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BRINGING THE TRAUMA HOME: SPOUSES OF PARAMEDICS

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Paramedics are exposed to events involving suffering and tragedy and consequently may experience posttraumatic stress symptoms and depression. Family support is a primary mediator of these reactions, yet family members may be vulnerable to transmitted stress and distress. This qualitative study explores the impact of trauma exposure on spouses of paramedics. Issues identified included managing everyday job stress, safety fears, and dealing with the paramedic's emotional reactivity and emotional withdrawal from family members following trauma exposure. Organizational support systems that have been developed for emergency workers generally neglect family members at the risk of depleting this important resource.

Paramedics are not only exposed to human suffering and tragedy on a daily basis but in addition are frequently in situations where their own safety is in jeopardy. One study of paramedics reported that more than 80% of those in a large urban area had experienced each of the following events: the death of a patient while in their care, the death of a child, events involving multiple casualties, and events involving violence perpetrated by one individual against another (Regehr, Goldberg, & Hughes, 2002). In addition, the same study reported that 70% had been assaulted on the job and 56% reported experiencing events on the job that they believed could potentially have resulted in their own death. This exposure frequently results in trauma response. In fact, cross-sectional studies in general have demonstrated that at any given

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time approximately one fourth to one third of paramedics have trauma symptoms in the high or severe range (considered consistent with a diagnosis of pasttraumatic stress disorder [PTSD]) (Alexander & Klein, 2001; Regehr, Goldberg, & Hughes, 2002). What remains unclear is the degree to which this trauma is contagious, rippling outward to encompass others such as spouses and children.

The support of family is paramount to reducing the impact of highly stressful work on emergency responders. In research conducted on emergency responders, the support of spouse, family, and friends has been significantly negatively correlated with scores on both trauma symptom scales and depression scales (Leffler & Dembert, 1998; King et al., 1997; Regehr, Hemsworth, & Hill, 2001; Weiss et al., 1995). Further, those who have higher levels of family support are less likely to take mental health stress leave from work following a traumatic event (Regehr, Goldberg, Glancy, & Knott, 2002). Yet, family members are not immune from the stresses encountered by their loved ones. Researchers have demonstrated how job-related stresses experienced in a variety of working environments can be transmitted to other family members once the individual returns home. In general, findings suggest that job stress dampens the quality of marital interactions and causes the other spouse to feel more negatively toward the relationship (Larson & Almeida, 1999; Thompson & Bolger, 1999). One study of police officers, for instance, found that emotional exhaustion and negative affective states of police officers are associated with their spouses' reports of family conflict (Burke, 1993). Another study utilized physiological measures and discovered that on days that officers reported higher levels of stress, both the officers and their wives showed greater levels of autonomic arousal during couple conversations that occurred several hours after the end of the work day (Roberts & Levenson, 2001).

It has been suggested that the traits and skills required to do the work of an emergency responder are often at odds with those required to be a good spouse or parent (Southworth, 1990). These skills include taking control, springing into action, remaining detached, making quick and decisive decisions, and questioning everything. Not only are the skills and traits necessary for the job a potential risk for healthy and happy family interactions, but so are the coping strategies employed by emergency responders.

Emotional numbing is one of the strategies used by emergency responders to cope with stressful events. This approach includes avoiding experiencing the emotional impact of tragic events by consciously minimizing emotions and focusing on the cognitive aspect of the job (Regehr, Goldberg, & Hughes, 2002). Research has suggested that numbing related to traumatic stress reactions is significantly associated with negative feelings of family members toward the relationship. In particular, the disinterest, detachment, and emotional unavailability that characterize emotional numbing may diminish parents' ability and willingness to seek out, engage in, and enjoy interactions with their children, leading to poorer quality relationships (Ruscio et al., 2002).

If individuals encountering workplace trauma workplace choose to share their distressing experiences, rather than suppressing them, this too may be problematic. Several research studies have looked at vicarious trauma in mental health therapists working with victims who repeatedly hear violent imagery about the atrocities that one human commits against another. It has been found that such exposure can result in experiences of terror, rage, and despair and symptoms of PTSD including intrusion, avoidance, dissociation, and sleep disturbance on the part of therapists merely by hearing the stories told by clients (Chrestman, 1995; Figley, 1995; Kassam-Adams, 1995). In a related area, another study found that researchers doing chart reviews of child maltreatment cases began experiencing symptoms of trauma. Steps had to be taken to protect them from exposure to the traumatic stimuli by limiting their time spent reading the material (Kinard, 1996). If mental health professionals and researchers who have both specialized training and a support network of other professionals experience this distress, how much greater will the impact be on family members who lack this training and support and who actually love the person who was traumatized?

A body of literature has examined the impact of posttraumatic stress experienced by one person on other members of the family (e.g., Weine et al., 2004). For instance, a study of Bosnian refugee couples found that PTSD symptomatology was the best predictor of marital functioning (Spasojovic, Heffer, & Snyder, 2000). That is, higher rates of trauma symptoms in one family member were related to poorer marital adjustment. Similarly, several studies have focused on the stresses experienced by wives of Vietnam

veterans as a result of trying to cope with their husband's PTSD symptoms (Verboski & Ryan, 1988). In addition to having intrusion symptoms such as flashbacks, nightmares, and sleep disturbances, there is considerable evidence from both community-based and laboratory studies that veterans with PTSD have higher levels of anger and hostility and more difficulty managing their anger than veterans without PTSD and men in the general population (Calhoun, et al., 2002; McFall et al., 1999). Veterans with PTSD also have been found to have less effective coping mechanisms and problem-solving skills (Nezu & Carnevale, 1987). Consequently, veterans with PTSD have been shown to exhibit more severe marital problems, parenting problems, and violent behavior in the family (Davidson & Mellor, 2000; Jordan et al., 1992). It is not surprising that these reactions have an impact on family members. Wives of veterans with PTSD report feelings of isolation and loneliness, confusion, being overwhelmed, and having a sense of no control over their lives.

The previous research of the author has involved studies investigating the experiences of trauma in paramedics. From that research arose questions about the impact of paramedic work on loved ones. This study therefore explores the experiences of spouses of paramedics and the degree to which trauma experiences affect family members.

Method

The research was conducted with spouses of members of two emergency medical organizations which provide paramedic services in a large urban area. Fourteen spouses who were married or living common law with paramedics participated in the study. Two of those interviewed were women in same-sex relationships with a paramedic. One participant was a male married to a female paramedic. One participant was South Asian, and the remaining were Caucasian. Two reported that this was a second marriage. Number of years together as a couple ranged from 2.5 to 28, with a mean of 14.5. Five of the participants had no children. Others had between one and six children, in two cases, these children were from their previous marriages. Nine of the participants were employed full-time, two were employed part-time, and one was retired. Five of these individuals were employed in the medical

field, primarily as nurses. The paramedic spouses of participants had been with the service from 2–28 years, with a mean of 13.33 years. The sample size was somewhat larger than that recommended for the long-interview method of data collection (McCracken, 1988). This larger size was selected in order to ensure that saturation had occurred (Cresswell, 1998).

Interviews followed a semistructured interview guide that included questions about family situation; the effects of shift work, the paramedic role, and specific traumatic events on the family; social supports and social challenges the family encountered; and strategies for managing challenges. The semistructured format ensured standardization in the broad areas explored but also allowed interviewers to pursue unexpected and unique avenues that were important to some participants (McCracken, 1988; Cresswell, 1998). Other sources of data included notes recording the interviewers' impressions expressed at peer debriefing sessions. The interviews were audiotaped to ensure accuracy of data and transcribed. Data were analyzed for themes with the aid of a computer program (NUD*IST Vivo, 1999). In the initial stage, open coding allowed for the development of broad categories, after which selective coding allowed the researchers to attempt to develop a meaningful narrative of the experience of the spouses.

Throughout this research process, members of emergency service organizations have acted as community partners working to develop the research questions and discussing data as portions of the analysis were completed. This process has provided an opportunity to confirm and expand upon the trends developed in the analysis. Tentative analyses were then presented to a group of emergency responders, and their reactions and comments further enhanced transferability and confirmability (Cresswell, 1998; Erlandson, Harris, Skipper, & Allen, 1993).

Results

Everyday Hassles

It is important to understand that traumatic events encountered in the line of duty frequently occur within the context of a stressful work environment. This environment sets the stage for trauma responses by potentially taxing the coping resources of both

responders and their family. One respondent clearly identified this connection: "I think what's happening is that there is ongoing cumulative pressure that without . . . healthy coping mechanisms, is going to become toxic." Hassles identified by participants in this study included increased call volume, inappropriate or nuisance calls, changing schedules, changing coworkers (especially partners), inadequate stocking of equipment by others, and scrutiny of workers' performance to ensure quality assurance. An additional hassle was the lack of respect that participants felt paramedics often received from the public, who viewed them simply as "ambulance drivers."

The most commonly cited everyday hassle identified by spouses in this study was dealing with shift work. For paramedics, this not only involves disruption of schedules that do not mesh with those of the majority of members of society, but also the unpredictability of overtime. Respondents indicated that it was often difficult to predict whether a shift might extend 2–3 hours because of a call that kept them tied up on the road or in a hospital. Several participants indicated that they "never know if [their spouse] is going to be home for dinner." This unpredictability reinforces concerns about safety, as frequently the nature of the event makes it impossible to call home and explain. "If I don't hear from him, then I always have in the back of my mind that he's either working late or something's happened to him."

A primary concern related to shift work is the degree to which family time is compromised and family responsibilities are not equally distributed. In terms of child rearing, many respondents with children described how they took on the primary responsibility for child care. Several participants indicated that they at times feel like single parents. For example, "the younger [kids] may not seem him for five days." Others described how household responsibilities were picked up by the partner who was not working shift. In response to being asked the most difficult part of the job for the spouse, one respondent replied: "Being the house husband; having a regular schedule and being available to be home [I do it all] . . . cooking, cleaning, laundry." Families frequently coped by having a great deal of flexibility around meal times and special events. "Family functioning? He's on shifts so everything we do is around his schedule. I work part-time so that family get-togethers, Christmas, birthdays are done around his schedule.

It can be challenging at times." Spouses elected to work part-time or not work to ensure that the children had consistent care. Many relied on extended family for assistance.

Couple time can also be compromised. One participant stated "We really don't get a chance to spend time together." Another indicated that "one of the jokes we have is that we're married for 28 years but it only feels like 10 because of time we had apart." In part this is due to the fact that once the paramedics return home, they are fatigued from long shifts that require a great deal of physical, emotional, and cognitive energy. One respondent specifically stated that the couple's sex life suffered from shift work, and others alluded to this. Social activities are difficult to arrange, and quality couple time can be difficult to count on. "I'm very cut off here. So when [my spouse] comes home, I am dying for company . . . can't have it . . . too tired." Spouses also discussed the need to develop independent interests and friends to reduce their sense of dependence and isolation. One spouse mentioned getting a dog to reduce fear of being alone at night. Conversely, one person discussed the benefits of shift work as including couple-alone time when both spouses were home during the week and the kids were away at school.

Concerns About Dangers of the Job

One aspect of being the spouse of an emergency responder is living with concern regarding safety. "I'd go to sleep at night wondering, what was he going to run into that night?" Paramedics are exposed to high rates of violence, as indicated earlier. Families are aware of and worried about this type of risk. One participant noted that the uniform of a paramedic is similar to that of a police officer, but that paramedics have no weapons or body armor to protect them. Another stated "He's knocked at the door and they met him with a knife or they've gone to a shooting and they've gone into a house and when they were checking the woman, the gun was under the bed." Large-scale events, even those far away, also raise concerns. "The September 11 thing made me worried about safety. Most people noticed the firefighters that died but most people don't know paramedics died." Further, just the concerns about being on the road in dangerous conditions worry family members. "The night of the ice storm, I was just beside myself.

There were five ambulances in the ditch throughout the region. He was late because he was one of the few left on the road. But I had no one to call."

Other concerns noted by spouses related to the risk of contagious disease. In this study, paramedics had been exposed to HIV, flesh eating disease, and SARS. "They had transferred a patient and they were called the next day and told the patient had a flesh eating disease, that it was airborne, and the hospital staff hadn't bothered to tell the paramedics when they picked him up and so they hadn't taken any precautions. It was dangerous and they had already come home and we had an infant. Stuff like that scares me." HIV was a particular concern for respondents whose spouses were exposed in early days of the illness. One participant described that when her husband was exposed to HIV, no treatment was available, and seropositivity was equivalent to a death sentence. "Two months after we were married, he got a needle stick injury, he had to go for HIV testing . . . Then as soon as he came off that, within a month he got spat in the face and had to do the HIV testing again." This respondent indicated that they had to begin using condoms and that her spouse became depressed about the possible outcome. Another stated "So we were living apart for about two weeks until the test results came in . . . . We didn't know what it took for transmission, not like we know now."

More recently, the city in which this study was conducted experienced SARS as a major health concern. In one of the EMS organizations included, many hundreds of staff were quarantined (approximately 200–250 in the first outbreak and 400 in the second outbreak), and about 400 staff needed to work while quarantined. All staff still must follow procedures that add a great deal of extra stress to their job. The effect on families was dramatic. With the quarantine, many family members could not attend work or social events. "Because he was quarantined, I didn't go to work either . . . . It affected my work because I didn't want to freak everybody out at work." The risk of transmission was unclear, yet many health care workers developed the illness and two nurses died. "He came home wearing a mask because he was going to be quarantined for five days. Our daughter hadn't seen him for five days and she came running around the corner and headed straight for him and I had to stop her and then all three of us started to ball. I tried to explain to her why she couldn't touch him and then as

I was explaining, I just went to pieces all of a sudden." Several of those who had not been faced with the possibility of life-threatening illness expressed confidence in their loved one's skills and caution and indicated that they were less concerned.

Effects of Stress and Trauma on the Paramedic

Some of the effects that respondents described were responses that their spouse had to specific traumatic events. These included a variety of symptoms consistent with PTSD, such as withdrawal. "He's not just withdrawing from me, he's withdrawing from our children as well. It's affecting us." Intrusion symptoms included nightmares. "He will cry out in his sleep . . . . He still has nightmares." At times, arousal symptoms continued long after the event. "Things that happened a couple of years ago and all of a sudden now its affecting him. All of a sudden, he will become very emotional. He'll get all teary eyed." Another respondent stated "She flies into a rage." In addition, a number of respondents pointed to depressive symptoms. "He feels hopeless, hopeless." In one case, the family member reported that the paramedic had suicidal ideation. "He wishes he died that night and this would all be over." Several paramedics had consulted a psychologist or psychiatrist for their distress, and a few had taken time off work after a major event.

Reactions described by respondents also included longer term effects related to persistent exposure to trauma, suffering, and stress. Some of these reactions were physical and included chronic sleep deprivation and stress-related somatic conditions. Other reactions were related to temperament and personality changes. "He's not as patient . . . I think he's become more aggressive driving . . . and I just notice his [lack of] patience. He just blows up sometimes." Another respondent indicated "She had a very empathic personality. But because of what is happening in her job, she is changing . . . . In order to keep doing [the job] you have to harden up. That's what she is bringing home. That's not a good thing . . . . If she were there 10 years, I wonder what would be left of the core personality because the longer she's there, the harder she becomes." Further, one respondent described how the job made her spouse less sympathetic and nurturing toward her. "If I was to tell him I was sick, before he was a paramedic he used to hug me and cuddle me. Now he's like 'suck it up.'" Converselys some

respondents indicated that they believed their spouse had become more adept at managing stress as the years on the job passed. "She learned to deal with [it]. She's found her way. Early on she came home really upset. Other times she'd come home and not talk for a week or so. She's definitely changed and matured in the way she deals with [it]. She found her zone, I guess you could say." One participant believed that her spouses improved coping was in part due to the fact that he had developed a greater sense of self-confidence.

Impact on Family of Stress and Trauma

Participants in this study were clear that stress and trauma encountered in the workplace do not stay at the job but are carried home. One participant described the tremendous impact of a workplace-related traumatic event on the family. "It's almost like a bomb going off. it hit him and just like an aftershock, hit all of us." Many of the effects are related to mood states of the emergency responder. "He gets grumpy and he gets quiet. it is not hard to tell, not after being around him this long." Or "She crowds in on herself. She becomes very quiet, won't talk. And of course, the flip side of that is if you press the wrong button, then BOOM." One respondent indicated that while her husband continued to function on the job, his difficulty managing the aftermath of a traumatic event was expressed at home. "He was crabby, he was angry, labile mood swing. I couldn't keep pace, he stopped doing everything. Like I had an extra child in the house."

Families appeared to develop a unique sensitivity to the mood state of their loved one. "I know, I can see it. He doesn't look good. He's not himself. . . . When he comes through the door, I know." As a result of this, some participants described trying to manage the mood states to avoid further distress and conflict. "When you find yourself living with somebody that is something of a mine field, you have to develop ways of not stepping on their mines. Whether that means you back off or you keep quiet or you try a very soft approach, you're mindful of the fact that you're having to kid-glove it all the time because you're not sure whether they're gonna go off." Not only spouses but also children developed this sensitivity. One participant who was also an emergency health professional stated "We'd pick the kids up from the sitter and my son

would know that we had bad days just by the way we hugged them. I'd think—Ok this is too scary."

Some of the paramedics chose to speak about their traumatic experiences, and some participants described their willingness to share the stress. "As far as I'm concerned, I'm a sponge. Talk to me. I'll soak it up." This can, however, result in vicarious trauma responses in family members. "I have this visual image in my head of what he saw. . . . He dumps it on me." Others indicate that they are unable to assist their spouse in this way. "He doesn't bring a lot of stuff home with him. He will tell me things but also I am completely a nonmedical person so he knows certain things will affect me. I want to be supportive to him, but it's not me."

Other paramedics coped with traumatic events by closing down or becoming emotionally distant. "When he goes to a call, automatically there's a wall he puts up. He says he functions within a frame that is very analytical. It can be difficult to keep that frame of mind if you're at a situation for three hours and the person passed away is there and the family is upset and the police are there. So when it gets to be a long frame of time, he keeps his distance from it because they can't or he can't keep that wall up for that period of time." It is possible that this coping strategy continues into the home environment and results in emotional unavailability and refusal to discuss events with family members.

Parenting was also influenced by trauma exposure. That is, paramedics may become overconcerned about the safety of their children. "Safety has always been up there, because he has seen the results of what happens if you don't." Or "We consider ourselves to be paranoid parents . . . we ask a lot of questions, we're very particular about who they go out with, where they go and we're always checking because there are a million things that could happen."

Coping Strategies in Spouses of Paramedics

Coping strategies of participants varied. One common strategy was joining with the paramedic spouse around medical issues. Several of the participants were also health professionals, and thus they felt they understood the stresses and could tolerate discussions about medical procedures and gruesome occurrences. Others tried to gain a better understanding through going on "ride-alongs" during

an ambulance shift or taking a medical course to better understand the language and procedures used. Children were also involved in this to a lesser extent by taking advantage of such events as "take your kid to work day." A number of participants indicated that they joined their spouse in gallows humor to lessen the impact of tragic events. For example: "We've developed a very left field sense of humor.... It's questionable, but it's good." "We have a terrible sense of humor that we wouldn't share with others."

Another strategy was to avoid highly emotional interactions. One participant believed that she had become more patient. Others stated, for example: "I avoid her, let her gather her thoughts." "Walk on egg shells. Bring them a drink. Don't ask." At times, this requires the spouse to subjugate his or her own needs. "I know that when it's been a bad day or bad call, most of my problems get put to the back burner. That's my choice for fear of triggering or making things worse. So if I had a bad day at work, I suck it up." Often this was a strategy learned over the years. "Early on I pushed 'What happened? Tell me about it. I'm here for you. It will be better if you get it off your chest.' And the pushing didn't help because [my spouse] wasn't ready. It's really at their pace. Just look after what they need and make sure their comfortable and that's how I've changed."

Additional strategies included developing independent interests and friends. One participant indicated "I try to keep myself busy doing other things. And I pray for his safety." A few talked about the importance of spirituality or a belief in the inevitability of life. Others discussed their faith in their spouses' skills and judgment.

Although perhaps not strictly a coping strategy, participants reported a great deal of pride in the career of their spouse. One described collecting press clippings and had a "hero tape" of news clips of events her spouse attended. Others stated that their children loved career day at school because their dad could bring an ambulance. Still others indicated, for example, "I'm very proud of her; she does a fabulous job" and "I think it is amazing. They do all this stuff that most people wouldn't know about."

Nevertheless, participants reminded us that while coping strategies helped, being the spouse of a paramedic has challenges. "You gotta be very strong to be an emergency worker's wife. You never know what's going to happen."

Supports Available

Support from colleagues and in particular partners was viewed by participants as very important to their spouses. People identified that a great deal of peer counseling occurred on the shift, although this was often not sufficient, and professional support was also necessary. Several reported that their spouses were good friends with other paramedics who provided mutual support. However, at times this could be problematic for family members. "Partners are very, very close. Sometimes, perhaps from the spouse's point of view, perhaps too close." In particular, mixed-gender partnerships were potentially difficult for heterosexual participants. "He has a female partner now. It's very difficult. She considers herself my friend. Well, it is very abrasive." Another spouse described dealing with jokes and innuendo from other paramedics who suggested that her husband may not always be just working with his female partner.

While supports may have been available for the paramedics, this was not true for the spouses. A few mentioned that the spouses did not connect. One stated that following a traumatic event "he got excellent support, but we got zero . . . nobody called me."

Discussion

Paramedics work in highly stressful environments involving unpredictability, pressure to make life-determining decisions, and pressure to act according to these decisions in less than ideal and often dangerous situations. They are faced with tragic situations beyond the scope of everyday experience. While for the most part they are equipped to deal with their emotional responses to these situations, they are at times confronted with images and losses that have a significant impact on them. Of the many factors that contribute to traumatic stress responses, the support of family is commonly reported as an important mediator (Leffler & Dembert, 1998; King et al., 1997; Regehr, Hemsworth, & Hill, 2001; Weiss et al., 1995). Yet, surprisingly little is known about the impact of trauma and providing support on the spouses of emergency responders. This study explored the experiences of 14 spouses of paramedics.

In addition to traumatic events, paramedics are faced with daily hassles regarding scheduling, equipment, and personnel

issues. While some of these hassles are related to organizational context and interactions with the public, others are related to shift work and unexpected overtime, which are central to the structure of the job. Shift work limits involvement in family activities, child rearing, and couple social time. It leaves the other spouse feeling at times like a single parent, solely responsible for the maintenance and nurturance roles in the family. The present findings are consistent with those of other researchers who identify that shift work causes hardships in terms of sustaining family relationships and social relationships (Costa, 1996; Grosswald, 2002). In addition, the fatigue that paramedics experience at the end of the shift and upon their return home, as noted in both this study and others (Costa, 1996; Härmä, 1996), further reduces their involvement with families. While not clearly identified in this study, others have suggested that children of emergency responders may feel isolated and abandoned by the absent parent and look exclusively to the other parent (usually the mother) for support (Maslach & Jackson, 1979). These hassles form the foundation upon which traumatic events are encountered. That is, workers and subsequently their families are faced with traumatic situations when they are already stressed and resources are already stretched.

As stated earlier, paramedics encounter many events that are described in the literature on workplace trauma as critical events. These include both witnessing the death of others and actual physical threats to their own safety. Family members in this study worried about risks associated with violent patients and risks associated with travel on the roads at high speeds, often in dangerous weather conditions. These family members also experienced real threats to safety from HIV infection, flesh eating disease, and SARS. When these threats were encountered, family members remained separate from one another and were quarantined, and all members had their activities significantly curtailed.

With regard to tragic events, all family members in this study recalled events encountered by the paramedic that had a significant impact on them. Family members witnessed symptoms of posttraumatic stress and felt the effects of these symptoms. Similar to studies of Vietnam verans with PTSD (Calhoun et al., 2002; McFall et al., 1999), families frequently reported issues regarding irritability and anger control in the paramedics following traumatic events. When family members encountered these responses, they

had learned to deescalate the situation and place their needs second. In those situations where the paramedic's trauma response persisted, spouses reported that this caused them distress.

Some paramedics coped with events by debriefing with family members. This was particularly true when the spouse was a health care professional who was accustomed to the gruesome and graphic details. In situations where the spouse was not a health care worker, this at times resulted in discomfort, distress, and visual imagery of the event. This is consistent with the notion of vicaious trauma (Figley, 1995; McCann & Pearlman, 1990). Other paramedics coped with the event by "putting up a wall" or "shutting down." While utilizing a cognitive focus and numbing emotionally may be an effective strategy for coping with the traumatic nature of paramedic work (Regehr, Goldberg, & Hughes, 2002), this strategy served to further isolate family members. It is not possible to identify from this qualitative study which of these two approaches, debriefing with family or protecting the family by shutting down, is more effective for emergency responders and their family members. From this study, it appears that both approaches are appreciated by some spouses, that is, the mutual experience of coping with trauma together or the fact that they are spared from gruesome details. It also appears that both approaches can cause distress in spouses and children, that is, vicarious trauma due to exposure or isolation due to being shut out. Further quantitative designs may be useful in determining whether one approach is superior for the majority of couples.

Both formal and informal supports within the emergency medical service organization were identified as being available to the paramedics. This was viewed as a positive resource. However, participants were clear that this support did not extend to family members, who were frequently left alone to manage events and their loved one's emotional response.

While this study focused on the experiences of paramedics, it is reasonable to assume that similar issues may be experienced by couples in other health care and emergency fields. Issues of shift work, for instance, have been demonstrated in a number of fields (Costa, 1996; Grosswald, 2002; Härmä, 1996; Maslach & Jackson, 1979). Further, trauma exposure is common to many professions, and limited evidence suggests that trauma reactions can be transferred to spouses of firefighters (Pfefferbaum et al., 2002), police officers

(Burke, 1993), and military personnel (Davidson & Mellor, 2000). Finally, emotional management is a common strategy for managing trauma that is actually taught in many professions as a means of improving performance (Regehr, Goldberg, & Hughes, 2002). Thus, while the nature of this study does not allow for generalization to other professions, it does raise questions for further research.

Conclusion

The aftermaths of traumatic events encountered by emergency responders are not experienced by the responders alone. Rather, the emotional consequences ripple out to encompass family members. Further, when traumatic events occur, they do so within the context of high paced and changing work environments in which stress levels of workers are already elevated and within families already separated and stretched by the demands of shift work and unpredictable overtime. Recent years have seen dramatic increases in the support services available to emergency workers within their organizations. These support services are undoubtedly important for the well-being of workers. However, these supports rarely extend to family members, who continue be the primary source of nurturance and safety for workers. If family needs are not considered by emergency service organizations, this valuable resource may not continue to function.

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