



2022

## Spouses of First Responders: A Narrative Inquiry of Survival, Recovery and Healing

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SPOUSES OF FIRST RESPONDERS:  
A NARRATIVE INQUIRY OF SURVIVAL, RECOVERY AND HEALING

By

Jennifer D. Geiger

A Dissertation Submitted  
In Partial Fulfillment of the  
Requirements for the Degree of  
DOCTOR OF EDUCATION

Benerd College  
Transformative Action in Education

University of the Pacific  
Stockton, California

2022

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A NARRATIVE INQUIRY OF SURVIVAL, RECOVERY AND HEALING

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SPOUSES OF FIRST RESPONDERS:  
A NARRATIVE INQUIRY OF SURVIVAL, RECOVERY AND HEALING

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By

Jennifer D. Geiger

## SPOUSES OF FIRST RESPONDERS: A NARRATIVE INQUIRY

### **Dedication**

This dissertation is dedicated to my family, and to all families of emergency responders, especially those suffering with posttraumatic stress, regardless of a diagnosis.

## SPOUSES OF FIRST RESPONDERS: A NARRATIVE INQUIRY

### **Acknowledgments**

My gratitude goes to the research director and an author clinician of the nonprofit that provides the healing retreats for first responders and their families for providing initial feedback on my brainstorming for the dissertation, including some choice interview questions. Special appreciation to the administrative assistant for digging into participant self-assessment data from multiple retreats and providing information and support for this study. I am thankful for my fellow peers, the chaplains, and the clinicians from retreats over the past few years as I crafted my dissertation for their unwavering encouragement and enthusiasm.

To my Benerd College course instructors, mentors, staff, fellow students, and friends, thank you for the ongoing nurturing, challenging, and encouragement through my years as a student in inaugural cohort of the Transformative Action in Education (TAE) doctoral program. A special shout out to my chair Dr. Rachel Hallquist, TAE program director Dr. Laura Hallberg, and committee member Dr. Linda Webster for your encouragement, thoughtful feedback, and steadfast support throughout this process to help me tell these stories.

My family and friends have cheered me on, as the first person in my family to pursue a doctoral degree. This work would not have been possible without the bravery of my participants or the love and support of my children and husband. I am deeply grateful.

# SPOUSES OF FIRST RESPONDERS: A NARRATIVE INQUIRY OF SURVIVAL, RECOVERY AND HEALING

## Abstract

By Jennifer D. Geiger

University of the Pacific  
2022

The nature of the work of emergency responders (i.e., firefighters, law enforcement, paramedics, and dispatch) includes high stress and direct experiences of traumatic situations. The experience of posttraumatic stress is common. The spouse or significant other is often the first person to see a change in their responder and the person most likely to be sought out for support from the responder, yet there is little support for the spouses or significant others of emergency workers. The purpose of this qualitative study using in-depth interviews and narrative inquiry was to learn about participants' experiences at the 6-day residential treatment (retreat) for significant others and spouses of first responders, the latter of whom were diagnosed with posttraumatic stress. This research identified ways the retreat promoted personal transformation for participants, how change theory contributed to participants' personal transformation, and how participants perceived the impact this personal transformation has on their family and perhaps their community. Evidence of Spouses of Emergency Workers program efficacy could increase funding sources and support program replication across the country to provide treatment support for significant others and spouses of first responders.

*Keywords:* posttraumatic stress, first responder spouses, treatment, support, narrative inquiry

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### List of Abbreviations

COVID-19	Coronavirus Disease 2019
EMDR	Eye Movement Desensitization Reprocessing
ERES	Emergency Responder Exhaustion Syndrome
FRR	First Responder Retreat (pseudonym)
IRB	Institutional Review Board
LEO	Law Enforcement Officer
MISTS	Memories, Insights, Symptoms/Behavior Changes, Triggers, Sleep/Dreams
PTS/D/I	Posttraumatic Stress/Disorder/Injury
RQ	Research Question
SA-SEW	Symptom Assessment-Spouses of Emergency Workers (Pseudonym)
SEW	Spouses of Emergency Workers (Pseudonym)
TSI-2	Trauma Symptom Inventory (2nd Edition)

## Glossary

During the COVID-19 pandemic, the news media talked about first responders, emergency responders, PTSD, and vicarious and secondary trauma. Because some of these terms are used interchangeably, it is important to understand them in the context of this paper on the topic of significant others and spouses of first responders.

**Codependency:** Over functioning for a loved one who requires support because of illness or addiction is codependent behavior. Such “helping” results in excessive emotional or psychological reliance on said loved one wherein the one person cannot cope without helping the other (The Freedom Center, 2019).

**Compassion Fatigue:** The impact of helping others through trauma or stressful experiences that takes a physical, emotional, and psychological toll on the helper can result in compassion fatigue (WebMD, 2020).

**Complex Trauma:** Caused by a number of traumatic events/experiences/critical incidents, complex trauma can occur between individuals and involves feelings of being trapped. These experiences may be ongoing or repeated which end up in more severe, persistent, and cumulative impacts. Complex trauma results in feelings of shame, lack of trust, poor self-esteem, challenges with identity and the ability to regulate emotions (Landes et al., 2013).

**First Responder/Emergency Responder:** In this paper, first responder/emergency responder are used interchangeably to identify police officers, firefighters, paramedics, dispatchers.

**Group Therapy:** Individuals coming together to share their personal experiences and learn from the experiences of others in group therapy. Facilitated by more than one therapist and can be a cost-effective form of therapeutic treatment (Kirschman et al., 2013; Tuckman & Jensen, 1977).

**Posttraumatic Stress Disorder/Injury:** Posttraumatic stress disorder/injury (PTSD/I) occurs in those who have witnessed or experienced something traumatic (e.g., violent personal assault or rape, combat or war, act of terrorism, a natural disaster, or serious accident). The American Psychiatric Association (APA) included it as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition). The term “injury” is preferred to “disorder” by the staff and volunteers of the nonprofit providing the FRR and SEW Retreat, as an injury is something from which one can recover.

**Psychoeducation:** Education and evidence-based therapeutic techniques to provide information and support on topics such as coping techniques, visualization, communication, stress management, positive thinking skills, and anger management are forms of psychoeducation (Auren et al., 2021; Mughairbi et al., 2020; Oxford Bibliographies Online, 2015; Phoenix, 2007; Rice & Moller, 2006; Whitworth, 2016).

**Residential Milieu:** Living in a safe, structured community while receiving therapeutic interventions immerses individuals in interactions and daily activities that are also the means of receiving therapy called the residential milieu (Healthline, 2020). Milieu is a French term for “middle.”

**Secondary Trauma:** Being exposed to the trauma experienced by someone via a telling of the traumatic event is secondary trauma (Cathrall, 2004).

**Self-Care:** Mindfully planning and following through on things that promote mental, emotional, and physical well-being is self-care (Afropunk, 2018).

**Self-Compassion:** Kindness toward oneself when in emotional pain rather than being self-critical for being human is self-compassion (Breines & Chen, 2012; Neff, 2003).

**Significant Other:** Parent, child, sibling, significant intimate relationship, coworker/partner of a first/emergency responder are significant others.

**Spouses:** Those married to a first/emergency responder are spouses.

**Trauma:** A psychologically overwhelming major event of any kind defines trauma (Baxter, 2013; Cathrall, 2004; Landers et al., 2020; Landes et al., 2013; Matsakis, 2004; Phoenix, 2007; Rice & Moller, 2006; Whitworth, 2016).

**Vicarious Trauma:** The experience of learning a loved one has experienced trauma by witnessing the pain, fear, and terror someone has endured is vicarious trauma (Cathrall, 2004). This differs from secondary trauma is that one has not been directly exposed to the trauma of another via telling the story of the trauma.

## CHAPTER 1: INTRODUCTION

A calling is being drawn inexplicably to a profession to make a difference in the lives of others. Some say they are called to teach, or to ministry, or to theater, so powerfully that any reason to reconsider is moot. A calling is indisputable. Spouses of emergency workers commit to support their first responders even when it is not *their* calling.

He said he had a calling. The calling would mean giving up a lucrative job where he was not happy. It would mean excitement and danger. The calling would put him in a job working for something significant outside of ourselves. I could see it was indeed his calling, a passion; his desire to make a difference in our own community resonated with mine. Therefore, there was no question that my husband would become a police officer in our hometown. I had no way of knowing how this decision would impact us, our marriage, and our family.

### **Introduction**

First responders sign up to be put in harm's way daily. Their shift is unpredictable and can be packed with adrenaline-fueled or mundane calls for service. Their work is dictated by the "chain of command"; federal, state, and local laws; and the needs of the public. There may be little personal control over the work; instead, first responders take things as they come. The unpredictability and severity of calls can cause trauma, which may or may not be addressed by the department, and which often goes untreated due to the "macho" culture of first responders to "show no weakness" (Miller, 2007).

Life outside of work may be filled with family, a spouse, children, parents, siblings, and friends. They might like to hear funny stories about calls going awry, but the experiences causing the trauma and hurt are not shared widely. Significant others and spouses are often the



first ones who notice a change in their first responder and the first to hear about a traumatic experience, but they often have few ways to seek support for themselves as they process these experiences of their loved ones and try to “keep the home fires burning.” The life of first responder families can be isolating as those outside of “the life” may not understand the stresses of shift work, mandatory overtime, and last-minute unavailability when plans change. Circles of friends become smaller and may only consist of other couples or families of first responders. Relationships within departments become challenging when one person gets passed over for a promotion given to another. This can strain inner-department friendships and those between first responder families, leading to increased isolation. Significant others and spouses may have difficulty finding others to unload to, not wanting to risk their first responders’ image in the department.

The focus of this study was to learn about participants’ experiences of the unique, 6-day residential treatment (retreat) for significant others and spouses of first responders, specifically those first responders diagnosed with posttraumatic stress (PTS). Using narrative inquiry, healing and recovery of significant others and spouses is conveyed via storytelling of direct personal experiences. This chapter provides a background for the study of significant others and spouses of first responders (the latter diagnosed with PTS), why the study is needed, the framework used to support the inquiry, the scope of the study, and definitions of terms used in this paper.

### **Background**

The impact of the work of a first responder spreads to those they live with, are related to, and with whom they spend time. The stories of calls, stops, and what the news portrays does not describe adequately the felt sense of living with a first responder: the fear of injury, the constant

threat of death, the worry of being portrayed in the media, and the hypervigilance that comes with trying to keep the family and first responder safe and comfortable in their own home. These are some of the things with which significant others and spouses of first responders cope daily. What is not disclosed to loved ones of first responders is the likelihood that they may experience vicarious or secondary trauma just by their relationship, hearing the stories, and knowing their loved one is regularly in harm's way (Friese, 2020) because of the job they have been called to do and their desire to serve the community.

### **Exposure to Trauma**

I would like to say the trauma came slowly. But it did not. The fun things, such as meeting him for dinner after a day at the police academy with his fellow recruits, ignited the feeling of being part of the "Blue Line Family." That sense of belonging helped make the long hours feel like the sacrifices we made were worth it in the beginning. Then he had his first critical incident. One month on his new job, still in training, he was beaten by a suspect who was inches away from grabbing his gun. This was covered in our local newspaper and was our first experience with media coverage. The stitches over his eye and sprained ankle he got from chasing the suspect after being beaten won him the "Blue Star" award, equivalent to the military's Purple Heart, for sustaining injuries and pursuing the suspect. My husband jokes that he got an award for getting his ass beat.

For 17 years, my husband took pride in his work. He was "one of the good ones" in a culture that promotes machismo and "tough guy" attitudes as Miller (2007) described. He participated in "choir practice" at the end of the work week, where he and his coworkers gathered in the early morning at a 24-hour bar to "talk shop," using gallows humor and alcohol to cope, as Landers et al. (2020) depicted. This was an acceptable way for them to work through

the ongoing horrors they witnessed during the week: auto fatalities, stabbings, rape, suicides, burglaries, child molestations, trying—and failing—to revive an infant, among so many others. The most frightening calls as a spouse were the unpredictable domestic violence calls or “suicide by cop,” where there was little an officer could do to talk a person into compliance. These calls were the most dangerous for an officer.

### **First Responder Culture**

Isolation in emergency responder professions is common due to the desire to “not show weakness” by asking for help with PTS or emotional distress. The stigma around seeking help prevents first responders from seeking out therapy or counselling services (Alrutz et al., 2020; Karaffa & Koch, 2016). The circle of friends tends to get smaller due to the need to keep trauma stories “close to the vest,” and family members rarely understand why your partner cannot tolerate social functions anymore (Matsakis, 2004).

### **First Responder Relationships (Marriage, Children)**

There was no debriefing of the critical incident for the family, for me. I felt like we, as a married unit, needed to just suck it up and move forward. That is the first responder culture. Sure, the officers and their wives would get together, the cops talking about the latest “dirtbag” they interacted with while the wives were at a table kvetching about the schedule, keeping the house and home life measured and secure for their officer, and parenting children alone, as both Friese (2020) and Karaffa et al. (2015) mentioned.

Parenting children alone was unexpected. And exhausting. Waking up for night feedings and keeping the baby quiet during the day so Daddy could sleep because he was working the night shift. I did not have a circle of cops’ wives’ friends when the kids were little. There was a lot of “keeping up with the Joneses”: the nicest house, the most toys (e.g., big screen TV, cabin

in Tahoe, motorcycle). That too was exhausting. Yet, they were the only group who understood what a shiftwork schedule was like. It was hard to defend my husband's absence from so many family things because "he's working." My husband was exhausted and exhibited "limited psychic energy" for relationships, common for trauma survivors (Matsakis, 2004).

### **Trauma Defined**

Inputting "types of traumas" in a search engine will net numerous causes of trauma, different diagnoses, and ways trauma can manifest. This paper focused on PTS, which the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V; American Psychiatric Association [APA], 2013) follows with "disorder," giving the acronym PTSD. Posttraumatic stress injury (PTSI) is preferred by some professionals to "disorder," as an injury is something from which you can recover. Complex trauma is caused by several traumatic events/experiences/critical incidents, which we learned was another layer to the challenges my husband faced. Although complex trauma tends to occur in early childhood and adolescence, it predisposes individuals to PTSD in adulthood (e.g., with military veterans; Landes et al., 2013).

As a spouse, I learned being exposed to my husbands' experiences simply by him sharing them with me left me vulnerable as well, as Friese (2020) explored. Secondary trauma refers to one who is "traumatized by being exposed to the experience" (Cathrall, 2004, p. 4) of the traumatized individual, and vicarious trauma describes one who is traumatized by learning a loved one "has experienced an emotional traumatic event" (p. 4). These terms are often used interchangeably, but I can see that, early in my husband's career, I may have experienced vicarious trauma and then secondary trauma as the stories continued and worsened.

Common phrases used by loved ones of first responders such as "walking on eggshells" and "taking the temperature of a room" are familiar to loved ones of those diagnosed with PTS

or who use substances to numb symptoms of stress (Matsakis, 2004). These phrases describe the regular challenges of significant others and spouses of first responders, yet these experiences are not typically shared in a social setting. The feeling of being alone and struggling with one's experiences is something that requires support.

The programs that launched our collective healing were provided by a nonprofit organization whose sole purpose is to support first responders, specifically those in law enforcement, fire, dispatch, and paramedics. My husband attended their retreat for first responders (known hereafter by the pseudonym FRR for First Responder Retreat), and I was a client at the retreat for spouses and significant others (known hereafter by the pseudonym SEW for Spouses of Emergency Workers Retreat) where I continue to volunteer as a supportive peer.

As one of a building full of volunteer peers, I do whatever tasks need to be done. These include dishwasher, meal prep assistant, spot cleaning one of the three floors of the house, presenter of psychoeducation topics, leading morning or afternoon walks, spending time getting to know the clients, providing validation and support, providing morning check-in examples, sharing my own challenges as the spouse of a first responder with PTSI, dealing with my own triggers in an authentic and vulnerable way, supporting the group processing time, conducting client history interviews, providing information for first-time peers, and anything else I am asked and able to do. It is an honor to support a program that was so meaningful to my healing when I was a client. For study context, a description of the SEW Retreat follows.

### **Residential Treatment Program**

Based on the model of the FRR treatment program, the SEW residential treatment program for significant others and spouses of first responders includes culturally competent clinicians (i.e., those who are well versed in working with first responders and their families), a

chaplain, and peers who have come through the SEW program as clients. This three-pronged support provides clients with counseling; guidance; and, through interaction with peers, normalizes the feelings and behaviors clients experience as described by the program website. The components of the 6-day retreat program include group processing, psychoeducation presentations, daily opportunities for walks and chapel, and community mealtimes. As described in an article about the FRR, being in constant community in the residential milieu reduces clients' ability to engage in avoidance and isolation and "encourages the client to focus on the psychological and physiological symptoms" they are experiencing. The residential milieu is an important factor in launching client healing processes described in research about the First Responder Retreat. Additionally, clients are more apt to open up if they sense the culturally competent clinicians will not judge their emotional and behavioral responses due to clinician awareness of first responder culture (Kirschman et al., 2013; Porter & Henriksen, 2016). Having clinicians who understand the lifestyle of first responder families allows families to share the challenges they face more easily. First responders may share their critical incident experiences that are shocking to a typically trained therapist. Decisions made by first responders are not typical of an average client (Kirschman et al., 2013). Having culturally competent clinicians is essential for the therapeutic process so first responders can share of themselves and know their therapist will listen without judgment.

### **Intensive Retreat**

The SEW Retreat is designed for significant others and spouses of first responders whose first responders were diagnosed with PTS, per the nonprofit organization website. The language around this diagnosis includes dropping the word "disorder" and replacing it with the word "injury" to indicate PTS is something from which one can recover and heal as opposed to

something being “wrong” with a person. The terminology of “retreat” can be misleading. Although it is a place to “withdraw to safety” (as in an army moving back after fighting), or withdrawing to a quiet place, clients do much emotional work. There are no spa treatments, and there is very little rest and relaxation, yet clients leave feeling buoyed, having let go of some of their burdens and armed with tools to use when they return home. These tools are specific to self-care, distorted thinking, and codependency, to name a few.

These treatment practices are supported in the description of an intensive outpatient treatment for individuals diagnosed with PTSD (Auren et al., 2021). During an 8-day outpatient pilot study, six participants engaged in exposure therapy, physical activity, and psychoeducation. The authors identified psychoeducation themes covered that included:

PTSD symptoms as common reactions to trauma; rationale for exposure [therapy]; benefits to physical activity; . . . avoidance and other maladaptive strategies; negative thoughts, beliefs, and cognitive distortions; importance of emotional processing as part of healing from trauma; self-image and self-compassion; [and] relapse prevention. (Auren et al., 2021, p. 3)

The intensity of the 8 days, although uncomfortable, limited distractions and avoidance behaviors and led to increased group unity and support. Auren et al. (2021) indicated participants felt it was “difficult, but worth it,” and all components worked well together to support their healing. The various components working well together was also a limitation to this study, as they could not tease out if one component provided more benefit than another (Auren et al., 2021).

## Peer Support

A significant component of the SEW Retreat is peer support of those who were clients previously. Support by those who have struggled through similar circumstances is thought to have great impact on healing (Arrendando et al., 2002; Landers et al., 2020) and helps to normalize client experiences (Phoenix, 2007; Whitworth, 2016). Prior to the COVID-19 pandemic, the six clients were supported by a house full of about 40 peers who had been clients previously. This significant peer support reduces feelings of isolation and promotes the ability to share painful experiences as one starts the healing process. Because of the pandemic, the retreat participant number was limited to 18 to allow for distancing; there were 12 peers plus the six clients. This made for a less intimidating opportunity for client disclosure (Volunteer A, personal communication, May 28, 2021).

The nonprofit website describes peer support (as applicable to FRR and transferable to the SEW Retreat) like this:

The peer support format is key to challenging the participant's belief that their experience is unique. The peer support format allows the participant to realize that they are part of an association of people who have experienced and survived similar incidents.

Throughout the program the participant listens to a variety of stories concerning each participant's critical event and observes and learns from the reactions of others. Having first responders on staff that have experienced and recovered from critical incidents provides hope and recovery modeling to participants.

This coincides with the research on using peer support in healing and normalization of experiences (Arrendando et al., 2002; Landers et al., 2020; Phoenix, 2007; Whitworth, 2016).



## Psychoeducation

Large chunks of each day of the retreat include presentations and psychoeducation on various topics to support the work of the retreat. Psychoeducation is the most frequently used intervention in trauma recovery (Whitworth, 2016). According to *Oxford Bibliographies Online*, psychoeducation is “a flexible strengths-based approach that incorporates both educational and therapeutic techniques that are evidence-based to provide support and information on such topics as positive thinking skills, anger management, communication, stress management, and visualization” (“Psychoeducation,” 2015). It facilitates change in trauma symptoms (Rice & Moller, 2006), reduction in symptoms (Mughairbi et al., 2020), and can be an important component in intensive outpatient treatment for PTSD (Auren et al., 2021). Phoenix (2007) articulated the importance of trauma education as it provides a framework for understanding personal experiences and reduces negative responses. Whitworth (2016) targeted psychoeducation as providing understanding in how trauma impacts daily life and ways to decrease that impact and heal from trauma responses. It can aid in recovery from PTSD symptoms (e.g., denial, intrusive thoughts, avoidance, and mood fluctuations related to trauma) and is most effective when it connects people to resources and focuses on resilience (Whitworth, 2016). However, Whitworth cautioned the reporting of symptoms may increase as people are made aware of their symptoms.

Themes of psychoeducation in trauma recovery include coping strategies such as relaxation and managing triggers, description of trauma symptoms to decrease the sense of “personal failing,” strategies for self-care, and normalizing trauma responses (Phoenix, 2007). Trauma responses are described as sleep problems, hypervigilance, hyperarousal, mood disturbances, intrusive thoughts, and avoidance (Whitworth, 2016). Psychoeducation on how

trauma impacts our brains can reduce self-blame and aid in healing; being connected to further resources on resiliency and coping is essential (Whitworth, 2016).

SEW Retreat programming is provided daily from 7:00 a.m. through 9:00 p.m. Daily walks, optional chapel, delicious meals, and snacks pepper the time between intense personal and group sharing, and psychoeducation presentations (Volunteer B, personal communication, February 17, 2021). Formal presentations are provided on sleep hygiene, PTS, emergency responder exhaustion syndrome (and corresponding spouse exhaustion syndrome), family and marital relationships, codependency, and coping skills, to name some.

### **Focus of the Inquiry**

The focus of this study was to learn about participants' experiences of the unique, 6-day retreat for significant others and spouses of first responders whose first responders were diagnosed with PTS.

### **Research Problem and Purpose**

There is a perceived lack of support services for significant others and spouses of first responders, possibly due to the lack of having “someone who could provide emotional or information support to them for their problems or worries because their partner was a military member or emergency responder” (Alrutz et al., 2020, p. 6). Few departments have family supports. Although first responders have been studied for responses to critical incidents and trauma at the FRR, spouses may not have the opportunity to debrief critical incidents and instead must live with their first responder without the opportunity for help. However, with the advent of social media, sites have cropped up for information and support; there are national and local organizations that provide support for spouses (e.g., National Foundation for Police Wives, United by Blue), blog posts with tips for spouses (e.g., Help for Our Heroes, 2022; Zemlock,

2020), and online educational programs to support first responder spouses (e.g., Resilience Academy, First Responders Foundation). There also are some books written by spouses and clinicians to provide a glimpse into their lives and provide support (Kirschman, 2006; Littles, 2011; Newman, 2011). Finn and Tomz (1997) described a supportive program for officers and their families that included programs staffed by those who understand agency-specific organizational stresses, promoting trust. Culturally competent clinicians can be difficult to find, as can be group support and treatment for recovery from trauma caused by being the significant other or spouse of a first responder (Kirschman et al., 2013). This support is critical as it is the spouse who is often the first person their first responder turns to for support. If the spouse has nothing to give, this harms the relationship (Alexander et al., 1996; Alritz et al., 2020; Beehr et al., 1995).

This study provides information on the power of a supportive healing program for significant others and spouses and support for replication of this program beyond the single location. The purpose of this qualitative study using in-depth interviews and narrative inquiry was to learn about participants' experiences at the 6-day residential treatment retreat for significant others and spouses of first responders whose first responders were diagnosed with PTS by asking the following questions:

1. What ways, if any, does the retreat promote personal transformation for participants?
2. How does change theory contribute to participants' personal transformation?
3. How do participants perceive the impact this personal transformation has on their family and perhaps their community?

### **Significance of the Inquiry**

The impact of short, residential treatment for first responders with PTSI has been investigated, demonstrating the effectiveness of the program. However, no studies have been

conducted on the efficacy of the SEW Retreat, and it remains the only one of its kind in the country (program website uncited to protect privacy of study). Evidence of SEW program efficacy could increase funding sources and support program replication across the country to provide treatment support for significant others and spouses of first responders. Using the lens of change theory and the method of narrative inquiry, I learned more about the experiences of retreat participants.

### **Theory of Change Framework**

Emerging from work at the Aspen Institute, Weiss (1995) articulated the need for using theory to support programmatic evaluation, using it to see if assumed changes were occurring because of the anticipated outcomes. According to Weiss (1995), “Tracking the micro-stages of effects as they evolve makes it more plausible that the results are due to program activities and not to outside artifacts of the evaluation, and that results generalize to other programs of the same type” (p. 73). The author also articulated problems with a “theories of change” approach in terms of “problems of theorizing, measurement, testing, and interpretation” (Weiss, 1995, p. 87). Overall, implementing a theory of change approach can lead to better understanding about why, how, and when “good is being done” in a program (Weiss, 1995).

The framework for using theory of change is to identify the principle, the problem or issue, the focus of change, the strategies, and the anticipated changes (Almanzor, 2020; R. Almanzor, personal communication, March 19, 2021). This is a systematic approach to a “cumulative study of the links between activities, outcomes and contexts” (Judge & Bauld, 2001, p. 24) of a program. The theory of change describes the SEW Retreat program well and was used to demonstrate program efficacy and personal transformation.

## **Applied Theory of Change**

The purpose of the SEW Retreat “is to provide a safe and confidential environment for the promotion of healing, education, and support” (nonprofit website). The problem/issue was maladaptive coping behaviors and secondary traumatic stress associated with the PTS experienced by their first responder. The focus of transformation was on the individual, using strategies such as psychoeducation, group processing, individual therapy, eye movement desensitization reprocessing (EMDR), and a 90-day follow up/action plan. Decrease in symptoms were the anticipated changes.

In addition to clinician-led interventions, the retreat location contributes to change as well as the retreat structure. The location is in the hills at the end of winding roads, in a beautiful, secluded spot. Walks among vineyards and down little-traversed streets distract from the daily activities of home. Participants are asked to limit cell phone use and social media intake, and phones are not allowed outside of client rooms. The isolation from home promotes focus on oneself. The retreat schedule is full, beginning with an all-call check in at 8 in the morning. Attendance at the 7:00 walk and 7:30 chapel is optional, but some arrange their time to accommodate these additional opportunities for connection. There are short breaks in the morning and afternoon, snacks available throughout the week, and three delicious meals each day. Tradition prior to the COVID-19 pandemic included peers clearing meal plates for the clients as a form of care.

Significant others and spouses are so often doing for others that they neglect themselves, except maybe for ensuring their appearance “keeps up.” This retreat time promotes inner focus, which can be difficult and painful but necessary for healing. You cannot address that of which you are unaware. Clients often come to “fix” their spouses but learn their sole locus of control is

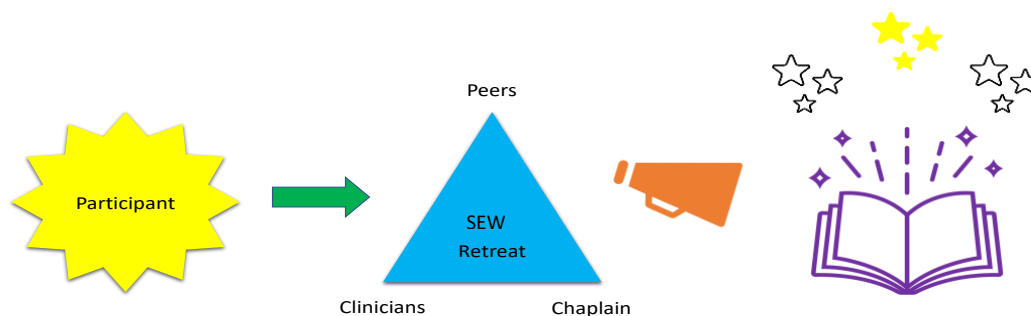
themselves. They learn traumas stemming from childhood experiences often trigger responses to current challenges. Retreat components help to raise this awareness and provide coping skills.

### Description of the Inquiry/Delimitations

A qualitative study design using narrative inquiry was used to explore how individuals involved in the retreat process make meaning of their participation (see Figure 1). In-depth peer interviews with a demographic component and permission to access self-assessment scores (the SA-SEW, Symptom Assessment-Spouses of Emergency Workers [a pseudonym], an organization-specific repeated design measure and the TSI-2, Trauma Symptom Inventory, 2nd Edition) were employed. Potential participants were drawn solely from the pool of willing attendees of past retreats, limiting sample size. Because there is only one location serving significant others and spouses, participants were from a limited geographic area, yet people come from all over the country to attend this one-of-a-kind experience. As the researcher, I am a former SEW client and a current volunteer peer, positioning me as an insider researcher. Through researcher notes, regular journaling, and check-ins with peers, I worked to acknowledge my biases and understand the impact of my positionality within the study.

**Figure 1**

*Narrative Inquiry as a Study Lens*



### **Plan of Study**

A qualitative research design using narrative inquiry was employed to learn about participants' retreat experiences through in-depth peer interviews, a demographic survey of participants, and with participant permission, access to their self-assessment scores (on the organization-specific repeated design measure, the SA-SEW and TSI-2). The following questions were addressed:

RQ1: What ways, if any, does the retreat promote personal transformation for participants?

RQ2: How does change theory contribute to participants' personal transformation?

RQ3: How do participants perceive the impact of personal transformation on their family and perhaps their community?

### **Chapter Summary**

First responders put themselves in harm's way daily because it is a requirement of their job. Although there are supports in place, first responders may not use such supports because of the "macho" culture but rather rely on their loved ones. There are few, if any, organizational supports for significant others and spouses. The supportive nonprofit organization has filled a gap in support services, providing 6-day retreats for both first responders diagnosed with PTS and a separate retreat for spouses of emergency workers (i.e., SEW). Using a theory of change, this study supports the efforts of the nonprofit and demonstrates the impact of the SEW Retreat. Further, the purpose of this study was to learn about participants' experiences at the 6-day SEW Retreat using narrative inquiry. The following chapter dives into the literature, demonstrating the importance of such a study.

## CHAPTER 2: REVIEW OF THE LITERATURE

Posttraumatic stress (PTS) in emergency responders is exacerbated by multiple traumas, organizational betrayal, loss of supportive relationships, and maladaptive coping behaviors as presented in research on the First Responder Retreat (FRR). Significant others are impacted and often left out of the healing, recovery, and/or problem-solving equation, yet they have the proximity to make the biggest impact on emergency responders' lives (Kirschman, 2006). Healing and recovery of significant others and spouses through a unique, intensive 6-day residential treatment (retreat) program was the focus of this narrative inquiry. A unique, supportive nonprofit provides a 6-day, culturally responsive, intensive inpatient treatment for first responders and their significant others in separate "retreats." "Retreat" and "intensive" seem incompatible and these terms are explored further. There is evidence supporting the efficacy of the FRR, which has been replicated in other states to provide this needed, unique treatment for emergency responders. However, no studies have been done on the efficacy of the Spouses of Emergency Workers (SEW) Retreat. Evidence of the SEW Retreat efficacy could increase funding sources and support program replication across the country to provide treatment support for significant others and spouses of first responders.

The chapter begins with background on types of traumas and PTS, what contributes to it, and its impact on families and relationships. To best understand the common experiences of significant others and spouses of first responders, this review of literature explores treatments and the work of the supportive nonprofit. These themes are explored through the lens of the theory of change framework. This literature review demonstrates support for the study to learn



about participants' experiences at the 6-day retreat for significant others and spouses of first responders whose first responders were diagnosed with PTS.

### **PTS and Secondary Trauma**

Trauma not only affects the individual but also bleeds into relationships with loved ones and impacts their work environment. Although there are different types and causes of trauma, treatments are available. However, in a “macho” first responder culture where one is to show no weakness, treatment may not be sought at the onset, causing individuals and their loved ones to cope in ways that may be ineffective (Baxter, 2013; Beehr, 1995; Cathrall, 2004; Fay et al., 2006; Karaffa et al., 2015; Miller, 2007; Mormon et al., 2020; Porter & Henriksen, 2016; Regehr et al., 2005; Tuttle et al., 2018).

### **First Responders**

Whether working in law enforcement, fire service, dispatch, or emergency medical services, first responders experience occupational stress that often carries into their family lives (Alexander et al., 1996; Alrutz et al., 2020; Arrendando et al., 2002; Beehr et al., 1995; Karaffa et al., 2015; Landers et al., 2020; Miller, 2007; Mormon et al., 2020; Porter & Henriksen, 2016). Such stress can be due to shift work (Alrutz et al., 2020), long hours (Alexander et al., 1996; Porter & Henriksen, 2016), unpredictable hours (Miller, 2007), work environment (Friese, 2020), critical incidents (Alexander et al., 1996; Alrutz et al., 2020), traumatic events (Landers et al., 2020), and a “macho” work culture (Miller, 2007), among others. Ongoing trauma compounds and can lead to emotional exhaustion (Fay et al., 2006), which can exacerbate symptoms of PTS. Although many of these authors recommended department support for spouses and families, few departments provide such support (Alexander & Walker, 1996).

Isolation in emergency responder professions is common due to the desire to “not show weakness” by asking for help with PTS or emotional distress. The circle of friends tends to get smaller due to the need to keep trauma stories “close to the vest,” and family members rarely understand why your partner cannot tolerate social functions anymore, as trauma survivors have “limited psychic energy” for relationships (Matsakis, 2004). Survivor cognitive mindset includes some characteristics of White supremacy, such as “all-or-nothing thinking, perfectionism” as well as “denial of personal difficulties and continuation of survival tactics” (Matsakis, 2004, p. 22).

### **Significant Others and Spouses**

First responders and their families are at high risk for psychological challenges related to the impact of secondary trauma on these families because of the nature of police work (Baxter, 2013; Friese, 2020; Tuttle et al., 2018). Vicarious trauma is when someone is traumatized by learning a loved one “has experienced an emotional traumatic event” (Cathrall, 2004, p. 4), whereas secondary trauma is one who is “traumatized by *being exposed to the experience* [emphasis added]” (p. 4) of the traumatized individual. Studies about spouses and partners of first responders demonstrate the impact of these types of stress on marital relationships, family, quality of life, and work–life balance.

Conflicting emotions arise as the significant other or spouse of a first responder; not much in advance can prepare a partner for the challenges faced on the job. Alrutz et al. (2020) surveyed a convenience sample of over 600 spouses of first responders and discovered 20% experienced “intrusive symptoms” associated with traumatic stress. These symptoms include avoidance behaviors, hyperarousal, and intrusive thoughts about the trauma their emergency responder has experienced, which the authors said is consistent with other studies on secondary

traumatic stress. Partners of responders benefit in connecting with other spouses with the same experiences due to lack of understanding of family and friends not involved in lives of emergency responders (Alrutz et al., 2020). Karaffa et al. (2015) wrote in their exploratory study that spouses of first responders lack support from their departments but question if it would be used if provided. Porter and Henriksen (2016) interviewed first responder spouses to discover their lived experiences and uncovered themes of safety, stress, pride, civic mindedness, identity, and finances. Although there is much pride in one's spouse and their work, and a sense of community within their departments, the stress of safety, finances, and scheduling impact their daily lives (Porter & Henriksen, 2016). Regehr et al. (2005) confirmed feelings of pride, challenges in family life, and attempts to "read" the mood of their first responder, supported by Mastakis's (2004) work.

A phenomenological study by Landers et al. (2020) confirmed the impact of responder trauma on the spouse as "ripple effects" of intrusive thoughts, nausea, mood changes, worry, fear, and anxiety, all symptoms of secondary traumatic stress. From the spouse's perspective, specific types of traumatic events seemed to impact their responder the most (e.g., events involving children, suicide, and officer death; Landers et al., 2020). Mormon et al. (2020) discovered marital quality is a moderator of both job stress and quality of life. Tuttle et al. (2018) talked about how marriage is affected by the demands of the law enforcement career. Work on the job results in "spillover" of emotions at home, which can lead to "negative relationship functioning" between spouses (Tuttle, 2018). These studies provide context for this current research.

## Family Disruption

Lack of stability in the family due to shift work and responders' trauma responses impacts each family member, whether it is the spouse needing emotional support (Alexander & Walker, 1996) or the children wondering why their parent is unavailable (Karaffa et al., 2015; Miller, 2007; Porter & Henriksen, 2016). Family and friends who do not live with first responders have difficulty understanding the impact of shift work "on everyday life" (Alrutz et al., 2020; Porter & Henriksen, 2016), which causes some spouses to feel like single parents.

In a descriptive chapter titled "Trauma and Its Impact on Families," Matsakis (2004) identified common experiences of first responder families, including "walking on eggshells" or taking the temperature of the room before engaging with a loved one. Matsakis (2004) described suicidality as common in first responders and quoted a spouse:

I edit everything I say to him so as not to upset him. I don't want him going off on me or, worse, going into a slump because of something I said or did. He's threatened suicide a few times. If he does it, I know it won't be my fault. But I don't want to be the one who pushes him over the edge. (as cited in Cathrall, 2004, p. 18)

Matsakis (2004) noted, "More police officers die as a result of PTSD than in the line of duty" (p. 18), describing how a police officer deals with triggers:

I know I hurt my family by over-reacting or under-reacting, but if I stay away, that hurts them too. It hurts me to see their hurt. It also hurts to be so angry or numb inside that that their hurt doesn't touch me. (p. 20)

Porter and Henriksen (2016) described a spouse feeling they needed to provide emotional support for their first responder, to "read their mood," and "to know when he's had a bad day and

provide encouragement” (p. 48). Not only do the traumatic experiences harm the first responder, but their unpredictability also takes a toll on those with whom they live and interact.

## **Treatments**

Treatments for PTS focus on alleviating symptoms and providing support, but there is little available for the loved ones of first responders. Some departments offer an orientation for families of new officers or postcritical incident debriefing for spouses (Alexander & Walker, 1996), but this is not available in every department. Marriage counseling, family therapy (Miller, 2007), group support (Arrendando et al., 2002), and individual therapy can be helpful in addressing stressors, trauma, and coping behaviors (Beehr et al., 1995), but there is stigma associated in asking for help in the “macho” first responder culture (Alrutz et al., 2020; Karaffa & Koch, 2016; Miller, 2007). Porter and Henriksen (2016) identified trust as a major barrier in first responder couples seeking treatment with clinicians who may not understand decisions made because of being in the first responder culture. Arrendando et al. (2002) found support groups for first responder couples helped with coping skills of job and family stressors. The study by Landers et al. (2020) recommended support of spouses through groups of first responder spouses who can resonate with the challenges and problems these families face. These partners can provide validation of experiences, leading spouses to feel less alone and isolated in their experiences. The concept of group support and treatment is exemplified in the work of the supportive nonprofit, which provides FRR and SEW retreats for healing from PTS. Part of the treatment components include coping skills, both positive and negative.

### **Positive and Negative Coping**

An important retreat component includes highlighting ways to cope with one’s own triggers and reactions to trauma. In work by Beehr et al. (1995), both maladaptive (alcohol and

cynicism) and supportive (religiosity and meditation) coping mechanisms were employed by police officers and their families. The author noted, “Coping activities of one spouse are related to the coping activities of the other” (Beehr et al., 1995, p. 6). If spouses are a primary support of the first responder, perhaps the first responder might be swayed by the positive—and negative—coping of their spouse.

### **Codependency**

Sometimes a difficult term to understand, codependency is used to describe over-functioning for another person (Volunteer B, personal conversation, February 17, 2021) as one attempts to provide care. It is “excessive emotional or psychological reliance on a partner, typically one who requires support on account of an illness or addiction” (“Codependency,” 2019). Often, SEW participants first learn about codependency during the psychoeducation component of the retreat. For some, it validates and explains decades of behaviors; for others, it is a complete shock to the system. Significant others and spouses of first responders who identify as independent, capable, talented, organized, etc., do not relate to a term that appears to indicate their reliance on “doing for” someone else.

Codependent behavior develops as a coping mechanism for illness and addiction of loved ones. Although maladaptive and unhealthy, it is also a way to survive the stress and unpredictability of a situation. Behaviors such as rescuing, doing for others, controlling circumstances, and attempting to control the behavior of others are examples of codependency. However, Weiss (2019) proposed a model of “prodependence,” defined as a new paradigm viewing previously thought of codependent behavior as something developed by an individual during a relational crisis to stay connected to a struggling family member in crisis (e.g., addiction or mental illness). Although codependency is grounded in trauma theory, Weiss’s (2019)

“attachment and crisis-centric model could be more effective than codependency when working with loved ones” (p. 178). SEW participants are encouraged to understand that codependent behaviors are not something to be ashamed of—these behaviors were developed to cope with something outside of their control. Bringing awareness to these often-maladaptive coping mechanisms can help one learn to heal and change these behaviors.

### **Self-Care**

U.S. society is surrounded by advertisements for self-care: from external (skin care, hair color, mani-pedis, stretch-and-tone) to self-help (how to say “no,” how to say your “best yes”). Citizens of Color have embraced “radical self-care” as introduced by activist, Angela Davis, to sustain themselves so they may continue advocating for human rights (Afropunk, 2018). Sonja Renee Davis promoted radical self-love in “The Body is Not an Apology” (Taylor, 2020), making the point that we each live in human bodies that deserve our love and compassion, regardless of what those outside of us say. These pioneers encouraged taking a closer look at ourselves, to care for ourselves, to live for ourselves first so, if we choose, we can be better at being present for others.

External self-care feels frivolous and like a reward for good behavior. Internal self-care is essential to one’s health and well-being; it is not selfish. Beyond treating oneself to ice cream or bubble baths, self-care incorporates daily actions to ensure one’s health and is instrumental in healing from trauma. It includes acting with self-compassion, self-validation, and self-love, all of which are difficult to do if the “negative committee that meets in your head” (Clinician A, personal communication, September 2018) will not be quiet.

Shift work challenges sleep hygiene, yet sleep is foundational for health. Movement is essential as well to keep the body flexible and mobile. First responders find themselves in

alternate states of waiting (sitting) and fast moving (responding to crises). Significant others and spouses must put their own health first to support their loved ones. This is easier said than done but essential for emotional, mental, and physical survival.

Sometimes finances play a role in self-care. External, pricey self-care feels like a luxury. These financial concerns were supported by Porter and Henriksen's (2016) research, as first responder families are often supported by a single income, so family care can be conducted by the spouse at home, as unpredictable schedules make caring for family challenging. It is common for significant others and spouses to push their own needs aside for their family, but if they let their emotional, physical, or mental health suffer, they cannot be the glue that holds their family together.

The SEW Retreat incorporates exercise, meditation, spirituality, reflection, listening, and sharing throughout the 6 days. The design focuses on whole-body awareness and a launching point for healing. The peer support among clients, returning peers, volunteer clinicians, chaplain, and cooks demonstrates the need to share experiences as a form of caring for oneself. The support allows clients to let their guard down, open up, and accept help. Boundary setting as self-care is discussed and brainstormed—with whom do you need to set boundaries upon your return home?

### **Self-Compassion**

Learning about ways of coping that have unintentionally caused personal, relationship, and familial harm brings feelings of shame to the forefront. The greatest antidote to shame is self-compassion. It is seen as a protective factor against “negative consequences of self-judgement, isolation, and rumination (such as depression)” (Neff, 2003, p. 85). Breines and Chen (2012) recognized self-compassion to treat oneself with “warmth and understanding during



difficult times” (p. 1133) and knowing that, as humans, we will make mistakes. Although self-compassion is not articulated during the SEW Retreat, all manner of care and discussion focuses on awareness of and kindness toward oneself as we learn, grow, heal, transform, and change. Using the lens of change theory helped to support the current study.

### **Theory of Change**

In addition to the work of Weiss (1995), who promoted using theory to support programmatic evaluation, Gass (2011) used the wheel of change to support personal transformation. Gass highlighted the need to work in three areas to effect change: hearts and minds, behavior, and systems—not necessarily in order and sometimes all at once. Transformation requires individuals to change the way they think and feel as limiting mindsets prohibit change. Actions are dependent upon mindsets and change can only occur if individuals choose to behave differently, based on changed hearts and minds. Although there is little control over systems, Gass asserted once hearts and minds have shifted and actions have changed, individuals can better impact their external environment, albeit slightly. The more change that occurs in hearts, minds, and behaviors, the more collective effort can go toward breaking down the interlocking, systemic barriers prohibiting true transformation.

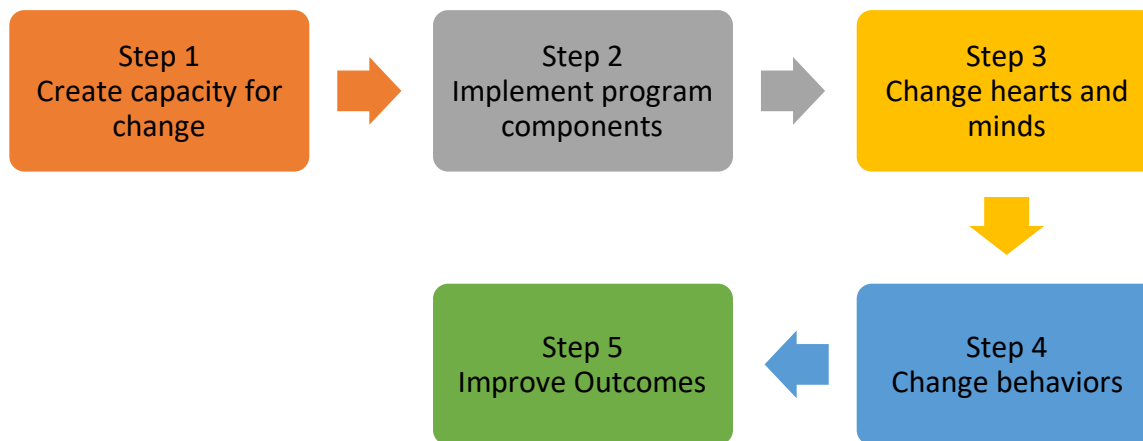
The framework for using theory of change is to identify the principle, the problem or issue, the focus of change, the strategies, and the anticipated changes (Almanzor, 2020; R. Almanzor, personal communication, March 19, 2021). This is a systematic approach to a “cumulative study of the links between activities, outcomes and contexts” (Judge & Bauld, 2001, p. 24) of a program. The theory of change describes the SEW Retreat well and may be used to demonstrate program efficacy.

## Applied Theory of Change

The purpose of the SEW Retreat “is to provide a safe and confidential environment for the promotion of healing, education, and support” (nonprofit website). The problem/issue is maladaptive coping behaviors and secondary traumatic stress associated with the PTS experienced by the first responder. The focus of transformation is on the individual, using strategies such as psychoeducation, group processing, individual therapy, eye movement desensitization reprocessing (EMDR), and a 90-day follow up/action plan. Decrease in symptoms are the anticipated changes. The wheel of change (Gass, 2011) can be used to highlight the transformation of hearts, minds, and behaviors over the 6-day retreat. Figure 2 articulates an initial change framework, adapted from the work of Judge and Bauld (2001).

**Figure 2**

### *Initial Change Framework*



## **Narrative Inquiry**

This narrative inquiry focused on participants' experiences of the SEW Retreat. Because of my personal experience at and with the SEW Retreat, the ability to share my story along with the stories of my participants was supported by the narrative inquiry research method. The shared context of being in relationship with a first responder is how our stories begin. However, throughout the retreat, we learn about and discover behavior patterns rooted in our childhood experiences. "Connecting the dots" across our lifetime is what the retreat is designed to do. This aligns with what Clandinin (2006) described as Dewey's "three dimensions of" narrative inquiry: (a) interactions between personal and social situations; (b) continuity along the past, present, and future; and (c) specific place or situation. Using narrative inquiry allows me to remain in relationship with my participants rather than bracket my experiences (i.e., as in phenomenological studies). The third dimension of narrative inquiry allows the retreat location to feature prominently in the study as well. The beauty and seclusion support the individual and collective healing during the retreat. Although the stories may not change the world (Clandinin, 2006), these experiences will bring to light the needs of those who support first responders and some ways SEW can be supported in their care.

As an insider researcher, I recognize the connection my participants and I have because of our shared experience of having participated in the retreat, though not at the same time or in the same way. However, there are themes flowing through the data. The method of narrative inquiry allows stories to be shared.

## **Conclusion**

The need for support for significant others and spouses of first responders is great. This study sought to bring awareness for the need of mental health support for the loved ones of

emergency responders and to decrease the stigma toward asking for help. You cannot heal that of which you are unaware. First responders are healthier when their support system is healthy. Communities benefit from healthy emergency responders and their families; healthy responders do more authentic work. My research supports the need for culturally competent clinicians and the need to replicate the SEW Retreat throughout the country. The SEW Retreat is a significant step toward personal healing, demonstrated by participant responses to interview questions and supported by self-assessment scores at the beginning and end of the 6-day residential treatment retreat. The following chapter explains how the study was conducted.

## CHAPTER 3: METHODOLOGY

The focus of this study was to learn about participants' experiences at the unique, 6-day residential treatment (retreat) for significant others and spouses of first responders, specifically of those first responders diagnosed with posttraumatic stress (PTS). Researchers have investigated the impact of short residential treatment for first responders with posttraumatic stress injury (PTSI), demonstrating the effectiveness of the First Responder Retreat (FRR) program; however, no studies have been conducted on the efficacy of the Spouses of Emergency Workers (SEW) Retreat. Evidence of SEW Retreat efficacy could increase funding sources and support program replication across the country to provide treatment support for significant others and spouses of first responders. Using narrative inquiry, the healing and recovery of significant others and spouses was conveyed via storytelling of direct personal experiences. To understand the phenomenon of participant experience, the following research questions were posed:

RQ1: What ways, if any, does the retreat promote personal transformation for participants?

RQ2: How does change theory contribute to participants' personal transformation?

RQ3: How do participants perceive the impact of personal transformation on their family and perhaps their community?

This chapter describes the approach of the study and how participant information was collected, synthesized, and protected. A description of the SEW Retreat is provided for increased understanding of the study context, along with a narrative of researcher positionality. Methodological steps are outlined and explained as they related to the inquiry and approach to the study.

## **Approach**

This narrative inquiry sought to understand the direct experiences of retreat participants and how they made meaning from those experiences. This qualitative approach sought deeper knowledge through semistructured, in-depth interviews to glean themes of participants' experiences. With participant permission, self-assessment scores were used to validate participant explanations. To maintain academic rigor, I engaged in member checking, peer debriefing, triangulating data, keeping fieldnotes, maintaining an audit trail, and reflective journaling.

## **Role of the Researcher**

As an insider researcher, I am the spouse of a medically retired law enforcement officer (LEO) who was diagnosed with PTSD and major depressive disorder with suicidal ideation. I am also a former client, having attended the SEW Retreat myself in 2018. Additionally, I have returned to the retreat as a volunteer peer seven times, serving as a first-time peer, an "inside" peer, and a retreat facilitator. Hosting post-retreat Zoom meetings during the COVID-19 global pandemic provided additional insight into the work former clients put in, along with the ongoing transformation of volunteer peers.

Through my own personal work and reflections on how I come to know what it is that I know, I discovered I hold an interpretivist philosophy and believe knowledge and meaning can be co-constructed. The subjective ontology I hold can be seen as limiting or "virtuous," as Peshkin described in his 1988 article on the topic, so I took care to check my research outside of my own perceptions, values, and biases.

As a compassionate listener who has continually learned to be a gentle disruptor, I have been called a "connector" by those who know me well. These characteristics served me well as I

sought to hear and connect stories of tender personal experiences. I identify as a cisgender, able-bodied, heterosexual, neurotypical, white, European American, upper-middle class, woman raised in the Christian religious tradition. I am a daughter, wife, and mother. I wrote this work from my hometown, located on the land of the Ohlone. Identifying areas of privilege allowed me to remain cognizant of biases that may come into play as I pursue my research.

A professional clinician and a board-certified music therapist since 1995, I was trained in verbal processing techniques, group facilitation, and clinical documentation. I have participated in continuing education to maintain recertification every 5 years. My music therapy work has largely been situated in inpatient psychiatric rehabilitation and with institutionalized older adults. These professional experiences supported my volunteer role at the SEW Retreat. I am a believer in “giving back” in gratitude for what I have been given by this organization, which also impacted how I approached this study.

### **My Outlook**

From the standpoint of significant privilege, the color of my skin and my position in society have insured my stability even when I have experienced oppression due to my gender. I recognize I held a position of power as the researcher, and I remained mindful of how participants may have been influenced by my privilege. As the spouse of a retired LEO, I have struggled mightily with social justice initiatives. I have also observed other retreat participants have struggled and was sensitive to a variety of opinions on this topic.

My culture has informed my outlook; as a white woman, I have often wrestled with whether I have a culture. But Tema Okun’s (n.d.) outline of White supremacy characteristics highlighted exactly the culture in which I was raised, including perfectionism, defensiveness, quantity over quality, there being only one right way, paternalism, either/or thinking, power

hoarding, fear of open conflict, individualism, the belief that I am the only one who can get things done, objectivity, and the right to comfort. This outline helped shake what I thought I knew about myself and have tried to deny for decades. Accepting my culture and aligned characteristics allowed me to move forward with an increased awareness about my privilege and the ways in which I can impact or effect societal change. I also recognized my study participants may not have been open to this outlook, and was sensitive to this potential difference.

I believe each person has agency and is born with value, and each person has the power to effect change; moreover, the power of the collective is great. I believe in individual truths and multiple realities and perspectives varying over time. I believe humans can co-create meaning. I believe in the power of storytelling to effect change. I believe individuals can turn to community for support and receive it. I believe in integrity, curiosity, and respect. In this study, I strove to be vulnerable, authentic, and responsible.

### **My Research**

I am organized, responsible, loyal, and have significant power because of my leadership and work experiences. My experiences as a leader; business owner; clinical trainer; educator; aspiring ally working toward antiracist and anti-oppressive practices; student; and as the spouse and sister-in-law of retired LEOs, aunt of a former LEO, and aunt of a paramedic have provided a foundation of knowledge to support my research interests and make me an insider researcher. After experiencing secondary and vicarious trauma because of the work of my family members, I was curious how significant others and spouses are supported to heal from their own traumatic experiences, which tend to be activated because of their loved one's job as a first responder. Specifically, how did the SEW Retreat impact their healing process? What draws individuals to

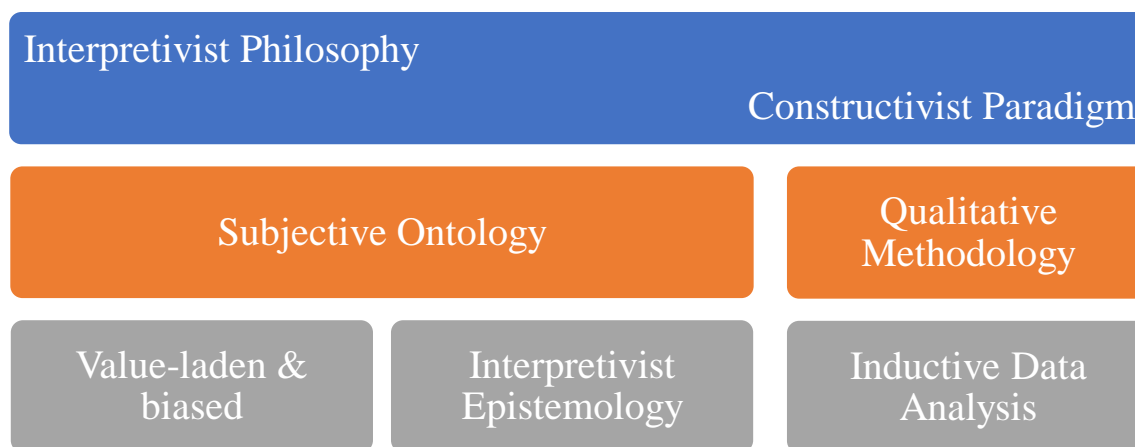


return as volunteers to the retreat, and how can the retreat organization broaden the support received in these client groups to be more accessible to those who need the support?

Research has been a barrier for me throughout my professional career—a necessary evil through which to push. My experiences with and about research prior to this study had often reflected an objectivist view, which never resonated with who I am. In the Transformative Action in Education program, I learned that my experiences, beliefs, and viewpoints are indeed valuable and valued in the research process, that I am deserving of care and compassion, and that what I bring to the table is worthy. Figure 3 illustrates my role as the researcher.

**Figure 3**

*Role of the Researcher*



A therapist myself, I value therapeutic interventions. I participated in SEW retreats as a client and a peer volunteer and personally experienced the healing benefits of the program. As one who needed this treatment and found it effective, I acknowledged bias toward positive evidence of this program. Through journaling and using a writing partner, I checked my biases

and reported them as limitations in my research. My belief in this program, desire to see it continue to be funded, and hope for replication motivated me to persevere in the research.

### **Methodology**

A researcher's methodology is comprised of one's ways of being (ontology), ways of knowing (epistemology), and personal values (axiology). It is as important to understand the role of the researcher as it is to understand the study purpose, as both informed the study design.

### **Study Design**

A qualitative research design using narrative inquiry was employed to explore participants' experiences of the SEW Retreat by using semistructured, in-depth peer interviews. For validation, and with participants' permission, their self-assessment scores pre- and post-retreat (as measured by the organization-specific repeated design measure, the Symptom Assessment-Spouses of Emergency Workers [SA-SEW pseudonym] and the Trauma Symptom Inventory, 2nd Edition [TSI-2], depending upon the timing of retreat attendance) were reviewed and compared to their interview transcripts.

### **Design Purpose**

Narrative inquiry is a storytelling method of research that allows the researcher to share personal experiences of study participants in their own words while also including the story of the researcher (Clandinin, 2006; Creswell, 2009; Hatch, 2002). Data can be triangulated by documenting the researcher experience while hearing participant stories and using a researcher journal to document personal feelings. As people share their stories, they learn more about themselves and about each other. The SEW Retreat experience is focused on personal story telling, whether those stories comprise the experience with their first responder and their job, or their childhood experiences. The more stories we as retreat participants share, the more we

realize we are not alone in our experiences. The peace that comes from the shared experiences is significant.

In this qualitative method, one-on-one interviews with participants provided the opportunity to share their retreat experiences and stories using a few general questions and some follow-up questions during the 60-minute recorded videoconference interviews. Comparison of their self-assessment scores (via either TSI-2 or SA-SEW) supported participants' retreat experiences, and the research journal helped triangulate the data. The phenomenon of participant retreat experiences was best discovered and interpreted by themes that emerged from the semistructured, in-depth interviews. The interview process provided participants the opportunity to share their experiences, which were validated by referencing the scores on their TSI-2 or SA-SEW at the start and conclusion of the retreat.

### **Methods**

After approval by the Institutional Review Board (IRB), participants were solicited via email invitation using the nonprofit's list of past SEW Retreat participants, with approval by the executive director of the nonprofit. This study used a convenience sample of willing volunteers. One-on-one interviews were held via recorded video conference (e.g., Zoom) with participant consent. The interview protocol had four basic questions and room for follow-up questions, and spanned up to 60 minutes in duration. Recordings were transcribed and shared with participants for accuracy and member checked for rigor, and the transcriptions were coded and assessed for common themes. Additionally, with participant permission, pre- and post-retreat scores from the TSI-2 or SA-SEW measures were used to support participants' experiences. Participants were asked to complete a demographic survey, which was used to describe the participant sample.

Participant data were stored in a password-protected “cloud,” accessible solely by me. Recordings, transcripts, and other participant-related data were destroyed after the completion of the study. Participants were asked to choose pseudonyms with which to be referenced in discussion of the study outcomes.

### **Participants**

A convenience sample was used for this study. Those eligible for the study included past participants of SEW retreats, whether as clients or as volunteer peers, whose first responders were diagnosed with PTS. Participants were solicited by the SEW Retreat coordinator via the nonprofit’s list of SEW participants who opted into such communications. As of the date of participant solicitation, 38 SEW Retreats had been provided by the supportive nonprofit since 2004. With approximately six clients per retreat, the population size could be as large as 228 significant others and spouses; however, only 150 people opted into receiving SEW Retreat communication. Even though snowball sampling was proposed as a recruiting tactic if needed, 11 individuals indicated their interest, which was more than the number of total participants permitted for this study.

Not everyone was eligible to participate in this study—only those whose first responder spouses or partners were diagnosed with PTS. From those prospective participants who responded to the initial invitation by completing the participant interest survey, nine were eligible and provided their email addresses to be emailed the participant consent form (see Appendix B). Eight eligible participants were subsequently contacted via email to set up an interview appointment in the order in which they responded. These individuals were also asked to complete a demographic survey (see Appendix C). Eight individuals participated in a 60-minute interview, although no participant needed the full hour to complete the interview.

Participants were asked for their permission to access their self-assessment scores pre- and post-retreat from the nonprofit; participants had the opportunity to review these scores if they wished. Interview transcripts and copies of their self-assessment scores were destroyed at the conclusion of the study.

The criteria for participation included those who had attended any of the past SEW Retreats, and whose first responders were diagnosed with PTSD. There were no criteria for age, gender, race/ethnicity, nor type of employment of the first responders. Participants needed access to technology that supported video conferencing along with the ability to hear the interviewer clearly and speak clearly for the duration of the recording. Interested study participants completed an online survey to determine eligibility (see Appendix A).

Participation was voluntary; participants were free to withdraw at any time and without giving a reason. Participant responses were anonymized, and their participation remained confidential. Individuals each chose a pseudonym for use in study references. Although participation in this study posed minimal risks, it is possible individuals could have experienced discomfort in sharing their experiences. To mitigate this risk, participants did not need to share anything they did not wish to share. No compensation was provided for participating.

### **Description of Participants**

The participant sample was homogenous. All eight participants self-identified as White women, with five in the 35–44 age range, two in the 45–54 age range, and one in the 65+ age range. Most participants resided in the western region of the United States, with one participating from the midwestern region. All participants were married, and three had been married to their first responder prior to them taking a first responder job. Five of the eight participants were fire wives. Most (seven) had been in committed relationships with their first

responder for over 20 years. An interesting averaging of number of years married and number of years as a first responder yielded very similar average numbers of years, at 23.5 and 22.9, respectively. Six of the eight participants' first responders were medically retired because of PTS.

### **Interview Process**

Participants were eager to share their stories and responded quickly to the call for interview appointments after receiving the consent form. Because the interview questions were direct, participants were able to share their experiences directly. None of the participants took the full hour of allotted interview time; thus, there was ample time for each participant to share additional information outside of direct and follow-up questions.

### **Data Collection**

After obtaining participant consent, interviews were held at a mutually agreed time for 60 minutes via Zoom. Verbal assent for interview recording was confirmed for each participant prior to beginning their respective interviews. To compare self-assessment scores with interviewees' responses, verbal assent to access their personal test scores was received. Participants interested in reviewing their self-assessment scores were given the opportunity to do so. Any copies of self-assessment scores were destroyed after the conclusion of the study. Four interview questions (see Appendix D) were asked to glean answers to the research questions. Questions about retreat experiences that elicited story telling were asked with follow-up questions as needed to gain more in-depth information.

Additional information was gleaned from past SEW Retreat agendas, slide decks from psychoeducation presentations (provided by the SEW Retreat coordinator), retreat handouts, my

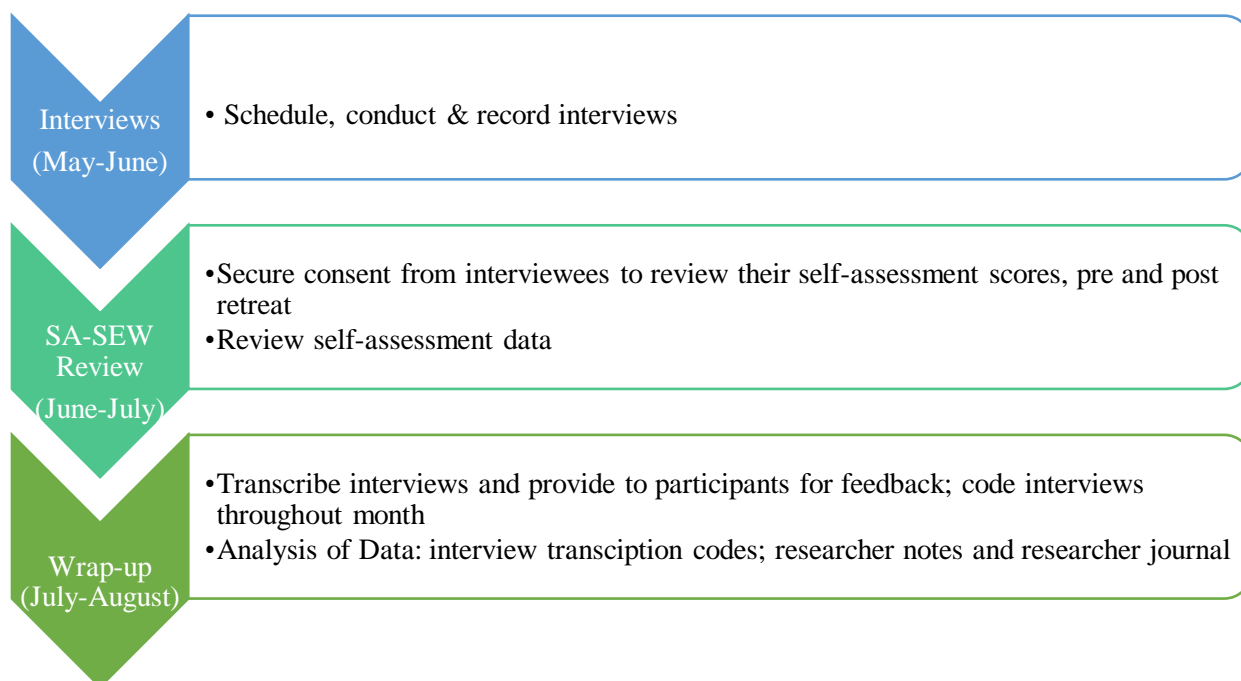
own SEW Retreat notebook and personal journal entries from when I was a client, along with the nonprofit organization website with information about the retreat.

### **Data Analysis Procedure**

With participant permission, interviews were recorded. After they were transcribed, each transcription was shared with the respective interviewee for member-checking accuracy and follow-up clarification. Using inductive analysis methods, I moved from specific data to categories, themes, and patterns. Transcriptions were coded and themes documented. The story structure yielded analysis topics using narrative inquiry (Bhattacharya, 2017).

Coding interviews and looking for emergent themes helped to answer RQ1, “What ways, if any, does the retreat promote personal transformation for participants?” and RQ3, “How do participants perceive the impact their personal transformation has on their family and perhaps the community?” Comparing self-assessment scores and reviewing retreat agendas helped to answer RQ2, “How does change theory contribute to participants’ personal transformation?”

Throughout the process, I kept notes and a journal, which were also reviewed for themes. Phases of data collection and analysis are illustrated in Figure 4. Previous SEW Retreat agendas, along with the slide decks of psychoeducation presentations and corresponding handouts, were reviewed for supportive information. I also reviewed my own SEW client notes.

**Figure 4***Phases of Data Collection and Analysis*

Self-assessment scores pre- and post-retreat were used to support participant interview responses and are included in Chapter 4. The self-assessment measured past experiences and PTS symptoms, some but not all of which may have been altered by SEW Retreat experiences.

#### **Trustworthiness of Data**

Techniques for rigor in qualitative research include triangulation of data, data saturation, audit trail, member checking, peer validation, and researcher self-reflection and journaling throughout the research process (Bhattacharya, 2017; Hernandez, 2020). Because of my belief in interpretive constructivism, engaging in a qualitative study using narrative inquiry aligned with my ways of knowing and being, and with my values. Aligning a study design with one's epistemology, ontology, and axiology is an appropriate way to demonstrate academic rigor



(Bhattacharya, 2017). Recognizing how my biases informed the study served as another demonstration of rigor, as was “acknowledging and documenting the iterative nature” (Bhattacharya, 2017, p. 23) of data collection and analysis. Bhattacharya (2017) illustrated the basic structure of an iterative approach to qualitative research as an oval surrounding shifting epistemologies that informs the phases of purpose, questions, methodology, methods, analysis, and re-presentation.

Interviewees were invited to check their transcript for accuracy and provide reflective feedback to ascertain if their answers were interpreted as intended (i.e., a method of member-checking). Participants also reviewed their narratives prior to inclusion in Chapter 4. Additional rigor was established by reviewing organization documents for themes and supportive information. Between triangulation of data and data saturation, I used an organizational system to audit my data. Peer review of data and personal journaling supported the rigor of the process and the trustworthiness of the data. Moreover, referencing participants’ self-assessment scores supported credibility of what was shared during the interviews. Narrative inquiry allowed “multiple points of entry into the research” using “rich contextual details” (Bhattacharya, 2017, p. 24) that also support academic rigor.

### **Ethical Considerations**

I imagined this study as a treasure chest; I recognized I may not reach the bottom of the chest, but I expected pearls of wisdom and jewels of experience to emerge. All data in this study were collected anonymously and deidentified. Those who engaged in the interview process had their anonymity protected by choosing a pseudonym, with the theme of precious gemstones (such as those found in a treasure chest: Amber, Amethyst, Fluorite, Jade, Opal, Pearl, Peridot, and Sapphire). Although participant data were kept confidential, it is possible participants may

come to know each other over time because of the relatively small pool of possible participants, and they may not be able to hold confidentiality among themselves. Participants were asked to hold confidential how others engaged; however, they may have shared the content of productive conversations with others, as helpful, to effect change in others with similar challenges or experiences.

### **Limitations**

Although these data provided additional insight into the needs and resilience of significant others and spouses of first responders whose first responders have been diagnosed with PTSD, details emerged from a limited number of individuals with homogenous backgrounds and experiences. Additionally, first-hand accounts may have impacted the way participants engaged in the study. Participants' willingness to participate may have also been a limitation in the study due to potential experiences of participants biased toward the positive. Volunteer participants may have been highly motivated to share their experiences and understandings of their retreat experiences. Because of participant bias, it is not possible to know to what extent participants were truthful (or fully truthful), as they may have told me what they thought I would like to hear. I also remained mindful of my personal assumptions about shared retreat experiences, and I attempted to stay clear about where their story ended and mine began.

Whether working full time, part time, at home, in school, or retired, participants may have had varied levels of privilege allowing them to engage in this research—which may have limited the number of overall participants in this study. Participation and level of engagement was dependent on participant availability, as some experienced life events pulling them away.

Finally, this study comprised a small, specific group of people; thus, the findings may not be generalizable to larger numbers.

### **Chapter Summary**

The focus of this study was to learn about participants' experiences at the unique, 6-day retreat for significant others and spouses of first responders, specifically of those first responders diagnosed with PTS. Eight individuals took part in one-on-one, semistructured interviews. No gender, age, or race and ethnicity requirements were required to participate; the common denominator was the participants' experience with secondary and/or vicarious trauma because of their relationship with their first responders. Interview transcripts were analyzed and reviewed by the interviewees for member-checking purposes, and I maintained reflective journaling. Data were coded, and themes and patterns were identified. Narrative inquiry was used to share participants' stories of their retreat experiences. Although generalizability may be limited due to the number of participants, study results could support replication of additional SEW Retreats around the country, which could reduce the number of those on the waitlist and provide more services to those in need.

## CHAPTER 4: FINDINGS

The Spouses of Emergency Workers (SEW) Retreat grew organically out of the need to support the partners of first responders through trial, error, and research. Traumatic experiences and childhood experiences magnified the behaviors spouses used with their first responders diagnosed with posttraumatic stress (PTS). Although there are other support groups and day treatments for individuals with posttraumatic stress injury (PTSI), books to reference, and scant departmental supports, SEW remains the only one of its kind: a 24-hour, residential treatment (retreat) program for spouses and significant others of first responders provided for 6 consecutive days. What an honor it was to bear witness to the stories of grief, trauma, angst, perseverance, and hope.

### **Introduction**

Families' lives are impacted by the "calling" of their first responders, as the families do not choose the job, but the job becomes an identity nonetheless. The job becomes all-consuming; the values of the first responder (especially those in law enforcement) change after becoming a first responder. In the case of a law enforcement officer (LEO), they must enforce laws they did not create.

As described in Chapter 1, this study sought to understand client experiences of the SEW Retreat. This chapter identifies findings from this study and addresses each of the research questions presented in Chapter 1. In addition to participant interviews, retreat agendas are reviewed, and repeated design measures that participants completed at the beginning and end of their retreat are presented to support their narratives. Common themes and patterns are shared, and challenges are identified.

## **Themes**

Multiple reviews of (a) participant transcripts, (b) participants' pre- and post-retreat self-report scores, (c) comparisons with retreat agendas, (d) my own retreat notes and journal entries from during my retreat, and (e) the notes I kept throughout the data collection process were used to identify emergent themes from the data. It was apparent the SEW Retreat was designed for change and built community among participants. Personal transformation was also identified, as were organizational discoveries.

Narratives are provided throughout this chapter that support or describe the findings. The description of each theme helps explain the categories identified in examples of codes pulled directly from participants' experiences.

## **Research Questions**

Using research questions as a guide for data analysis, the following inquiries guided my research:

RQ1: What ways, if any, does the retreat promote personal transformation for participants?

RQ2: How does change theory contribute to participants' personal transformation?

RQ3: How do participants perceive the impact of personal transformation on their family and perhaps their community?

The following narrative was written with feedback from study participants who provided additional details about the retreat location to ensure a full description of the property.

### ***Healing Locale***

Imagine . . . no cooking, no cleaning, no demanding family members, no work meetings. Just solace. Among the trees. With meals provided. Walks among nature. Taking time for yourself. Because you are worth it. The SEW Retreat location is an integral part of the

treatment experience. The retreat is located in a secluded, rural setting atop a small mountain along a private road. Participants engage in daily walks past vineyards, by a small lake to one direction, brambles of blackberries to the other. Mornings are brisk regardless of the season; evening walkers are rewarded by the sun setting behind the vineyards and tall trees.

The retreat program is provided in a large home, originally a home for male youth. The bedrooms are large; one room sleeps up to seven people. The three-story house has a detached two-story building called the annex. The annex has been converted to include six treatment rooms, a community space, and an accessible toilet downstairs. Staff provide 1:1 sessions in the private rooms, and then meet around the large dining room table. The upstairs of the annex has a large community room, a half bathroom, and a chaplain's room at the back. This large space houses the daily group processing and optional morning chapel (during the COVID-19 global pandemic, chapel was held on the back deck after breakfast, weather permitting). Participants fondly referred to the upstairs of the annex as the “rubber room.” Some call it this because shared stories bounce off the walls. Others call the large community room the “vomitorium” because this area is where participants spill dark secrets (and in a few cases, actual emesis, as the body rids itself of long-held demons from the past). The rubber room is a sacred place, comprising a circle of couches and chairs with a bright carpet, large windows with a gorgeous view. The daily group processing can be scary at first, especially as a client who has no idea what might happen. As a volunteer, I see the rubber room as a healing space, a receptacle for purging, letting go, and supporting healing among cushy couches, pillows, chairs, and handmade quilts.

The house is welcoming. There are scenic photographs, portraits of firefighters, police officers, works of art, words of encouragement, individual stories, and collections of badges

from various agencies who have had individuals come through for healing. These pieces can be reminders of home, and help participants recall what they learned when they go home.

The front entrance opens to a large, sunken room on the main floor, halved by furniture to create the dining and presentation space, and a sunken conversation seating area with a couch and many chairs known as the “pit.” Two steps down from the entrance to the left is the library, a small office that houses the peer willing to get up in the middle of the night if a client need arises. There are four round tables near the large screen TV mounted above the fireplace mantel. Each table has approximately six chairs. There is a desk with a computer used to present various psychoeducation components. Across the room is “the pit,” where retreat participants gather in the evening and where peers gather while the clients are in the rubber room. A sideboard holds snacks on top and houses creative supplies and over-the-counter medications in drawers as needs arise. There is a two-story window that looks out onto the deck and the tall trees behind it. We joke it is shaped like Darth Vader’s helmet. Looking up from the pit, one can see the railing of the top floor. Across from the window is a half bath, easily accessible if needed during presentations. Opposite the front door is a door leading out to refinished, wraparound deck. There are two large tables and lots of outdoor seating for meals, chapel, breaks, or general congregating among birds and trees.

The industrial kitchen, located off the pit, is a favorite place among clients to visit with the friendly cooks, help themselves to coffee, enjoy soft drinks, eat fresh fruit, and make any dietary requests they have. The dishwashing station in the back, with its own bathroom, was “home” to a nearly 7-foot-tall volunteer, a former police officer who was the retreat dishwasher for many years until his recent passing. He was always good for a story, a laugh, and a friendly,

listening ear. He was also the first one to cry at any retreat as he shared his story. The oldest adult in the room, he provided comfort, humor, and support.

The lower floor has five sleeping rooms, most with two beds each. The room at the end of the hall can comfortably hold up to four beds. There is a staff work room, two bathrooms, washer, and dryer. Client records are housed in a large, locked closet next to the office.

To the left at the top of the stairs on the top floor is the largest of the bedrooms, dubbed the “client” room, which can hold up to seven beds. A large slider door leads out to a balcony. Beyond that room is a larger bathroom area with two private toilets, two communal sinks, and a large lighted mirror over plenty of counterspace. Around the corner are two private showers. To the right at the top of the stairs is a railing that looks down into the pit and extends down the hallway with three bedrooms and a full bathroom. Before the COVID-19 global pandemic, the house was filled with as many volunteers as could sleep there; however, operations during the pandemic allowed for client services to continue by limiting the number of volunteers who could attend the retreat.

Behind the annex is a sacred outdoor space for the memorial bricks and rock pile. Memorial bricks are created by clients who spend retreat time working through the grief of a loved one: an officer shot in the line of duty, a firefighter suicide, the death of a child. The rock pile is a foot deep in the ground and was moved to this location from the previous retreat location. The rocks symbolize clients’ desires to let go because of what they processed during the retreat. Each time I return to the retreat location, the pile of rocks has grown, visibly signifying what was too heavy to carry and was no longer serving—what was let go.



### **A Retreat Designed for Change**

The previous narrative describes the setting of the retreats held for both the first responders and spouses. The retreat setting itself is conducive to personal change. Amethyst, a research participant, said, “Little things in the house help you remember your time, where you have been, and your goals of where you are going.” She shared a photo she took of a framed quote by a previous client on a wall in one of the common areas which says, “PTSD was my cancer and [the retreat] was the chemo . . . the things I learned will be the cancer drugs I will use to combat the cancer. – 2010 Client.”

Living in community with others for 24 hours a day for 6 days prevents self-isolation. Amethyst went on, “There is always someone to hang out and communicate with . . . someone to take turns to stay up late with you or get up early with you.” Community is built through shared experiences via storytelling, and in the daily routine of walks, presentations, group processing, and meals; this routine is the therapeutic milieu.

Morning check-ins follow the same prompt each day, using the acronym “MISTS” for memories, insights, symptoms/behavior changes, triggers, sleep/dreams. These prompts are helpful to help the speaker focus and provide guidance. Listening to check-ins also allows the staff and participants to learn more about clients’ progress throughout the week, provide redirection, foster encouragement, and challenge negative thinking. Figure 5 shows an example of the daily retreat agenda and is color-coded based on type of retreat strategy: (a) blue for psychoeducation presentations, (b) gold for group processing, and (c) green for community mealtimes.

**Figure 5***Retreat Agenda Example*

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
	Morning walk Chapel (Optional)	Morning walk Chapel (Optional)	Morning walk Chapel (Optional)	Morning walk Chapel (Optional)	
	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
	MISTS Check in	MISTS Check in	MISTS Check in	MISTS Check in	MISTS
	Psychoeducation Presentations: Emergency Responder Exhaustion Syndrome & Spousal Exhaustion Syndrome	Video: R. Chung “Domestic Violence” Psychoeducation Presentations: Intimate Partner Violence Codependency	Letter to First Responders Psychoeducation Presentations: Stinking Thinking Video: “Still Face Baby” Impact of Previous Relationships	Group Process, Phase 4: “What do you want to do next, and what might get in the way?”	Separate Debriefing (Clients/ Peers) Clients take SAFER SOS v. B & Post Traumatic Growth Inventory
	Lunch	Lunch	Lunch	Lunch	Graduation
SAFER SOS v. B Administered	Group Walk	Group Process: Complete Phase 1	Group Process, Phase 3: “Because of that relationship...	Psychoeducation Presentations: Coping Video: Exercise	
Welcome & Introductions	Life History Questionnaire	Phase 2: “What do you think in your childhood or past has set you up for this?”	Continued: I believed that I...; I continue to feel like I...;	What to Aim for in Relationships	
EMDR Resourcing Client to Client Interviews	Video: B. Brown “Power of Vulnerability”	Group walk, yoga, or any catch-up on presentations	Continued: I am afraid that I...”	EMDR	
Dinner	Dinner	Dinner	Dinner	Dinner	
Client to Client Introductions Sleep Hygiene Guided Imagery	Group Process, Phase 1: What brought you here? OR “What is most important?”	Al-Anon Meeting Group Process: Complete Phase 2	(Possible AA Meeting) Video: “Stumbling Stage” Psychoeducation Presentation: Forgiveness/ Letting Go of a Grudge	90-Day Plans & Safety Plans (Video Night or Creative Arts Activity)	

Psychoeducation presentations include information on emergency responder exhaustion syndrome (ERES) and the complimentary spousal exhaustion syndrome; cognitive distortions (“Stinking Thinking”); codependency; and ways to care for oneself whether via coping strategies, exercise, or relationship and communication tips. These presentations are among the evergreen topics necessary to promote changes of heart, mind, and behavior.

The retreat employs a figure of a donut to illustrate what is within and outside of one’s sphere of influence. Inside one’s “donut” are those factors over which an individual has control, including their own thoughts, emotions, and behaviors. Those inside one’s sphere of influence are thoughts, feelings, and behaviors of family and friends. An individual’s behavior may influence those close to them. Conversely, those things outside of one’s sphere of influence are the media, politics, and law; over these elements, one has no control.

Representing personal evolution is the image of a nautilus as a metaphor for growth and transformation. The retreat promotes learning and growth as participants make new discoveries about themselves. As clients move forward creating new habits, their old ways no longer serve them, and this new awareness is a bell one cannot un-ring. Clients must accept their new awareness and reimagine behaviors.

### ***Pearl’s Perspective***

One retreat participant, Pearl, talked about her personal evolution because of her experience at the retreat. She noted:

My husband and I were having some problems with our marriage when I first attended the retreat. Being among peers and other clients who were in the same type of situations was the most impactful part of the retreat. I learned about codependency for the first time. I honestly didn’t understand what it was, let alone able to apply it to my own

situation, so that was probably the biggest tool I took away from the retreat. Because of the retreat, I learned how to identify my own issues. The retreat really started the ball rolling. I was able to look at myself instead of pointing to others as the problem or issue, to see myself as part of the bigger problem. This was really difficult. That it wasn't only my husband's PTSD but also my own issues—like together, we're part of the problem.

Going back as a first-time peer, both my husband and I had attended our retreats and we now had a similar language with which to talk about our issues. And we were both doing our own work. We communicated better because of sharing the same retreat language experience.

In terms of pushback, it was more difficult to make changes after going to my own retreat, than after returning as a peer. I was better able to determine what boundaries I needed to put in place for me and letting go of what I couldn't control. After my retreat, I wasn't really able to do that.

Support from couple's counseling, my husband, and some of my coworkers has been helpful. I have sought support from other spouses through a local group. In fact, I've tried to create a Zoom group, like what the retreat does. It just hasn't gone over here very well. I attribute that to being out in the middle of the country, where everyone is of Scandinavian and German descent: We just don't talk about our feelings out here! I don't know if that's true or not, but I guess that's my perception. So, it's been difficult to find a formal support structure, so I've had more informal support. Being with other first responder spouses makes a difference. Just knowing that there are people who have the same struggles I do and know what it's like to have the husband work weird hours. And you are trying to do work, get the kids where they have to go, and put it all together.

Then, get up and do it all over again tomorrow. Just knowing there's other people out there, and we can actually talk about it. It doesn't have to be difficult, and I don't feel like I'm judged. Because those other people have essentially the same type of life I do.

I am really grateful for opportunities to both go out there and be a client and return as a peer. Both times in my life were when I knew I needed help. But I'm very proud and it's difficult for me to ask for help. I'm so used to "Fake it til you make it" until I'm ready to crack. Then I'm scrambling and asking for help. I'm trying to learn how to reach out for help sooner. It's difficult. I think a lot of that has to do with the way I was raised. I still hear my mother's voice in my head and I'm trying not to hear her criticism of "Don't do that. Why are you doing that? Do it this way." I'm learning to not listen to those. I don't have to do what my mother's voice in my head is telling me to do.

When I went to the retreat as a client, it was a nice refresher of what I learned over the years in my career as a first responder and trying to help others learn skills they don't have, or never had. But when I returned as a peer, I realized that I needed to apply what I was learning to MY [emphasis added] life, more so than trying to help other people. I can certainly help other people, I have those gifts and talents, but I need to be able to help myself first before I reach out to help them. Like putting on your own oxygen mask first before you assist others.

Pearl's perspective articulated not only the need for change, but how her own thoughts changed because of what she learned at the retreat. When women are told to push aside and push down their feelings in marriages to men employed by a "macho" first responder culture that shames them for any emotional expression aside from acceptable and often impressive displays of anger,

the result is an unhappy and miserable partnership for which neither party signed up. Pearl was not the only participant who identified how the retreat supported her ongoing process and helped her recognize over what she has control. She also expressed gratitude for being surrounded by community of women with similar struggles.

### **Creating Community**

A unanimous theme from participants was that the SEW Retreat helped them find their people. A seasoned volunteer clinician liked to say the “big secret” about this retreat is the organization is “building community.” As such, clients experience less isolation in their struggles. Building relationships and normalizing experiences had the greatest impact on participants.

### **Normalizing Experiences**

Participants cited experiences such as finding their people, “meeting others with similar experiences,” and “being among others.” One participant said it was helpful “to see that [she] wasn’t the only one going through it,” and another participant described the benefit of “being with other people who had gone through the same thing.” Participants overwhelmingly described how impactful it was to be surrounded by those with whom they did not have to explain themselves. They identified similar experiences of keeping their first responders’ health a secret, feeling loneliness, experiencing isolation, and holding everything together for everyone. Sharing their experiences helped normalize their experiences and lessen feelings of fear, loneliness, and isolation (Phoenix, 2007; Whitworth, 2016).

Ongoing peer support via Zoom was instituted from 2020–2022 to check on clients for COVID-19 symptoms post-retreat because of the COVID-19 global pandemic, but 1:1 peer support existed beyond and up to 90 days via phone, text, or sometimes in-person visits (if

distance and pandemic protocols allowed). However, the clients must do the follow-up work. Volunteer peers are instructed by SEW Retreat staff not to “work harder than the client does,” which might mitigate peer codependency. SEW Retreat personnel recommend clients to return as peers if they do the work and can demonstrate such. One participant in this study, Fluorite, provided a great testimony as a returning peer. She saw a dramatic decrease in her somatic symptoms after attending the retreat for the first time and has remained a regular at retreats, serving in significant capacities as a volunteer peer.

### ***Fluorite’s Findings***

According to Fluorite:

My husband had attended the retreat for first responders and his therapist told him that I needed help for my stress and throwing up. I would throw up every day, or dry heave, due to stress. A significant behavior change for me in the first 6 months of the retreat was not throwing up every day anymore. I thought it was from nerves—not knowing what was going to happen with my husband’s PTSD symptoms and thinking it might get worse. I go back so regularly because I want others who feel as bad as I felt to have an opportunity to get better and see what that looks like. I go back for selfish reasons because I get a “tune up” every time I go back. It’s like 6 months of therapy in 6 days.

The most impactful part of the retreat is being with others who had gone through the same thing. My client table was the same or somewhat the same in their experiences with their first responder. It’s the almost immediate, collective understanding and validation of your own experiences. As a peer, the best part is witnessing the changes in the clients—on the last day of the retreat when they are so happy, or the next-to-last day

when they kind of got it. They have a better understanding of themselves, in addition to insight about their first responder and their relationship.

The biggest tool I learned at the retreat is the idea of being “good enough.” This was a huge insight that has stayed with me. I didn’t even know that was an option in life! The idea that I didn’t have to be perfect was shocking!

The retreat helped me have a better understanding of what the problem was in my marriage. My picture was too narrow, and I had a fuller picture of the problem when I left the retreat. The retreat opened my eyes to what I could actually control. Which turned out to be nothing. Or at least, that I can’t control what others do, but I can work on myself. I found I had more peace because I didn’t have to control everything. I could step back and look at an issue. Before the retreat, I couldn’t even look at what the problem was. In the 1st year after the retreat, I didn’t cry as much, and I was more open to telling a few people what was going on. A very few, but a few. I also embraced my “used to’s,” things I previously enjoyed but had neglected because of the need to control for so many out-of-control variables related to my husband’s PTSD. I began gardening again, flower arranging, cooking, painting. I didn’t have any pushback related to changes I was making. My husband was doing his work, too. I noticed our relationship dynamics had changed. My husband never used to get mad at me, he stuffed it all. This made life pretty easy, but now he fights back a little, which was hard in the beginning. When he would get angry before, it would mean we were going off the railroad track. But now, he gets angry and lets it out just like I do. Even though we’ve been working on our relationship for a few years, I still get thrown by his anger; it brings up old anxieties and feelings.



In terms of support, I stayed close with my client group and returned to the retreat as a peer as soon as I could. They were my support group. I don't have family support and I still don't really want to confide in my best friend. I felt support from my husband, too, we had support from each other as we were both doing our work. Outside of the retreat community, I have limited support. Because my husband is retired, there were no departmental supports, we don't have contact with anyone in the department. There were certainly not supports for me as a spouse. It took me 2 years after having been to the retreat to return to therapy. But I feel like it helped a lot. Even now, returning to the retreats will bring up things I had forgotten about, and therapy helps me work through more things. I have had insight looking at my family of origin and my childhood. I am amazed at how my childhood experiences have impacted my entire life.

### **Peer Support**

Resonating with my research participants, the retreat also helped me “find my people.” Because we spouses are the glue, the connective tissue, the stability for the family, finding others in the same challenging situations provided reassurance, validation, and comfort that we are not alone in our experiences. We are the select few, married to individuals who put themselves in harm's way daily, some who are vilified in the media. We spouses must hold down the fort at home and make it a safe and welcoming place for our first responder.

### ***Jade's Journey***

Research participant Jade talked about finding her community and the need for knowledge so she could best advocate for her first responder, and noted:

I felt lost. I was struggling emotionally, struggling with stability at home and in my marriage. I didn't know what to do about it. My husband declined with PTSD

symptoms; he was pretty checked out. His mind used dissociation to cope with traumatic symptoms. The retreat helped launch my journey on a path of learning and healing. It was the beginning of an intense and intensive journey of self-discovery, self-healing, and self-awareness.

Fear. I was tail spinning. The sky was falling. The retreat brought me community. I felt heard, seen, and had my experience validated. Knowing that there were others there struggling in similar ways. Seeing spouses who had struggled but were on a healing path, had found tools for healing, and that gave me hope. The retreat gave me hope and community. I could be vulnerable, and it was safe. I became aware of how my experiences in childhood impacted relationships I had with myself, my husband, and with the world.

Tools I learned at the retreat helped me create a better balance in my life. Boundaries are making the biggest difference for me. I felt changed by my retreat experience. The suffering and struggle propelled me to attend the retreat. The desire for understanding kept me going down a healing path. The awareness of boundaries helped me advocate for myself. I better understood how adverse childhood experiences impacted the choices that I had made in my adult life and in my relationships. The more healing I did for myself, the more compassion I had for my spouse. I found myself being more vulnerable in advocating for myself, speaking more authentically, and asking for help. I received pushback from my spouse. I think that my change in behaviors brought fear for my spouse. As a people pleaser, I was afraid to set boundaries because of possible repercussions. My son did not like it when I held him more accountable. Rather than turn to my family for support, I went outside of the home to various resources,

books, podcasts, social media, other retreat peers. I feel like I was the trailblazer in terms of doing things differently and modeling relationships at home, including parenting.

During the interview with Jade, when asked about seeking outside supports, she checked in with herself, wondering if she felt triggered. The question activated something in Jade, and she became frustrated with herself. This moment was brief, and she moved on, but Jade also mentioned feeling curious about the flood of emotion she felt. Was she triggered? Resentful?

She continued, sharing:

Al-Anon meetings in person and online have been helpful. I have participated in counseling, with several counselors, both marriage and individual. I sought out support groups, webinars, websites. A lot, a lot. I was consuming books. It exhausted me to the point where I realized that you can't make people heal. You can't force other people to heal.

My previous retreat experiences brought little nuggets of exposure to things, the still-face baby video being one. That presentation just grazed the surface of attachment trauma but did not offer depth, like, what was that video about and what is happening in the body? I remember being hungry for more, but was told to go home and determine my bottom line. I felt frustrated because I knew something was really wrong with my husband and I couldn't just sit there and not do anything about it. I was pissed that I'd gone up to the mountain to find healing for us both, but instead I found it in further research from others. It took me more time than I would have liked to respond to him differently. Like now when he gets worked up, I ask, "I don't know, what are you going to do about that?" instead of trying to fix things for him.

I came away from the retreat with community, validation, and lots of little pieces, but not enough resources to be able to continue the path that I needed to, to get to the place where I felt like I was more stable. It was on my own, with my self-directed healing that I began to understand how the nervous system works, how attachment system works, what happens to the brain with PTSI. It was like an involved treasure hunt of trying to continue to find those nuggets. I wished that I would have gone home with a resource page of information.

After the retreat, I made a pact that every time I saw a first responder spouse, I would reach out and make a connection. After 3 decades in the industry, it has taken a toll on me, my husband, and our family. I learned that 98% of the people I spoke with were struggling. Several of the spouses shared during those conversations that they were planning to leave their husbands within the next few months. They also shared that their spouses were showing signs and PTSI; however, none of them had been educated about the effects and signs of PTSI and after years of struggling, I recently found information in a book that matched my spouse's symptoms. All the spouses I spoke with seemed scared to have their family's status and reputations threatened by being seen as damaged or weak. They were concerned about anyone knowing their family was struggling. I would offer to listen, make books suggestions, therapist recommendations, share online information, anything that I could to support the spouses.

During one of these frequent encounters, I ran into a young mother of three children whose spouse was in the fire service. When I asked how things were in regard to her spouse's repetitive exposure, the wife replied, "Things are fine. He is fine." But 6 months later, the spouse reached out to me in crisis, explaining that her spouse "won't

leave the house. He has an imaginary injury and just won't leave the house. He is acting scared of everything.” She was terrified for her family's financial survival and explained in rage that “somebody's got to make the mortgage! He’s got to get his ass up and go back to work!” I would say, “He needs help, let’s get him some help,” and I offered resources, including a local therapist. I used to constantly criticize due to fear, but since educating myself about PTSI and the nervous system’s normal reactions to the constant exposure to trauma, I offer compassion instead of criticism. I provide support to other first responder spouses because of the leadership position my husband had as a fire chief. We have first responders in the immediate family, my in-laws, seeing changes between them, that things had become so hard, the couple turned into robots. I knew they were struggling, that they were suffering. He was a battalion chief, and she was an ER nurse; he would witness the trauma on the call, and she would be exposed to the same trauma in the emergency room. Two months after I came home from the retreat, my sister-in-law died by suicide. I have seen the devastating impact of this line of work. Anything that I can do to bring awareness or healing, I try to find a way to advocate.

### **Personal Transformation**

Study participants reported personal transformation based on the SEW Retreat as impetus for change, whether via education, permission, or personal readiness. Gass’s (2013) wheel of change applied to this theme. As a systems approach to change, Gass addressed how a person’s feelings and thoughts about themselves impact what they do and how they behave. The wheel of change “guides us to attend in an integrated way to each of these three domains: our inner life . . . our behavior . . . our environment” (Gass, 2013, p. 1). As evidenced by the retreat agenda alone, the SEW Retreat is designed to change hearts, minds, and behaviors. As retreat

participants continued to share their stories, it became evident that treasure existed among the darkest depths.

### **Retreat Launches Healing**

For quite a few participants, the SEW Retreat launched pursuing and continuing their own healing after their SEW experiences. Participants also noted psychoeducation pieces contributed to personal healing and transformation, helping mitigate struggles of codependency, ERES, “Stinking Thinking,” and learning about being or having something be “good enough.” The EMDR experience was invaluable for some; one participant noted, “I feel lighter,” whereas the experience was concerning for others. Another participant stated, “I had no control over where my brain would go.” Whether through the daily MISTS check in or the tools provided, retreat participants practiced new behaviors.

The retreat design is designed specifically for change, and exploring this design addressed RQ1 (i.e., What ways, if any, does the retreat promote personal transformation?) by providing information grounded in research on topics relevant for personal healing. In addition to psychoeducational components, I found the therapeutic milieu promotes community and community living. Clients sleep in the same room, eat together with peers, staff, and clinicians, and all meet as a group multiple times throughout the day. Not only are clients and peers there because of circumstance similarity, the community-based design disallows isolation and avoidance—one cannot get away from their own burdens, rather they must address them and be open to addressing them. The group calls out falsities and avoidance behaviors. Addressing one’s own barriers is a step toward healing. Retreat participant Peridot spoke on this topic further.

### *Peridot's Perception*

As Peridot noted:

I recognize struggles stemming from my childhood, through adolescence and adulthood that led to my coping behaviors. Upon returning from the retreat, the support of my husband was key. He trusted the program and knew that they were doing right by me. I had behavior changes upon my return home but struggled with old behavior patterns when emergency coping was needed. Codependency shows up for me when I'm activated in being needy with my husband, who is my security blanket. I try to ask myself "What's this all about?" I recognize my need and desire to fix others, knowing that I cannot, but that I can be present for and with others. I check in with myself when I see myself wanting to be there for others, "Am I doing it for myself or for others?" "Does this benefit me right now?" People who truly care will understand my need to care for my own well-being as I set healthy boundaries around relationships.

The ability to feel my feelings was one of the changes I noticed at the retreat. Initially angry with being there, I decided to embrace feeling the feelings that arose. Part of what led me to the retreat was concern over what others thought and doing what I thought was expected of me. However, when I finally released that and did things for myself, that is when I started to feel what I was feeling. Anger was the first emotion I felt. As I finally expressed and let go of the anger, I began to feel other emotions, like sadness and happiness. I noticed that this emotional shift was being embraced by the peers and staff at the retreat. This allowed me to feel without judgement. It was being granted permission to feel whatever I wanted or needed to feel. It was freeing to let go—to take the top off the boiling pot of water, instead of holding it down, suppressing the

spittle of water that tries to escape the pressure. I didn't think that people would want to see that side of me—that vulnerable, authentic side—and yet that's exactly what was being encouraged at the retreat. With the permission I didn't know that I needed, I was finally able to feel my feelings. As my biggest fan, my husband was supportive of my needs when I returned home. However, my workplace was less amenable to necessary boundaries to aid my mental health. I experienced pushback from my employer. I felt used and taken advantage of because of my work ethic. My boundaries made things change, so much so that I am no longer employed there. As I sought help, I ran into struggles with my identity. Because I was “just” a secretary or “just” a clerk, unsworn in law enforcement, I was never seen as a first responder. But I heard and saw the same things that my husband did at work. I carry my own posttraumatic stress because of my workplace experiences, but there has never been assistance provided. For nearly two decades, I gave of myself to the organization, and it feels like there is no recognition of those efforts, of what I experienced.

With the identity of a first responder, that while not sworn, and not with that official title, my experiences align with that of first responders in what I have witnessed at my job. Some of the battle scars and issues I have had in my own life and the way I interact with my children have come from things that I have seen in the field. For example, seeing a child die because of a dresser falling on top of them, which became a big deal in my house, leading to hypervigilance about securing furniture to avoid such tragedies. The scars I have through my job have bled onto my own family.

I tell others about the retreat program, that you don't have to be at a low point to go and gain something from it. That it can enhance your life, your marriage, your



relationships overall, and how to cope with the first responder life. This life is different than anyone else's and it bleeds on to your family. My children are held to a higher standard and given more responsibility because their dad is a cop. Friends ask my son to go to the mall with their kids because they felt he had "street smarts." First responder children are seen as extra responsible and aware, all because of their parent's job.

There was a presentation at the retreat—the still face baby video—that stood out to me. It activated me and brought on a panic attack. You feel like you're gonna die. I was amazed by how I was helped. I was told, "We're here for you and we're going to get you through it; it's not going to last forever, and now we're going to give you the tools of how to get through a panic attack." Tools I use to this day. The lead clinician spoke calmly, asking everyone to move back and give me space. The clinician gave me direction calmly and without laying hands on me. When you go through a panic attack, you're all over the place. The clinician had me pull out my chair and stand up against a wall, "Feel the wall and focus on your breathing. Put your hand on your chest and feel your breathing." The clinician provided a safe space and was a safe person who I could trust. The entire room waited it out with me, and I came out of my panic attack with that group support, and with tools that I could use on my own whenever I needed to.

Then my mind shifted: Everybody's staring at me, and I soon realized that I was very hyper aware of what was going on and people staring at me. And I immediately go to the negative, the judgment, there's judgment behind it. Then I recognized that everyone is here for the same reason. I remember people saying, "We got you," but wouldn't stare at me, and they gave my space to be. And to feel. They gave me that room.

I am participating in this research study as part of my own healing journey. I was grateful that I got to share and step outside my bounds a little bit. It's good for my soul to share with others and to help. Selfishly, I did this for myself. Sharing one's journey is an important part of the healing process. It's ok to work through it. We can't do it alone.

### **Behavior Changes**

Retreat participants shared how they learned to set boundaries and how they found their voices. Behavior change at the SEW Retreat is promoted by practicing tools related to minimizing distorted thoughts, setting boundaries, practicing self-affirmation, engaging in physical exercise, and developing sleep hygiene. So many spouses of first responders deny their own needs to give themselves fully to their (often mentally, emotionally, and physically wounded) first responders, which presents unhealthy risks for everyone. "Doing" for the first responder denies the first responders' autonomy. Rescuing the first responders from themselves decreases the spouses' self-worth. Still, as mentioned by Peridot, codependent tendencies to "fix" are the behaviors learned for relationship survival when helpless to change the situation.

### ***Amber: In Her Own Voice***

Retreat participant Amber shared her poignant story about codependent behaviors that were necessary for survival, noting:

How can you focus on anything else when your life partner is in crisis? My husband was unwell, and I would do anything to change that. His symptoms manifested in his inability to drive or even hold a pen to sign papers. I had to do everything for him: drive him to medical appointments, make his appointments, be the go-between with his department, advocate for his privacy. Oh, and did I mention that I was also raising our two children? My husband was the first to medically retire in his department, but he

started a trend. No one knew that he had PTSD, it was hidden well; it was a well-kept secret. He was suicidal and I didn't know, he didn't tell me. He was very unhappy, and I experienced him as annoying. I was irritated at him all the time. But when I found out later how miserable he was, I felt bad because I didn't know.

Going through the process of a medical retirement was like jumping through unending hoops. He had to go on to worker's comp[ensation] and do all the different things to prove that he could not return to work: the QME [qualified medical examination], the deposition. I thought the QME was determining if it was work's fault, or my fault. His appointments were 4 hours away from our house because of where we live. I was constantly struggling with what I was supposed to do: when am I being supporting and when am I not? He would go to his doctor's appointment and lie to the doctor, saying that he was fine. But we knew the medication needed to be changed, and I was like, he's not fine! It was a really intense time.

At one psychiatrist appointment, we were asked if we had any guns in the house. My husband was wearing one, but did not disclose it. The psychiatrist talked about suicide and said that if he's suicidal, we need to call 911. Later, we got into a fight because, who's going to show up? Where are they going to take him if he calls 911? We know the people who will come to our house. We know people who work where they would take him. So basically, there's nothing I can do. I was so angry. I felt so helpless. All the systems are so broken. Worker's comp took us forever. And they were not going to give him psychiatric care. I wouldn't let them not help him. I don't think he would have gotten better without me.

Amber's story felt so familiar—the wife just holds it all together for everyone so life can go on as normal. First responder spouses and partners are the glue, the connective tissue, holding down the fort, managing the family, providing stability for the children, “doing” for their first responders because they cannot. Then, many first responders resent them for this work and feel controlled. When these first responders feel they cannot do anything right, they stop doing, which pisses their partners off even more. As participants noted, the cycle stops when the spouse lets go and relinquishes the desire to over-control. As the first responder heals and becomes more capable, over functioning for them is less needed, and the spouse needs to look at the ways these behaviors negatively contribute to the relationship. Still, the anger continues, because if the spouse or partner had not been over-functioning, the family may not have survived the crisis intact. Amber continued, noting:

No one knew that my husband went into retirement. We pretended like it wasn't happening, so all the fire department knew was that he was off for 4 months. It was so weird pretending. After his retreat, leaders came up to the department to do some peer training, so the police and fire departments were there. My husband said that he was going to go to this training, and he wanted me to come with him. I was like, okay, because I will do anything. So, I go to the training and we're at a table with a bunch of people from his department and a bunch of police officers. It comes to his turn, and he says, “Yeah, I'm off work because I have PTSD.” And I was like, oh! We're doing this! It was really public for me, like now we're talking about this. It was so hard in that training, hearing about how many of them were so hurt. In the breakout groups, I was with a bunch of traumatized cops. It was super intense. Then my husband decided that

he was going to go share with his battalion what's been happening with him, and I'm like, okay.

It was just hard to know when the time was right to help and when the time was right to stop helping. I was really scared, and the stakes just felt really high. I am still working on it, figuring out what's the way to help and what's not helpful. We continue to work on having an emotionally equal relationship because my husband has discovered that he has feelings about things and wants to express them. I've been supportive of that, being open and making space for him to be able to try that out. Sometimes it doesn't feel even. So now, it's more subtle. Sometimes I can tell he's having a feeling before he realizes it. It seems like an ineffective way for you to discover your feelings and I don't want to do it like this anymore. Could you check in with yourself so you can figure out what's going on with you? We've agreed to this arrangement so that he doesn't get defensive. Like, I felt fine before you walked in the room, so I feel like it might be you.

My husband would describe his symptoms to me. He felt like he was reexperiencing calls, his mind would fill with all the images. He had flashbacks. When he would share this with me, I felt so angry! I was sexually assaulted as a teenager, and I too experienced flashbacks, and similar symptoms to what my husband described. But when I would share my experiences back then, he would tell me that I need to stop doing that, it's weird. I was young, but I really wanted to be a grown-up woman with a good man and have a successful life. So, I did all of this stuff to suppress the experience that I had. When he started sharing his experience decades later, I was livid! Are you kidding me? You're telling me this like I never shared my experiences with you?! I was so pissed. It was a really terrible and intense experience that was really isolating and lonely.

We're different now, in really good ways that both of us could not have imagined. Like him working for the fire department sounds terrible now. He wasn't around for our children when they were little. They're teenagers now, and we're expecting a third child. I had always wanted a third child, but he didn't. He was afraid because he had been to calls where babies died. But he'll be present for this child, available. It will be a different experience.

The retreat brought me a community of those who had similar experiences, which was essential because I was so lonely. They also gently—or not—informed me that some of what I was doing was part of the problem. Because they had similar experiences and were working on their own behaviors, they were the right people to share that information with me. Two specific tools that I still use are “Stinking Thinking” and the morning check in. The check-in structure has helped my husband and I share our feelings better. We'd been together for 15 years without sharing our feelings, so it's been a hard change. It's been hard to know if it's ok to share myself, or if I should be guarded to protect myself.

My behaviors changed because of the retreat: I don't make his doctor's appointments for him or speak for him at his appointments. I stopped treating him like a child around this experience. I don't check that he's taken his medications anymore. I can speak up and say what I needed, that I needed him to do things to be healthy, to be ok. If we were going to stay in our marriage, I needed him to take care of himself. But it was so hard! I was so angry, so defensive. How was I supposed to know what I'm supposed to stop doing for him? And why am I the one who's supposed to figure this shit out? And then, if I do something I'm not supposed to do, that's me being bad? This was hard

for me to figure out. But now I can say what it is that I want, what I need in order to move forward with our relationship in healthier ways. I work daily to release habits of codependency.

When my husband came home from his retreat, he said that he can't go back to work and that he was mad at his mom. But with him not returning to work, that was a big deal and lots of things started to change. I would not have been able to talk about my husband's or my experience before going to the retreat. My husband's PTSD was a secret. His diagnosis was a secret from everybody. There was no one I could talk to about it. Even the children. I thought I had told them, but apparently, I hadn't. But they were little. Our daughter knew he'd hurt his knee. That's a more concrete reason for not returning to work. My husband's PTSD was a secret from the kids, on accident.

While I have support of some friends and individual therapy, I don't find support from other first responder spouses [outside of the retreat]. It was a secret, first of all. But a lot of times when they wanted to talk to me, it's because they were having a really hard time. My husband is known as the person who was the first to medically retire in his department because of PTSD. Also, relationships with women are hard for me sometimes. I also found that I didn't want to have relationships with people that he worked with, especially if they weren't the same rank. If my husband is your husband's boss, let's just do Easter at the station and not anything else. In terms of sharing what was happening to me with select friends, but especially in therapy, the more I was able to talk about what I was going through, the less alone I felt. My husband needed a lot of support, but he couldn't reciprocate the support. I had to expand where I was looking for support to help take some of the pressure off him to provide what he couldn't.

Listening to Amber, I remember the loneliness of my own experience, the isolation; the sense of helping because it was coping and necessary. Until it was not. The fact that the PTSD and suicidal ideation was a secret. Like my husband's challenges were somehow a personal failing on his part, or on mine. So, we didn't tell other people out of fear of judgment. I do remember that when the "worst" of our trauma was over, I could finally risk telling people. I wasn't so raw. As with Fluorite referencing there are still things she cannot share with her best friend about her husband's PTSD, I remember feeling very detached from emotion, and acting matter of fact when telling my dear friends. This period was a time when the practice of internalizing emotions came in handy.

### *Amethyst's Avoidance*

From doing everything possible to maintain the family unit, to doing everything possible to maintain control, the following narrative came from Amethyst's interview, when she noted:

I am a go-getter. A do-er. I don't like to be idle. I am more than a wife, a mother; I am a DJ, a shop manager, a dog owner. My husband is a firefighter; I am a volunteer firefighter. I work long work hours. I know that I work too much. I work, and work, and work. You may wonder, "Why does she work so much? Is there something she is trying to avoid?" It's probably life that I'm trying to avoid.

At the retreat—I see all the things that need to be fixed. I wanted to fix it! I jived more with the clinicians than the peers or fellow clients. I just attended the retreat this year. I have an adult child at home who requires additional attention and care. I have a lot of energy, but I know I need to stop and breathe.

I am "hyper-independent," not codependent. People who are codependent need to be needed, they are weak. I was surprised at how needy they are! I don't need that kind



of attention. They don't want to get better. They just complain and do nothing to change the situation. In life, none of us make mistakes, we make choices. Mistakes are what kids make on a spelling test. Everything in life we do is a choice. Every road we take is a choice. If you're doing the same thing every week, it's insanity.

I drew a hard line when my husband was drinking—I threw him out and demanded a year of sobriety before he could come home. I was willing to walk the road by myself until he got sober. I was hopeful about attending Al-Anon, but it wasn't as impactful as the experience I had at the retreat, with the meeting held there. The Al-Anon group I attended at home, people wouldn't hold their boundaries; they kept redrawing another line in the sand when it was crossed. It's like the finish line in a motor race keeps moving. You start the race, and it is 100 laps, but then you're sent to the back of the field because you spun out. So, they added 30 laps, but then you get a flat, so you need 25 more laps to catch up. It is getting too hard! You make it to the front, so that last 25 are knocked down to 13 laps. We all have boundaries in life, in parenthood, at work. Why would we move our lines because someone, who says they love us, pushes them? Or knocks them down?

At my retreat, I was only one of two women who remained married. I wish there had been more of a focus on staying married. That's a hard thing to do. I wonder how many people came out of the retreat still married. It was hard to go home and still be married. It was a hard journey to come back home, recognizing that you must know where you are before you can understand where your first responder is. There wasn't information on marriage at the retreat.

Amethyst's sentiment reflected a curious phenomenon of the retreat. First-time peers often exclaim certain presentations were not offered when they were a client. Volunteers who have been around for a few more retreats nod in understanding and assure them, yes indeed, those presentations were provided at their retreat, and perhaps they heard the content of such presentations when they were ready for it. People may not recall the presentations for a few reasons. First, there is so much information provided during the retreat that it can be overwhelming. Sometimes information from a previous presentation activates an emotion, feeling, or thought pattern that distracts from the next part of the agenda. I described the presentation related to domestic violence, and Amethyst had a realization at the retreat that she was a perpetrator of mistreatment in her relationships. I wonder if these thoughts prevented her from focusing on the presentations that followed. Amethyst continued:

I found my willingness to be vulnerable and authentic after the retreat. I opened up to my husband to share that I was going to a supportive Zoom meeting hosted by the retreat peers. I never would have opened up in the past to let anyone know that I needed to talk to someone. My husband calls me strong. Yet, those who are strong still need support. Because my husband had attended the First Responder Retreat [FRR], he believes in the program. But he still has a way to go in his healing. It's hard because he's lost in his own head, and I just want everything miraculously fixed! You know, every wife has a problem with their mother-in-law. There was a situation where I used self-control and set a boundary with my mother-in-law in front of the family. My husband noticed that I didn't jump and attack. One of the things I worked on at the retreat was self-control, and that change was evident to my husband.

Part of preparing for the retreat is to seek counseling prior. It was helpful to prepare me for the questioning and self-disclosure that happens at the retreat. I am glad that I got a therapist after being asked to do so during the intake process. I was able to ask my therapist about the line of questioning and about body language that led to some of the questions. I am a straight-talker, honest, I am what I am. A fellow client at the retreat questioned whether the world I lives in really exists! I need control. I didn't like the EMDR experience because you can't control where your brain goes. In therapy, I am working on releasing control, and it's frustrating. I lose control of the conversation, of the direction it's going, because I recognize that I can't always have control. But I always like having control. In my firefighter experience, I work to have control so that even when I'm not in charge, I am in control of myself. The word given to me at the end of the retreat week was "acceptance" because I must accept that I cannot always be in charge.

I had some challenges during the retreat. It was my first experience being in a house of women. I grew up in a guy's world of racing and was used to rooming with guys at the firehouse. But women are different. One woman came to the retreat to try to fix her ex-husband, but you can't fix someone who doesn't want to be fixed. Thinking about the donut [sphere of influence], you can't fix somebody, period. While my husband recommended that I attend the retreat to better understand him, I most benefitted from seeing that I wasn't the only one struggling with a first responder diagnosed with PTS. We all go through our own journeys, and mine is not like anyone else's. We're all battling the same thing: being with somebody that doesn't know if they want to be with themselves. I'd like more support for married couples at the retreat. What about a

couple's work weekend at the retreat site? This would be for couples who each attended their own retreat to not only get support from and with others, but to give back and provide support to the retreat site itself!

Amethyst's narrative was fast paced. In email conversations during member checking, Amethyst reflected upon her need to "fix," to maintain control, and to pause. She said she found herself trying to avoid the big picture. Insights and reflections remained ongoing and part of her important healing process and personal transformation.

### **Impact of Transformation**

The impact of personal transformation was very individual, yet participants noted their transformations were noticed most directly by family members and within the family unit. As described by Pearl, Jade, Peridot, and Amethyst, behavior changes led to decreased codependency in work and service structures along with healthy boundaries. It was interesting to witness ongoing healing in clients who returned as peers—it seemed like the more open they were to their own recovery, the more insight they gained with each retreat attendance, and the more dots they connected.

### ***Opal Finds Her Voice***

Research participant Opal shared how her experiences impacted those around her, noting: I came to the retreat because my husband went to his retreat and told me about one for spouses. I thought that I could probably have extra help. Like many spouses, I am always taking care of others, both personally and professionally. As a wife, mother, daughter, and a student training to be a clinician. To be in a space that was completely centered around me and my healing was unusual. It felt strange to become in tune with my feelings and experiences. There is a common misnomer about the retreat: that

because my husband recommended it, the information would be centered around how to help him more. We all seem to come to “fix” our husbands. But it was like, no, we’re here for YOU [emphasis added]. And I got to heal.

Learning about emergency responder exhaustion syndrome [ERES] was eye-opening. Learning about how their injury affects us and making it personal to our situations and experiences was valuable. It shed light on why they behave the way they do. Personal therapy recommended prior to attending the retreat was helpful. However, it was the retreat that propelled me into bigger realizations and having the time to sit with them. My weekly therapy sessions improved my anxiety symptoms, but after the retreat, I was able to decrease my anxiety medication use. Three months after the retreat, I stopped taking my anxiety meds and I stopped having panic attacks.

After the retreat, I used the skills I learned. I started to be able to stand up for myself at home and get my voice again. The changes I experienced were due to the mixture of therapy, the retreat, and doing the work. Having done some work prior to the retreat and doing the work after led to significant changes in my behaviors. I created boundaries in relationships. And I created a safety plan with my son, who has extreme behaviors. I realized that I needed a safety plan to protect myself from his significant behavior abnormalities. I never saw him as an abuser because he’s a kid who’s acting up. But that recognition for my own safety needs was another big moment. So, when he’s acting up, I remind him that there’s a safety plan, that he needs to work on his safety plan in order to not enact mine. That was a pivotal moment for me.

Thinking about ongoing changes since the retreat, I continue to do my personal work, not letting go of that importance of healing. It would be easy as time goes on to go

back to old habits. I maintain therapy monthly. I recognize that I don't do everything I wrote about in my 90-day plan, but I have found ways to maintain my healing process. I took those big chunks of things that I knew I needed to change in my life, and I am sticking with it. Making a conscious decision to continue with boundaries because it's easy to let those boundaries down. That goes a long way to supporting my voice, like no longer putting up with getting stepped all over. It would be very easy to go back to old habits; it's a big deal to maintain healthy practices and it's hard.

I experienced some pushback on setting boundaries at home. My family was shocked that mom's not going to take all the shit anymore, wife's not going to, either. My husband commented that I seem like I've been miserable since my awakening. "Oh no," I told him. "I've been miserable for years before that. You just hear about it now in the times when I'm unhappy, when your mood or your behavior affects me. You just get to hear that I have feelings that are surrounding your mood. I know you have this injury, but I shouldn't be feeling the effects of that." My husband is starting to notice and realize the impact of his behavior on me and on the family and is quicker to apologize. It's been worth it to stick with it and to speak up for myself.

That goes for me, too. I feel better about not being walked all over. My son has been diagnosed with oppositional defiant disorder. His therapist says that he is transitioning beautifully to either borderline or narcissistic personality disorder. My son is careening through his teen years, and he is a difficult child. But the tools I have learned have given me the strength and courage to not put up with it, even though I have received pushback from him regarding the changes that I have made to keep myself healthy.

Staying healthy includes having supports. I continue with individual therapy (thank goodness for Zoom!) and am involved in a local charity group. I like to have an extracurricular that is just for me. I am also a student in a faith-based relational program that is training me to become a therapist. I have made close friends in the program that are supportive and can provide prayer. My close friends and family have also been supportive of me during this healing process, including my mom and dad. Once my husband retired, the first responder “family” fell by the wayside. They are a little scared of the PTSD “contagion.” It hurts to feel left out of the community, although his close friends have checked up on him and still come by. These are the tried and true, they’ll be there for anything kind of friends. But the department has been behind the buck in terms of support to the families. They have peer support now because several guys are out on stress leave. They are trying to broaden support to the families a little bit. But this did not exist when I needed it.

The retreat organization and location are community, somewhere I can go, whether there are the same people there who I know or not. It’s a beautiful community up there. When I returned as a first-time peer, I felt a little social anxiety bubbling up, not sure if I would know anyone. A little nervous. But the more times I have been up to support the retreats, the nicer it’s been, the more connections I have made with others. As a client, I found it really rewarding to attend my own retreat. That, regardless of what happened with my family or others, I bettered myself, and that was good enough. That was the important part: that I felt better.

Opal’s statement was incredible to analyze, particularly the important moment when Opal stated, “I feel better.” Reflecting on (a) the “enough” sentiment from Fluorite and (b) Opal’s assertion

that *her* feeling better was the *important* part helped me reflect upon my own self-worth. Such personal transformation goes beyond oneself, whether in the form of healthy boundaries at work as described by Peridot or healthy relationship boundaries described by both Opal and Jade. From the most healed perspectives, spouses and partners of first responders can accomplish more for themselves, and if they so choose, for others.

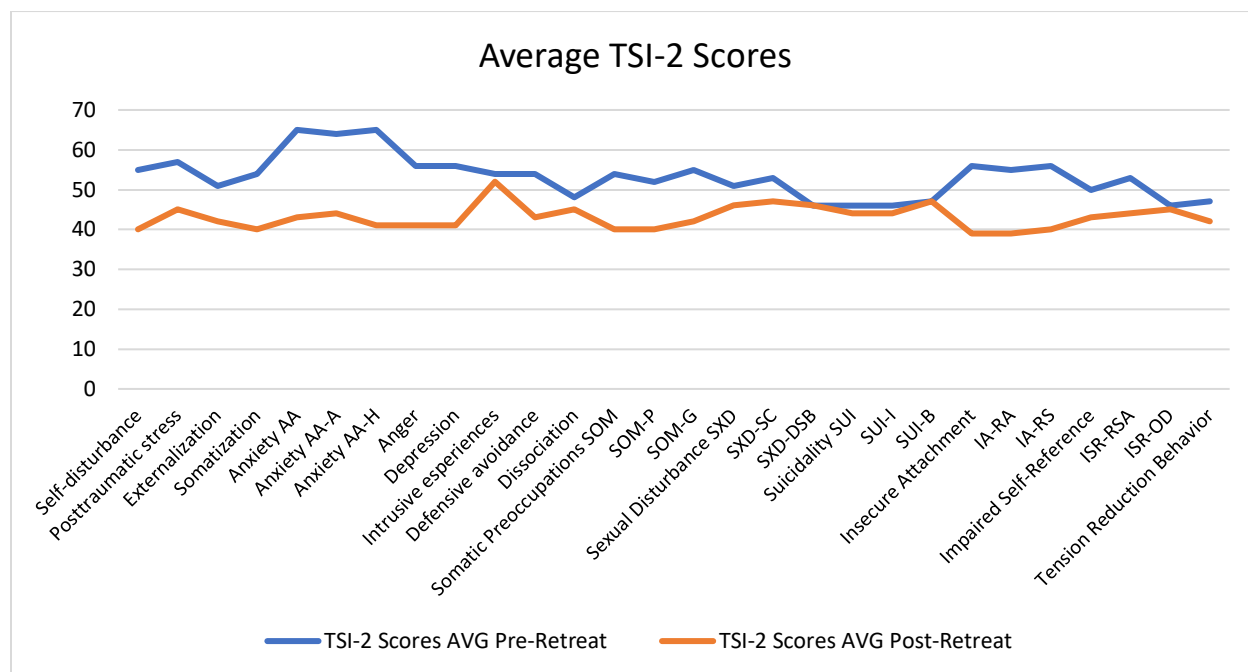
### **Self-Assessment Highlights**

Looking at the self-assessment scores of the research participants, it appears they all left their retreats feeling better. Of the eight research participants, four took the Symptom Assessment-Spouses of Emergency Workers (SA-SEW) pre and posttest and the other four took the Trauma Symptom Inventory, 2nd ed. (TSI-2) pre and posttest. The use of different self-assessment measures was due to the timing of the creation of the organization-specific measure, SA-SEW. The organization provided me with the relevant self-assessment scores, and I reviewed them. Overall, the difference between pre and posttest scores on each measure indicated there was a difference in self-perception pre- and post-retreat. Figures 6 and 7 show participants' averages for each measure.



**Figure 6**

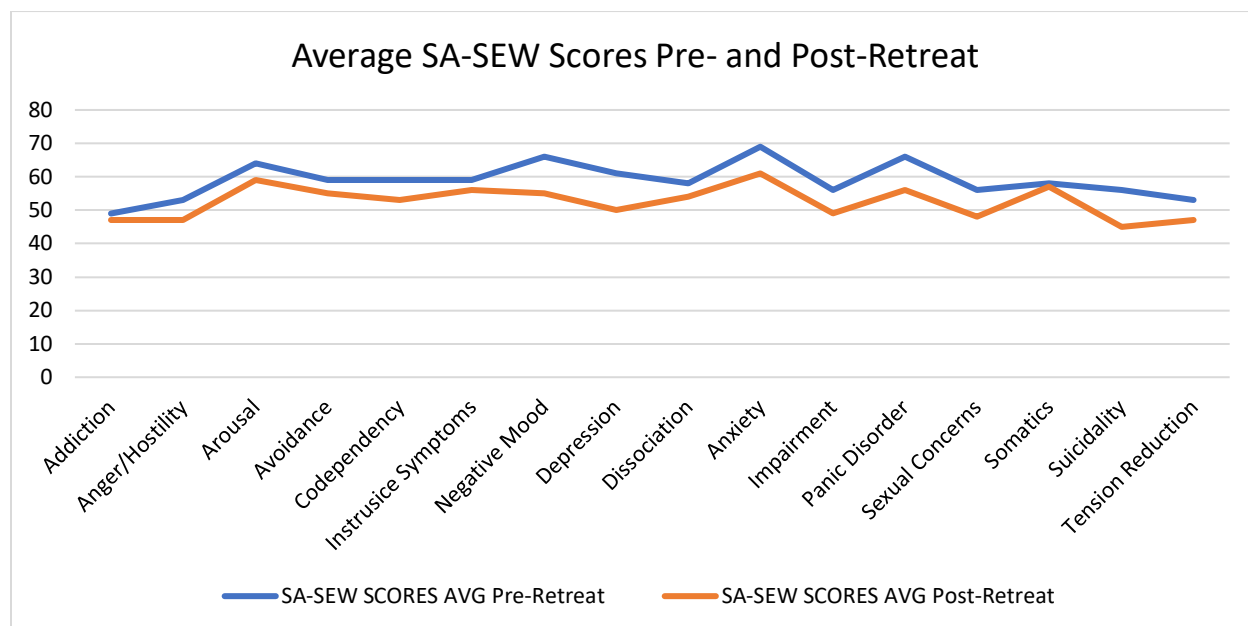
*Average Trauma Symptom Inventory (2nd ed.) Scores*



The average TSI-2 scores indicated improvement in many areas (see Figure 6). Anxiety was the most pronounced average pre-retreat, whereas suicidality was the lowest average. The greatest decrease appeared to be in anxiety. Few participants indicated suicidal ideation as a symptom pre-retreat; therefore, there was little change post-retreat. Fluorite experienced a marked decrease in somatic symptoms post-retreat, which supports her desire to “help with [her] stress and not throwing up” every day. Amber experienced a significant decrease in anxiety post-retreat, having received the information, education, and tools to better understand and cope with their post medical retirement lifestyle. All four clients indicated a decrease in anger, depression, and insecure attachment.

**Figure 7**

*Average Symptom Assessment-Spouses of Emergency Workers Scores*



The SA-SEW indicated a decrease in all areas, even if slight (see Figure 7). Negative mood, depression, and suicidality had the most pronounced decreases for these four participants. Amethyst had the greatest decrease in anxiety, whereas Jade recorded the greatest decrease in depression. Opal's scores were a bit flatter and suggested a slight increase in codependency and impairment. These slight increases could be due to an increased awareness of Opal's symptoms and behaviors after psychoeducation, as literature suggests this awareness can occur (Whitworth, 2016).

Sapphire saw the greatest decrease in negative mood and avoidance. In her member-checked narrative re-presentation, Sapphire commented she had really been on a "shame train." She felt exhausted and resentful. Her husband's "I'm fine" front made her doubt herself even as she carried the weight of the world on her shoulders. Sapphire expanded further to describe the negative mood and how it impacted her self-perception, noting:

My desire for control and perfectionism masked the lack of self-confidence and self-worth. And that mask was so violently and publicly ripped away. I took on his actions as a direct reflection of me and in my mind, everyone could now see I was lacking, and his shit “proved” how worthless I really was. . . . It’s amazingly awful how your mind can make you feel so worthless—and I learned to be nicer to myself, to allow a little grace. When I put down my rocks [burdens] —I did so with purpose and a confidence I didn’t have until [the retreat] showed me the way. What a precious gift I received from [SEW] and it’s a gift that keeps on giving.

Sapphire’s interview was the first one I had and the first transcript I reviewed. After member checking, I reviewed her transcript again and created a song out of Sapphire’s transcript. The song was the first narrative re-presentation I did. Each word came from her, each phrase relatable to spouses of PTSI-diagnosed first responders.

### *Sapphire’s Song*

The responsible one. Doing everything for everyone. Utterly rudderless. Lost. Alone. Angry. Afraid. Naked. Exposed. No power . . . no control. I felt trapped. I wanted to flee, wanted to run, I could just disappear. I didn’t know what else to do.

I wonder why I had to get so low to get help. Something has to give . . . I wish it hadn’t gotten so bad. Life changing. It was the best experience. I hadn’t felt so light in so long. I felt solid. Grounded. I could stand up and move on.

With support, learning, listening and care, that care was so important to me. As I go along this healing journey, I know that I’m not alone.

The responsible one. Drowning in my insecurities. I felt discarded. Ignored. Second class to the job . . . Second class to the \*\*\*\*\*job. I was ashamed of me—a failure as a wife—how can we go on?

I can't picture my life without him. I hated him. But he's my soul mate. How can I make sense of what I can't understand? I felt helpless, hopeless, worthless. Utterly defeated. And I still . . . cry . . .

I don't know what I would have done. Without you, without the support. The community. I didn't know what else to do.

### **Additional Retreat Feedback**

At the end of each interview, participants were invited to share what they wished, and to further answer questions or to provide feedback about the program; all feedback was welcome. Feedback varied, as much of the recommendations participants suggested seemed to have been already put in place by what I had witnessed over time at the SEW Retreat. Specifically, improvements had made with each retreat. The retreat experience is also dependent upon which peers attend, who the clinicians are, and who leads the retreat.

I also observed some of what participants desired from the SEW Retreat was indeed covered by a presentation; however, it is common for participants to remark statements such as, “I don’t recall seeing [and/or] learning about that at my retreat!” Staff always say the content and presentations are “evergreen” and the same topics are indeed provided at each retreat. Still, when individuals are activated by new surroundings and new information, and are asked to behave in ways that are outside of the usual, it is difficult to concentrate on all the topics being presented, some of which are very new.

Each day of the SEW Retreat includes multiple learning opportunities, presentations, and introduction to tools to care for oneself. One participant described wanting more information about neuroscience and attachment theory. She felt she did not get enough information about her husband's PTSD and how it impacts the brain and behavior. Another participant wished there were more tools and information on staying married.

Part of the SEW Retreat process also includes clients being accompanied in the first few days of the retreat (i.e., not left alone); however, one client felt she was left alone too much. She did not gel with the peers and wished the peers were assigned to rotate in accompanying clients, especially in the early days of the retreat. A few participants who are familiar with the retreat-hosting organization spoke about systemic personality challenges in the organization, preventing growth of the retreat for spouses and significant others. Among the challenges cited by interviewees were a power grab by individuals, or the fact that organizations exist to survive, regardless of the impact on individuals. A few participants mused the SEW organization perpetuates systemic flaws in first responder departments, organizations, and culture via a top-down approach. One participant drew a direct link between codependent volunteers and staff and "scrappy nonprofits." A common saying by staff at SEW Retreats is "Let go or be dragged." The comment made about codependency and nonprofits made me wonder how this nonprofit is practicing this saying.

At SEW, individuals are encouraged to let go of thoughts and behaviors that no longer serve them. This nonprofit organization has been run by founders (i.e., those who established the organization a few decades ago) ever since the organization was established. Although a research base was used to establish the retreat programs, there remain questions as to whether the organization has remained current in its methods. Could there be changes for the better? Do the

founders support such changes, or prohibit them? Of what might the organizations or individuals need to let go of, lest they be dragged into the future? Perhaps they could go willingly.

### **Conclusion**

Similarities among participants were striking, from their personal identities to their reports of retreat experiences. Each participant identified having been changed by their SEW Retreat experience, an experience designed with the purpose of providing education and support for spouses of first responders. SEW is also responsible for changing hearts, minds, and behaviors to promote individual and collective healing from symptoms of PTS. Research participants reported gaining a community of understanding and solace of not being alone in their experiences, in addition to being able to make personal changes that increased their self-esteem and had a positive impact on those with whom they lived and worked. The self-assessments, although different, also indicated an overall change in symptoms between pre- and post-retreat measures. Participants additionally provided thoughtful feedback about the retreat operation itself. In Chapter 5, I discuss these findings in relation to the research questions and the literature reviewed; yet first, I present another narrative composite as a restoried and poignant example of client experiences.

#### ***Learning to Love Ourselves, A Composite Narrative***

This is a love story. But not the kind you might imagine. This love story flows from pain, from insight, and from desire. The pain of never being good enough. The insight that more is possible, if one is open. And the desire to do differently, to be differently than one has become.

We start out in relationship, the result of lust or friendship, which grows into a lifelong commitment to each other. We agree to compromise and to support one another. But we cannot

count on how life could upend our romance, on how things would change so significantly in our relationship because our spouse is a first responder. The job is grueling. Our spouse is a hero to many, a villain to some. The hours are relentless: mandatory overtime, midnight callouts. But the commitment to family was made, so our loved one drags himself to family functions, holiday parties, dance recitals, baseball games, concerts, and soccer practice. Until he doesn't. Because he can't.

We find ourselves making excuses first to friends, then family, then to our children about why Daddy can't come. Can't get out of bed. Can't get away from the bottle. Is he an alcoholic? Or is he self-medicating, trying to make the demons of his job—or his childhood—disappear? Maybe he's spending extravagantly, engaging with prostitutes, or exhibiting other risky behaviors. He can't get away from drugs, from food. He's using things to distract him from his hurt. But these are the things we don't talk about. We put up with his rage, his depression, his anxiety. His distance. We see him trying to numb the pain of reality. There is no debriefing the death of a baby at work. They just have to keep "shagging calls." Their lieutenant thinks they're faking the back injury after falling through a roof during a house fire. Work wants them to "snap out of it," "man up," or "get over it, already."

Things are worse when they get physically violent: slapping us, hitting us; or emotionally abusive: ignoring us, icing us out. Using threats of suicide to manipulate us. Or maybe we are seen as the enemy, so they lie, sneak around, are extremely jealous and suspicious. There may be constant fear of knowing that our loved one is suicidal but refuses help. We can't tell the department because he could lose his job. And then where would we be?

So, we over-function for them—we do everything we can to keep them calm, make their lives easier. Or make our lives easier to keep them from flying off the handle at the slightest thing.

We do everything so much that they begin to feel helpless, like they can't do anything for fear of setting us off. The cycle is vicious and never ending. We feel helpless, hopeless, and worthless. Our codependency has reduced our self-esteem to ash. We know there is a problem, but we have no idea who we can turn to, who we can trust, or if anyone would even understand.

Enter the SEW Retreat community: spouses of emergency workers who have been there. They understand. The community provides compassion, reassurance, and tools to help us get out from under the bad habits we have created to survive a first responder who has been diagnosed with PTS. It is not easy to unlearn, it is not easy to practice. But in a supportive environment, transformation is possible. SEW is a "back to myself" 6-day retreat program that provides care for care providers. By excavating the muck of self-doubt, we unearth the jewels that we are. The knowledge we are worth our own time and energy. We take the step forward we need to take so we can learn to love ourselves.



## CHAPTER 5: DISCUSSION

The purpose of this qualitative study using in-depth interviews and narrative inquiry was to learn about participants' experiences at the 6-day Spouses of Emergency Workers (SEW) residential treatment (retreat) program for significant others and spouses of first responders whose first responders were diagnosed with posttraumatic stress (PTS), by asking the following questions:

1. What ways, if any, does the retreat promote personal transformation for participants?
2. How does change theory contribute to participants' personal transformation?
3. How do participants perceive the impact this personal transformation has on their family and perhaps their community?

### **Introduction**

To answer these questions, prior SEW Retreat participants were solicited for one-on-one interviews, and the following materials were reviewed: (a) self-assessment scores in context to the interviews, (b) retreat agendas, (c) psychoeducation slide decks and handouts, and (d) my personal retreat notebook and journal entries. I also maintained a researcher notebook and journal. Eight participants were interviewed via recorded Zoom video conference for less than 60 minutes each. Transcriptions were provided for member checking and then formed into narratives, which were also reviewed by participants. Participants chose pseudonyms to protect their identities, but anonymity was only maintained if participants did not share their involvement in this study with others. Ongoing email conversations with many participants continued as member checking remained ongoing until manuscript submission. This process supported the idea of research conducted *with* participants as opposed to research *on* participants (McNiff, 2017). Participants also reviewed and provided feedback on the composite narratives

that were not participant-specific for accurate representation. Participant feedback was integral to the final narratives presented, as multiple perspectives shaped the reality and trustworthiness of the re-presentations.

This study answered Research Question 1 (RQ1; i.e., What ways, if any, does the retreat promote personal transformation for participants?) which included several components: (a) the secluded retreat setting, (b) therapeutic milieu, (c) group processing sessions, and (d) psychoeducation presentations. These components all contributed to answering Research Question 2 (RQ2; i.e., How does change theory contribute to participants' personal transformation). The SEW Retreat aligns with Gass's (2011) wheel of change by changing hearts, minds, and behavior. Many participants cited the use of and respect for personal boundaries as a tool they learned at the retreat that impacted work and family life, which answered Research Question 3 (RQ3; How do participants perceive the impact this personal transformation has on their family and perhaps their community?).

This chapter is divided into sections based on the research questions, drills down into the findings and the methodology used, suggests practice implications, and concludes with ideas for future research.

### **Retreat Promotes Personal Change**

This section answers RQ1 by identifying some of the ways participants noted the SEW Retreat promoted their personal transformation. The secluded setting of the retreat location, the 24/7 therapeutic milieu, and the retreat agenda itself comprise the design of the SEW Retreat to promote personal transformation, or "soul evolution," as one lead peer referred to the program. As described by the *Healing Locale* narrative, retreat participants are placed in a setting outside the normal hustle and bustle of daily life. Getting outside of one's routine forces change.

Because of the community living setting, self-isolation as a coping mechanism is less feasible. The 24-hour, 6-day therapeutic milieu provides ongoing opportunities for learning and growth and the space to practice new behaviors with others who are doing the same, which aligns with previous studies (uncited to protect privacy of study) on the First Responder Retreat (FRR).

The psychoeducation topics during the retreat provided foundational knowledge on various topics that were meant to be more introductory rather than in depth, similar to Auren et al.'s (2021) study. Some participants learned new and possibly shocking information about themselves, their personal histories, and their relationships as they connected the dots of information from retreat presentations to their personal experiences. This finding aligned with previously cited literature on how psychoeducation can provide information and support for those recovering from trauma (Mughairbi et al., 2020; Phoenix, 2007; Rice & Moller, 2006; Whitworth, 2016).

The group processing experience allowed participants to share their most wounded places (if they were willing to go there) to learn from one another and to practice new skills. This session aligned with existing literature about the importance of group work (Arrendando et al., 2002). Each study participant cited community as the most impactful part of the retreat, as they learned they were not alone in their difficult experiences. Whether the participants engaged with one other or with peers who had walked the road ahead of them, they found solace and support in company and support in understanding. Such support was normalizing. Participants stated as the week went on, they grew to be more assertive with one another and lovingly (or not) called one another out for various behaviors, having learned about “Stinking Thinking” and codependency earlier in the day or week. Reflecting upon my observations at several retreats, it seemed as if those who were willing to be most vulnerable and authentic in sharing their

experiences were those who gained the most from their retreat experiences; however, some study participants cited the times they felt unsafe to share due to shame or felt isolated even among community when being left alone because they were seen as “angry.”

While reflecting on the presentations on thought distortions and codependency, I was reminded of the need for self-compassion. These thoughts and behaviors are ingrained forms of survival and coping. As individuals learn new skills and behaviors, they need to be gentle with themselves, recognizing they will return to old patterns out of habit, and if retraumatized, out of survival. Self-compassion is difficult for those who believe themselves unworthy of love, care, and compassion (Breines & Chen, 2012; Neff, 2003). Yet, this recognition is part of what participants learn at the retreat—that they are worthy of their own love and compassion.

The personal interviews were rich in story and experience. Comparing those experiences to the SEW Retreat agendas elevated the structure of change that the retreat enables. Additionally, the individual self-assessment scores supported the impact of change because of the retreat. Despite initially requesting Symptom Assessment-Spouses of Emergency Workers [SA-SEW] scores, I learned the self-assessments used differed depending upon when study participants attended the retreat. The Trauma Symptom Inventory, 2nd Edition (TSI-2) was used while the SA-SEW was in development. Regardless of the self-assessment used, change was evident because of the retreat experience.

There was an overall decrease in intrusive symptoms per the average self-assessment scores, which was significant being associated with traumatic stress (Alrutz et al., 2020). An overall decrease in anxiety was also evident, cited as one of the symptoms of secondary traumatic stress (Landers et al., 2020). Reflecting upon participant stories and existing literature, one can indeed see the “ripple effects” of the first responder experience on the family (Landers et

al., 2020), marriage quality (Mormon et al., 2020; Tuttle, 2018), and the experiences of the children (Karaffa et al., 2015; Miller, 2007; Porter & Henriksen, 2016). Participants discussed having to read the moods of their spouses (Mastakis, 2004) and identified trust as a major barrier to relationships overall, specifically with clinicians (Porter & Henriksen, 2016).

Because the SEW Retreat supports individual change, their behaviors at home help change the context of home, work, family, etc. A presentation about the nautilus is held on the first day of the retreat (see Figure 8). The nautilus is an excellent representation of the evolution of process and a metaphor for growth and transformation. As the nautilus grows, it seals off the previous chamber and creates one that better fits (Hoff, 2018). This retreat promotes learning and growth as individuals make new discoveries about themselves. As individuals move forward creating new habits, their old ways no longer serve them. “You can’t un-ring a bell,” is a phrase often heard at the retreat; participants must accept their new awareness and reimagine their behaviors. Once they learn the truth of their experience, they cannot go back to the ways things were. One’s history can no longer support the individual; hanging on to the past may no longer serve the them. I came to understand that I could no longer hold on to my old feelings of hurt: What is the point of holding onto old narratives? A favorite saying at the retreat (that some have had inked onto their bodies for a reminder) is: Let go or be dragged.

**Figure 8**

*Nautilus Cross Section (Chris73, 2009)*

**Change Theory Contributes to Personal Transformation**

Throughout this study, I discovered the SEW Retreat aligns with theories of change, specifically with Gass's (2011, 2013) wheel of change: the changing of heart and mind leads to behavior change, which only then can lead to systemic change. Study participants articulated what they learned at the retreat changed their hearts for (a) more compassion for themselves and their first responder; (b) their minds over their spheres of influence; and (c) subsequent behaviors, specifically around setting boundaries, whether with themselves, family, or work. These examples of change directly answered RQ2 on how change theory contributes to participants' personal transformations.

Participants noted the psychoeducation component was particularly integral to changing hearts and minds. Behavioral changes were observed and practiced during group processing sessions and in the community living space. Participants took this new information home with

them, where their personal transformations impacted their homes lives, work, and their broader communities.

### **Personal Change Impacts Others**

This section addresses RQ3, how participants perceived the impact of transformation on their families and communities. Most study participants discussed the importance of setting boundaries once returning home from the SEW Retreat. Boundaries are an essential form of self-care (Beattie, 1990). Although healthy for each participant, some experienced pushback. This finding was unsurprising, albeit with unexpected changes; if an individual is used to someone doing whatever they ask or wish and they suddenly stop, such a shift can be jarring or upsetting. Participants talked about setting boundaries with their first responders around their own care after the retreat, putting the responsibility for care onto the first responder, and giving him the chance to take care of himself. This change required the spouse to let go, which presented a challenging behavior change itself.

Other participants shared the change of boundary setting in their households. Two participants had children with more intense needs and boundaries, allowing for increased autonomy of the child in a mutually safe way. The subsequent pushback from children (even adult children) was significant, but participants held firm, having learned the importance of taking care of themselves so they could better be there for others.

Work was another area participants cited as having to set boundaries. Rather than always doing for others, whether out of the need to please or be liked, participants talked about the various ways they set boundaries to care for themselves. A few participants changed jobs to remove themselves from toxic work environments and dysfunctional relationships. The retreat helped participants see their worth and determine whether they needed to stay if their

experiences were so detrimental. A few changed their work hours to better accommodate their own needs rather than those of the employer. There may have been initial pushback, but one participant talked about their employer being glad they made the change, as it made for a healthier and happier employee. A few participants engaged in conversation around institutions who will not give their employees as much as the employee gives to them. The sentiment was clear that one cannot expect an employer to care for themselves as much as the individual cares for themselves.

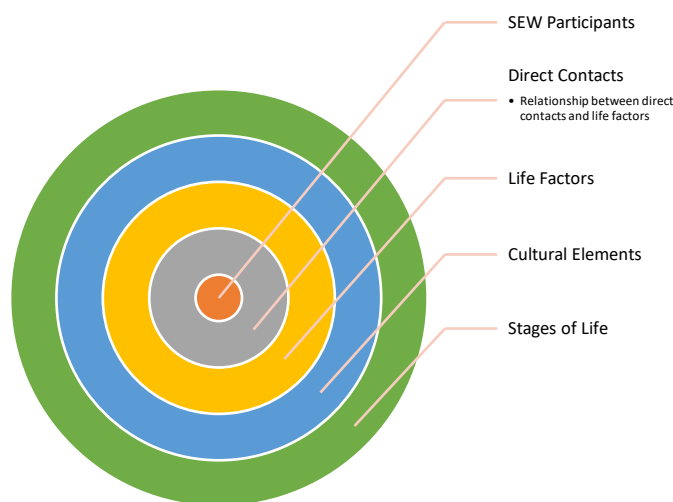
It was helpful to have a course assignment during my doctoral journey on seeing the dissertation as its own system. This allowed me to see connections among systems for myself and study participants, including the impact of culture on interpersonal relationships and the potential for change. From Bronfenbrenner's ecological systems theory (Guy-Evans, 2020; Vélez-Agosto, et al., 2017), I recognized my curiosity and inquiry are at the center, as are the clients and participants and our collective experiences of secondary trauma (see Figure 9). Our microsystem includes family and friends as direct contacts, along with the first responders' organizations and workplaces. Support systems such as service or faith organizations could be included here as well. Areas of coping include interactions between (mesosystem) direct contacts (microcosm) and life factors (exosystem). Codependency as a survival skill could show up in the mesosystem. The chain of command, media, and first responder organizations comprise part of the life factors. These components fall outside one's "donut," but personal change of heart and mind could impact how one engages here. Grounding oneself in one's values and recognizing one's customs, culture elements, social classes helps when exploring how those components play into daily life; coping brings awareness, making change possible



(macrosystem). Recognizing how time of life may impact one's ability to cope, again, brings awareness (chronosystem).

## Figure 9

### *Bronfenbrenner's Ecological Systems Theory of This Study*



## Significance of Support

One requirement for SEW Retreat attendance is seeking therapy support ahead of the retreat so participants have a familiar provider for support upon returning from the retreat. Many participants cited this requirement as a significant form of support for them to explore their needs and practice behavior change. Outside of therapy support, participants described struggling to find a community, or even an individual who could understand their needs. As the primary supporter of a first responder, it is essential for spouses to have support (Beehr et al., 1995; Landers et al., 2020).

Asking about departmental supports elicited eye rolls or guffaws, and many responses of “No. None.” Conversations around the lack of support for their first responders to even debrief

critical incidents paired with incredulity that even when there were debriefs, participants were discouraged from talking about their feelings and encouraged to stick to the facts of a call. If no emotional support exists for first responders, how can there be support for their spouses and families?

Each participant cited the new SEW Retreat community of peers and clinicians as current supports, whether the structure was one person with whom they connected as a client, their fellow group of clients, peers to whom they were assigned, or clinicians who were particularly supportive. There was some discussion around disconnect with peers with whom participants did not “gel,” making new relationships a challenge. Many participants recalled attending supportive Zoom calls provided by the nonprofit organization. These video conferences are held regularly to support past retreat participants. Some attend regularly, some attend when they need additional, specific support.

This community of first responder spouses “gets it.” There was no shame in sharing personal stories, emotions, desires, or crushed dreams. This group understood first responder culture; challenges of living with a loved one with PTS; the struggle of shift work and scheduling; parenting alone; or feelings of isolation and loneliness, even while sitting next to a loved one on the couch. No judgment existed, only compassion and care, which can be hard to find outside of the retreat community; yet, prior researchers have discussed the importance of support for first responder families and spouses (Alexander & Walker, 1996; Alrutz et al., 2020; Karaffa et al., 2015; Porter & Henriksen, 2016).

### **The Richness of Narrative Inquiry**

As a storyteller, reader of literature, and a reflective journal writer, narrative inquiry as a research method aligned with my way of knowing, being, and acting. It was initially difficult to

imagine rewriting study participant experiences, and was difficult to complete the interviews because of all the experiences shared by participants; I had to give myself time for recovery after reviewing transcripts and re-presenting their stories. Their experiences reminded me of my own; I needed to give myself time to manage my triggers when feeling activated by a story or a phrase.

The first narrative I wrote was not a narrative; rather, the narrative emerged as a song, a poem that flowed directly out of reviewing a participant transcript (i.e., “Sapphire’s Song”). The words were all her own and they were poignant, powerful. I shared a voice recording of “Sapphire’s Song” with the participant who felt heard, seen, and recognized for the pain she had long felt. The song resonates for me as well. In fact, I have found myself humming and whistling the tune regularly.

Writing creatively was the impetus I needed to flesh out how I wanted to re-present the other participant stories. After writing and editing each narrative, I sent them to the participants for their review and member checking. I also shared my composites with them (i.e., *Healing Locale*, *Learning to Love Ourselves*, and *Golda*), and edited them as suggested for accuracy and relatability. I received high praise from participants for my writing style and for how well I represented their own experiences, even in a composite narrative. The following narrative was intended to serve as an introduction to the purpose of the study.

### ***Golda, A Composite Narrative***

Golda was a middle-class woman who was relatively comfortable in means, but whose finances were precarious enough that if her husband couldn't work, the family would be in trouble. If he couldn't work due to illness, then he couldn't take care of the kids while Golda

returned to work—that is, if Golda could find a decent-paying job to provide health benefits after years of being at home raising her children and supporting her first responder husband.

Lately, Golda’s husband had been coming home later from work; drinking more on the weekends; and isolating himself from her, the kids, and his friends. When she would talk to him about her concerns, he would lash out in anger. She found herself “walking on eggshells” around him. He would not talk to anyone, but rather, would nap during the day and watch TV at night. Golda found herself making excuses for why her husband couldn’t attend events. Those he worked with knew he had the time off, so his coworkers would not accept working as an excuse. Family began to blame Golda for not doing enough to motivate him beyond work, but her husband had changed so much that he barely had any energy for the job. He began to call in sick and not show up for training days.

She managed the household, the bills, and the children. She was exhausted. She was heartbroken. She felt guilty because could not seem to manage her husband. She needed him to work because the alternative was untenable. What happened to his passion for the work, his calling? What was wrong? What could she do? Where could she turn?

*Golda, A Composite Narrative* was created as I learned more about using narrative inquiry to represent my participants’ experiences. Each participant offered suggestions and feedback so the narrative resonated with all eight individuals. If I were writing a book, this narrative would be placed at the beginning to provide context; however, in meeting the writing requirements for this dissertation, such a structure was not possible. For journal publication, Torrissen and Stickley (2018) provided a helpful example of narrative inquiry block text I attempted to emulate in this work. I used Level 3 headings for all narratives developed during this study; however, I wanted this narrative to appear prior to Chapter 1 under a Level 1 heading,

defying the desired writing style. This change was one way I wanted to disrupt the dissertation structure and system.

### **Member Checking**

Member checking was interesting in that participants felt reviewing their own stories was indeed activating, as were the composites. One participant, Amber, declined to review her final narrative due to having been activated by reading the composites; however, she wished me well, and hoped her story would be helpful both to others and to my research. One participant, Jade, discovered my blatant biases written within her own story and questioned me. Together, we rewrote her narrative until it represented her more accurately and was free of research bias.

Candela (2019) described the use of member checking as a reflective process for study participants that goes beyond a procedure to maintain validity. To triangulate the data, member checking serves as a key to trustworthiness of the data (Bhattacharya, 2017; Candela, 2019; Hernandez, 2020). But what should be done when reading about one's experiences triggers a difficult emotional response? In communication with my dissertation chair, we decided it was important to value Amber's desire to share her story with her blessing, without requesting further review. Jade and I also traded numerous emails after her initial narrative review. She said it was difficult to read each draft. Both Amethyst and Sapphire demonstrated self-reflection after reviewing their narratives, eliciting new insights into their own behaviors and experiences. Member checking was integral to the trustworthiness of my data; however, that trustworthiness was not more important than my participants' mental health. Balancing the need to demonstrate trustworthiness and caring for my participants' mental health was an unexpected part of my data analysis process.

### **Implications for Practice**

My reason for choosing this topic of study was to elevate the stories and experiences of the spouses of first responders. This study demonstrated evidence of SEW Retreat efficacy, which could increase funding sources and support program replication across the United States to provide treatment support for significant others and spouses of first responders. There is nothing exactly like this program, although other means for support via local or national groups (e.g., United by Blue, National Police Wives Association) or online programs (e.g., First Responder Resilience Academy) may exist. This study suggested the combination of (a) the secluded setting, (b) 24/7 therapeutic milieu, (c) group processing sessions, and (d) psychoeducation components facilitated personal transformation that was felt beyond the first responder spouse. Spouses of first responders are the glue who hold their families together so their loved ones can serve the broader community. The SEW Retreat is the community that holds the spouses of first responders together so they can fall apart safely, leave feeling renewed and whole with a community of ongoing support.

Based on stories shared in this study, it was necessary to ensure that the SEW Retreat experience is available to all first responder spouses who would like to participate in it. This expansion will require funding and awareness of the program. Recent dedicated funding sources for the retreat have ceased; thus, sharing stories from this study more broadly could generate interest in donating and increasing revenue for the nonprofit, thereby supporting the expansion and replication of the program. Study publication in varied venues would increase awareness of program availability, increasing interest both in support and participation. Presentations to departments and first responder organizations espousing program benefits are also needed so departments can recognize the impact of a first responder's life on their loved ones.

Further, presentations—not only about PTS in first responders, but also secondary trauma in their loved ones—could be state mandated in employment trainings for fire service, law enforcement, paramedics, and dispatchers. If first responders are trained to be aware of their own responses to trauma as well as how they carry trauma home with them, and provided ongoing support, perhaps the need for the SEW Retreat and other supports could lessen. The results of this study indicated there needs to be a complete shift in first responder culture, and further change in the culture of a country that trains individuals to serve their communities without adequate psychological support for them and the families embedded in services provided to employees.

### **Future Research**

This study was the first attempt to bridge the gap of information about this unique retreat program for spouses and significant others of first responders, specifically whose first responders were diagnosed with PTS. Using the theory of change for programmatic evaluation as described by Weiss (1995) and Judge and Bauld (2001) could be beneficial to understand further the impacts of retreat components. Suggestions for program improvement based on updated research could be implemented, and future research considered. These suggestions could also serve to ensure current research findings are implemented in retreat programming. A program evaluation study could be conducted to increase firsthand and additional perspectives about the program through those who have attended a retreat, including former clients and volunteer peers, along with both past and present, current, and former staff; board members; clinicians; chaplains; cooks; and first responders and their spouses.

I also became curious about conducting further research on returning peers. Do peers' levels of self-acceptance increase after each return to the retreat? Self-acceptance measures

could be used to investigate this question. How does the history of group support play into the retreat program? What about assessing feelings of organizational betrayal experienced by volunteers who have not returned? Is the reason volunteers do not return due to these feelings of organizational betrayal or because of experiencing burnout?

In all the data reviewed, participants made little mention of the chaplain. None of the participants identified the chaplain or chaplain component as integral to their process; however, the catch phrases from beloved chaplains were repeated by participants when speaking fondly about the retreat (e.g., “Don’t say sorry!”). Spirituality is incorporated in the retreat, but what meaning does it have for participants? Does spirituality normalize that formal religion is not necessary for healing, but rather relinquishing control to a higher power is necessary? Significance of the chaplain presence could be an area of future study.

The SEW Retreat appears to be one that is trauma informed. What makes a program be described as such? Future researchers could include the impact of increased creative processes that support reflection, self-awareness, and self-compassion. I observed anecdotal evidence of the positive impact of inserting creative arts into the retreat program. The addition of music, art, movement, and the act of creating could enhance the personal transformation so desperately sought. Creative components could be conduits for self-awareness and personal reflection.

### **Conclusion**

In seeking to explore participants’ experiences during a 6-day retreat program for spouses of those first responders diagnosed with PTS, I came to understand their similar experiences. Even though each person had a slightly different backstory, their need for community, understanding, and support was significant. The participants received these benefits at the SEW Retreat when no other kind of support was available, and their verbal reports were verified by



their self-assessment scores pre- and post-retreat, indicating overall improvement of symptoms of secondary traumatic stress. Representing their experiences through narrative inquiry brought richness to their stories, allowing deeper understanding. In Sapphire's words:

Some first responders abuse the drink and some abuse the drug, some lash out verbally and some lash out physically, some threaten, and some withdraw, some make excuses and some end it all. While the journeys may be different, the trauma is the same. [These retreats] provide the variety of tools needed to meet those who suffer where they're at. They only have to be brave enough to take it.

May there be more understanding of the need and more access to support because of the bravery of those who seek change at the SEW Retreats. The next and final chapter includes my reflections as a novice qualitative researcher during this journey of self-exploration and personal transformation.

## CHAPTER 6: REFLECTION

The benefit of using narrative inquiry as a research method is that I had the opportunity to reflect not only on my research process, but also on my experience as the spouse of a first responder. What follows in this chapter is my own narrative, like my participants already shared, and answers to my own interview questions about my Spouses of Emergency Workers (SEW) residential treatment (retreat) experience. I am biased toward the benefits of the SEW Retreat because of my first-hand experience of personal transformation due to my participation in and attendance at the SEW Retreat. Aligned with Gass's (2011) theory of transformation, I believe the retreat was designed to change my heart, my mind, and my behaviors so I could impact those around me. Because I attended the retreat and have returned numerous times, the impact of what I have learned at the retreat about myself, my innermost thoughts, and how my thoughts impacted the way I behave has paid dividends in improving my relationships with myself, my family, and those with whom I work. I also believe I changed my heart, mind, and behaviors about the system of a dissertation by selecting a methodology aligned with my values. I finish this chapter by reflecting upon my learning and growth as a scholar researcher.

### **My Narrative**

My family enjoys current benefits because of my husband's job as a first responder: our children are attending college, I can pursue a doctorate degree, and I do not have to rush to find employment because my husband was a first responder. And yet, my experience as the spouse of a first responder makes me feel as if these privileges are hard-earned. As if they are the rewards for the sleepless nights, the fear of walking in public and him being recognized as a cop, the midnight callouts, the missed holidays, birthdays, and interrupted anniversaries, the regular

answers to “Where’s your husband?” = “He’s working.” Are these privileges rewards for listening to the stories of rape victims, child molestations, stabbings, homicides, infant deaths or drownings, high-speed chases gone awry, holding the hand of an accident victim as she died? Where are the benefits of being the spouse of a first responder?

I think about my participants’ stories, experiences, emotions, and how, even if they are different, the underlying commonalty of the lives of first responders knits us together. What we have survived as spouses, mothers, care providers. What we have had to do to survive; what we have had to give up within ourselves to survive. I look back and wonder how I survived the first responder life. I resonate with the secret of PTSD, the shame of not having a physical injury to point to, that we were not “strong enough” to overcome the mental anguish that comes from repeated traumatization. This is silly, of course. The world, society is nothing but repeated traumatization with few skills to cope with such. Our family is lucky to be intact; lucky to be alive. First responder culture is toxic, oppressive, and persistent.

As I write, we have just passed the sixth anniversary of my husband being removed from duty. It has been 6 years since our lives were upended and he was told he could not return to duty. He had been drinking more and more excessively to numb himself from all he was feeling. There were a couple of bad night shifts, and he decided not to attend a day shift training. I knew that, but he had not communicated it to his department. Two peer support officers banged on the front door around noon, waking him. He was given the ultimatum of being escorted to a police psychologist for evaluation later that day.

Over the next few months, I learned my husband had a plan to kill himself. It involved him being at work and using his duty weapon. He was off from work, but work was not paying him medical disability; he was using up his sick time. My husband was the sole breadwinner;

my part-time work would never cover our family's expenses, and I still needed to be home to care for and shuttle the kids.

One of the psychiatrists who met with my husband asked him a standard question, if there were any weapons in the house. Indeed, we had several weapons locked up in our safe. My husband was asked to remove the weapons from our home. Working to figure out how we would accomplish this while keeping my husband's situation "under wraps" was difficult. Our options involved telling my parents about the seriousness of my husband's—our—situation or telling my husband's sister and her husband. This also involved telling our children about why we were loading guns in the trunk and driving to Aunti and Uncle's house. Somehow, removing the firearms from home was a significant symbol that things as we knew them would never be the same again. It was a necessary step, but the terror of the unknown, of what might be next, was palpable.

I will never forget being on a walk at a local park with a lovely trail by an arroyo. There were trees lining the banks. My husband squeezed my hand tight as he looked toward the bank. When I asked him what was up, he said, "I just can't wait until the meds kick in." I thought nothing of it until a month or two later when he asked me if I remembered that. When I asked why, he responded, "Because I was looking at those tree branches, trying to assess if they would be strong enough to hold me from a rope." This was an image that I worked through at an SEW Retreat, as a first-time peer. A clinician used a version of eye movement desensitization reprocessing (EMDR) to help me work through the image until it did not hold the emotional power over me anymore. For reference of time, our walk took place in Fall 2016; my EMDR session didn't occur until January 2019. And yet, the healing from that situation remains.

My husband was medically retired abruptly from his department. They never did provide disability while he was off the street. He went through all his sick time, then all his vacation time. I remember completely freaking out because we did not have a plan! We could not plan because we did not know what the department would do, how they might help us, because his injury was work related (although no one wanted to admit that). We had sought legal counsel to help us address the medical disability. It took time before we found someone who was willing to fight for us. We did not want to sue; we just wanted what was owed to my husband and our family so we would figure out what was next. My husband was asked to come into the department one day. It turned out to be his last day. They asked him to clean out his locker, sign separation papers, and leave. There was no fanfare. No formal goodbyes. No administration came down to shake his hand, say thank you or farewell. After 17 years of unwavering commitment, my husband was medically retired. He remembers sitting in the briefing room for the last time, looking around the room, thinking about the camaraderie that happened there, and how, suddenly, his career as a cop was over.

He attended the First Responder Retreat (FRR) after his retirement. I am so glad he did—his retreat saved our marriage. My husband returned home a different person. He had let go of some burdens at the retreat. He shared experiences with me that he never told me about, which shaped the person he was and why he wanted to be a cop in the first place. We spoke more about what he might like to do next. The retreat experience gave us a new lease on our relationship.

### **My Retreat Experience**

He was the one who told me about the SEW Retreat. I grabbed the piece of paper out of his hand and called the number on it as soon as I could. The waiting list was LONG. I attended

over a year after I made the initial phone call. But it was worth the wait. I struggled at the retreat being identified as a “client.” Having been a clinical music therapist for over 25 years at that point, I had trouble doing the work of a client. I also experienced a challenging client group—one of whom dissociated in ways the retreat staff did not appear to be able to manage. This made me feel unsafe as a client, and I locked my emotions up tighter. I saw the benefit of the retreat, I learned from it, and I let go of some feelings of anger and isolation while there. But it took returning as a peer to bring about more healing.

The first time I returned as a peer, I took so many more notes! So many more things made sense! I was more open to the psychoeducation presentations. A major insight I had was around letting go of the grudge I was holding toward my husband’s department. Wanting to hold them accountable for supporting my husband was an unenforceable rule to which I was tired of giving my time. I recognized law enforcement is a system uncondusive to healing and support, which are mutually exclusive with law and order.

I found a community of others with similar experiences in first responder culture, and I learned I was worthy of healing. I could let go of that which no longer served. I could hold boundaries for my own health and well-being. I learned more about codependency. A peer up at my first retreat from my hometown agreed to go with me to a Codependents Anonymous meeting. On my 90-day plan, I had identified marriage counseling as a step toward healing. My husband and I finally went 3 years later. It was worth the wait and has paid dividends in our relationship.

I was changed by my retreat experience. It changed how I related to my spouse, my children, my parents, my work, my volunteer service. Through the retreat and my ongoing work, I have changed my heart toward myself, which has changed how I think about myself, which has

changed how I behave toward myself and my own needs. I learned it is okay to feel my own emotions and to let them out. I have an understanding about triggers and how to manage them, and what I can learn from them. I indeed gained a community of support I am a part of. What I experienced as the spouse of a first responder is not unique, but I would never have known that if not for the SEW Retreat. Although I initially attended the retreat to try to “fix” my husband (a common theme), it was being surrounded by other who understood my story without judgment because they felt similarly isolated, hopeless, and helpless.

I eventually spoke my mind at the retreat. I learned how to take care of the little girl inside myself and needed to be the one to start cherishing myself. During my EMDR session as a client, I imagined I was caring a backpack filled with what I needed for me. I was walking side-by-side with my children and husband, each of whom were carrying their own backpacks of what they needed for themselves. I learned at the retreat how to set boundaries with others to care for myself, yet I also recognized how I had pulled away from other relationships to make myself “solely available for [my husband] and the girls.” I believe my SEW Retreat experience increased my self-awareness and launched me on a path toward self-acceptance. I believe the retreat was designed to effect change. It provided normalization of experiences and was a launchpad for healing.

### **Research Process Reflections**

The self-doubt I have carried as a novice researcher has been prohibitive to my process. I keep revisiting undergraduate and graduate research experiences and how inadequate I felt as a researcher. This was due to both how I was taught and who I was surrounded by; the ongoing judgment and comparisons were detrimental to my ability to see myself as a researcher. Of course, this was 25–30 years ago and views of research in my profession have changed. But

really, it is the TAE program that has changed my perspective about what research is. What I am learning is that living life is research! We do research ALL the time, from every day decision making, to the big choices we make that have impacts beyond ourselves. We do research to make our decisions.

Discovering ways of engaging in doctoral level research that allow me to work in ways that align with who I am as individual has been invaluable. My crushing self-doubt still impedes my progress, but it is no longer a roadblock, rather a caution sign to move through. Part of my research involved reviewing my own researcher journal and notes. I found that it was easier for me to do this with a detached and “researchy” persona, initially. Some of my observations reminded me of being activated by the words of my study participants, so I needed to proceed carefully at first, then I could return to my own writing after having integrated the difficulty of emotions that arose. It has been work to integrate my emotions but ultimately easier than avoiding them all together. That’s how triggers happen, I think, when emotions I haven’t dealt with (likely because I hadn’t even recognized them) arise so quickly that they overwhelm me and my typical coping abilities.

It has been exciting to do data analysis. My experiences have been validated and I have received new information that helps me think about those things outside of my experiences. My process included chunking on the whiteboard, color coding, taking photos of the data, rearranging it, writing it in narrative, then re-reading it, and color coding that for themes. Initially not looking forward to returning to transcripts after having written participant narratives, I found the transcriptions helpful in bringing my own biases to light. I would have ignored those biases if not for the additional check of the transcripts.



During one reflective journaling time, it was after I'd reviewed Amber's narrative, again.

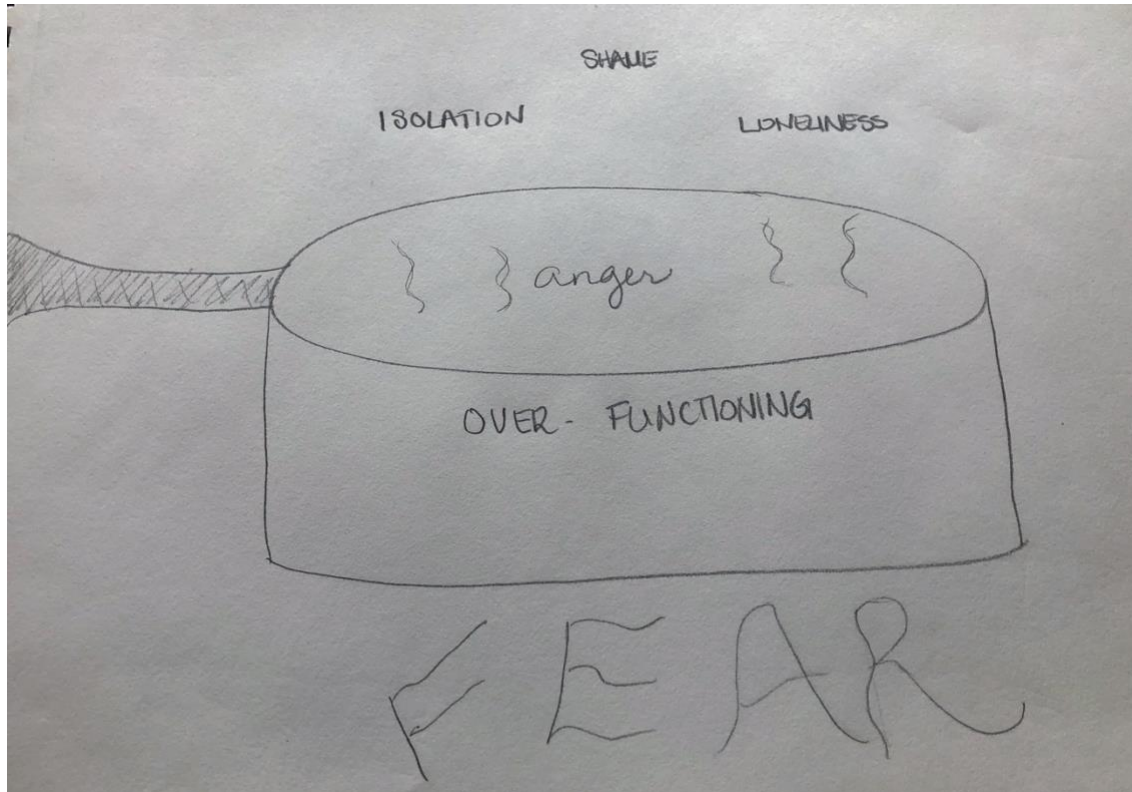
I reviewed the whiteboard:

Fear (of the unknown, of loss, of change). Isolation (no one to turn to). Loneliness.

Over-functioning ("helping"). Shame ("secret"). Everything else up on my whiteboard is positive, hopeful, but these are the deeper common themes: Anger. I feel these in my body, and I let out deep sighs. Letting go. Feeling tears prick my eyes. Pausing as my eyes pass over "self-compassion," recognizing that's what I am practicing.

Avoidance. This is why I stepped away after each interview and review. I wasn't ready to feel (and after the interviews, I was filled with elation that I was doing research and accomplishing it!). It takes time and energy to feel the feelings. The retreat allows for that too. We've been numb from our inner feelings for so long, with anger being the easier to express.

I spent some time on these thoughts over the next few days and sketched out relationships between fear, isolation, loneliness, over-functioning, anger, and shame. Recalling the image Peridot shared about a boiling pot with its lid closed tight, I created the image in Figure 10. Fear is the heat that boils the open pot. To contain the chaos, I over-function for others, which creates anger. But my anger is what is visible; it's really the result of isolation, shame, and loneliness.

**Figure 10***Boiling Pot***Writing as a Form of Inquiry**

An avid journal writer, book reader and listener, and one who likes to tell descriptive stories, I have been amazed at how the act of writing during this process has indeed been a form of inquiry. Here are a few gems:

These are indeed important stories to tell, regardless of the homogeneity of participants. What might further research show about patriarchy, matriarchy within a white supremacy culture that is harmful all the way around? Where men feel empowered to dominate women in all areas: professionally, personally, sexually, politically? If there wasn't a

“macho” first responder culture, but one of compassion, would people WANT to become first responders? Would first responders be respected? How might compassion change the culture of policing? Is compassion even possible? What if it were essential to the survival of first responders and [and could dismantle] white supremacy culture? (7-22-19)

I think back to Bronfenbrenner’s systems model as culture encompasses everything and impacts interpersonal relationships. It relates to the ongoing tragedies of the killing of Black bodies, that are not related to personal failings or lack of training, but to a culture that continues to lift up white bodies in favor of anybody else. The call to center Black, Brown, Indigenous, Asian, Latinx, people of color is the call to center cultures other than white. The stiff upper lip, show no weakness, macho culture that is white supremacy defined has not been working for us – either as individuals or humankind. Those of us in white supremacy culture could learn from cultures that value introspection, creativity humility, vulnerability, and authenticity – even or especially if feeling expression makes others uncomfortable.

What would it be like if an interaction with a police officer and a Black body included the drawing of words/emotions instead of weapons? What if both parties could declare “This situation frightens me, and I just want to go home to my family!”? But like the “tapes” that run in our minds of others’ telling us what to do, there are those that run in Black and police bodies that may go against their own gut.

I spent time looking at my own emotions that came up during my journaling. I began to get curious about them, “What is my envy trying to tell me? Is it really grief, loss? Hurt, regret?” In sharing about this, I was reminded that “data analysis is relationship analysis” and

that “human research is not separate from one’s humanity” (Qualitative Research in Education, 2022).

### **Insights**

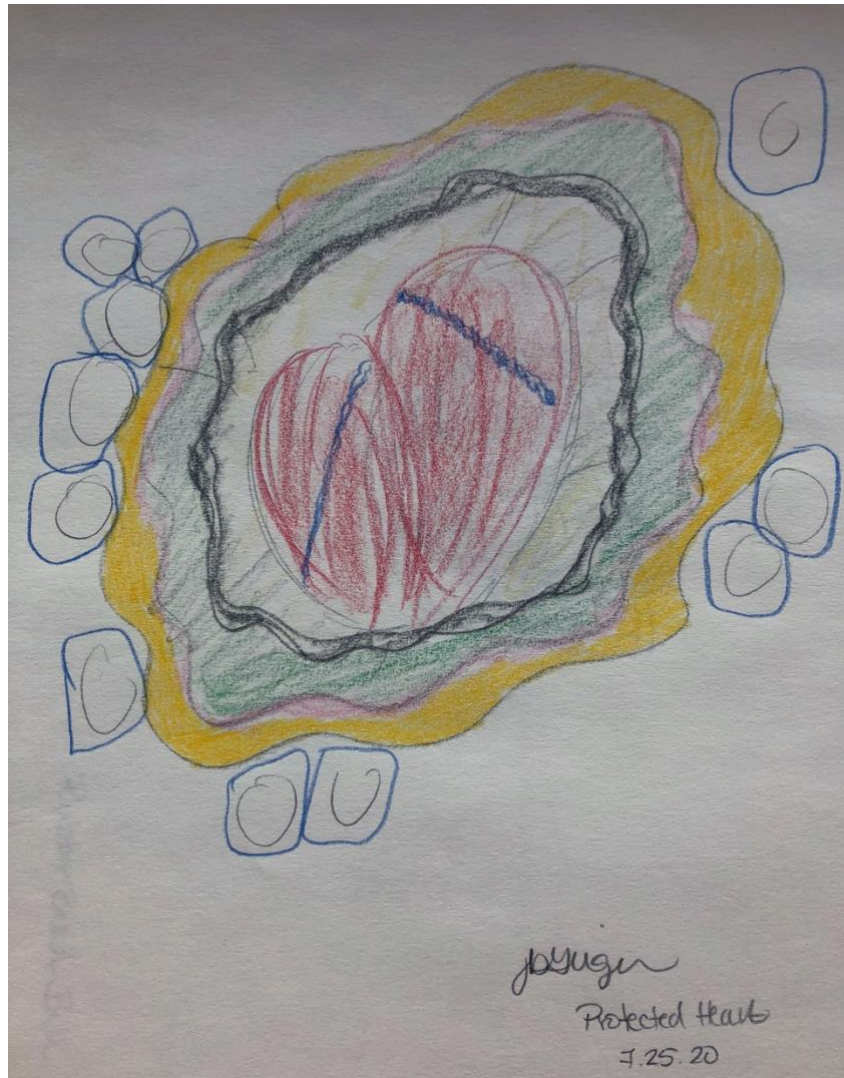
The researcher journal and notebook I kept has provided invaluable reflections and insights. I noted “having to prove my worth to others is exhausting.” Although this was related directly to methodological rigor, it transects every facet of my life. It was often difficult to journal immediately after an interview as my body was hyped up and my brain was firing, often with my own narrative or retreat memories. I cultivated self-compassion with the care I gave myself after working on my dissertation topic. This turned out to be essential to my motivation and perseverance, caring for myself. Throughout the research process I see a push-pull/struggle with reviewing transcripts, working to mitigate my own biases, passing judgment anyway, then circling back to recognize the judgments I was passing on others were directly related to my own behaviors that I judge. Like using avoidance to keep “doing, so that I don’t have to face the way I am being.” Returning to the transcripts and reading participant stories reminded me of my own. Yet, reading through the transcripts for the third time led to creative outcomes of songs, poems, composite narratives, and mapping deeper themes beyond that my first responder husband was my “ticket” to the retreat. I was reminded that learning through stories is meaningful and engaging.

### **Creative Process**

I was surprised by the creativity flowing throughout my dissertation process, which began in the first year of study. Because I felt there were certain societal standards to meet to be an artist, I did not consider myself “creative.” This I have overcome and embraced. I am a creative being who needs to create to express, ponder, and process. Processing my thoughts and

emotions creatively has become second nature and has provided some interested data as part of my dissertation process.

In my first summer of doctoral school, I sketched a version of my heart (see Figure 11) wrapped up in layers of protective materials. The image arose from a description I had written in a journal back in June 2017, “A heart wrapped in layers of protection: ice, cellophane, aluminum foil, fleece, silk, Kevlar.” I further assigned properties to each of those layers after I created the 2020 sketch, “Silk encases, fleece comforts, foil shields, cellophane preserves, Kevlar protects.” I note that the space next to “ice” is blank, there is no property assigned. Upon reflection, I realize ice freezes and preserves. I wonder if I was too afraid to write down that insight, or if I could not see that at the time I was assigning properties, lest I see myself as “cold.”

**Figure 11***Protected Heart*

Yet, during my third summer of doctoral school, I sketched a completely different version of my heart (see Figure 12), one that is open, giving, and receptive. Expansive, multicolored, this creation filled the page (which I believe is also indicative of my “self”—the

willingness to take up space). This figure served as a piece of data to me, symbolizing my own personal transformation of opening my heart so I might open my mind as well.

### **Figure 12**

#### *Open Heart*



An exercise I referenced earlier had us imagine our dissertation as a metaphor. Figure 13 shows the treasure chest I created with gemstone and precious metals named. This happened about 2 months prior to asking participants to select pseudonyms, which are circled in this drawing.

**Figure 13***My Dissertation as a Treasure Chest*

It was important for me to express myself creatively, whether via pencil and paper, song, or creative writing. Working creatively was unexpected during an academic program; but perhaps not so outside the norm of one focused on transformative action.

### **Conclusion**

I came to this dissertation process as one wounded by toxic culture and invested in my personal healing. I knew I was changed by an experience and was delighted to be validated by hearing about others who had similarly been transformed. I could not have predicted how I would grow from the process of dissertation research and writing. With gratitude and a nod to Schwartz (2003), "I have been changed for good" (p. 112).



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### Appendix A: Participant Interest Survey

Thank you for your interest in participating in a study about SEW Retreat participant experiences. Please complete the following brief survey to determine your eligibility.

1. I have attended an SEW Retreat. YES NO
2. My first responder has been diagnosed with post-traumatic stress. YES NO
3. I have access to a computer for an interview via videoconference YES NO
4. With anonymity maintained, I agreed to have my interview recorded YES NO
5. With confidentiality maintained, I agree to give access to my SA-SEW scores, pre- and post-retreat YES NO
6. Please provide your email address as your permission to contact you directly to provide a consent form and schedule an interview. \_\_\_\_\_

## Appendix B: Informed Consent Form

### BENERD COLLEGE RESEARCH SUBJECT'S CONSENT TO PARTICIPATE IN RESEARCH SPOUSES OF FIRST RESPONDERS: STORIES OF SURVIVAL, RECOVERY AND HEALING

**Lead Researcher: Jennifer Geiger**  
**Faculty Advisor: Rachel Hallquist, EdD**

You are being invited to participate in a research study and your participation is entirely voluntary. My name is Jennifer Geiger, and I am conducting a study about SEW Retreat participant experiences in partial fulfillment of a Doctor of Education degree in Transformative Action in Education at Benerd College, University of the Pacific under the supervision of Dr. Rachel Hallquist. I am interested in learning more about what draws participants to the retreat, what tools they take with them, and what they find most meaningful about their retreat experiences.

You are receiving this invitation because you opted into the email list of the supportive nonprofit organization. Should you choose to participate, you will be asked to respond to interview questions over recorded video conference (via Zoom) lasting no more than 1 hour. You also give permission to access your SA-SEW scores from the nonprofit before and after your retreat participation. Should you wish, you may have the opportunity to review these scores. Interview transcripts and copies of SA-SEW score information will be destroyed at the conclusion of this study.

Your participation in this study is voluntary; you may decide whether to take part in this study. If you decide to participate in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw from this study at any time and without giving a reason. Withdrawing from this study will have no effect on any relationship you may have with the researcher. If you withdraw prior to the completion of data collection, your data will be destroyed. It is possible that experiences you share may be turned into something that may generate revenue which you will not share in.

Participant responses will be anonymized, and your participation will be confidential. You may choose not to respond to interview questions with no negative consequences. Participation in this study involves minimal risks. You may experience emotional discomfort in sharing your experiences; you do not need to share anything you do not wish to share. Should you experience emotional distress, you may see a clinical psychologist or talk with someone if needed. There is no compensation provided for participating. You may benefit from sharing your stories and these stories may provide support to others in similar situations. These stories of retreat experiences may support the growth and funding of the SEW program. You will not be notified about the results of this study unless you specifically request it.

If you have any questions or concerns about your rights as a participant, please contact the Human Subjects Office at 209-946-3903 or [IRB@pacific.edu](mailto:IRB@pacific.edu). Should you have any questions about this study, please contact Rachel Hallquist, EdD at [rhallquist@pacific.edu](mailto:rhallquist@pacific.edu).

#### Consent

Your signature below indicates that you have read and understand the information provided above, that you have been afforded the opportunity to ask, and have answered, any questions that you may have, that your participation is completely voluntary, that you understand that you may withdraw your consent and discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled, that you will receive a copy of this form, and that you are not waiving any legal claims, rights or remedies.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Research Study Participant (Print Name): \_\_\_\_\_

## Appendix C: Demographic Survey

Demographic Survey: Please answer the following questions as you desire.

1. Please identify the following personal characteristics (based on Friese, 2020):
  - a. Age range
  - b. Gender identity
  - c. Race/ethnicity
  - d. Regional location (e.g., West, Midwest, other state, etc.)
  - e. Relationship status
  - f. Length of relationship with first responder
  - g. If first responder was in law enforcement with the relationship began
  - h. 1<sup>st</sup> responder type
  - i. Employment status of 1<sup>st</sup> responder
  - j. Number of years as a first responder
  - k. Any other personal characteristics you would like to identify?
2. Year you first attended the SEW Retreat:
  - a. Approximate number of times returned:
3. Does your spouses' department provide support for their significant others? Yes/No
  - a. If yes, in what ways do they provide support?
4. Any other information you would like for me to know?

## Appendix D: Interview Questions

During a 60-minute recorded videoconference, participants will be asked the following questions, with follow up clarifications as/if needed.

1. What brought you to the retreat?
2. What was the most impactful part of the retreat?
  - a. Follow-up questions could include those regarding boundaries, codependency, self-compassion, supportive relationships
3. Did you experience change because of the retreat? Why/why not? What was the change?
  - a. Potential follow-up question: In what ways did your behavior change because of the retreat? In the first 6 months? In 6-12 months?
  - b. Did you experience pushback to changes you made? Were there environmental (e.g., at home) supports to make changes?
4. What kinds of support have you sought as the significant other or spouse of a 1<sup>st</sup> responder?
  - a. How did it make a difference for you?