and EMS. All have peer people as part of our team. And when it happens, you're familiar with an entire team of your peers and clergy with family support, too. Medic 5

> There is **no stigma with CISM (critical incident stress management)** that there was when I was coming through. It was you to come by and be brief you don't say anything kind of thing. There's no longer that mindset. **I don't have to be macho and suck it up.** I can hear. Medic 6

The patient condition has improved in the reassessment. Storytelling, whether on patient care form or with others, was indicated as a factor.

> Part of the healing comes in finishing their documentation because in the documentation that beginning to be able to tell the story you cannot heal until this story and pull all the documentation is only the beginning of it. But **you're at least allowing them to begin to tell the story**. Medic 5

> You do your job... you know, you do your objective PCR. You get the paperwork done... you get the clinical side done. Then an opportunity to **talk about that emotional side through stories**. Medic 3

I ***<u>needed to write them about of all these things-</u>*** *the good and the bad. It has helped…*

----------End of patient care form ----------

Aaron Deason, Licensed Paramedic (Retired), 20 June 2020

Chapter Nine: Eggs, Bacon, and Gravy

> *I loved working overtime shifts with Gravy. We would check out the truck and head to the local café for breakfast. We got half price. The Texas breakfast of 3 eggs, 4 bacon, hash browns, and biscuits and gravy cost $2.50. I ate it all…except the gravy. Every time, Gravy grabbed my bowl, and, true to her nickname, sucked up the cream gravy using a straw, then used her fingers to clean the bowl. Gravy was an awesome overtime partner! She taught me two things: 1) Get your work done, and 2) Never leave the gravy.*

This multimethod grounded practical theory study explored the systemic affect of critical incidents on emergency medical service personnel communication using ethnography and autoethnography. In lay terms: the things EMS experience shape their communicate with self, partners, co-workers, other health workers, and patients. The systemic affect is the shifting communication patterns over time and changes in mental health. This concluding chapter discusses the implications of the major findings related to gravy making and gravy sopping. Finally, this romp around communication theory forced me to find myself as scholar as I made sense of EMS communication.

Getting Things Done: Making the Gravy

Just a few more stories… Many years ago, I was stationed in my hometown working with three awesome men that I had known since as far back as elementary school. Many days we would head to a local café for breakfast. One shift, we decided to make our own breakfast feast. How hard could it be? We soon learned gravy making is tough. Our cream gravy was a lumpy, flour-filled concoction best saved for grouting tile. Eggs and bacon are simple. Eggs and bacon are the skills in EMS taught in class and perfected in clinicals. Gravy is the emotional work in EMS.

I had failed but not for lack of trying. I could not do it on my own as much as I really wanted it to happen. My wife taught me gravy making the next day; I made a semi-edible gravy on the 12th attempt. She watched, laughed, and offered correction after each attempt. EMS preceptors serve the same mentoring and skill monitoring function (Best, Hajzler, Ivanov, & Limon, 2008; David & Brachet, 2009; Gurchiek, 2011). Preceptor involvement is over once students are released into the field with good skills but little emotional management skills.

EMS have been taught to switch professionalism "on" for calls (Noe, 2011). Medic 3 said "*We may bitch and complain to each other while in the truck, but, once we step out of the truck, we are the nicest people on the earth to the patient*." Medic 4 perfectly summed, "*I see bad things, but I flip a switch when I talk to patients. I am caring, compassionate, thoughtful… even to the assholes. Just sit back and let them talk it out. It they can talk that much they are not that injured.*" What we were never taught was how to turn it off afterwards. I took the "offness" home too many times creating patterns of interpersonal *dyscommunication* with my wife. It is not that I did not care, it was that I was so disconnected I became unable to communicate effectively. The constructed reality on my days remained clinical- get work done, make gravy, eat… *except y'all know I can't make gravy.* I was unpresently present for years.

The old guard machismo "offness" attitude in EMS culture and training created generations of people unable to make gravy. We EMS became ducks on water; however, "inhibiting the outward expression of negative emotion fails to provide any relief from the subjective experience of negative emotion." (Gross, 1998, 232). The professional calmness, or surface acting, increases work exhaustion and decrease mental health (Blau & Eggerichs-Purcell, 2012). In other words, the "show no emotion" thinking in EMS created a vat of gloopy gravy.

Chef Kelly Fields, winner of the 2019 James Beard Award for Outstanding Pastry Chef and owner of New Orleans' award-winning restaurant Willa Jean, said, "If you think too much about it, that's when you start to make mistakes" (Ramdene, 2016). This is true in EMS where skills and knowledge are the eggs and bacon. As shown in the literature, autoethnographies, and interviews, EMS are adept at lifesaving skills, which are drilled into memory until instinctive. They can make great eggs and bacon. During this move from outsider to insider, EMS learn the language of their new tribe. Early language development is linked to better outcomes in EMS because:

> Facility for language improves and the store of their encoded thoughts enlarges, they develop an increasingly powerful system of beliefs on which they rely in negotiating their way through life. **At some point, perhaps early in this process, the system of beliefs a person develops become sufficiently influential in his or her life that it shapes and orients every experience** beyond those of simple reflex. (Deigh, 1994, pp. 894-850)

My medic class instructor taught us emotions kill people. The old-school EMS culture perpetuates the ideas by telling newbies emotions cannot be part of any decision and must be turned off in patient care. Emotional suppression during calls is taught from day 1 in EMS. What is not taught is how to turn those emotions back on…. All eggs and bacon…no gravy. Gravy making skills are taught by people who do not know how to make gravy creating generations of EMS who suck at gravy but make good eggs and bacon. EMS avoided those showing emotions as "the stigma of being seen as crazy or insane was feared due to its impact on social perceptions or social standing." (Shannon, Wieling, Simmelink-McCleary, & Becher, 2015, p. 292). In other words, EMS will NEVER say anything about their own lack of gravy-making skills to anyone. The fear of sharing increases the stigma as normals do not want to be associated with the affected population. (Sussman, 1994). Emotions and feelings, the key to good gravy making, are tossed aside as dross, made pariah, and placed in bottles on a shelf.

Making bad gravy is part of the learning process in cooking; however, chefs rinse the pot and start over with fresh ingredients. In EMS, unfortunately, bad gravy makers are celebrated and elevated to demi-god status. Post-call storytelling sessions become the "place for sensemaking processes where the collective sharing and reconstruction of professional culture is materialized through stories (Bangerter, Mayor & Doehler, 2011, p. 211). Emotional repression as a cultural norm is propagated to the next generation. By the time they understand the process, they have become experts at bottling the gravy and stuffing in a bookcase with infinite shelves for gravy jars with labels from past critical incidents. Each label- *CPR on a 3-year-old, my EMT partner suicide, car vs. train, MCI bus wreck,* and *farmer gored to death by bull*- is visible only to self. The outsider label reads "I'm fine." Except, a magic gravy librarian pixie pulls up in the mind every related gravy jar even as a new bottle is being filled for shelving. I am NOT fine!!!

As humans experiencing bad things, EMS cannot separate themselves fully from the bottle of gravy. Perturbations are caused from the conflict, or dissonance, between critical incidents and the emotions. More about this idea later in the discussion. For now, it is sufficient to know EMS may repress emotions to avoid being devalued by others. (Sznycer, et. al., 2016). Interestingly, Noe (1995), a non-EMS researcher, stated: "There is a danger that cynicism, and even further detachment, occurs when EMS workers

withdraw into their own worlds and fail to communicate with others" (p. 94). Furthermore, "the shame feelings are likely to increase the individual difficulty in regulating emotions, and this in turn could lead to an increase in hostile attitudes and psychopathological symptoms" (Velotti, Garofalo, Bottazzi, & Caretti, 2017, p. 182).

The bookcase is no secret to other EMS personnel as they have their own visibly hidden gravy jars. We know they have seen things. We know they want to talk about it. We know they will not. We will not do anything, except attend a funeral where we can show emotions without judgment. This macho, suck-it-up culture began with the old guard EMS in the 1970s and 1980s. I learned how to make eggs and bacon from this group… but not gravy making. Several of these non-gravy makers became my supervisors during my career. This could be a reason gravy shelving increased to gravy stockpiling as EMS felt limited administrative support from the non-gravy making supervisors (Beane, 2011). *"I don't trust the bastards*" said Medic 1. This anti-administrative trust sentiment is echoed throughout the interviews. EMS feel alone in their gravy making efforts (Greene-Shortridge, Britt & Castro, 2007).

Until recently, PTSD was an openly hidden mental illness in EMS. It is possible "individuals with hidden disabilities may suffer the painful indignity of being judged as illegitimate claimants" (Green, Davis, Karshmer, Marsh & Straight, 2005, p. 207). The still-persistent machismo attitude in EMS may contribute to the lack of professional seeking help. Consider the following:

> We cannot determine whether this strategy (of gravy shelving) is unique to individuals with PTSD or common across a range of diagnostic categories. Finally, these data do not speak to causality- the development of PTSD may lead to a tendency to strategically withhold, premorbid strategic withholding may predispose one to develop PTSD following traumatic exposure, or the two may both result from a third variable. (Roemer, Litz, Orsillo, Wagner, 2001, p. 154).

It is difficult to determine which came first- the flour or the gravy. The two competing forces to seek help and to save self create perturbations forgotten simmering on the soul's back burner until the gravy is scorched.

Never Leave the Gravy: Sopping It all Up

Researchers identified troubles in gravy making as far back as 1986. The answer was Egyptian hieroglyphics to EMS administrators. The Rosetta stone would have shown them that:

> The **absence of fatigue, sickness, and other psychophysiological markers of stress may mislead supervisors into believing that paramedics are not stressed**. The critical markers of occupational stress within this population may be what the paramedic says about the organization, his coworkers, and patients. (Hammer, Mathews, Lyons, & Johnson, 1986, p. 539)

The truth was in the stories told in the ER parking lot, in the driveway at shift change, and on bar stools….and those stories about mental health were ignored because EMS personnel did not look distressed. They were "fine," and then turned to substance abuse or suicide to numb their inner demons.

In 2011, EMS turned the ripe old of 40 as an organized profession. Few EMS agencies had Standard Operating Procedures (SOPs) to address employee mental health. EMS was ready for a midlife crisis. The younger generation of EMS, like me, had been taught incorrect maladaptive gravy making skills. The number of emergency service suicides jumped from 58 in 2011 to 158 in 2017 (Dill, 2017). Many EMS services realized the enormity of the situation and began changes to address mental health (Regehr & Millar, 2007) "To be sustainable and prevent PTSD from developing, changes must ultimately occur within the paramedic socioenvironmental culture." (Drewitz-Chesney, 2012, p. 262). In other words, there needed to be a shift in thinking about gravy in EMS.

The change came after I left/retired from EMS. As Medic 5 related, many services began adding resiliency, mindfulness, and mental health self-care to mandatory semi-annual continuing education sessions for employees. EMS managers began attending specialized trainings about recognizing stress, burn out, emotional fatigue, and career departure which are common indicators of incorrect gravy making (Edwards, 2008; Popa, Arafat, Purcărea, Lală, & Bobirnac, 2010). Resiliency and critical training increased in EMS mental health, but it was not "conducted by scholars who lack either the direct experience of stigma or vicarious experience of courtesy stigma." (Green, Davis, Karshmer, Marsh & Straight, 2005, p. 211). I would like to say there were researchers helping, but that is a lie. There is no federal funding for the "amalance driver people." All

the “gubmint” wants to do is slash Medicare/Medicaid reimbursement (Wu, 2020), which created more stress as we became fearful of losing jobs. The change started as EMS who were jacked up by the bad calls …*tired of fighting emotions… tired of the nightmares… tired of triggers…tired of attending funerals… tired of divorces... tired of substance abuse… tired of not knowing what real gravy was anymore…* said enough is enough!

Limitations of Gravy Research

I am completely biased in the autoethnography because I am relying on old journals and memories. Memories that have been skewed with retelling stories which may have morphed from actual truth to believed truth about gravy. This study is full of my thoughts and feelings coming from inside the bubble of gravy making process. I suffer depression. I have PTSD… I hate what EMS did to me… but I love what EMS did to me because I wouldn’t have a dissertation discussion about gravy making.

The New Gravy Boat

One of the biggest challenges is finding a gravy recipe with affect, autoethnography, and ethnography as key ingredients. This study had participants from many states and different sized services providing a broad cross-sectional analysis of EMS and emotions producing saturation for this data set. Quantitative research could help with correlation of emotions in EMS. Regional comparisons might discover different themes. With the changes in resiliency training, future studies could be longitudinal to track changes in symptomologies and etiologies. Finally, my notion of *dyscommunication* should be tested and explored in EMS narratives and storytelling.

Conclusion

My goal was to explain what I see as dyadic conflict between cognition and psychology which creates a duel of dualism where I find myself fighting to understand the world inside my head and the real world itself. I found myself in liminality where the communication is separate from communicative episodes yet intertwined within the spoken and written EMS narratives. The power in communication and social constructionism comes from BOTH. Some would balk at the combination; however, “communication can be constituted symbolically in many different ways.” (Craig, 1999, p. 127). Finally, the observant reader will see the duel between the dyad in the duality of communication.

Being able to see communication as a dyad of duality allows me to understand the conversations my fellow paramedics/EMTs have privately and the alternate meanings in society. Conversations in the ER driveway refer to calls from days, weeks, months, and sometimes, decades ago. These stories are filled with a deep narrative of egocentric glory, but often reflect the inner turmoil with messages that discoverable and interpretable meanings. The outside researcher, not understanding the eyes and terseness of the answers, misdiagnose the data/situation/conversation. I did not realize I learned social constructionism as a paramedic. Macro is the far focused lens to capture the entire scene; micro allows me to feel the conversations (Pearce, 2009). This dissertation takes a macro researcher-oriented approach by looking at why/how/when/where the things experienced shaped communication, then turns inward to the micro side of social constructionism as I discuss my *dyscommunication*.

You see, this entire dissertation mimics my EMS career. The literature review is the knowledge and skills learned through hours and years of study, practice, and messing up. Learning medications, procedures, differential diagnosis, and skills was a process was tedious and full of algorithms. It taught me to think in constant what-ifs creating perpetual hyperarousal. For any given patient condition, I had 5-6 different protocols to know and use. The literature review was much like medic class… I studied and studied. I had to spend hours reading so the research became part of my new reality…each article triggering a memory. EACH ARTICLE… I was muddling through trying to find myself as a scholar. Yes, the literature is long *almost 60 pages*; there are no surprises in my world. *It's a hyperarousal thing.…* I know why I chose affect vs effect. Clearly the calls affected me, but didn't they have an effect, too? Effect is temporary…*affect creates a wonderful world of constant hypervigilance, deepening depression, suicidal ideation.… The lasting affect created a zombie who couldn't laugh or cry. The life of hypervigilance, long-hour shifts, and lots of Dr Pepper left me unable to control anxiety which manifests in my constantly shaking hands. I cannot freaking eat soup with a spoon. I seldom sleep more than 4 hours per night. Most of that sleep is filled with vivid, disturbing nightmares. Affect is deep, ugly-ass scar seen years later…and always brings the memories.*

An outside researcher would never see those deeply rooted internal conversations mainly because **I** would never share those thoughts and feelings. This is the missing

element is research…it goes deeper than micro (10^{-6}) …maybe to *nano* (10^{-9}) ... or even to *pico* (10^{-12}). My autoethnographies show the affect of critical calls during my career and the lasting affect extending to today.

Chapter 8 is the SOAP (subjective, objective, assessment, and plan) documentation to write this patient care report (dissertation). The symptoms are documented on a patient care report (PCR). Missing from the PCR is a discussion of WHY Mrs. Jones had an exacerbation of her congestive heart failure (e.g. Could not afford medicine, no car to get medicine, poor eating habits, depression about condition and giving up hope). At the house, I would look at all reasons. Enroute to the ER, I would talk to the patient to get a deeper sense of Ms. Jones' internal conditions Those side conversations are reported orally to the nurse or a social worker. While not a psychic, I do not need a crystal ball to see the jadedness of my dissertation patients, especially Medics 4, 17, and 18. Their dark humor hides a truth missed when the monitor is treated and not the patient.

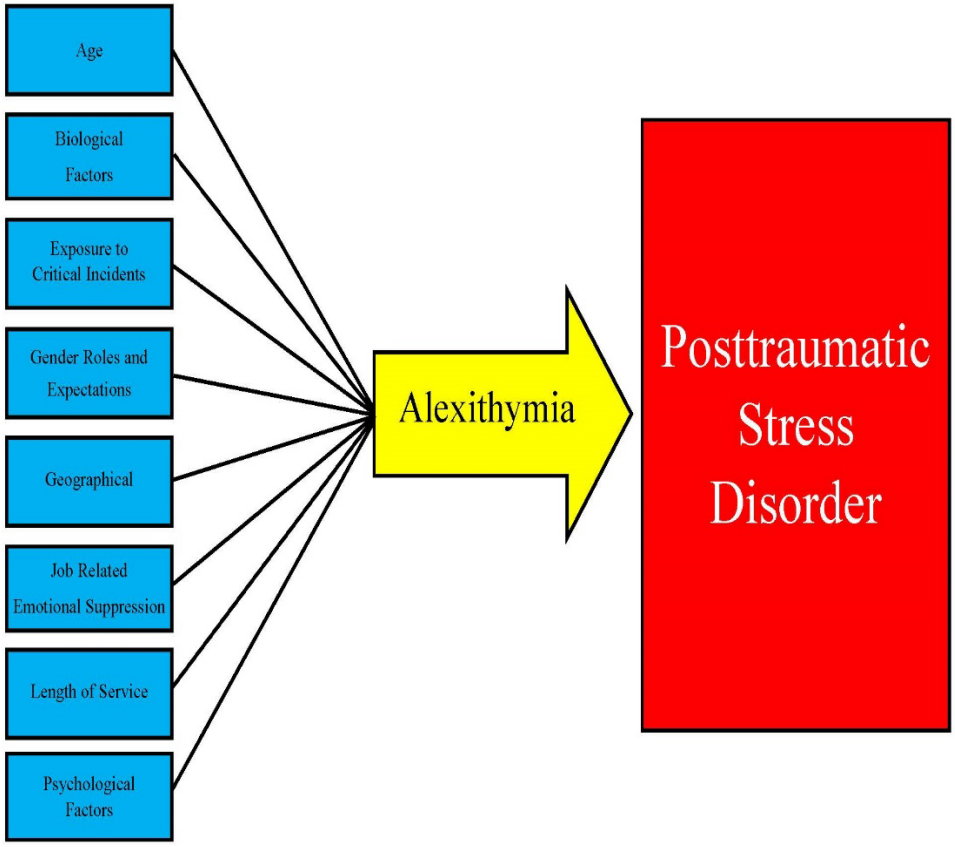
I believe this dissertation's uniqueness is combining the outward MACRO-level structural elements and the hidden *pico*-level internal conversations. In other words, my scholarship is enhanced because the nouns, adjectives, and invectives of the research group; I speak "paramedic" (Graf, Bilewicz, Finell, & Geschke, 2013). The stories of other EMS combined with mine show there is an effect on communication, but what I did not expect was discovering the affect and interaction between mental health and communication.

Some academics would dismiss this dissertation because of my insider bias or my casual writing. To them I say (*in my nicest Southern voice*), "**FUCK YOU!!!**" I have held too many people as they took their dying breath. I have heard, seen, and smelled things only seen in horror movies. Even though I retired in 2011, I still see/hear/smell it… You have no idea how scarred and scared I am. You cannot understand the systemic affect and fight I have fought to stay alive…

But in the end… I am a ***DYSCOMMUNIHOLIC***!!!

Appendix A

Possible Factors leading to Posttraumatic Stress Disorder



Appendix B

IUPUI Counseling Center Clinical Report

Data removed by “suggestion.” Charts are available upon request to Aaron Deason.

Appendix C

Systemic Affect of Critical Incidents on EMS personnel Communication Interview Guide

Potential Questions

- As a First Responder, are you familiar with PTSD Signs and Symptoms?
- How do you talk about PTSD?
- How many EMS have PTSD and do not know/understand?
- Can a provider function in EMS with PTSD?
- How would you feel about working with a partner if you knew he/she had a known PTSD diagnosis?
- What do partners talk about between calls normally?
- What do they talk about on the way to a potential critical call?
- What do they NOT talk about going to the call?
- What are taboo subjects? Why?
- What are the inward thoughts if not talking?
- Does this self-talk help prepare for a potential critical incident?
- Does the self-talk or in cab talk change if call is NOT dispatched as critical (i.e. Transfer)?
- How do providers communicate in-cab after a critical incident?
- What does the communication MEAN?
- How long does that talk last? (Minutes, Hours, Days, Weeks?)
- What do regular partners talk about after a call?
- How do empathy levels change in long-term partners?
- How does the talk change if no regular partner?
- How deep do those conversations go?
- Do you trust your regular partner?
- Do you trust the EMT/Paramedic of the day?
- What resources are available after a critical incident?
- How often do providers experience critical incidents?
- Does the nature of the call affect communication between provider and patient?
- Does the nature of the call affect communication between partners?
- If EMT/Paramedic has PTSD diagnosis how does that change perception of abilities?
- How would PTSD diagnosis affect standing in company?
- Does gallows and dark humor help/hurt?
- Why do providers use gallows humor?
- What are the purposes of these stories for in-grouping?
- Why do we share the stories with out-groups?
- Is there a PTSD stigma?

- Does continual recounting of stories help/hurt?
- Would therapy/therapist without lived experience understand?
- Would you trust that therapist?
- What do you tell your family about the calls?
- Do you discuss the particulars of the calls with your significant other if not EMS provider?
- What advice would you give to a rookie to deal with the stress and potential calls?
- What stress-related communication training did you receive during school?
- What coping strategies do you use to combat stress of job?
- Do those strategies help or hurt dealing with critical stress?
- What advice do you wish you had received?
- What would you tell a rookie about dealing with stress?
- How supportive is your work with needed resources after critical incident?
- What do you think about people who have PTSD?
- What do you think about the TV/Movie/Media portrayal of EMS?
- Is this accurate portrayal?
- How does this affect public perceptions of EMS?
- How does media affect EMS culture?
- Is the emotional experience of the call relived through writing a PCR?
- Does it happen with every call or just critical incident?
- Does the emotional side of the call increase memories and descriptions of the scene and patient care?
- If treated patient bad and realized while writing PCR, does that change attitude or treatments in the future?
- Do medics with mostly negative PCRs have increased PTSD?
- How do negative/positive PCRs affect stress and PTSD?
- Does time together affect communication?
- Does time affect empathy levels?
- Same emotions dispatched vs actual
- Are the conversations different between EMT/Paramedic vs Paramedic/Paramedic?

Appendix D

National Registry of Emergency Medical Techincians Advanced Level Psychomotor Examination Patient Assessment- Medical

National Registry of Emergency Medical Technicians
Advanced Level Psychomotor Examination

PATIENT ASSESSMENT - MEDICAL

Candidate:_____ **Examiner:**_____

Date:_____ **Signature:**_____

Scenario:_____

Actual Time Started: _____	**Possible Points**	**Points Awarded**
Takes or verbalizes appropriate PPE precautions	1	
SCENE SIZE-UP		
Determines the scene/situation is safe	1	
Determines the mechanism of injury/nature of illness	1	
Determines the number of patients	1	
Requests additional help if necessary	1	
Considers stabilization of spine	1	
PRIMARY SURVEY		
Verbalizes general impression of the patient	1	
Determines responsiveness/level of consciousness	1	
Determines chief complaint/apparent life-threats	1	
Assesses airway and breathing -Assessment (1 point) -Assures adequate ventilation (1 point) -Initiates appropriate oxygen therapy (1 point)	3	
Assesses circulation -Assesses/controls major bleeding (1 point) -Assesses skin [either skin color, temperature, or condition] (1 point) -Assesses pulse (1 point)	3	
Identifies priority patients/makes transport decision	1	
HISTORY TAKING AND SECONDARY ASSESSMENT		
History of present illness -Onset (1 point) -Severity (1 point) -Provocation (1 point) -Time (1 point) -Quality (1 point) -Clarifying questions of associated signs and symptoms as related to OPQRST (2 points) -Radiation (1 point)	8	
Past medical history -Allergies (1 point) -Past pertinent history (1 point) -Events leading to present illness (1 point) -Medications (1 point) -Last oral intake (1 point)	5	
Performs secondary assessment [assess affected body part/system or, if indicated, completes rapid assessment] -Cardiovascular -Neurological -Integumentary -Reproductive -Pulmonary -Musculoskeletal -GI/GU -Psychological/Social	5	
Vital signs -Pulse (1 point) -Respiratory rate and quality (1 point each) -Blood pressure (1 point) -AVPU (1 point)	5	
Diagnostics [must include application of ECG monitor for dyspnea and chest pain]	2	
States field impression of patient	1	
Verbalizes treatment plan for patient and calls for appropriate intervention(s)	1	
Transport decision re-evaluated	1	
REASSESSMENT		
Repeats primary survey	1	
Repeats vital signs	1	
Evaluates response to treatments	1	
Repeats secondary assessment regarding patient complaint or injuries	1	
Actual Time Ended: _____		
CRITICAL CRITERIA **TOTAL**	48	

_____ Failure to initiate or call for transport of the patient within 15 minute time limit
_____ Failure to take or verbalize appropriate PPE precautions
_____ Failure to determine scene safety before approaching patient
_____ Failure to voice and ultimately provide appropriate oxygen therapy
_____ Failure to assess/provide adequate ventilation
_____ Failure to find or appropriately manage problems associated with airway, breathing, hemorrhage or shock [hypoperfusion]
_____ Failure to differentiate patient's need for immediate transportation versus continued assessment and treatment at the scene
_____ Does other detailed history or physical examination before assessing and treating threats to airway, breathing, and circulation
_____ Failure to determine the patient's primary problem
_____ Orders a dangerous or inappropriate intervention
_____ Failure to provide for spinal protection when indicated

You must factually document your rationale for checking any of the above critical items on the reverse side of this form.

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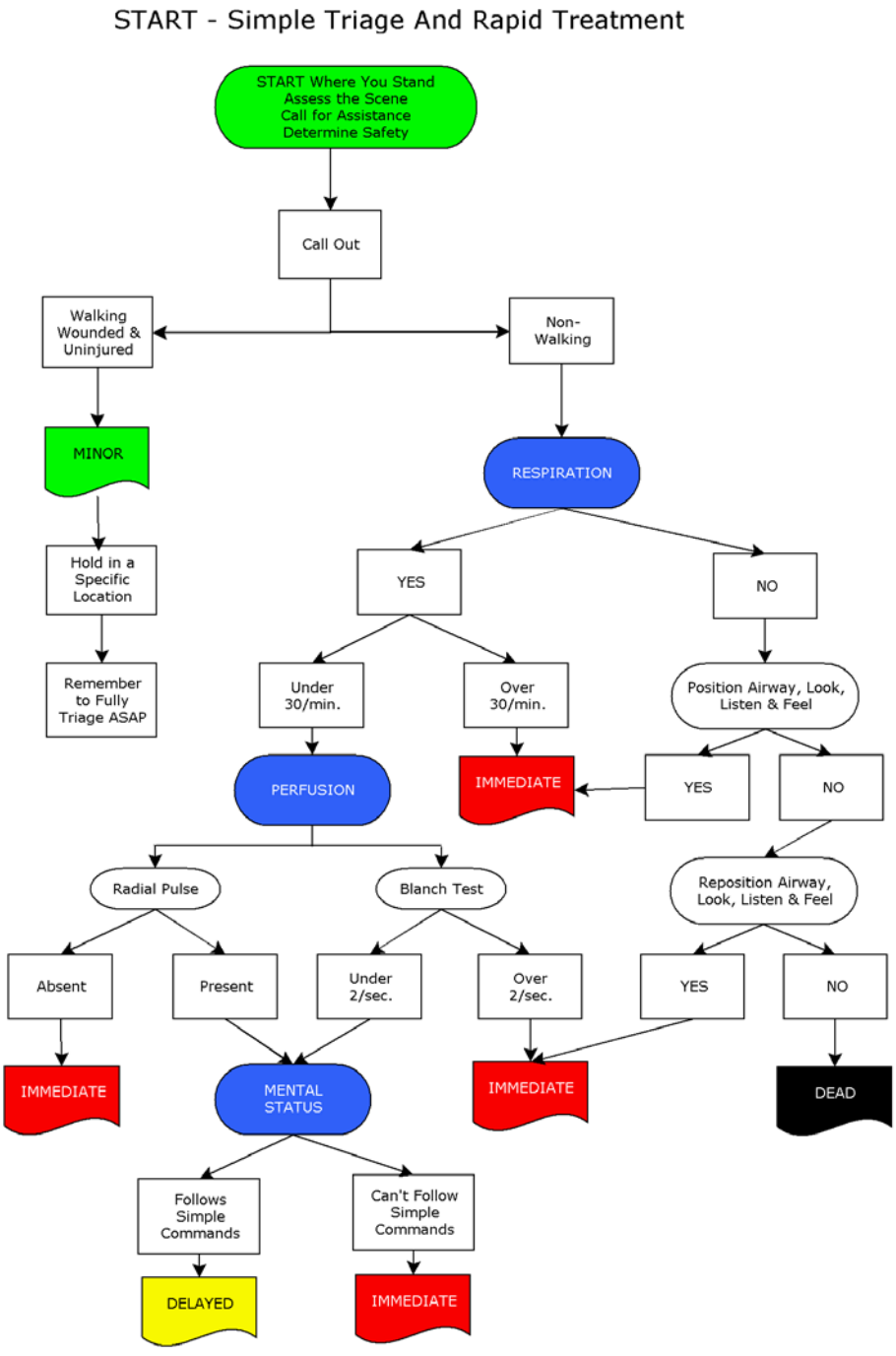
Appendix E

START Triage Method



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START

By using a casualty sorting system, you are focusing your activities in the middle of a chaotic and confusing environment. You must identify and separate patients rapidly, according to the severity of their injuries and their need for treatment.

En route
Even while you are responding to the scene of an incident, you should be preparing yourself mentally for what you may find. Perhaps you've been to the same location before. Where will help come from? How long will it take to arrive?

Initial Assessment - Stay Calm
The first thing you should do upon arriving at the scene of an incident is to try to stay calm, look around, and get an overview of the scene. These visual surveys give you an initial impression of the overall situation, including the potential number of patients involved, and possibly, even the severity of their injuries. The visual survey should enable you to estimate initially the amount and type of help needed to handle the situation.

Your Initial Report - Creating a Verbal Image
The initial report is often the most important message of a disaster because it sets the emotional and operational stage for everything that follows. As you prepare to give the first vital report, use clear language (no signals or radio jargon), be concise, be calm, and do not shout. You are trying to give the communications center a concise verbal picture of the scene.
The key points to communicate are:

- Location of the incident
- Type of incident
- Any hazards
- Approximate number of victims
- Type of assistance required

Note: Be as specific with your requests as possible. Field experience has shown that a good rule of thumb initially, in multiple- or mass-casualty situations, is to request one ambulance for every five patients. For example, for 35 patients, request seven ambulances; for 23 patients request five ambulances, and so forth.

Before starting, take several deep breaths to give your mind time to catch up with your eyes and to try to calm your voice. You might give the following report: "This is a major accident involving a truck and a commercial bus on Highway 305, about 2 miles east of Route 610. There are approximately 35 victims. There are people trapped. Repeat: This is a major accident. I am requesting the fire department, rescue squad, and seven ambulances at this time. Dispatch additional police units to assist."

Sorting the Patients

It is important not to become involved with the treatment of the first or second patient with whom you come in contact. Remember that your job is to get to each patient as quickly as possible, conduct a rapid assessment, and assign patients to broad categories based on their need for treatment. The patients who are left in place are the ones on whom you must now concentrate.

The START System: It really works!

The Simple Triage And Rapid Treatment (**START**) system was developed to allow first responders to triage multiple victims in 30 seconds or less, based on three primary observations: **R**espiration, **P**erfusion, and **M**ental Status (**RPM**). The **START** system is designed to assist rescuers to find the most seriously injured patients. As more rescue personnel arrive on the scene, the patients will be re-triaged for further evaluation, treatment, stabilization, and transportation. This system allows first responders to open blocked airways and stop severe bleeding quickly.

Triage Tagging: To Tell Others What You've Found

Patients are tagged for easy recognition by other rescuers arriving on the scene. Tagging is done using a variety of methods determined by your local Emergency Services System. Colored surveyors' tape or colored paper tags may be used.

The Four Colors of Triage

MINOR	delayed care / can delay up to three hours
DELAYED	urgent care / can delay up to one hour
IMMEDIATE	immediate care / life-threatening
DEAD	victim is dead / no care required

The First Step in START: Get up and Walk!

The first step in **START** is to tell all the people who can get up and walk to move to a specific area. If patients can get up and walk, they are probably not at risk of immediate death.

In order to make the situation more manageable, those victims who can walk are asked to move away from the immediate rescue scene to a specific designated safe area. These patients are now designated as **MINOR**. If a patient complains of pain on attempting to walk or move, do not force him or her to move.

The patients who are left in place are the ones on whom you must now concentrate.

The Second Step in START: Begin Where You Stand

Begin the second step of **START** by moving from where you stand. Move in an orderly and systematic manner through the remaining victims, stopping at each person for a quick assessment and tagging. The stop at each patient should never take more than one minute.

REMEMBER: Your job is to find and tag the patients --those who require immediate attention. Examine each patient, correct life-threatening airways and breathing problems, tag the patient with an **IMMEDIATE** tag and MOVE ON!

How to Evaluate Patients Using RPM

The **START** system is based on three observations: **RPM**--**R**espiration, **P**erfusion and **M**ental Status. Each patient must be evaluated quickly, in a systematic manner, starting with **R**espiration (breathing).

Breathing: It all STARTS Here.

If the patient is breathing, you then need to determine the breathing rate. Patients with breathing rates **greater than 30 per minute** are tagged **IMMEDIATE**. These patients are showing one of the primary signs of shock and need immediate care.

If the patient is breathing and the breathing rate is **less than 30 per minute**, move on to the circulation and mental status observations in order to complete your 30-second survey.

If the patient is not breathing, quickly clear the mouth of foreign matter. Use a head tilt maneuver to open the airway. In this type of multiple- or mass-casualty situation, you may have to ignore the usual cervical spine guidelines when you are opening airways during the triage process.

SPECIAL NOTE: The treatment of cervical spine injuries in multiple or mass casualty situations is different from anything that you've been taught before. This is the only time in emergency care when there may not be time to properly stabilize every injured patient's spine.

Open the airway, position the patient to maintain the airway and — if the patient breathes —tag the patient **IMMEDIATE**. Patients who need help maintaining an open airway are **IMMEDIATE**.

If you are in doubt as to the patient's ability to breathe, tag the patient as **IMMEDIATE**.

If the patient is not breathing and does not start to breathe with simple airway maneuvers, the patient should be tagged **DEAD**.

Circulation: Is Oxygen Getting Around?

The second step of the RPM series of triage tests is the patient's circulation. The best field method for checking circulation (to see if the heart is able to circulate blood adequately) is to check the radial pulse.

It is not large and may not be easily felt in the wrist. The radial pulse is located on the palm side of the wrist, between the midline and the radius bone (forearm bone on the thumb side). To check the radial pulse, place your index and middle fingers on the bump in the wrist at the base of the thumb. Then slide it into the notch on the palm side of the wrist. You must keep your fingers there for five to ten seconds, to check for a pulse.

If the radial pulse is absent or irregular the patient is tagged **IMMEDIATE**. If the radial pulse is present, move to the final observation of the RPM series: Mental Status.

Mental Status: Open Your Eyes:

The last part of the RPM series of triage tests is the mental status of the patient. This observation is done on patients who have adequate breathing and adequate circulation.

"Open your eyes." "Close your eyes," "Squeeze my hand." Patients who can follow these simple commands and have adequate breathing and adequate circulation are tagged **DELAYED**. A patient who is unresponsive or cannot follow this type of simple command is tagged **IMMEDIATE**. (These patients are "unresponsive" to verbal stimuli.)

START is Used to Find Patients

This system is designed to assist rescuers to find the most seriously injured patients. As more rescue personnel arrive on the scene, the patients will be re-triaged for further evaluation, treatment, stabilization, and transportation. A patient may be retriaged as many times and as often as time allows.

Remember that injured patients do not stay in the same condition. The process of shock may continue and some conditions will become more serious as time goes by. As time and resources permit, go back, and recheck the condition of all patients to catch changes in condition that may require upgrading to attention.

Working at a Multiple- or Mass-Casualty Incident

You may or may not be the first person to arrive on the scene of a multiple- or mass casualty incident. If other rescuers are already at the scene when you arrive, be sure to report to the incident commander before going to work. Many events are happening at the same time and the incident commander will know where your help and skills can best be used. By virtue of training and local protocols, the incident commander is that person who is in charge of the rescue operation.

In addition to initially sizing up an incident, clearly and accurately reporting the situation, and conducting the initial **START** triage, the first responder will probably also be called on to participate in many other ways during multiple- and mass casualty incidents.

As more highly trained rescue and emergency personnel arrive on the scene, accurately report your findings to the person in charge by using a format similar to that used in the initial arrival report. Note the following:

- Approximate number of patients.
- Numbers that you've triaged into the four levels.
- Additional assistance required.
- Other important information.

After you have reported this information, you may be assigned to use your skills and knowledge to provide patient care, traffic control, fire protection, or patient movement. You may also be assigned to provide emergency care to patients, to help move patients, or to assist with ambulance or helicopter transportation.

In every situation involving casualty sorting, the goal is to find, stabilize and move Priority One patients first.

Triage in Hazardous Materials Incidents

Hazardous materials (Hazmat) incidents involving chemicals occur every day, exposing many people to injury or contamination. During a hazardous materials incident, responders must protect themselves from injury and contamination.

REMEMBER: A hazardous materials placard indicates a potential problem. But not all hazardous materials problems will be placarded. Be sure to find the proper response to the problem before beginning patient treatment.

The single most important step when handling any hazardous materials incident is to identify the substance(s) involved. Federal law requires that hazardous materials placards be displayed on all vehicles that contain large quantities of hazardous materials. Manufacturers and transporters should display the appropriate placard, along with a four-digit identification number, for better identification of the hazardous substance. These numbers are used by professional agencies to identify the substance and to obtain emergency information.

IF THERE IS ANY SUSPICION OF A HAZARDOUS MATERIALS SPILL – STAY AWAY!

The U.S. Department of Transportation published the Emergency Response Guidebook, which lists the most common hazardous materials, their four-digit identification numbers, and proper emergency actions to control the scene. It also describes the emergency care of ill or injured patients.

Unless you have received training in handling hazardous materials and can take the necessary precautions to protect yourself, you should keep far away from the contaminated area or "hot zone."

Once the appropriate protection of the rescuers has been accomplished, triage in hazardous materials incidents has one major function--to identify victims who have sustained an acute injury as a result of exposure to hazardous materials. These patients should be removed from the contaminated area, decontaminated by trained personnel, given any necessary emergency care, and transported to a hospital.

REMEMBER: Contaminated patients will contaminate unprotected rescuers!

Emergency treatment of patients who have been exposed to hazardous materials is usually aimed at supportive care, since there are very few specific antidotes or treatments for most hazardous materials injuries. Because most fatalities and serious injuries sustained in hazardous materials incidents result from breathing problems, constant reevaluation of the patients in Priorities Two and Three is necessary so that a patient whose condition worsens can be moved to a higher triage level.

Summary

Every responder must understand the principles and operations behind your casualty sorting system. The **START** system is an excellent and easily understood triage or casualty sorting method.

Responders should be involved in periodic community disaster drills so that their skills and capabilities can be tested and improved.

You Should Know:

- The responder's role at multiple- or mass-casualty incidents.
- How to use the **START** system.
- How to recognize a hazardous materials placard.

You Should Practice:

- Using the **START** system during a simulated multiple- or mass-casualty incident.

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Curriculum Vitae

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Education

PhD, Indiana University, 2020
Dissertation: *"I'm Fine": The Systemic Affect of Critical Incidents on Emergency Medical Service Personnel Communication*
Chair: John Parrish-Sprowl, PhD
Major: Health Communication
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MA, University of Texas at Tyler, Tyler, TX, 2014
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Professional Experience

Licensed Paramedic, Texas	2001- 2017
Emergency Medical Technician	1997- 2001

Academic Fellowships

IU Center for Interprofessional Health Education and Practice	
Interprofessional Fellow Award	2016
IU Graduate School	
President's Diversity Fellow	2017
Graduate Emissary	2017-2018

Related Conference Presentations

Deason, A. (2017, November). *You Can't Make Lemonade Out of Angst*: An Autoethnography of Dark Humor in Emergency Medical Personnel. Paper presented at annual National Communication Association Conference, Dallas, TX.

Deason, A. (2017, November). *Sorting Through Dead Bodies to Find My Own*: A Sensory Autoethnography of Mental Health in Emergency Medical Services. Paper presented at annual National Communication Association Conference, Dallas, TX.

Deason, A. & Park, D. (2017, July). Metaphors for Depression among Paramedics in the Code Green Campaign: An Application of the Job Demands-Resources Model. Paper presented at annual Communication, Medicine, and Ethics Conference (COMET), Indianapolis, IN.

Deason, A. (2016, November). *Even Superman cries*: Autoethnographic Visual Analysis of Sundahl's Art. Paper presented at annual National Communication Association Conference, Philadelphia, PA.

Deason, A. (2016, November). *Skeletons in the closet*: Stigma, emotions, and PTSD in paramedics. Paper presented at annual National Communication Association Conference, Philadelphia, PA.

Deason, A. (2016, March). *Alone, dark, and messy:* Autoethnographic visual rhetoric through Sundahl's paintings. Paper presented at the annual Doing Autoethnography Conference, San Angelo, TX.

Deason, A. (2015, February). *Grumpy, Happy, and other Smurfs:* A content analysis of a Twitter account to find paramedic mood. Paper presented at the Media+Health Symposium, Virginia Commonwealth University, Richmond, VA

Deason, A. (2015, February). *Why can't we be friends?:* An autoethnographic view of friendship. Paper presented at the annual Doing Autoethnography Conference, San Angelo, TX.

Deason, A. (2014, April). *Presumptive diagnosis*: Media ecological surveillance as an interpretive tool of paramedic consciousness. Paper presented at the annual conference of the Southern States Communication Association Conference, New Orleans, LA.

Deason, A. (2014, April). *More tales of a dyscommuniholic*: My paramedic communication culture. Paper presented at the annual conference of the Eastern Communication Association Conference, Providence, RI.

Deason, A. (2014, March). *Tales of a dyscommuniholic*: An autoethnography of my paramedic culture. Paper presented at the annual Doing Autoethnography Conference, San Angelo, TX.