

Article

From Mission to Mindset: How Organizational Purpose Shapes First Responder Resilience-Building

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Abstract

This study aims to investigate how an organization's purpose (*raison d'être*) dictates first responder resilience-building. While existing studies often treat first responders as a homogeneous group, this research argues that significant interprofessional differences exist. Using a socioecological framework, the study employs a qualitative, comparative design to analyze three first responder systems: the Slovenian Armed Forces, the Slovenian Police, and Slovenia's public healthcare system. The analysis is grounded in 31 semi-structured interviews, supplemented by analysis of official documents. The findings reveal three pillars of resilience—training, planning, and experience—and three distinct institutional paradigms. The military fosters a culture of proactive, institutionalized resilience-building oriented toward macro-level crises. The police exhibit a more reactive approach, where resilience-building is often undermined by chronic organizational stressors. In the healthcare system, resilience-building is fragmented and localized, with the burden falling on smaller organizational units to manage micro-level crises of capacity overload. The study concludes that an organization's *raison d'être* is a vital socioecological factor that shapes its approach to resilience.

Keywords: resilience; organizational resilience; first responders; crisis management; mental health; stress; Slovenia

1. Introduction

First responders—police officers, firefighters, paramedics, and other emergency personnel—operate in environments characterized by high risk and high stress and exposure to human tragedy. Their work inherently exposes them to a combination of operational (e.g., potentially traumatic events) and organizational (e.g., bureaucratic friction, resource shortages) stressors [1,2]. Extensive research confirms that first responders experience elevated levels of occupational stress, leading to a high prevalence of adverse mental health outcomes, including post-traumatic stress disorder, depression, anxiety, substance abuse, sleep disturbances, and burnout, at rates significantly higher than in the general population [1–5]. Given these significant risks, a critical area of research is identifying protective factors that can mitigate negative outcomes. Central to this inquiry is the concept of resilience.

Although resilience is ubiquitous in scientific discourse, its definition and operationalization remain debated [6–9]. For example, Duchek [8] (p. 224), who focuses on organizational research, defines resilience as a “meta-capability consisting of a set of organizational capabilities/routines that allow for a successful accomplishment of the three resilience



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stages”—anticipation, coping, and adaptation. In contrast, narrower definitions are generally used when discussing mental health. For example, Herman et al. [9] (p. 258) define psychological resilience as a “positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity”. However, the capacity for resilience is not monolithic, as it is underpinned by personal, biological, and environmental-systemic (microenvironmental and macrosystemic) factors [9].

When addressing mental health, it is common to distinguish resilience from the related concept of coping [10,11]. According to Fletcher and Sarkar [7] (p. 16), the primary difference lies in timing and function: resilience is a capacity that influences how an individual appraises a potential stressor, whereas coping refers to the strategies employed after an event has been appraised as stressful. Therefore, resilience is a proactive capacity for positive adaptation, while coping is a reactive process. Consistent with this distinction, this paper will focus on the former, narrowing the scope to proactive dimensions and sidestepping aspects that overlap with or are more closely aligned with coping.

As noted above, resilience is not merely an individual attribute; rather, it is a quality that operates at multiple levels [8,9,12]. A socioecological approach posits that resilience is a dynamic process, shaped by the interactions between individuals, their families and peers, their organizations, and the wider community. This framework moves the onus of resilience from being a solitary burden to a shared, organizational responsibility, influenced by factors like supportive policies and work environment. However, in first responder research, this approach has often been neglected, as the existing literature frequently falls into one of two categories: (1) generalist studies that treat first responders as a single, homogeneous group, largely overlooking inter-professional differences [13–15], or (2) siloed studies that focus deeply on a single profession without a comparative context [16–18]. Both approaches risk missing the link between macro-level organizational factors and individual-level psychosocial dynamics. This study fills this gap by employing a comparative design rooted in a socioecological framework to understand how specific institutional missions create divergent resilience outcomes.

Using the Republic of Slovenia as a case study—a nation that has recently managed a variety of major crises, including the COVID-19 pandemic [19–21], migrant crisis [22,23], and the devastating 2023 floods [24,25]—this paper delves into three distinct first responder systems: the Slovenian Armed Forces, the Slovenian Police, and the Slovenia’s public healthcare system. We address the following research question: how does organizational context influence the development of resilience among first responders in Slovenia?

The findings presented in this paper are derived from data obtained for the “Socioecological Dynamic Models of Mental Health: Complex Crisis Burden Among Professions of Critical Importance for the Society” research project [26]. The findings contribute to the project’s overarching goal of examining the socioecological context of the resilience, mental health, and well-being of first responders during and after a crisis.

2. Methodology

2.1. Research Design

The study utilizes a qualitative, comparative case study design to explore the resilience-building within each organization [27,28]. The research was conducted in two phases, where the findings from the first (main) phase guided the additional data collection and analysis for the second (supplementary) phase:

- Phase 1: 31 semi-structured interviews were conducted and analyzed with first responders. This “bottom-up” approach allowed us to map their perceived resilience frameworks and identify significant, unexplained differences in the dominant themes across the three organizations, enabling the comparison on the horizontal axis [27] (p. 14).

- Phase 2: After identifying key differences, we initiated a “top-down” analysis of macro-level evidence in policies, strategic documents, and legislation. The purpose of this phase was to identify institutional factors that could explain the divergences that emerged from the interview data, thus enabling comparison on the vertical axis [27] (p. 14).

2.2. Participants

Interviewees were selected using a purposive sampling strategy to recruit information-rich individuals capable of providing deep insights. A total of 31 semi-structured interviews were conducted between 25 September and 4 November 2024. The sample included ten participants from the Slovenian Armed Forces [interviews 1–10], ten from the Slovenian Police [interviews 11–20], and eleven from the Slovenia’s public healthcare system [interviews 21–31]. The inclusion criteria were: (1) currently serving in one of the three sectors; and (2) having direct experience in crisis response operations (e.g., pandemic, floods, migration crisis, international military operations). To capture a range of perspectives, the sample included a variety of roles, ranks, and genders. The latter corresponds to the gender structure of each organization observed (see Appendix A). After conducting the interviews, the project leader used field notes to assess whether data saturation had been achieved and confirm that sufficient data had been collected for analysis.

2.3. Data Collection

Interviews lasted between 30 and 90 min, either in person or via a secure video conferencing platform. The interviews were audio recorded, transcribed verbatim, and anonymized to ensure confidentiality. The transcripts are available upon request from the corresponding author of this paper.

The interviews were guided by a set of eight core questions, aligned with the research project’s objectives, that were asked to all participants. These questions were supplemented by 24 potential sub-questions (see Appendix B). The semi-structured format ensured consistency across all interviews while simultaneously allowing flexibility to explore emergent themes. Researchers were instructed to pose each main question first, allowing participants to respond in their own words. Then, at their discretion, the interviewers used the sub-questions to probe deeper into specific areas, clarify general responses, or explore personal feelings and interpretations not addressed in the initial answer.

Although only one section of the interview (see Question 4 and its sub-questions in Appendix B) explicitly addressed the concept of resilience, subsequent coding revealed that resilience-related insights also emerged in other parts of the dataset.

2.4. Data Analysis

The interview transcripts were analyzed using thematic analysis, following the methodology of Braun and Clarke [29], with the help of MaxQDA 24 software. To ensure reliability, two researchers first coded a sample of three interviews independently. Then, they convened to compare results, resolved discrepancies, and finalized a coding system. The analysis employed a hybrid approach combining deductive codes, which were derived from the research question and inductive codes, which emerged from the data [29,30]. Once the coding framework was established, one researcher coded the remaining 17 interviews, and the other researcher coded the remaining 11 interviews. The final step of the Phase 1 involved a cross-case comparative analysis to identify patterns of convergence and divergence across the three sectors.

Phase 2 involved a “top-down” analysis of macro-level evidence guided by the interview findings. In August 2025, policies, strategic documents, and legislation were analyzed to identify each organization’s official mission, how it frames a crisis, and its

formal structures. The analysis was restricted to the most current documents in effect as of 2025, including white papers, strategies, long-term development resolutions, statutory acts and official doctrines, where applicable. The final step was a cross-case comparative analysis that synthesized both data sources.

2.5. Ethics Statements

The entire research process was evaluated and approved by the Ethics Committee at the Faculty of Social Sciences at the University of Ljubljana. Approval was also acquired from all participating institutions, including the Slovenian Armed Forces, the Slovenian Police, and the two participating hospitals.

Participation by first responders was voluntary and contingent on informed consent. All participants were informed of their right to withdraw at any time and signed an anonymized consent form governing the use of their data. A 100% retention rate was achieved.

During the preparation of this manuscript, we used the generative artificial intelligence chatbots Gemini 2.5 Pro and 3 Pro to conduct literature searches, assist with wording, and refine syntax. We also used DeepL Translate and DeepL Write for translations and language editing. Generative artificial intelligence was not used to directly analyze empirical data. The authors reviewed and edited the outputs and take full responsibility for the content of this publication.

2.6. Limitations

The objective of the study was not to statistically generalize the data, but rather to identify specific differences in the process of resilience-building. The findings are based primarily on self-reported perceptions and experiences, which are subject to recall bias. Additionally, the study is situated within Slovenia's specific national and institutional context, so dynamics may differ in countries with different organizational structures or cultural norms. These limitations highlight promising avenues for future research, including quantitative, longitudinal, and/or cross-national comparative studies.

3. Results

Although the interviewees' emphasis on resilience-building measures varied, these largely fell into three main categories: training, planning, and experience. We will now take a closer look at each of these categories. Finally, the chapter will conclude by addressing the specific measures that respondents desire from their employers to further strengthen resilience.

3.1. Training

Although the interviewees generally acknowledged the importance of training, some conceded that it can *"sometimes become a real drag"* [interview 7]. Nevertheless, first responders across all three investigated sectors agreed that high-quality, regular training is invaluable for building resilience. This is especially true in the military, where servicemembers' lives depend on their ability to respond appropriately to unforeseen, high-stakes events:

If I may exaggerate a little, our everyday life is geared towards and prepares us for such circumstances. In my experience, dealing with somewhat more demanding situations becomes much easier. This doesn't mean we're immune to everything or that nothing affects us, but it does mean we're mentally prepared. [interview 8]

During the first adrenaline-filled hour, learned behaviors and past training come to the surface. In other words, a person reacts based on learned automatism. [interview 10]

Although there are some reports of being rushed through the training sessions [interview 2], it seems that servicemembers of the Slovenian Armed Forces are rather satisfied with the quality and quantity of training they get. They report that *“the military tries to train its personnel. In fact, the military as such tries to do everything it can to ensure that its personnel are as well-trained as possible”* [interview 5] and that *“it is crucial for the military to train and prepare for crisis situations in times of peace. That is our mission”* [interview 10].

On the other hand, police first responders were explicit about their need for more frequent and effective training. Although officers reported having one day per month set aside for this purpose, they were divided in their opinions on its value. Some dismissed the sessions as perfunctory, with one describing the experience as *“repeating some [martial arts] throws [...] or going for some walks or exercising. The way it works now is pointless, but at least the employer can tick the box”* [interview 16]. Others viewed the time more pragmatically considering it an opportunity for camaraderie: *“It’s like team-building for employees. They give us a small, free block of time, and we make something of it”* [interview 14]. On a more positive note, some police officers found the training courses to be thematically relevant and topical, citing training sessions on how to respond to active shooter and amok incidents [interviews 14, 17, 19]. Regardless of these differing views, a consensus emerged—Slovenian police officers desire more extensive and higher-quality training, especially for major crises and large-scale emergencies:

There are certain lectures and training courses. However, they are so rare ... in short, there is not enough emphasis on them. [interview 20]

They don’t prepare us for crises. We receive training in specific areas of work, such as investigations [...]. However, when it comes to anything bigger than that, we’re on our own. [interview 12]

Currently, our organization is lacking in this area. We don’t have much training, and what little we have is supposed to be taken away soon. Therefore, we should make a much greater effort in this area. I think we are unprepared to respond to a crisis and when it comes to providing first aid, using firearms, or using physical force and things like that. [interview 18]

The training experiences among Slovenia’s public healthcare first responders are notably varied. Some report having participated in training courses on mass casualty incidents [interviews 21, 25, 27, 29], the use of personal protective equipment [interviews 22, 23, 24, 25, 27] and coping with stress [interviews 22, 23, 28]. This commitment to training is exemplified by a hospital that designates a specific day each week for internal training, a practice only paused during summer holidays. The potential for intensive, rapid upskilling was illustrated at the onset of the COVID-19 pandemic. A department head recalled *“receiving extensive training on the new way of working, the use of personal protective equipment, and how to treat patients,”* reflecting *“I think we learned so much that everything we would usually think about for 20 years, we learned in one day”* [interview 27]. However, a contrasting trend has emerged more recently. Several healthcare professionals report that training opportunities have diminished since the pandemic: *“Not much, not anymore. Now, after the pandemic, there aren’t many training opportunities”* [interview 25]. This decline is partly attributed to a geopolitical shift in national priorities, as another interviewee explained: *“The mainstream focus is now on a completely different level than before. Now, it’s all about war, war, war. We may get attacked. Defense [is the focus]”* [interview 28].

Interviewees from all sectors studied were unanimous about the additional benefits of training. They emphasized that training is crucial not only for developing the necessary skills to perform in crisis, but also for managing stress. Well-designed training mitigates the stress response to extraordinary events and reduces overall stress levels in everyday work:

Personally, I find the demanding training I underwent during my military career to be a huge relief. [interview 6]

The more stressful the training is, the less stressful the crisis will be. The closer the training is to a real crisis, the less stressful the crisis will be. I have always believed this to be true. In my opinion, I am not far off the mark. [interview 2]

If you are well-trained and trust yourself, stress will be minimal. [interview 3]

More training would help because, when faced with a crisis, you'll be less stressed knowing that you're prepared and will do a good job. While you can never be completely prepared, you can be partially prepared. [interview 18]

Having more prior knowledge makes things easier. Stress levels are lower when you know the internal plans and how to react. If a person is unfamiliar with the issues, their stress level is higher. Stress is usually caused by unfamiliarity or fear. [interview 31]

3.2. Planning

While training builds a foundation, an organization's resilience is forged when this knowledge is codified into common organizational plans, protocols, and procedures. These documents are intended to systematize crisis response. However, interviews with Slovenian first responders reveal a divergence in how planning is approached.

The Slovenian Armed Forces demonstrate the most structured planning culture. For servicemembers, planning is not a secondary task but a core function that progresses from individual drills to complex procedures for unforeseen events: *"First, there are drills. [. . .] Second, there are procedures. [. . .] There are always rehearsals of crisis procedures. . . of unforeseen situations"* [interview 1]. This proactive stance extends beyond conventional combat scenarios to include low-probability, high-impact events. Interviewees confirmed the existence of national-level protocols for events such as nuclear disasters [interviews 3 and 8]. Their system is designed to be iterative. They acknowledge that mistakes happen during execution, but they emphasize a culture of identifying and flexibly correcting mistakes to constantly refine their plans: *"We often mess up [. . .] because we're quick and eager. Even though we think, we don't always think things through completely. However, once we identify a mistake, we are very flexible in correcting it"* [interview 7].

In contrast, the Slovenian Police appear to be in a more elementary stage of planning efforts. There is a clear and growing effort to create formal plans for major emergencies such as floods, earthquakes, and terrorist attacks:

Yes, I remember that plans were made for every crisis this year. Well, not for all situations, but for most. For example, a plan was drawn up on how the police should respond to floods and earthquakes, as well as the protocol and measures to be taken in the event of an infectious disease epidemic or a terrorist attack involving some kind of nuclear weapons. [interview 14]

However, there is still a gap between planning and practical confidence. Some officers note a lack of specific training for certain scenarios despite the existence of plans, while others point to a difference in the perceived feasibility of the plans. As the interviewees stated, plans are useless if they cannot be realistically executed, and they are of questionable quality if they are never tested:

The various plans we have do not hold water. [. . .] A few years ago, I tasked local police officers with creating contingency plans for all the banks and post offices in the area. One of my colleagues made an excellent plan with arrows and 17 patrols, all in different colors. Then I asked him, 'How many patrols do you have?' 'Well, two.' 'Then this plan's no good.' [interview 13]

We have plans ready, but we won't know if they are adequate until something happens and we have to put them into action. But yes, we are working to minimize the stress that would result if something were to happen. [interview 19]

The Slovenia's public healthcare sector is characterized by inconsistency. Unlike the more uniform approaches seen in the military or police, preparedness in healthcare varies greatly from institution to institution. This was evident during the COVID-19 pandemic. At one end of the spectrum, some organizations felt unprepared. They lamented the lack of official national guidelines and resorted to *"solving things on the fly"* daily [interviews 21, 26]. At the other end of the spectrum, a different institution reported feeling better prepared. They had received advance notice and were operating with *"fairly well-written instructions"* that made their response to the first patients with COVID-19 significantly easier [interview 29]. This disparity suggests that, although planning is occurring at the state level, its implementation at the local organizational level is uneven, leaving the healthcare system's planning fragmented. This has even prompted a reevaluation of historical doctrines. One interviewee, for example, reconsidered the former *"Nothing Should Surprise Us"* (NNNP—*nič nas ne sme presenetiti*) drills and concluded that this ex-Yugoslav approach was more effective than often assumed: *"In fact, more and more research shows that this wasn't such a bad thing. Certain units and countries are now introducing similar measures. These measures are already being introduced to the general public, as well as to elementary and high school students, and college students"*.

Despite these differing levels of reported preparedness, a universal truth emerges: No amount of planning can cover every eventuality. Even the highly prepared military was caught off guard when a soldier died by suicide on an international deployment [interview 6]. In any major crisis, improvisation becomes essential. This should not be viewed as a failure of planning, but rather as a vital sign of adaptability.

3.3. Experience

Beyond formal training and planning, the responder's accumulated experience was recognized as the third pillar of resilience. There was a consensus across all surveyed sectors that the wisdom gained from prior crisis navigation is an indispensable asset. Responders consistently emphasized the value of hands-on experience.

One theme was that experiencing stress directly forges personal resilience, strengthening an individual's ability to cope with it over time. As one respondent put it: *"In my opinion, every crisis makes a person stronger. [. . .] I think age and life experience make a person stronger"* [interview 2]. This sentiment was widely shared, with others noting that resilience is built incrementally through difficult situations:

How you deal with this also depends on your experience and how many crises you have gone through. This increases your resilience, your inner resilience. At least, I would say you can improve your attitude toward stress. [. . .] I think individual resilience, similarly to societal resilience, is built through certain measures and processes [. . .]. The more difficult experiences you have in life that don't destroy you, and you still function, the greater your resilience and resistance. In my opinion. Today, after [many] years of service, I am much more resilient than when I finished college and entered the officer candidate school. [interview 6]

Over the course of their careers, first responders report to become *"more resistant to these various environmental factors"* [interview 28], learning to manage crises in a way that is *"as least stressful as possible"* [interview 26].

Furthermore, respondents noted that over time, experience begins to complement and even supersede formal training, fostering a more intuitive form of judgment. This was emphasized by professionals from all three sectors:

It's true that as you get older, you use less of what you learn in the courses, but more of your experience. You know exactly 'well, that, that's important'. Experience guides you more than courses do. [...] After so many years of work, you can look at patients and, even if they appear stable, know which ones won't stay that way for long. Your view is different due to experience. [...] Over the years, as you gain experience, you realize that you are somehow stronger. [interview 21]

This is the case because of my age, the experiences I've had, and my personality. I have already gone through similar situations several times in my life. It is easier for me than for someone younger who is experiencing this for the first time. [interview 17]

The good news is that we have experienced servicemembers, many of whom have been to Afghanistan and Iraq. [Difficult] situation doesn't stress them out much. [interview 4]

This hard-won intuition allows veteran responders to react more effectively than their junior counterparts, who may not have the same frame of reference. From an organizational standpoint, this accumulated knowledge represents an invaluable collective resource. This makes retaining seasoned personnel an imperative. Whether gained through daily emergencies or major deployments, veteran responders' expertise is the foundation of an organization's ability to function effectively under pressure. This underscores the importance of minimizing staff turnover to preserve hard-won human capital:

In crisis situations, the most important people are those with experience. This includes older staff members. Everyone else is useless. If a work organization knows how to retain educated, experienced employees, it has won. However, I have a feeling that the opposite is happening here right now. [interview 11]

However, experience comes at a potential cost. The trap of gaining experience as a first responder is that it is (at least partially) forged through exposure to potentially traumatic events. While navigating adversity generally builds resilience, repeated contact with high-stress scenarios or critical one-time events carry the risk of psychological injury. The same mechanisms that generate hard-won intuition can also lead to strain rather than post-traumatic growth:

Personally, I can't drive over trash with my car. No, I can't. If I have to, I close my eyes. If there's trash on the side of the road, I'll swerve automatically.

[Even now? Sub-question from the interviewer]

Dead calm. And I get a little tingly, sometimes I sweat.

[Is that the image, is it coming back? Sub-question from the interviewer]

That's what's left. Yes, there are things that remain. I know exactly what time it is. Now, if you want to hear the term PTSD and that's the trigger, fine, go ahead. [interview 7]

This complicates the idea that experience equals resilience. While veteran responders are an organization's greatest asset, they are also a vulnerable population. If trauma is ignored, the experienced judgment that organizations prize can be eroded by untreated stress injuries. This ultimately threatens the very human capital the organization seeks to preserve.

3.4. Desired Measures

To conclude the investigation into resilience factors, interviewees were asked to identify specific measures they desire from their employers to enhance well-being, including resilience-building measures. Distinct patterns emerged across the three sectors regarding the primary deficits they wish to see addressed. For the Slovenian Armed Forces, the primary need was for better leadership. A surprising number of respondents emphasized

the need for leaders and commanders who possess emotional intelligence and genuine care for their subordinates. Servicemembers argued for a shift toward a leadership style that balances mission accomplishment with personnel welfare:

What else could be added? Perhaps more work on leadership and psychological preparation, which I would say are very general. I think the generational leap is particularly noticeable among the younger ones, especially those who come from the faculties [to become commissioned officers]. Today's 24-year-olds—or us when we were 24 and joined the military—need to make a significant mental leap. [interview 9]

Yes, it is absolutely necessary to work on leadership development, because leadership is what pulls out the red thread of response that is needed in critical moments of an organization's development, when there are crises in the field. Therefore, leadership development is necessary from the lowest tactical level to the highest strategic level. [interview 1]

In contrast to the military's focus on leadership, the Slovenian Police responses centered on the desire for more frequent and realistic training:

I would [recommend] a variety of training types so that there wouldn't be just one type of training for one emergency situation, such as an amok situation. There should be more training and coverage of more fields as well as legal aspect. [interview 17]

The system is good. It could be even better [...] with some additional training. [...] It would certainly make sense to stage a crisis situation, such as an earthquake. Prepare some kind of exercise. I'm talking about the local level because there are several levels, and we are at the local level. At the national level, they had earthquake drills, but the local police were not involved in these programs, training, and refresher courses, if I remember correctly. There should certainly be more of these programs so that police officers do not freeze up in stressful situations. Depending on the situation, they should at least know how to react correctly and appropriately, whether we are talking about an earthquake, a fire, or a flood. [interview 14]

Finally, healthcare professionals' responses were focusing heavily on systemic constraints. For the Slovenian medical staff, the primary obstacle to resilience appears to be the severe shortage of personnel. This shortage creates a vicious cycle: staff cannot attend resilience-building training because there is no one to cover their shifts:

The crisis means that we do not have enough staff. We are under a lot of stress because there are too few of us. We are working with the bare minimum of staff, which is really difficult. You work almost every day, and even on your days off, you're always afraid they'll call you in. You have no peace. It's chaotic, especially in our department, where the situation is particularly bad at the moment. [...] There is a shortage of personnel. I think it has now reached its peak. [interview 23]

Now, to be clear, when we send someone to training, we essentially remove them from the work process. This means that there is one fewer ambulance available that day. When we send someone to a mass casualty incident course, there are two or three fewer people in the field for three days. Ideally, we would have enough employees to plan for 10 to 15 percent of them to be out of the office for training every day. That would be the goal. [interview 29]

4. Discussion

4.1. Sector-Specific Resilience Landscapes

Our findings suggest that the mechanisms for cultivating resilience are not uniform, although three common pillars emerged from the interview data across the investigated

sectors: training, planning, and accumulated experience. Since resilience-building measures vary significantly across organizations, it is reasonable to posit that they depend on context-specific variables. The existing literature has already identified several of these.

For example, military research emphasizes collective strength and highlights protective mechanisms such as unit cohesion, teamwork, and a positive command climate [18] (p. xv). Consequently, resilience strategies often focus on leadership [31] and training under stress [32] designed to reframe stressors as challenges, thereby ensuring operational readiness [33]. This aligns with our research—the servicemembers we interviewed attributed their resilience to the continuation training and daily operational realities of the military institution, rather than to initial training alone. Unlike in civilian sectors, where a crisis is viewed as an interruption of routine, Slovenian military culture appears to successfully normalize crisis conditions. This validates the concept of stress exposure training—the idea that exposure to simulated high-stakes events creates a psychological buffer that allows personnel to rely on learned automatism rather than cognitive improvisation during the initial shock of a real event. Furthermore, the military’s iterative approach to planning, in which mistakes are anticipated and corrected, supports the system’s adaptive capacity [34]. However, despite the robustness of the Slovenian military’s structural resilience, interpersonal aspects—especially the leadership—remain a point of friction.

Research on the police force often highlights the detrimental impact of a distinctive combination of organizational stressors on resilience and psychological well-being [35,36]. Although convincing evidence shows that resilience training reduces harmful physiological and psychological responses to acute and chronic stress in police officers and positively affects many areas of life [37], police organizations often struggle to translate these findings into operational reality due to entrenched cultural and structural barriers. Specifically, the prevalence of a police culture that values toughness, emotional control, and self-reliance, and the stigmatization of help-seeking behaviors can render resilience initiatives ineffective, as officers may view participation as a sign of weakness or fear career repercussions [38]. Our interview data sheds further light on the systemic disconnect. While officers expressed a desire for frequent and realistic training, they often described existing measures as mere formalities rather than genuine capacity-building efforts. This suggests that, in the Slovenian Police, the organizational scaffolding for resilience is often perceived as bureaucratic rather than operational.

In the Slovenia’s public healthcare sector, the resilience framework is defined not by uniformity, but by heterogeneity and systemic fragility. Unlike the standardized approaches of the military or the police, our findings indicate that healthcare resilience is highly localized, varying significantly between institutions and even departments. The dominant theme emerging from the interviews in the health sector is a vicious cycle of resource scarcity: the severe personnel shortage creates a structural barrier to resilience-building. As staff cannot be released from clinical duties to attend training without compromising patient care, the mechanisms intended to build resilience are sacrificed to maintain immediate operational output. This corroborates with broader literature on healthcare burnout [20,39,40].

4.2. *Raison d’être and the Ontological Perception of Crisis*

To understand the causes of these divergent resilience paradigms—and why the Slovenian military institutionalizes resilience while the police and public healthcare sectors struggle with reactive or fragmented approaches—we looked beyond surface-level procedures to the purpose, or *raison d’être*, of each organization. Our analysis of strategic documents and interview data suggests that an organization’s mission fundamentally

frames its ontological perception of crisis, which in turn dictates the structural scaffolding available for resilience-building.

For the Slovenian Armed Forces, the primary mission is unambiguous: the military defense of the nation against external aggression. Strategic documents unequivocally establish the Slovenian Armed Forces as the ultimate instrument of state power [41–43]. This mission necessitates an institutional logic where crisis is not an anomaly to be managed, but the fundamental state for which the organization exists. The armed forces' mission shapes how the institution and its servicemembers perceive crises, as the organization is inherently oriented toward crisis response, a focus reflected in its official doctrine, where crisis-related terms appear 92 times [44]. Servicemembers are conditioned to prepare for the ultimate crisis of armed conflict and are trained to view events that others might perceive as overwhelming chaos as manageable situations: *"To me, a crisis is a situation in which we must change established behavior or an operation. [...] It's a situation that might be considered abnormal elsewhere. I wouldn't say it's normal for us, but at least we're somewhat prepared for it."* [interview 2]. Because the military is designed for the ultimate crisis of armed conflict, its resilience framework is proactive. This explains why military respondents reported high satisfaction with training: the organization's *raison d'être* justifies the expenditure of immense resources on preparation for events that may never happen. In this socioecological context, resilience is a systemic imperative, woven into the fabric of daily operations.

In contrast, the Slovenian Police operate under a mandate to ensure internal security, the rule of law, and public order. Unlike the military, which focuses on external threats, the police are primarily responsible for internal security and public order [45]. Consequently, the police perceive a crisis as a disruption to social order. A police response is typically characterized by immediate, localized interventions aimed at controlling the situation and restoring normalcy. However, a dissonance emerges in how the police define crisis. While their statutory mission focuses on public order, our interviews reveal that officers frequently perceive crises as resulting from internal organizational failures, such as *"an issue of staffing"* and *"split shifts"* [interview 14] or *"a lack of resources and logistics. That's when the crisis is at its worst"* [interview 11]. Officers are caught in a double bind: they are mandated to project control outwardly to stabilize society, yet internally, they feel destabilized by the very institution meant to support them. Moreover, their experience largely aligns with the reactive resilience paradigm [46].

The public healthcare system operates on a distinct paradigm, defined by the mandate of continuous, patient-centered care [47]. Therefore, a crisis in healthcare is primarily defined by capacity overload—when the demand for care exceeds the available resources. A crisis *"occurs when we can no longer perform our work with the available resource—be it personnel or facilities"* [interview 27]. This operational reality, coupled with the system's less centralized structure compared to the military and police, results in fragmented resilience. The ethical and legal mandate to treat all patients prevents the system from having the operational flexibility necessary for extensive proactive training, as seen in the military. Personnel shortages further exacerbate this deficit, creating a vicious cycle in which the day-to-day tempo itself prevents the workforce from engaging in training, planning, and rotation, which would make crisis operations more manageable. Resilience, therefore, becomes a largely localized and predominantly reactive endeavor.

The fundamental distinctions among the three organizations can be comprehended as mission-driven "crisis ontologies," which refer to sector-specific conceptualizations of crisis. These ontologies are then reflected in the organizations' resilience architectures. The systems diverge in their approaches to anticipating missions, allocating resources, and managing organizational slack (e.g., time, staffing buffers, and institutional space for preparation). Although the three sectors rely on similar core components to build resilience

(training, plans, and experience), the way these components are interpreted and applied in practice largely hinges on an organization's purpose.

5. Conclusions

5.1. Main Findings

This study positions first responder resilience as a structural manifestation of an organization's socioecological niche. A comparative analysis of Slovenian first responders reveals that training, planning, and accumulated experience are universally recognized as the pillars of resilience in all investigated sectors. However, their relative importance and operational efficacy depend on the organization's core mission.

The organization's purpose, or *raison d'être*, acts as a socioecological filter that determines how a crisis is perceived, which resources are used to address it, and the pathways through which the institution cultivates preparedness. Therefore, an organization's *raison d'être* is a vital socioecological factor that shapes approaches to resilience. First responder resilience should thus be regarded as a systemic output, not merely an individual trait. True organizational resilience requires aligning the mission with the appropriate resilience-building mechanism to ensure the structural support provided to personnel matches mission-driven "crisis ontologies".

5.2. Implications

The findings offer several insights for leaders, policymakers, and mental health professionals who work with first responders.

First, support must be tailored to the specific mission. Our argument that *raison d'être* acts as a blueprint for crisis perception demonstrates that a "one-size-fits-all" approach is insufficient. Given that each system is confronted with a distinct dominant crisis logic, it is imperative that resilience programs be sector-specific by design, rather than merely being rebranded across professions.

Second, systemic remediation is imperative, as interview data corroborates the premise that organizational stressors often cause more harm than operational ones. Across sectors, organizational stressors have been shown to erode the benefits of training, planning, and experience. Therefore, optimizing workplace well-being must be recognized as one of the most fundamental organizational engineering issues.

Third, organizations must invest in realistic training and planning by replacing superficial exercises and idealized plans with realistic ones that replicate real-world constraints. This allows practitioners to develop the adaptive expertise necessary for navigating the tension between plannability, operational friction, and the unpredictability inherent in crisis response.

Finally, leaders must value experience and retain experienced staff. They must understand that high turnover is not just a staffing issue, but also a loss of critical institutional knowledge. Therefore, retention strategies should promote career sustainability and provide access to early, stigma-free support, as well as foster credible leadership practices.

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Appendix A

Table A1. Socio-demographic characteristics of participants.

Institution	Health	36%
	Police	32%
	Military	32%
Gender	Man	61%
	Woman	39%
Age	30–35	10%
	36–40	19%
	41–45	19%
	46–50	42%
	50<	10%
Work experience	2–10	10%
	11–15	16%
	16–20	19%
	20<	55%
Children	Yes	81%
	No	19%
Marital status	Single	26%
	In relationship	74%

Appendix B

Appendix B contains a translation of the interview questionnaire. Note the use of the term “employee in a critical profession” instead of “first responder.” The Slovene literal translation of “first responder,” *prvi posredovalec*, generally refers to an individual

with no professional training who responds to a life-threatening emergency with the aim of performing immediate lifesaving measures until the emergency medical service arrives. For the “Socioecological Dynamic Models of Mental Health: Complex Crisis Burden Among Professions of Critical Importance for the Society” research project, the term *zaposleni v kritičnih poklicih* (employees in critical professions) was chosen to be used, as it encompasses professionals who are essential to societal security and vital functions. Since these individuals are typically the first to provide professional assistance during emergencies, this term more accurately reflects the intended meaning of “first responder” in a Slovene professional and research-oriented context.

1. As an employee in a critical profession (first responder), what does a crisis mean to you?
2. How would you describe how an employee in a critical profession copes with stress during a crisis?
3. We are interested in how employees in critical professions handle crises. Please recall the last crisis you experienced. Please tell us: (a) How did it start? (b) When were you activated? (c) How did you deal with or cope with the crisis?
 - 3.1. How did your feelings change over time if the crisis lasted a long time? For example, did you experience lack of sleep, dissatisfaction in your family due to your prolonged absence, fear for your own life, or burnout?
 - 3.2. Was there anything that was particularly stressful for you during the last (or any previous) complex crisis? Can you tell us what it was?
 - 3.3. Describe a situation in which you feared for your life or the lives of your coworkers or family as vividly as possible (e.g., the pandemic).
 - 3.4. How do you cope with stress as a woman or man? Would you cope differently if you were a different gender?
4. In this section, we would like to learn more about your organization’s role in crisis training and preparedness. Please tell us what your organization does or does not do in this regard.
 - 4.1. Have you had experience with support measures (e.g., programs, counseling, expert assistance, or interpersonal support) that help employees cope with crises/stress? How does your organization communicate these measures? Are these activities intensified during a crisis, or does your organization regularly provide “resilience” activities?
 - 4.2. Do you receive any training to manage crisis situations and improve your professional resilience?
 - 4.3. What would you like your employer to provide to help you cope and improve your well-being during a crisis? What would you like your employer to provide to help you improve your well-being after a crisis?
 - 4.4. Do you feel mentally prepared to respond in times of crisis?
5. We are now interested in how others were involved in your coping with stressful events and crises. These people may be team members, friends, coworkers, or superiors. Please tell us what role these people played during and after a crisis.
 - 5.1. Who do you talk to at work when a very stressful situation or emotionally difficult event occurs?
 - 5.2. Do you seek informal support?
 - 5.3. In what situations would you decide to seek formal psychological help at work? For example, you might consider it if you experienced stressful events at work that were difficult to cope with and that caused problems in your work or personal life.

- 5.4. How would your management respond if you sought psychological help? How would your coworkers respond?
- 5.5. What could the decision to seek psychological help mean for your career? How might it affect your identity as a police officer, doctor, or soldier?
- 5.6. How do you typically respond to stressful situations?
- 5.7. How would you describe the demands of your work? Are they equally stressful for people of all genders? In your opinion, how do gender differences manifest themselves?
- 5.8. Is there any aspect of your work that relieves or motivates you? If so, how?
6. Describe how the public's attitude and expectations toward your work in the event of a crisis.
 - 6.1. How do you experience public support (or lack thereof)? Do you think public support (or lack thereof) affects your performance and health?
 - 6.2. Have you noticed any changes in the public's attitude toward your work during or after a crisis?
 - 6.3. Do you think public expectations differ depending on whether the assistance is provided by a man or a woman?
 - 6.4. In relation to your individual or family circumstances and needs, how do you perceive society's expectations on your fulfillment of duties during a crisis?
7. Describe the role, if any, that your family and loved ones play when you experience stressful events at work or are activated due to a crisis.
 - 7.1. How does a crisis affect your family?
 - 7.2. How do you communicate with your family during times of crisis?
 - 7.3. In what ways does your family caregiving affect your professional life, work commitment, job satisfaction, and relationships with coworkers and superiors?
 - 7.4. Do you think your coworkers face similar challenges balancing their professional and personal lives?
8. Slovenia has a nuclear power plant, and Ukraine and Russia are also known to have nuclear power plants. When you think about the possibility of a nuclear accident, what worries you the most? How do you see your role in such a situation?

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