The Partner at Home: Psychoeducation and Spouses of Public Safety Personnel

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A thesis submitted to Saint Paul University in partial fulfillment of the requirements for the degree of Master of Arts in Counselling and Spirituality

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Acknowledgements

Firstly, I would like to thank the participants who offered their time and effort to participate in this study. Participants were generous with their time and it was an honour to interview them. I would like to thank my significant other Juliana for her support and consistent optimism, and Dan Bowers for the inspiration and motivation. I would also like to thank my family for their support, my thesis supervisor Dr. Stephanie Yamin, and my thesis committee Dr. Cynthia Bilodeau and Dr. Yuanyuan Jiang.

Abstract

An online survey conducted by Carleton and colleagues (2018a) from 2016-2017 revealed that 44% of public safety personnel (PSP) screened positive for clinically significant symptoms of mental health disorders. PSPs, including law enforcement officers, paramedics, and firefighters, are more likely to experience mental health concerns than the general population in Canada (Carleton et al., 2018a). When PSP do seek mental health support, they are most likely to seek support from their spouse or significant other (SSO) and less likely to seek professional support from their organization despite services being at their disposal (Carleton et al., 2020; Henry et al., 2023; O'Toole et al., 2022). This qualitative study, involving interviews with 12 SSOs of PSP, aims to explore SSOs' experiences in providing support, appraisals of psychoeducation received, and suggestions for improvement. While a significant proportion (50%) of participants shared experiences of secondary traumatic stress, 83% (n =10) reported not having experienced formal psychoeducation/PFA training. SSOs perceived that PSP rely heavily on informal support systems, highlighting the need for targeted psychoeducation programs to enhance mental health outcomes for both PSPs and their SSOs. Administering proactive psychoeducation may help improve mental health outcomes among both PSPs and their SSOs while also benefiting PSP organizations by having a healthier workforce.

Keywords: public safety personnel (PSP), spouse or significant other (SSO), psychoeducation, psychological first aid (PFA), potentially traumatic event (PTE), secondary traumatic stress (STS), occupational stress injury (OSI)

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The Partner at Home: Psychoeducation and Spouses of Public Safety Personnel

Public safety personnel (PSP) are more likely to experience mental health symptoms than the general population. In fact, Carleton and colleagues (2018a) found that 44% of PSPs have experienced psychological symptoms consistent with one or more mental health disorders based on self-reported survey data compared to rates of about 10% in the general population (Carleton et al., 2018a; Pearson et al., 2013). Other researchers have found that rates of posttraumatic stress disorder (PTSD) range from 6-32% in police officers, 9-22% in paramedics and 17-32% in firefighters (Alexandar & Klein, 2001; Arbona et al., 2016; Armstrong et al., 2014; Bennett et al., 2004; Berger et al., 2012; Berninger et al., 2010; Carlier et al., 1997; Corneil et al., 1999; Heinrichs et al., 2005; Lewis-Schroeder et al., 2018; Maia et al., 2007; Marchand et al., 2015; Perrin et al., 2007; Robinson et al., 1997; Pinto et al., 2015; Wagner et al., 1998; van der Ploeg & Kleber, 2003). The variability of rates of PTSD diagnoses between the tri-services may be explained by several factors. Firstly, although the category of occupation entitled PSP describes many different careers, such as the tri-services (e.g., police, firefighter, and paramedic), corrections officers, and call center operators/dispatchers, the PSP category is not a homogenous group (Berger et al., 2012; Carleton et al., 2018a). For example, different PSPs may work in the same disaster while experiencing different rates of PTSD diagnoses (Berger et al., 2012; Perrin et al., 2007). Berger and colleagues' (2012) systematic review of worldwide prevalence rates of PTSD in PSPs found that PSP careers may differ in sociodemographic backgrounds and experience different types and frequencies of potentially traumatic events (PTEs). For example, Berger and his team (2012) found that paramedics had higher rates of PTSD than all other PSPs perhaps as a result of having closer contact with victims (Sacchetti et al., 2020), responding to more emergency-related calls than both firefighters and police combined (Marmar et al., 1996),

and/or exposure to greater occupational stress (Young and Cooper, 1995). The prevalence of mental health symptoms in PSPs may be explained by the fact that PSPs are more likely to be exposed to traumatic events than the general population (Alexander & Klein, 2001; Declercq et al., 2011; Lewis-Schroeder et al., 2018; Marchand et al., 2015; Marmar et al., 2006; Statistics Canada, 2012). Traumatic event exposure has been linked with an increased risk of PTSD, major depressive disorder, generalized anxiety disorder, social anxiety disorder, panic disorder, and alcohol use disorder (Bonde et al., 2016; Carleton et al., 2018a; DSM-5-TR, 2013; Fetzner et al., 2011; Sareen et al., 2007).

PSP careers have been reported to be associated with experiences of PTEs, which may include life or limb-threatening experiences to oneself, a colleague, or a civilian (Carleton et al., 2018a; Galatzer-Levy et al., 2011; Komarovskaya et al., 2011; Lewish-Schroeder et al., 2018). Repeated exposures to PTEs can result in occupational stress injuries (OSIs), which is an umbrella term to describe the impact of one's occupation on psychological, emotional, and behavioural functioning (i.e., anxiety, depression, PTSD) (Antony et al., 2020; Carleton et al., 2019; Flannery, 2015; Jones, 2017; Senate Canada, 2015). Thus, PSPs have an increased risk of mental health disorders as their career involves routinely being exposed to potentially traumatic events (Galatzer-Levy et al., 2011; Komarovskaya et al., 2011). A study conducted by Carleton and colleagues (2018b) on suicide rates of 5,148 Canadian PSPs deriving from a self-report survey found that 27% have experienced suicide ideation, 4% had suicide plans over the past year, and 4% of respondents attempted suicide throughout their lives (Carleton et al., 2018b). The suicide rates of Canadian PSPs appear to be greater than the general population, which aligns with reports of higher rates of mental health disorder symptoms in PSP than in the general population (Carleton et al., 2018a; Carleton et al., 2018b). For example, according to the Public

Health Agency of Canada, in their lifetime, 12% of Canadians experience suicide ideation, 4% of Canadians have made plans for suicide, and 3% of Canadians have attempted suicide (Public Health Agency of Canada, 2012).

The risk of experiencing potentially traumatic events may not be the only contributor to PSPs' increased risk of mental health disorders. Brown and colleagues (2020) conducted a review of the literature on shift work and found that shift work was related to poor sleep, depressed mood, anxiety, suicide ideation, and substance use. Consistent with these findings, Angehrn and their team's (2020) online survey on Canadian PSP sleep patterns revealed many participants experiencing symptoms of clinical insomnia. In fact, 55% of respondents screened positive for insomnia, while rates in the general population are much lower (25%) (Angehrn et al., 2020; Chaput et al., 2018). Poor sleep patterns are reported to be significantly associated with symptoms of mental health disorders (Angehrn et al., 2020). Additional factors that may influence increased rates of mental health disorder symptoms in PSP are long working hours and chronic stress (Wright et al., 2022). Mental health issues and OSIs affect the well-being of PSPs and can also have an economic impact due to direct costs of healthcare (e.g., medication and physician visits), indirect costs of income loss (e.g., disability), and productivity loss (e.g., work absences) (Trautmann et al., 2016).

Economic Impact of Mental Health Issues among PSP

The economic implications of mental health challenges among PSPs are profound, affecting not only the individuals but also their families and the broader healthcare system. For instance, the Ottawa Provincial Police (OPP) incurred $3.5 million in six years in injury compensation for police officers due to exposure to traumatic events (Marin, 2012). Additionally, the medical cost of treating an anxiety disorder (e.g., GAD, PTSD, and PD) in the

United States of America (USA) was reported to be, on average, $6,475 per individual over a three-year period (1996-1999) (Marciniak et al., 2005). What can be gleaned from these estimates is that mental health disorders inflict considerable costs on economies (Konnopka et al., 2009). The true economic impact of Canadian PSPs' mental health issues is unknown; however, the Conference Board of Canada (2012) reported that an estimated $20.7 billion is lost yearly due to mental illness and is expected to grow to $29.1 billion by 2030 (Wilson et al., 2016). Mental health-related challenges that PSPs experience can inflict costs on the individual, their primary caregivers, and their healthcare providers through sick leave, which ultimately affects occupational productivity and labour (Antony et al., 2020). In the PSP community, workplace culture and help-seeking behaviors appear to be additional factors that impact mental health issues.

PSP Workplace Culture and Impact on Mental Health

While PSP's lengthy work hours, shift work, and increased exposure to potentially traumatic events influence mental health symptoms, their workplace culture seems to perpetuate mental health issues. Rikkers and Lawrence (2021) offer a brief glimpse into the help-seeking experience of Australian PSP in their national survey. The researchers found that out of 14,868 respondents, 60% of participants experienced a need for mental health support in the past year, and less than half sought help (Rikkers & Lawrence, 2021). Although the majority of respondents revealed that they sought mental health support, close to a quarter of PSP who experienced PTSD (24%), considerable psychological distress (22%), or suicide ideation (24%) postponed help-seeking for more than 12 months (Rikkers & Lawrence, 2021). The more severe a PSP's PTSD was, the more likely they were to view that the help they received was insufficient (Rikkers & Lawrence, 2021). An additional thread to this study was the finding that only 11% of

PSPs attended mental health training, with less than half of the participants finding it extremely useful (48%) (Rikkers & Lawrence, 2021). Considering the increased risk that PSPs have of developing mental health disorder symptoms, these Australian PSP help-seeking behaviors are concerning and may be influenced by stigma.

Barriers to Help-Seeking Behaviors for PSPs

Stigma has long been a barrier to help-seeking behaviours in PSP, which has been evidenced by many studies (Henry et al., 2024; Miller & Silverman, 1995; Haugen et al., 2017). Stigma is the avoidance of seeking mental health support because of a disinterest in being associated with mental illness and the harm that this may bring (Corrigan & Anderson, 2004). Stigma also appears to be an umbrella term for several forms of stigma such as self-stigma (Corrigan & Anderson, 2004), public stigma, (Ben-Zeev et al., 2012) structural stigma, (Corrigan et al., 2004; Hatzenbuehler, 2016) and stigma by association (Phillips & Benoit, 2013). Ben-Zeev and colleagues (2012) recognized label avoidance as one form of self-stigma, which is the purposeful avoidance of participating in mental health services to avoid the harms of diagnoses. Public stigma is recognized as a large group of individuals disparaging a smaller group of individuals based on their mental health, while self-stigma occurs when individuals of this smaller group internalize the public's devalued perceptions of them (Ben-Zeev et al., 2012; Corrigan & Rao, 2012). Structural stigma is the influence of cultural norms and/or institutional policies that limit opportunities for stigmatized individuals (Corrigan et al., 2004; Hatzenbuehler, 2016). Stigma by association is disapproval of one's behaviours simply by being affiliated with a stigmatized person (Phillips & Benoit, 2013). As demonstrated, several types of stigma are present in PSP culture, ranging from systemic levels to individual and these types of stigma impact PSP in a variety of deleterious ways.

Impact of Stigma on PSP

Stigma affects the individual by reducing their self-esteem and ultimately preventing the individual from improving their wellbeing through social opportunities (Corrigan & Anderson, 2004). Self-stigma reduces one's self-esteem, and lower self-esteem may include self-handicapping behaviours such as disengaging from others, avoiding feedback that poses a danger to their self-esteem, procrastination, and anti-social behaviours (Baumeister et al., 2003; Corrigan & Anderson, 2004; Corrigan & Rao, 2012; Donnellan et al., 2005). Self-stigma also impacts self-efficacy, which is the belief that one can conduct an activity or behaviour in a particular situation (Bandura, 2012; Corrigan & Anderson, 2004). Therefore, reduced self-efficacy is the occurrence of one's lower expectations of oneself, which may inhibit the pursuit of goals and achievement (Corrigan & Anderson, 2004). Public stigma has been recognized as another form of stigma (Ben-Zeev et al., 2012) and is the most prominent form of stigma, as public stigma influences self-stigma (Corrigan & Rao, 2012).

Carleton and colleagues' (2020) survey on PSP attitudes toward support found that 74% of PSP chose their SSO before PSP leadership (67%) and would only approach professional support (43-60%) as a last resort (Carleton et al., 2020). The rhetoric behind these choices is speculative, although they include limited mental health literacy, stigma, and concern of potential consequences for reaching out for professional care (Carleton et al., 2020). This speculative rationale for unwillingness to approach formal mental health support is consistent with legitimate findings. For example, in Haugen and colleagues' (2017) systematic review and meta-analysis, the most common stigma-related barriers to seeking help were fears about confidentiality and concerns about career consequences. Gulliver and colleagues' (2019) survey of firefighter access to behavioral health programs found that stigma-related barriers often surfaced as reasons for not

accessing health services. Furthermore, culturally competent clinicians were noted as a need for health service providers (Gulliver et al., 2019). Ricciardelli and colleagues (2020) conducted a large survey of 828 Canadian PSPs investigating barriers to seeking care. Ricciardelli and their team (2020) listed stigma related to mental health disorders and inaccessible care as the two greatest barriers to help-seeking. There were varying opinions about mental health disorders being legitimate reasons for being on leave while receiving a paycheck, and this is where stigma amongst many PSPs seems to stem from. For example, it was proposed that some PSPs take advantage of the system and are dishonest with their mental health challenges, whereas others do legitimately need support (Ricciardelli et al., 2020). This cynical perception of abuse of mental health resources seems to perpetuate stigma because if a PSP is legitimately facing mental health challenges, they may not want to seek professional help due to career consequences and judgement by their colleagues (Ricciardelli et al., 2020). This speaks to the presence of structural stigma where PSPs are concerned about receiving a negative performance review by supervisors if they come forward with a mental health injury (Ricciardelli et al., 2020). Furthermore, if a PSP were to go on stress leave, their peers and organization would be affected by the increased workload, which raises an additional reason not to go on stress leave (Ricciardelli et al., 2020). Budget constraints and employer needs may be exacerbating structural stigma in the PSP context (Ricciardelli et al., 2020; Griffiths, 2014) while policewomen and officers on leave may experience higher levels of perceived stigma than their male counterparts (Bikos, 2021). To put it succinctly, a PSP taking stress leave may experience marginalization by their superiors and colleagues, which brings career consequences. This fear of career consequences is consistent with Carleton and colleagues' (2020) findings, and that SSOs are typically the first form of support for a PSP. These researchers also found that professional services were only considered

as a last resort (Carleton et al., 2020). The impact of stigma in PSP culture has been well researched, as it is a prevalent problem in help-seeking behaviours. Institutional betrayal and experiences of sanctuary trauma appear to perpetuate and exacerbate the prevailing stigma in this culture.

Institutional Betrayal and Sanctuary Trauma

Institutional betrayal, defined as an organization's failure to address misconduct, significantly impacts the mental health of police officers, particularly among marginalized groups (Bikos, 2024; Heber et al., 2023). This betrayal can exacerbate feelings of isolation and distrust, leading to increased mental health issues such as anxiety, depression, and mental health disorders such as PTSD and borderline personality disorder (BPD) (Freyd & Birrell, 2013; Smith & Freyd, 2014). Institutional betrayal acts could include silencing, discrediting, and minimizing reports of workplace abuse, which impact employee mental health, retention rates, and interest in reporting instances of abuse (Bikos, 2024). According to betrayal trauma theory (Freyd, 1996), betrayal trauma is more harmful from a trusted source than abuse from a stranger, as the victim creates extended unawareness (e.g., blindness) to cope with the abuse (Smith & Freyd, 2014). This blindness potentially exacerbates the betrayal trauma because the relationship (e.g., between the organization and PSP) is maintained despite mistreatment (Freyd, 1996; Smith & Freyd, 2014). Sanctuary trauma is an extension of institutional betrayal, as sanctuary trauma describes the experience of the individual or employee who has been mistreated or abused by the organization in which they felt safe (Heber et al., 2023). A scale assessing feelings of betrayal or embitterment in PSP communities does not exist (Huang et al., 2022); therefore, a pilot validation study conducted by Huang and colleagues (2022) assessed the functionality of their workplace assessment scale (WAS) that measures workplace satisfaction with 21 PSPs (e.g.,

police, paramedic, and firefighter). Huang and their team (2022) found minimal results regarding the association between their WAS and psychiatric scales; however, it is important to note that all 22 participants of this study were Caucasian, which may not be representative of the ethnic backgrounds of the individuals who experience more frequent experiences of institutional betrayal (Bikos, 2024). Considering the high rates of mental health disorder symptoms (Carleton et al., 2018a) and suicidal ideation of PSPs (Carleton et al., 2018b), as well as the high prevalence of stigma in these communities (Ricciardelli et al., 2020)., institutional betrayal and sanctuary trauma, may be more prevalent, especially for marginalized groups (Bikos, 2024). Many factors influence PSP risk to mental health symptoms; however, a considerable source of support that helps buffer mental health issues for PSP is their spouse or significant other (SSO).

Spouses and Significant Others Supporting their PSP Partners

Carleton and colleagues (2020) gathered self-report survey data from PSPs from 2016-2017, assessing their attitudes toward support and found that the most sought-out form of mental health support was their spouse or significant other (SSO) (74%). SSOs were compared with friends, PSP colleagues, PSP leadership, physicians, psychologists, psychiatrists, employee assistance program, and chaplains (Carleton et al., 2020). These results are consistent with Gulliver and colleagues' (2019) survey, where (67%) of the surveyed firefighters sought their spouse or family for mental health support before private mental health services (60%). Experienced firefighters were more likely to seek private mental health services, whereas early career firefighters were more likely to seek support from family and colleagues (Gulliver et al., 2019). This interest in seeking informal support through an SSO has been noted in O'Toole's (2022) call to action and Tjin and colleagues' (2022) narrative review of 24 articles involving first responders' trusted others' support behaviors. Considering results from previous studies

(Carleton et al., 2020; Gulliver et al., 2019), achieving a better understanding of what informal support looks like may be an important endeavor. Tjin and colleagues' (2022) narrative review of the support first responders receive from their trusted others (e.g., SSO, siblings, close friends) found three main themes: providing support, finding support, and support needed for the trusted others. The four ways trusted others support first responders include emotional, instrumental, appraisal, and informational support (Tjin et al., 2022). Emotional support involves creating a safe space, providing agency for recovery, encouraging positive coping strategies, and ensuring emotional needs are met (Tjin et al., 2022). Instrumental support involves completing practical needs, maintaining household tasks, and encouraging treatment (Tjin et al., 2022). Appraisal support involves reassuring the first responder and providing positive reframes (Tjin et al., 2022). Finding support is the second theme Tjin and their team (2022) found, and this includes formal and informal support. Formal support involves mental health clinicians and psychoeducation-related training while informal support involves intrapersonal (e.g., self-regulation and action planning) and interpersonal (e.g., peer support). The third theme of Tjin et al.'s (2022) study, the support needed for trusted others, includes inadequate communication skills and maladaptive coping strategies. Inadequate communication skills were described as struggling to approach the first responder after a critical incident, unable to manage mental health symptoms, and limited knowledge of available resources (Tjin et al., 2022). Maladaptive coping strategies were described as hyper-masculinity, avoidant behaviors, substance use, disempowering beliefs, and withdrawal (Tjin et al., 2022). Although SSOs provide crucial support to their PSP partners, the mental health risks PSP are exposed to may also impact SSOs.

Secondary Traumatic Stress (STS) and SSOs

Understanding the support behaviors of trusted others helps inform future programming; however, there are still several gaps in need of clarification. While SSOs are most likely to support their PSP partners after they have experienced a traumatic event, SSOs are also at risk for developing secondary traumatic stress (STS) in the process (Casas & Benuto, 2022; Henry et al., 2023; Hill et al., 2024; McKeon et al, 2021; Tjin et al., 2022). Alrutz and colleagues (2020) in their New Zealand study found that 20% of 646 respondents revealed symptomology consistent with secondary traumatic stress after completing a 17-item secondary trauma scale. Some SSOs have even reported greater levels of stress than their PSP partner (Cox et al., 2022). Casas and Benuto (2022) conducted a systematic review of STS in first-responder families and found that SSOs tend to take on the role of a supporter for their partner as they are aware of their partner's exposure to traumatic events. This supportive role tends to be achieved by sacrificing the SSOs' well-being and comfort (Casas & Benuto, 2022). Aligned with these findings is Bolger and colleagues' (1989) study on stress contagion in couples, where they found spouses (e.g., particularly wives) would alter their household efforts to compensate for their spouse's (e.g., men in particular) decreased effort at home. Thus, occupational stress experienced by one spouse can influence their effort levels at home and affect their spouse's well-being (Bolger et al., 1989). The impact of this occupational stress influences many facets of an SSO's life.

Impact of Occupational Stress Spillover on SSOs

SSOs may experience STS, which includes symptoms of anxiety, mood changes, and intrusive thoughts, amongst others (Casas & Benuto, 2022). Results from this systematic review (Casas & Benuto, 2022) are consistent with Tjin and colleagues' (2022) narrative review of how trusted others support their PSP loved ones. Spouses tend to provide more instrumental care,

such as completing household duties and offering emotional support in the interest of reducing their partner's emotional volatility; however, this support may be achieved by sacrificing the SSO's needs, which results in loneliness (Casas & Benuto, 2022). Seeking support from the first responder community (e.g., other SSOs of PSP), family, and engaging with hobbies unrelated to their partner are prominent coping mechanisms for this population (Casas & Benuto, 2022). Additionally, Sharp and colleagues (2022) conducted an international systematic review of the mental health and well-being of SSOs and children of PSP and found results that are consistent with earlier findings (Casas and Benuto, 2022; Tjin et al., 2022). These researchers found that SSOs may experience extreme pressure attributed to their partner's occupation, feelings of sole responsibility in maintaining household duties, supervising children, and worries about their partner's occupation-related danger (Sharp et al., 2022). The nature of PSPs' work (e.g., shift work, long hours, unpredictable hours) seems to contribute to SSOs feeling like they are single-parenting in a two-parent family (Sharp et al., 2022). Henry and colleagues (2023) recently conducted a study on relationship satisfaction between PSPs and their SSOs and found that within their sample of 30 couples, a PSP with increased mental health symptomology was associated with an SSO with increased symptomology. Furthermore, increases in PTSD complexity were found to be negatively associated with SSO relationship satisfaction (Henry et al., 2023). This study further supports current evidence-based suggestions that SSOs of partners who are at risk of experiencing PTEs may be at risk of developing STS. STS and/or the presence of trauma not only impact individual SSOs but also impact the overall family functioning.

Family Functioning in a PSP Home

Sharp and colleagues (2022) found that SSOs may sacrifice their own emotional needs to compensate for their partner's emotional needs. This additional responsibility of regulating one's

own emotions to compensate for their partner's emotional needs may reduce interpersonal conflicts; however, it also may result in reduced well-being for the SSO (Cox et al., 2022). For example, resentment may grow from the spousal perspective as PSP organizations demand so much time (e.g., shift work), PSPs may be spending more time outside of the home, or as a result of failures in communication or reduced quality time (Cox et al., 2022). It is noteworthy that younger families appear to have struggles in balancing family roles as they are adapting to a new PSP career, novel relationship interactions, and parenthood simultaneously (Cox et al., 2022). Furthermore, what appears to be one of the most salient sources of stress for spouses of PSP is the absence of their partner during holidays (Cox et al., 2022). From the perspectives of SSOs and children, concerns over the lack of quality time spent with their PSP parents were troubling for them, as special events or children's sporting events were missed (Cox et al., 2022).

A qualitative review on PSP and their families conducted by Richmond and colleagues (2024) found several themes aligning with previous research, such as SSOs' experience of worry for their partner, communication challenges, SSOs accommodating their schedule for their partner, and an absence of peer support opportunities for SSOs. Despite the challenges SSOs and their partners face, a USA study on police families found lower rates of divorce than the general population (McCoy & Aamodt, 2010). In fact, Carleton and colleagues' (2018) study on Canadian PSP found that participants who were single or were otherwise separated from their spouse (e.g., divorced or widowed) were more likely to report experiences of mental health disorder symptoms than participants who were married or in a common-law relationship. Although this detail is noteworthy in the context of this paper, it is unsurprising given that married adults in the general population reveal better mental and physical health than their single counterparts (Horn et al., 2013). Additionally, Richmond and her team's (2024) qualitative

review of 18 articles involving PSP and their families found that SSOs, regardless of their sex, did not differ in their experiences. Considering the demands of PSP work, the risk of experiencing potentially traumatic events (PTEs), and the greater risk of developing mental health disorder symptoms and suicidal ideation (Carleton et al., 2018a; Carleton et al., 2018b), SSOs of PSP may be at greater risk of experiencing STS than SSOs of civilians. Theory may improve our understanding of the impact trauma and STS have on committed dyadic relationships.

Couple Adaptation to Traumatic Stress Model

The Couple Adaptation to Traumatic Stress (CATS) model, published in the USA by Goff and Smith (2005), offers a theory of how trauma experienced by one individual in a dyadic partnership impacts the other. An individual who experienced a PTE may experience peritraumatic effects during the PTE and may experience posttraumatic effects after as well (McCan et al., 1988). PSPs are at greater risk of experiencing PTEs as a result of their occupations and thus are at greater risk of experiencing mental health-related symptoms than the general population (Carleton et al., 2018a; Declercq et al., 2011; Statistics Canada, 2012). The CATS model recognizes family members, social support, resilience, education, and financial assets as personal resources for individuals who have experienced trauma (Goff & Smith, 2005). Symptoms of trauma may include dysregulation in one's biological, emotional, cognitive, and behavioural life domains (Goff & Smith, 2005). Biological symptoms of trauma may include physical disorders; emotional symptoms may include anxiety, depression, or anger; cognitive symptoms may be intrusive memories or flashbacks of PTEs; and behavioural symptoms may involve suicidal ideation or plans (Goff & Smith, 2005). Secondary traumatic stress (STS) may be a result of the primary trauma survivor's dysregulation negatively impacting the secondary

individual in the dyadic partnership (Goff & Smith, 2005). Goff and Smith (2005) also argue that this relationship may be bi-directional, where dysregulation in the secondary partner may exacerbate trauma symptoms in the primary trauma survivor. Predisposing factors such as unresolved trauma or individual attributes contribute to one's capacity to process future traumatic events (Goff & Smith, 2005), which aligns with Violanti and colleagues' (2021) findings, where they found a significant positive association between PTSD and adverse childhood experiences (ACEs). Additional relationship problems may include intimacy, parenting problems, and reduced satisfaction in the relationship, among others (Goff & Smith, 2005). Mechanisms of traumatic stress in the couple were also theorized to involve attachment, chronic stress, identification and empathy, projective identification, conflict, and physiological responses (Goff & Smith, 2005). That said, British researchers Powling and colleagues' (2024) qualitative study on partners' experiences of their spouse's trauma revealed that Goff and Smith's (2005) mechanisms of traumatic stress within their CATS model were unsupported. The CATS model is an applicable model to PSP romantic relationships because of the high rates of mental health disorder symptoms as a result of frequent experiences of PTEs. Furthermore, literature on occupational stress spillover and STS reveals that bi-directional effects do occur between individuals in a dyadic partnership; thus, reinforcing the applicability of the CATS model to PSP romantic relationships. Fortunately, understanding trauma and its impact on couple relationships has a dearth of interest; therefore, additional models have been created in hopes of better conceptualizing this experience.

Dyadic Responses to Trauma Model

The Dyadic Responses to Trauma (DRT) model is a more recently developed framework designed to describe the impact that a traumatic event may have on a couple (Marshall & Kuijer,

2017). Marshall and Kuijer (2017) conducted a literature review on emerging research on the experiences of committed couples in which at least one individual experienced a traumatic event. The DRT model asserts that many processes are involved in both individuals of the dyad, such as the potentially traumatic event (PTE), trauma-related stressors, event interpretation and coping, psychological responses, relationship processes, and relationship evaluations and stability (Marshall & Kuijer, 2017). These various processes influence one another and appear to be mediated by one's vulnerabilities and resources, which ultimately influence whether romantic relationships change for the worse or for the better as a result of a traumatic experience(s) (Marshall & Kuijer, 2017). Indeed, it is important to note that not all experiences of traumatic events may negatively influence an individual and thereby the committed relationship, as posttraumatic growth (PTG) has been recognized (Canevello et al., 2016; Tedeschi & Calhoun, 2004). The DRT model applies to PSP romantic relationships as PSPs frequently experience PTEs while typically choosing their SSOs as their first source of support. Because SSOs have been naturally one of the most immediate points of contact helping their PSP partners respond to and process PTEs, SSOs are at risk of exposing themselves to STS, and the DRT model accounts for this. The CATS and DRT models recognize the bi-directional processes involved with couples as both individuals bring their strengths and vulnerabilities into the relationship. Campbell and Renshaw (2018) effectively summarize available models and theories of the impact of traumatic experiences in dyadic relationships.

PTSD/PTSS and Relationship Functioning

The impact of posttraumatic stress disorder/symptoms (PTSD/PTSS) on romantic partnerships has been well established as PTSD/PTSS is often related to relationship distress in one or both individuals in the dyad (Campbell & Renshaw, 2018; Marshall & Kuijer, 2017;

Monson et al., 2012; Taft et al., 2011). Campbell and Renshaw's (2018) meta-analysis of existing research offered another relevant framework that aligns with both the CATS and DRT models. For example, Campbell and Renshaw (2018) recognize that the experience of a traumatic event on one individual in a dyad is mediated by intrapersonal (e.g., attachment styles) and interpersonal constructs and behaviors (e.g., emotional and/or physical intimacy). Also consistent with the CATS and DRT models, Campbell and Renshaw (2018) recognize the influence of contextual moderators such as the individual domain, relationship domain, and environmental domain (e.g., access to treatment, employment) on the impact of PTSD/PTSS on committed relationships. Improving our understanding of mediators (e.g., elements that explain an association) and moderators (e.g., elements that strengthen or weaken associations) may result in greater treatment outcomes (Campbell & Renshaw, 2018). One particular moderator of relationship functioning is the help-seeking behavior of SSOs, as this behavior could strengthen or weaken one's wellbeing.

Barriers to Help-seeking Behavior for SSOs and Needs of SSOs

Australian researchers Waddel and colleagues (2020) interviewed SSOs of veterans and PSP who have partners with PTSD diagnoses and identified some barriers to seeking support. These researchers found a perceived lack of services for SSOs and healthcare providers' lack of recognition for spousal experiences (Waddel et al., 2020). This sense of craving for recognition is consistent with the findings reported in Alrutz and colleagues' (2020) mixed-methods study on partners of PSP. In this study, 30% of 646 respondents perceived they received no emotional or informational support (Alrutz et al., 2020). SSO participants perceived that their families and friends may not fully understand what life with a PSP partner working shift work is like and how impactful this type of work can be on the SSO (Alrutz et al., 2020). Therefore, formal, or

informal opportunities for SSOs to create meaningful connections with other SSOs who understand this experience may be valuable (Alrutz et al., 2020). There is a sense of loneliness in the lives of SSOs that seems to be pervasive in the literature. SSOs reported that they seek increased transparency between PSP employers and SSOs about workshops, communication of their partner arriving home later than expected, event invitations, and being notified that their partner may have experienced a traumatic event seems to be of interest (Alrutz et al., 2020). A narrative review conducted by Cox and colleagues (2022) found that formal debriefing of a major event may be led by a PSP organization; however, family members are not invited. A consistent finding is an interest from both spouses and researchers that SSOs would like to be included in major event debriefings (Cox et al., 2022). These findings reveal that effective resources are unavailable to SSOs, ultimately leading to SSOs feeling like there is a lack of recognition of their experience. A potential intervention for mitigating debilitating outcomes like STS and improving the mental health and well-being of SSOs and their partners is psychoeducation/psychological first aid training.

Psychoeducation and Psychological First Aid

Psychoeducation involves a combination of cognitive behavioral therapy, group therapy, and education that aims to improve patient/client knowledge of the various symptoms of a mental illness while exploring the treatment plan and any other relevant information (e.g., crisis management) (Sarkhel et al., 2020). Psychoeducation may be conducted in individual and family formats as well as in group formats, which is most relevant for PSPs and SSOs (Sarkhel et al., 2020). Homogenous groups of people (e.g., individuals experiencing similar illnesses) are most desirable and may last up to an hour in weekly intervals (Sarkhel et al., 2020). Meanwhile, psychological first aid (PFA) has been recognized as an additional intervention for survivors of

disasters and emergency services working in disaster zones, which was developed as a method to reduce the psychological impact of PTEs (Shultz & Forbes, 2013).

Psychoeducation and PFA for PSP

Psychoeducation and psychological first aid for PSP exists in many forms in Canada such as Road to Mental Readiness (R2MR), various Critical Incident Stress Management (CISM) programs, Critical Incident Stress Debriefing (CISD) programs, and various peer support programs (Anderson et al., 2020). CISM programs are designed to improve PSP competence in responding to potentially traumatic events, preventively and remedially (Robinson, 2000) CISM programs include trauma response education, individual and group counselling as well as Critical Incident Stress Debriefing (CISD), which are implemented following a distressing critical incident in a group format (Robinson, 2000).

Meanwhile, CISD programs include a seven-step model that is hosted by trained peers and mental health professionals (Robinson, 2000). Modern CISD training has stemmed from the "Mitchell Model," which was created in the 1970s and 1980s and distributed internationally to countries including Canada (ICISF, 2024; Mitchell & Everly, 1996; Robinson, 2000). International Crisis Incident Stress Foundation (ICISF) offers CISM training, and so Canada's own Critical Incident Stress Management & Peer Training organization (CISM & Peer Training, 2024; ICISF, 2024). This training is offered to all interested although it is predominantly dedicated to training PSPs interested in participating in peer support (CISM & Peer Training, 2024; ICISF, 2024). A Canadian meta-analysis of The Road to Mental Readiness (R2MR) program outcomes was conducted by Szeto and colleagues (2019) with promising results regarding the effectiveness of this prominent Canadian program. Participant perceptions of their resilience were increased and stigmatizing attitudes decreased three months post-intervention

(Szeto et al., 2019). However, the program was identified to have some limitations, including the absence of randomized controlled trials and a lack of long-term follow-up (Szeto et al., 2019). Thus, researchers have argued that programs like R2MR have "*no evidence supporting its ability to reduce mental health symptoms over time. Furthermore, the evidence for its ability to reduce stigma is mixed"* (McCreary, 2019, p. 7). In a search on the internet for Canadian organizations that offer peer support for PSP, six organizations were found, including Boots on the Ground (2019), Wounded Warriors, Badge of Life Canada (2023), PSPNET (2023), Wings of Change (2023), and Canada Beyond the Blue (2024). Almost all of these peer support programs appeared to include family support either through a program or online meetings (Badge of Life Canada, 2023; Canada Beyond the Blue, 2024; PSPNET, 2023; Wings of Change, 2023; Wounded Warriors, 2019). While it is promising that peer support organizations dedicated to PSP in Canada have peer support available for families, globally, these sources of support for SSOs appear to be in short supply.

Psychoeducation and PFA for SSOs of PSP

A search for local peer support or psychoeducation workshops within evidence-based and grey literature resulted in no such organizations dedicated to supporting SSOs of PSPs. Hill and colleagues (2024) conducted a scoping review of six studies, which revealed evidence of secondary traumatic stress in SSOs of paramedics, yet there were limited resources available to this community. None of the six studies evaluated psychoeducation-related resources that target reducing secondary trauma stress in SSOs (Hill et al., 2024). Sharp and colleagues' (2022) international review of resilience in PSP families also found no widely available resilience-related programs that target PSP families. Meanwhile, interventions for secondary traumatic stress have been explored in professions such as primary care physicians, mental health

professionals, first responders, and nurses (Sprang et al., 2019). Tjin and colleagues' (2022) narrative review found that the only organizations that included trusted others in their programming were veteran-based. Existing literature encourages evidence-based psychoeducation as a possible method to improve support for PSP, considering SSOs may be the first resource first responders' approach (Carleton et al. 2020; Henry et al., 2023; Hill et al., 2024; O'Toole 2022; Tjin et al., 2022). Further, psychoeducation may improve SSOs' ability to support their loved ones and/or increase the likelihood that PSP access timely mental health services (O'Toole et al., 2022; Shultz & Forbes, 2013). Public Safety Canada (2019) identified internet-based cognitive behavioral therapy (ICBT) as an intervention for PSP to mitigate posttraumatic stress injuries (PTSI), which resulted in PSPNET, a platform where ICBT modules are tailored to and available for PSP (Hadjistavropoulos et al., 2023). PSPNET (2023) offers both therapist-guided and self-guided courses to PSP and their SSOs, as part of the Government of Canada's National Action Plan on posttraumatic stress injuries. These courses have been developed to specifically target PSPs and SSOs and are effective for treating PTSD amongst other mental health disorders (Andersson et al, 2019a; Andersson et al., 2019b; Titov et al., 2018). PSPNET participants found that clinically significant mental health challenges they faced were reduced (Hadjistavropoulos et al., 2021). However, Beahm and colleagues (2022) conducted a qualitative analysis of an ICBT program run by PSPNET and identified a need for spousal support for the partners of PSP.

These findings motivated Hadjistavropoulos and colleagues (2023) to develop an ICBT spousal psychoeducation program. In this study, 26 participants agreed to be interviewed about their ICBT experience as part of their formative evaluation study (Hadjistavropoulos et al., 2023). Out of the 26 SSOs, 92% of spouses felt that at least one of the skills they learned was

useful and 88% agreed that ICBT overall was helpful (Hadjistavropoulos et al., 2023). Most of the 26 participants shared their appreciation of the program being web-based, highlighting convenience and accessibility as considerable needs for SSOs in attaining psychoeducation (Hadjistavropoulos et al., 2023). Canadian PSPNET (2023) research in ICBT development for SSOs reveals the needs for psychoeducation for this community, the benefits that stem from such initiatives and the willingness of the Government of Canada to fund them. While psychoeducation/PFA are prevalent programs for PSP, similar helpful programs are only in their infancy for SSOs. Discussing the validity of psychoeducation/PFA programs or workshops for SSOs is important, as evidence of their effectiveness provides a rationale for their implementation.

Validity of Psychoeducation for SSOs as an Early Intervention. Psychoeducation helps individuals who are experiencing trauma-related symptoms by providing a cognitive framework of their experience and reducing the consequences of experiencing PTEs (Phoenix, 2007). Understanding the reasons for how and why trauma symptoms arise facilitates coping strategies as they offer victims a sense of control over how they respond (Phoenix, 2007). Furthermore, understanding the causes of one's symptoms reduces threats of self-criticism and harming one's self-esteem (Phoenix, 2007). Early intervention techniques, such as group debriefing in the context of the UK prison service (Ruck et al., 2013), as well as emergency services and military, have indicated reductions in PTSD symptoms, improved social functioning, and increased support-seeking behaviors (Creamer et al., 2012). Critical Incident Stress Management (CISM) and Critical Incident Stress Debriefing (CISD) programs were first developed by Jeffrey Mitchell as the "Mitchell Model" and swiftly distributed and adopted internationally (Anderson et al., 2020; ICISF, 2024; Mitchell & Everly, 1996; Robinson, 2000 in *Psychological Debriefing).*

Canada offers military personnel and first responders many peer support organizations such as Boots on the Ground, Wounded Warriors, Badge of Life Canada, PSPNET, Wings of Change, and Canada Beyond the Blue (Badge of Life Canada, 2023; Boots on the Ground, 2021; Canada Beyond the Blue, 2024; Wings of Change, 2023; Wounded Warriors, 2019). Social support mediates psychological distress, such as anxiety and depression, and is associated with job satisfaction (Guilaran et al., 2018), and it appears that Canada's peer support organizations have taken advantage of this effective resource. Meanwhile, formal psychoeducation/PFA workshops or programs dedicated to SSOs are largely absent across the globe (McCreary, 2019; O'Toole et al., 2022). Fogarty and colleagues (2021) found in their Australian study that when SSOs have a greater understanding of the rhetoric for their partner's behaviour, they are more likely to be considerate of the time and space needed for the PSP to open up.

Validity of PFA for SSOs as an Early Intervention. PFA has been included in the guidelines for treating the mental health and well-being of victims of disasters based on expert opinion and objective observations as the driving support (Fox et al., 2011). While PFA has yet to undergo a rigorous assessment of its validity through controlled studies, PFA is still the most used approach to disaster events (Fox et al., 2011; Ruzek et al., 2007; Shultz & Forbes, 2013; Vernberg et al., 2008; Watson et al., 2011). PFA is applied to individuals who have experienced a disaster and offers an acute method to reduce distress, facilitate adaptive functioning, and connect victims to additional resources if needed (Watson et al., 2011). Considering its benefits, several researchers have published work on PFA, revealing support for its application in varying contexts.

For instance, a study in South Korea on PFA training for undergraduate students and school counsellors found that a six-hour PFA training significantly improved PFA knowledge and

perceived competence in using crisis intervention-related skills in both groups (Lee et al., 2017). The first three hours were lecture-based, while the remaining three hours were dedicated to simulation/immersive training (roleplays) (Lee et al., 2017). Similarly, a six-hour PFA workshop for non-mental health-trained individuals was developed by Everly and colleagues (2014) in the USA, named RAPID-PFA offered and involved a presentation and practice opportunities in groups. These practice opportunities involved roleplay where one participant would act as the recipient of PFA, one participant would act as the provider of PFA, and one participant would be observed offering feedback (Everly et al., 2014). The team found that crisis intervention knowledge, self-efficacy in being able to perform PFA on a distressed individual, and personal resilience increased either moderately or greatly (Everly et al., 2014). However, there appear to be mixed opinions in the literature on the effectiveness of psychoeducation or PFA to improve mental health awareness and reduce stigma in PSP organizations. For instance, according to McCreary (2019), there are limited evidence-based findings that point toward the effectiveness of psychoeducation and/or workplace mental health prevention programs. McCreary (2019) argues that further research and development of mental health programs are needed; therefore, there appear to be mixed opinions on the effectiveness of programs aiming to improve mental health awareness and reduce stigma.

Study Objectives

To summarize this review of the literature, PSPs have an increased risk of viewing or experiencing potentially traumatic events; therefore, they have an increased risk of experiencing mental health disorder symptoms compared to the general population. Furthermore, long working hours, shift work, and the culture of these occupations are additional factors that may perpetuate the risk of mental health disorder symptoms. There is a need for this study because

the PSP community is at greater risk of developing mental health disorder symptoms than the general population. The PSP community sacrifices at times, life, and limb for the needs of others; therefore, conducting research that targets this population to improve their mental health and well-being is a method to reciprocate PSPs' commitment to the communities they serve. Psychoeducation/PFA-related workshops and early interventions exist for PSP, and yet there is limited formal support for SSOs. SSOs are often the first source of support for PSP; therefore, they are in a convenient position to offer PFA to their partner. That said, PSP occupational stress may influence their SSOs at home, which may result in secondary traumatic stress, so formal psychoeducation may also improve SSO wellbeing. Based on existing literature, SSOs' proximity to PSPs offers an opportunity for researchers and organizations that support PSPs and their families to bolster PSPs' existing support. PSPNET's self or therapist-guided internet-based cognitive behavioral therapy (ICBT) courses appear to be a productive step in the direction of offering greater support for PSP families (PSPNET, 2023). It has been recognized that providing SSOs with psychoeducation on crisis intervention principles, stress response signs and symptoms, and coping strategies may improve their abilities to support their loved ones and themselves (Carleton et al., 2020; O'Toole et al., 2022). While the benefit of psychoeducation for SSOs has been reported (Tjin et al., 2022), little is known regarding best practices in providing psychoeducation to SSOs. Therefore, this study aims to gain insight into SSOs' experiences in providing support to their PSP partners; SSOs' appraisals on the psychoeducation they have received, and to uncover SSOs' views on how psychoeducation provided to them can be improved (e.g., format, content, duration, and timing). In exploring these various experiences of SSOs, practical solutions for mitigating mental health issues in PSP communities may arise. Practical solutions that local police, fire, and paramedic departments can apply to better serve

and support their employees and families. Lastly, this study aims to be a catalyst for future research in creating effective evidence-based psychoeducation/PFA workshops for SSOs of PSP.

Method

Recruitment

Before recruiting participants, approval was attained from Saint-Paul University's Research Ethics Board (Appendix G). Initially, one recruitment email (Appendix F) containing a recruitment poster was sent to contacts within each local first responder organization, who helped disseminate the recruitment poster (Appendix E) and study information internally. Three representatives (e.g., one from each service) were contacted, and only the firefighter representative appeared to disseminate the recruitment email and poster. Meanwhile, a mental health professional who focuses much of their practice on PSP disseminated the advertisement to their network. Naturally, the response rate was greater from firefighters and their SSOs because of the responsive firefighter representative, while response rates from SSOs of paramedics and police officers were minimal. In total, the principal investigator received 17 responses demonstrating interest via email in participating in the study. If an individual expressed interest in participating, a SurveyMonkey link was shared with them, which contained a questionnaire and presented information about the study. The questionnaire also contained eligibility assessment questions, which assessed their admissibility via the study's inclusion and exclusion criteria. If prospective participants were eligible, they were able to sign their names on the consent form to voluntarily participate in the study. The principal investigator's contact information was provided in case participants had any questions before participating to ensure informed consent. Finally, an interview time, date, and method (i.e., videoconferencing via Zoom) were determined based on the availability and preference of the participants.

This study was set in Ottawa, Ontario, Canada and recruited SSOs of PSPs working in the local tri-services (e.g., police, paramedic, and firefighter). This particular location in Ontario was chosen for several reasons. First, a review of the local psychoeducation resources available to SSOs of PSPs was conducted using Google's search engine, revealing minimal existing support services or resources. Only one registered Canadian charity, Badge of Life Canada, appeared during this search (Badge of Life Canada, 2023). This charity offers PSP across Canada and their SSOs weekly psychoeducation virtual sessions, crisis resources, and a group support program (Badge of Life Canada, 2023). No other peer support, psychoeducation-related program or workshop dedicated to SSOs of the local region resulted from the search. Therefore, a needs assessment of SSOs living in this area appeared to be relevant. Additionally, recruiting participants from the same local area allows the participation of a more cohesive sample who are subjected to similar provincial and city-wide policies, and have access to similar psychoeducation resources.

Participants

Purposive and snowball sampling strategies were used to seek members within the local region with characteristics that could best address the aim of this research study (Thorne, 2016). For this study, participants were SSOs of PSP. SSOs were eligible to participate if (1) they had a partner who was either a currently working or retired paramedic, police officer (e.g., municipal, provincial, or federal), or full-time firefighter, (2) their partners had been working as a first responder for at least a year, (3) cohabitating for at least a year with their partner and (4) able to fluently speak and understand English. The inclusion criteria aimed to acquire participants who were the target population intended to benefit from the research findings in addition to facilitating communication between the principal investigator and the study's participants.

Exclusion criteria included (1) if the spouse was a widow or had separated from their partner and (2) if the PSP resided outside of Ontario. Although SSOs who are widowed or separated may have considerable experience to share, the research team believed a separate research study focusing solely on the unique needs of these SSOs may be more appropriate.

A total of 15 participants were successfully recruited to participate in this study; however, two participants did not complete the background and demographic questionnaire, and a third participant could not be interviewed due to the study's time constraints. Thus, 12 participants completed the background and demographic questionnaires and participated in a semi-structured interview. The online survey took participants between seven and 35 minutes to complete, with an average time of 15 minutes. The interviews ranged between 37 minutes and one hour and 40 minutes, with an average duration of 55 minutes. The 12 interviews were conducted by the principal investigator over two months (e.g., August-September).

Most interpretive descriptive studies have reported a sample size between five and 30 participants (Thorne, 2016). For this study, the decision was made to stop recruiting after 12 participants because this number resulted in the study collecting a variety of participant experiences while achieving depth with each participant (Sandelowski, 1995). Moreover, this study aligned itself with the principle of saturation as it is recognized as the “gold standard” for identifying sample sizes in qualitative research (Fusch & Ness, 2015; Guest et al., 2016; Vasileiou et al. 2018). This study achieved data saturation by the 12th interview as no new data were being developed (Fusch & Ness, 2015; Guest et al., 2016; Vasileiou et al., 2018); therefore, previously known information was repeated (Guest et al., 2016; Rahimi & khatooni, 2024; Saunders et al., 2018). Meanwhile, this study achieved thematic or code saturation once the 12th interview was analyzed as a repetition of previous codes and themes were identified (Rahimi &

khatooni, 2024; Saunders et al., 2018). As the data analysis phase continued, the use of reflexive thematic analysis by the principal investigator uncovered meaning saturation, which occurs when participant issues are fully understood and no new interpretations are being developed (Hennink et al., 2017; Rahimi & khatooni, 2024; Yang et al., 2022). To further support the decision to conclude the sample size of 12 participants, Hennink and colleagues (2017) assessed two types of saturation – meaning saturation and code saturation. Hennink and her team (2017) found that code saturation was achieved within nine interviews, while meaning saturation was achieved within 16-24 interviews. This study's sample size of 12 appears to be within the range of contemporary sample sizes to achieve code saturation; however, it appears to be just short of typical sample sizes to achieve meaning saturation, which may influence the richness of this study's data.

Participant Demographics

All participants were female, while all PSP partners of the participants were male, except for one female. Six participants were SSOs of firefighters, four participants were SSOs of police officers, and two participants were SSOs of paramedics. Nine of the participants' partners are currently working PSPs, while three of the partners are retired. Regarding age ranges, ages were split evenly among participants (e.g., four participants per category) between the three categories: 26-25 years old, 36- 49 years old, and 50+ years old. Ethnic backgrounds were not diverse, as 10 participants identified as Caucasian, while one participant identified as Indigenous, and another participant identified as Middle Eastern. The lack of diversity in this study from gender and ethnicity points of view may reduce the generalizability of the findings of this study. One participant has achieved a PhD or higher; another participant has achieved a master's degree, 33% of participants have a bachelor's degree (n = 4), three participants have obtained a

college diploma; two participants have obtained some college, and one participant has achieved a high school diploma or equivalent. Moreover, 66% of participants are employed full-time (*n* = 8), two participants are self-employed, and two participants are retired. Five participants indicated that their PSP partners have worked for over 20 years as PSPs, while three PSPs have worked for 10-15 years, two PSPs have worked for 5-10 years, and two PSPs have worked for less than five years. Finally, 50% of participants have been in a relationship with their partner for over 20 years, and 58% of participants have lived with their partner for at least 16-20 and most of them (75%, *n* = 9) do not have dependents living with them under the age of 18.

Procedures

This qualitative study is framed by Witkin and Altschuld's three-phase process model of needs assessment (Witkin & Altschuld, 1995). A need is a discrepancy between the current circumstances and what is being desired (Witkin & Altschuld, 1995). To bridge the discrepancies and fill the gaps, a needs assessment process can be undertaken, which involves the evaluation and identification of priorities that will influence the application of future improvements and the allocation of resources (Witkin & Altschuld, 1995). The needs assessment framework, as proposed by Witkin and Altschuld is appropriate for this qualitative study because this study aims to obtain an improved understanding of a population's experiences and needs to potentially inform future programming. Witkin and Altschuld's (1995) needs assessment framework has a three-phase structure: (1) pre-assessment, (2) assessment, and (3) post-assessment (Kaufman & Triner, 1996; Witkin & Altschuld, 1995).

Phase one, the pre-assessment phase, involves identifying the context of the problem by understanding what is already known about the population that is being studied (Kaufman &

Triner, 1996). A non-systematic literature review was conducted to achieve this phase by understanding the current state of knowledge related to the needs of SSOs.

Phase two, the assessment phase, involves gathering and analyzing the data (Witkin & Altschuld, 1995). Five steps are included within this phase; (1) selecting a target group, followed by (2) analyzing the data (e.g., determining the discrepancy between what is and what should be), (3) prioritizing level one needs (e.g., needs of SSOs of PSPs), (4) conducting causal analyses, and (5) synthesizing all of the data relating to the needs of the target population (Witkin & Altschuld, 1995).

In the context of this master's thesis study, phase three – the post-assessment phase, involves proposing solutions and formulating potential plans for future programming (Witkin & Altschuld 1995). Overall, this framework aligns with the aim of this study, to describe the psychoeducation needs of SSOs and propose a plan to fill the gaps and satisfy their needs (Witkin & Altschuld, 1995).

Interpretive description methodology was chosen for this study because it aligns with this study's real-world research questions grounded in what is known and a recognition of what is unknown based on empirical evidence (Thorne, 2016). Moreover, interpretive description aligns well with both the applied nature of this study as well as the fact that this study intends to reveal human experience within the health domain (e.g., psychological well-being) (Thorne, 2016). Interpretive description also overlaps well with Witkin and Altschuld's (1995) needs assessment framework as this study intends to shed new light on an overlooked community while generating new insights that influence practical change for SSOs of PSP (Thorne, 2016). Ultimately, interpretive description helps this study achieve outcomes that include producing greater clarity

about the experience of SSOs of PSP and generating real-world change in support for SSOs (Thorne, 2016).

Zoom

The internet-based application Zoom was chosen as the method to record interviews, as Zoom is a reliable platform for recording interviews and uploading said recordings and transcripts to the principal investigator's computer. A "Zoom Business" subscription was paid for so that the principal investigator had access to recording interview transcripts. Although technical issues with virtual devices occasionally occur, the principal investigator only experienced one technical issue where the transcript of one recording did not capture the entire interview. To resolve this issue, the principal investigator typed by hand the remainder of the transcript while the recording played. In-person interviews were never considered, as the benefits of virtual interviews far outweigh the benefits of in-person interviews. For example, the research team believed that setting interview dates and times with participants in a virtual setting increased response rates and facilitated participant interest. Considering the sensitive nature of some of the topics the interview was going to explore, the principal investigator comforted participants by actively listening, offering a non-judgmental demeanour, and vocally appreciating their time and effort.

Ethical Guidelines

The principal investigator emailed interested parties an informed consent form (Appendix A), which included the purpose of the study, risks and benefits to the participants, how sensitive information about participants will be stored, confidentiality, right to withdraw, how the results of the study will be disseminated, the participant rights and concerns, as well as participant legal rights. The consent form (Appendix A) aimed to explain the purpose of the

study and revealed how the study would be conducted to ensure that participants knew precisely what they were signing up for, while providing them with the opportunity to not participate. Furthermore, prior to recording the semi-structured interviews, the principal investigator reiterated the purpose of the study, informed participants of their rights, and asked if participants had any questions or concerns before beginning to ensure participant understanding. As detailed in Appendices A and B, participants were offered referrals to distress and crisis organizations within their community if the topics discussed evoked a distress response.

Privacy and Confidentiality

Electronic informed consent forms (Appendix A) were shared with interested individuals before data collection began. Within the informed consent form, how the study will be conducted, the purpose, the risks, and benefits, and how the principal investigator intends to secure participant information were detailed. Therefore, participants thoroughly understood what information may be made public and what information is prohibited from being made public (e.g., identifying information). Additionally, the informed consent form (Appendix A) revealed to participants how the data would be stored and protected over time, as well as how the data would be securely destroyed. For example, the original data and its copies will be secured at Saint Paul University's campus throughout a five-year retention period. All recordings and data files will be deleted once five years have passed since the study's completion.

Measures

Firstly, a demographic and background questionnaire was automatically provided to the participants if they consented to the study via the recruitment questionnaire (Appendix C). The purpose of the demographic questionnaire was to develop a better understanding of the diversity of participants and included questions about their age, gender, ethnicity, level of education,

career-related questions about their partner, a question about the SSO's most preferred resource for support as well as better understanding the SSO's interest in psychoeducation programs. The questionnaire was validated via a review of past qualitative studies investigating similar phenomena, like participant demographics, as well as intrapersonal and interpersonal issues in the PSP community (Helfers & Nhan, 2022; Newton et al., 2024; Sinden et al., 2013). The questionnaire involved one open-ended question to offer participants an opportunity to share their opinion of what psychoeducation should look like in the future. Coupled with this open-ended question were many closed-ended questions in the form of self-report Likert scales (Appendix B). The implementation of Likert scales in the questionnaire is supported by contemporary psychological-related literature as it is one of the most common and convenient methods of evaluating unobservable constructs (Clark & Watson, 1998; Clark & Watson, 2019; Jebb et al., 2021). The chosen number of points used in the questionnaire was also chosen purposively as five-point unipolar Likert scales tend to have increased reliability than three-point scales (Boateng et al., 2018). One rank-order question was included in the questionnaire to reveal which resources SSOs would approach first if they were to experience mental health challenges, while the second rank-order question applied to whom SSOs thought their partner would seek out first as a source of support. This particular question found its inspiration from Carleton and colleagues' (2020) Canada-wide study on PSP opinions regarding their first choice of mental health support.

To gain deeper insight and understanding of the participants' support needs and their experiences, individual semi-structured interviews were conducted. Interviews were semi-structured because they offer flexible, free-flowing thought and allow prompts from the interviewer that uniquely fit a particular moment (Magnusson & Marecek, 2015). For example,

when a participant needed additional encouragement to share, the semi-structured approach allowed participants to reach greater depths into their thoughts, feelings, and beliefs (DeJonckheere & Vaughn, 2019). Semi-structured interviews may also help participants share more sensitive topics and, in general, are well-suited for revealing open-ended qualitative data (DeJonckheere & Vaughn, 2019). This method is aligned with qualitative methodology and effective for eliciting deep personal experiences from participants to an "outsider" (Magnusson & Marecek, 2015). The interview questions were validated via a pilot interview with an SSO of a PSP, where new questions were created while others were edited or removed as they lacked clarity or did not sufficiently align with the research questions. Additionally, a researcher with experience studying PSPs met with the principal investigator to further evaluate the interview questions.

Before asking study-related questions to the participants during the interview, participants were provided with a preamble reminding them of the purpose of the study, reinforced the voluntary nature of their participation, and requested verbal consent before continuing the interview (Appendix B) (DeJonckheere & Vaughn, 2019; Magnusson & Marecek, 2015). Every question that was asked was either open-ended or was accompanied by an open-ended prompt. Semi-structured interviews that adopt open-ended questions tend to cultivate rich and compelling data by allowing participants to form their answers without being influenced by the structure of the question (Magnusson & Marecek, 2015). The structure of the interview guide was carefully designed to begin each interview by asking broader questions, followed by more focused questions (Appendix B) (Krueger & Casey, 2015). The purpose of this sequencing was to gradually guide participants to discussions of greater detail and depth (Krueger & Casey, 2015). Questions that relate to one another were also clustered together to achieve greater depth

on one topic before moving on to another (Magnusson & Marecek, 2015). Questions that were perceived to inquire about more sensitive topics were grouped within the main body of the questions as well. The purpose of this was to help develop a rapport with participants at the beginning of the interview while also not ending the interview on a painful note, as this may be the last memory the participant has of their interview experience (Magnusson & Marecek, 2015). Additionally, questions were made to address internal validity by ensuring that questions addressed the purpose of the study. Words within the questions were also vetted for jargon and complicated grammar to avoid confusing participants, while care was also invested in avoiding leading questions (Magnusson & Marecek, 2015).

Data Analysis

The data was analyzed using hermeneutic methods of reflexive thematic analysis (RTA) by finding themes and patterns with the coding (Goodrick & Rogers, 2015). This decision is in keeping with hermeneutic concepts of recognizing the principal investigator's ability to interpret the collected data (Goodrick & Rogers, 2015). RTA is fitting for analyzing this study's dataset for many reasons; (1) it is a qualitative analysis method commonly used among social and health sciences, (2) it can be modified to fit the needs of this study and aligns with the practical aim of this research, (3) it is accessible for an inexperienced researcher, and (4) it is effective at unveiling similarities and differences among participant responses (Braun & Clarke, 2006; Braun & Clarke, 2021; Nowell et al., 2017). Additionally, RTA aligns with this study's objectives because the research questions attempt to uncover needs and perceptions as well as improve understanding of people's lived experiences (Braun et al., 2022). While grounded theory is similarly flexible and applicable in qualitative research, the aim of this study is not to create an explanatory theory about the uncovered data (Chun Tie et al., 2019). An ethnographic approach

to this study's data analysis also does not align with this study's methodology because this study is collecting data via a questionnaire and semi-structured interviews, not by observing participants in their natural environment (Kostera & Harding, 2021). A phenomenological approach to the data analysis portion of this study may have been equally as effective as RTA as the phenomenology approach seeks to understand the meaning of an experience (Neubauer et al., 2019). Where this study subtly misaligns with phenomenology is in its purpose, as this study aims to elicit themes across participants to generate practical solutions, rather than focusing on the unique experiences of individuals (Neubauer et al., 2019). RTA acknowledges the role of a qualitative researcher's bias as being an asset while also reminding researchers to be critical of their role (Braun & Clarke, 2021). RTA includes 10 assumptions, which this study intends to uphold. The following assumptions are noteworthy: the researcher's subjectivity is the primary tool, data can be either weak or strong, not inaccurate or accurate, themes are not summaries, and it implores creativity (e.g., within a foundation of rigour) (Braun & Clarke, 2021). Limitations of RTA include "analytic paralysis," where too much flexibility may slow down the analysis process, reduced interpretive power if not combined with existing theories and issues related to rigour, relevance, resonance, and reflexivity (Braun & Clarke, 2021; Finlay, 2021).

This study's data analysis followed RTA's six phases (1) familiarizing oneself with the dataset, (2) coding, (3) generating initial themes, (4) developing and reviewing themes, (5) refining, defining, and naming themes, and (6) final write up (Braun & Clarke, 2021). Phase one involved deeply understanding the content of the dataset by listening to the recordings, transcribing the content, and making notes (Braun & Clarke, 2021). The principal investigator immersed themselves in the dataset by considering patterns while critically engaging with them (Braun & Clarke, 2021). Phase two involved systematic coding, where some responses were

tagged with multiple different codes because some responses had multiple meanings (Braun & Clarke, 2021). Phase two involved identifying the most meaningful responses from what has been explicitly and implicitly said (Braun & Clarke, 2021). As such, the meaningful data was also labelled and subsequently consolidated into their respective themes. Phase three included identifying patterns in the dataset that were deemed closest to answering the study's research question (Braun & Clarke, 2021). An important thread to phase three was recognizing that meaningful themes were revealed from the interactions between the search in the dataset, the research question, and the researcher's knowledge of the topic at hand (Braun & Clarke, 2021). Phase four included the development and review of the previously identified themes. This involved comparing said themes to the dataset and discerning if the themes have identified the most salient responses accurately (Braun & Clarke, 2021). Phase five included deciphering what stories the identified themes told, and it involved titling themes with compelling names (Braun & Clarke, 2021). Phase six demanded the creation of a thorough narrative about the findings in the dataset (Braun & Clarke, 2021).

As for the results of the demographic questionnaire, this information was analyzed in the Statistical Package for the Social Sciences (SPSS), which established descriptive statistics of this study's sample. The purpose of establishing descriptive statistics was to summarize the data in an accessible format (Cooksey, 2020). Examples of descriptive statistics that were analyzed include measures of central tendency (e.g., mean, median, and mode), measures of variability (e.g., variance and standard deviation), as well as measures of frequency.

Rigour

This study followed Guba and Lincoln's (1982) naturalistic inquiry methodology. Consistent with naturalistic inquiry, the principal investigator derived themes that were grounded

in the uncovered data rather than theorizing potential themes and fitting the data into the pre-established theory (Guba & Lincoln, 1982). Credible themes from the data were revealed and although employing multiple coders may have facilitated a more honest and persistent observation of the data (Guba & Lincoln, 1982), it is neither essential nor more desirable to employ multiple coders (Braun & Clarke, 2021). This study engaged in purposive sampling; therefore, Guba and Lincoln's (1982) value of transferability was met via detailed explanations of the data (Ahmed, 2024), although it must be noted that generalizing 12 participants' responses to the rest of the SSOs of the PSP population is unrealistic. This study achieved dependability by engaging in a dependability audit, which entailed a reflective journal detailing decisions made throughout the study (Ahmed, 2024; Guba & Lincoln, 1982). Additionally, minutes were written during meetings with the thesis supervisor throughout the study to ensure concerns were readily monitored and resolved. Lastly, this study achieved confirmability and reliability by frequently reflecting on what subjective thoughts and biases arose from the principal investigator's perspective by journaling in a Microsoft Word document (Ahmed, 2024; Guba & Lincoln, 1982). Within naturalistic inquiry, confirmability is the acknowledgement that a researcher cannot be objective; rather, objectivity is grounded in the data, which is consistent with the values of reflexive thematic analysis (Guba & Lincoln, 1982). Thus, five crucial tenets of trustworthy qualitative research were followed by achieving credibility, transferability, dependability, confirmability, and reliability (Ahmed, 2024). This study maintained rigour by following the values of Guba and Lincoln's naturalistic inquiry.

Results

This study aimed to understand the realities of SSOs in providing support to their PSP partners, their perspectives on psychoeducation received and their interests and needs related to

psychoeducation/PFA. This section describes the results of the study as they relate to the aim and research questions. Overall, the reflexive thematic analysis of interview data revealed six main themes and seven subthemes, which can be found below in Table 1: (1) Scarce formal support: past experience of psychoeducation/PFA, (2) Reading the room, (2.1) Gentle and direct, (2.2) Comfort in contacting PSP coworker or supervisor, (3) Experiencing Occupational Stress, (3.1) Police officer and paramedic stress: mix of specific calls and work demands, (3.2) Firefighter stress: specific calls, (3.3) A common thread to all: Calls involving children are the most impactful, (4) Occupational stress spillover, (4.1) Expressions of occupational stress symptoms/fatigue, (4.2) Impact on SSOs, (5) Barriers to help-seeking behaviors: self-stigma and structural stigma, (6) A need for future programming. Aligned with reflexive thematic analysis, interpretations of data extracts are provided throughout this section; however, interpretations of themes are more thoroughly discussed in the discussion section as they relate to contemporary literature on these topics.

Table 1

Themes and Subthemes

Theme	Subthemes
1. Scarce formal support: past experience of psychoeducation/PFA	
2. Reading the room	2.1 Gentle and direct 2.2 Comfort in contacting PSP coworker or supervisor
3. Experiencing occupational stress	3.1 Police and paramedic stress: mix of specific calls and work demands 3.2 Firefighter stress: specific calls 3.3 A common thread to all: calls involving children are the most impactful

4. Occupational stress spillover	4.1 Expressions of occupational stress symptoms/fatigue 4.2 Impact on SSOs
5. Barriers to help seeking behaviors: self-stigma and structural stigma	
6. A need for future programming	

Demographic and Background Questionnaire

Table 2

Sociodemographic Characteristics of Participants

Gender	*n (N = 12)*	*%*
Female	12	100%
PSP career partner has/had		
Police	4	33.3%
Paramedic	2	16.7%
Firefighter	6	50.0%
Retired PSP		
Yes	3	25.0%
No	9	75.0%
Age		
26-35	4	33.3%
36-49	4	33.3%
50+	4	33.3%
Ethnicity		
Middle Eastern	1	8.3%
White/Caucasian	10	83.3%
Indigenous	1	8.3%
Education level		
High school diploma or equivalent	1	8.3%
Some college	2	16.7%
College diploma	3	25%
Bachelor's degree	4	33.3%
Master's degree	1	8.3%
PhD or higher	1	8.3%
Employment status		
Employed full-time	8	66.7%

Self-employed	2	16.7%
Retired	2	16.7%
Any dependents under the age of 18 living with you		
Yes	3	25%
No	9	75%

Table 3

Characteristics of SSO and PSP Relationships

How many years partner has worked as a PSP	*n (N = 12)*	*%*
Less than 5 years	2	16.7%
5-10 years	2	16.7%
10-15 years	3	25.0%
Over 20 years	5	41.7%
How many years have SSO and PSP been together		
Less than 5 years	1	8.3%
5-10 years	2	16.7%
10-15 years	1	8.3%
16-20 years	2	16.7%
Over 20 years	6	50.0%
How many years have SSO and PSP lived together		
Less than 5 years	2	16.7%
5-10 years	2	16.7%
10-15 years	1	8.3%
16-20 years	7	58.3%

Tables 2 and 3 above offer a summary of the demographic characteristics of participants. Following these demographic-related questions were questions dedicated to uncovering the background information of participants (Appendix C). This questionnaire found that 50% of participants feel that they are somewhat connected to the first responder community, and 66.7% (n = 8) of participants believe that their mental health-related needs are being met by the first responder community. That said, 75% (n = 9) of participants stated that their PSP partner has

experienced mental health-related challenges, and 50% (*n* = 6) of participants stated that they had experienced secondary traumatic stress. All participants feel either very comfortable discussing mental health issues with their partner (58.3%, *n* =7) or considerably comfortable (41.7%, *n* = 5).

Rank Ordering Resources

Participants were asked if they were to rank a list of resources that they prioritize for personal support if they were to face mental health challenges, from most likely to use to least likely to use, 58.3% (*n* = 7) of participants listed a therapist as their number one resource. The remainder of the participants (41.7%, *n* = 5) listed their partner as their number one resource. Thus, if faced with mental health challenges, the two most sought-after resources for participants were therapists and their PSP partners. Participants were asked this same question, but to answer from their PSP partner's perspective. Similarly, 58.3% of participants (n = 7) believed that their partner would seek themselves (i.e., the SSO) as their most likely used resource during experiences of mental health challenges, and the remainder (41.7%, *n* = 5) would seek a therapist as their first choice of support.

Opinions About Psychoeducation

Several questions on the demographic and background questionnaire were dedicated to SSO opinions on the content and delivery of a psychoeducation/PFA workshop. Most notably, 91.7 % (*n* = 11) of participants believed that a psychoeducation/PFA workshop is needed for SSOs of PSP. Most participants were moderately interested in participating in a workshop on psychoeducation/PFA (41.7%, *n* = 5), while the remaining participants were largely very interested or extremely interested.

Participants' satisfaction related to current resources for their community resulted in a mix of some participants feeling very satisfied, and most feeling neither satisfied nor dissatisfied (41.7%, *n* = 5). Participants were also asked about their preferred mode of delivery of a psychoeducation/PFA workshop, and most participants (41.7%, *n* = 5) stated that in-person delivery would be their choice, while the remaining answers were a blend of virtual or web-based (i.e., self-paced).

Lastly, participants were asked what should be included in psychoeducation to improve support for SSOs of PSP. 66% (*n* = 8) of participants responded to this question, while the other four participants skipped. Two prominent themes were revealed in the answers to this question, which include social support and education. Regarding social support, participants listed resources, community, and group/peer support as recommendations for the delivery of psychoeducation. As for education, participants revealed an interest in attaining greater knowledge in recognizing mental health signs and symptoms (e.g., red flag behaviours) what to do when you notice this and where to go next if distress continues, knowledge of how critical incidents affect PSP, and how to set and respect boundaries and needs.

Research Question 1: What psychoeducation-related experiences have SSOs had and what are their perspectives about it?

Table 4

What Psychoeducation-Related Experiences have SSOs had and What are their Perspectives About it?

Theme	Representative data extracts from SSOs
Scarce Formal Support: Past experiences of psychoeducation	"From my knowledge, there's very little that's been offered." (ID03) "There was none." (ID04)

	"No, never heard of anything…Not offered by the employer." (ID05)
	"I haven't had any of that available to me." (ID07)
	"I don't know if there really are. I've never even heard these terms to be honest until you define them." (ID08)
	"None" (ID11)

Theme 1: Scarce Formal Support for SSOs: Past Experiences of Psychoeducation

Table 4 summarizes the results of this question's inquiry by revealing a list of quotes that represent theme 1. Out of the 12 participants, two SSOs of firefighters experienced formal psychoeducation via a day led by a local fire department. The remaining 10 participants have not experienced formal psychoeducation or PFA workshops. A day that was dedicated to families of PSP involved psychoeducation for SSOs of newly hired firefighters. Meanwhile, a local police department does not host any day of psychoeducation or psychological PFA for SSOs. One evening was dedicated to SSOs of recently hired police officers; however, this was more of an introductory meeting for SSOs to get acquainted with their partner's department. Additionally, the local paramedic service does not offer SSOs a day of psychoeducation/PFA. Regarding the local fire department's dedicated day for families of recruits, newly hired firefighters may invite one person to participate in this day. This day included a practical education, for example:

> You get garbed up, you can do the, you know, go up the tower with all the equipment, you can put out a fire, you have to go into the burning kitchen, you try out, you know, you can break apart a car like it's all the all the stuff that they do frequently, you get to do all that (ID02).

The psychoeducation/presentation portion of the day includes an introduction by a spouse of a firefighter with many years of experience, offering advice and testimonials of what it could be like being an SSO of a firefighter. Additionally, emergency scenarios were explored, and participants were encouraged to read emergency-related scenes. Examples of "bro culture" were discussed as well, which reveals the leadership's interest in being transparent to their audience about some cultural aspects of the local fire department. The leaders of the presentation heavily encouraged PSPs and SSOs to seek mental health support. This day has been a recent development, having been created a few years ago, and it is only offered to families of new hires. Thus, SSOs of previously hired firefighters are not included, nor is this experience offered to firefighters who developed a meaningful relationship with someone post-hiring. Another SSO recalled a time when she participated in wearing firefighting equipment while putting out fires in a mock-up kitchen. According to this SSO, this was the closest experience to the definition that was provided to her regarding psychoeducation/PFA. This SSO did not express that a presentation on mental health, firefighting culture, or stigma-related issues was discussed on this day. The latest developments in a day dedicated to families of PSP is a step in the direction of developing an understanding of psychoeducation in SSOs; however, it is limited to SSOs of newly hired firefighters.

Other Resources. For the remaining 10 participants who have not experienced formal psychoeducation or PFA workshop, other resources that they have used include therapy, friends and family, an employee assistance program (EAP), leaning on their own education from previous years, and psychoeducation training via their own initiative, which appears to be via reading books, listening to podcasts, or learning from their partner's experience with peer support training such as Road To Mental Readiness (R2MR).

Two participants experienced EAP, which is part of some employers' benefits package, and this usually includes six counselling sessions with a mental health professional. EAP appears to be relatively effective as short-term support; however, it does not meet the needs for matters that demand a greater number of sessions. For example, ID12 stated that it was a waste of time, while ID05 stated it would never be enough, as she was referring to a friend's spouse who experienced the death of their spouse.

Participants found other informal ways of seeking education on mental health matters, such as leaning on their own psychology courses they completed in university, books that were recommended to them by their spouse's employer, and podcasts or books that they found on their own initiative. One participant's spouse is involved in peer support for their respective fire station, and they shared R2MR information and reading materials with the SSO. ID03 experienced this indirect access to R2MR training and valued this training.

> More specifically, the details of what PTSD is, what it means, what it looks like or what it can look like. Getting the more detailed, nuanced information has been the most helpful for me (ID03).

Participating in therapy was the most commonly used resource by participants. Eight out of the twelve participants revealed that they have experienced therapy before or are continuing to see a therapist. The remaining four participants may have seen a therapist in the past, and it simply did not come up in the interview. Two SSOs also revealed that they have experienced couples therapy. The local fire department offers an insurance plan that covers a sizable portion of the costs of therapy, although there were differing understandings among participants regarding the scale of this coverage. For example, one participant stated that it was unlimited, while another participant questioned what "unlimited" means, as in her experience, there was a

limit to the amount of coverage they received. The local police department also offers its police officers and their SSOs significant insurance coverage for therapy sessions. It is unclear whether the local paramedic service offers SSOs an insurance plan for therapy.

Social Support. Another common resource for participants to reach out to for support was friends and family. Two participants lean on their friends as support, especially another SSO of a PSP, as they experience more validation and understanding from this population. Connecting with another SSO regarding the challenges of their partner's shift work appears to be different than speaking to a friend without a PSP spouse, as illustrated by the following excerpt:

> Simply talking about it and having it being validated by someone that feels the same way is like night and day difference versus if you just talk to a friend (ID01).

ID08 echoed this sentiment as she stated that other SSOs of PSP understand the scheduling stressors and that "there's no need to explain or there's no questioning about it." Reaching out to a close family member has also been an occasional trusted source of social support, especially if it is a family member who has been an SSO of a PSP themselves. Meanwhile, connecting with other SSOs of PSPs in the context of social support appears not to be as important for other participants. This was illustrated by ID09 when she stated that it has been helpful at times, but it is more about finding things in common with others, especially if they are of a similar age and have kids. Meanwhile, another SSO revealed that they would prefer not to contact other SSOs of PSPs.

> There's no brotherhood. It's like everyone's out to get everybody. So, if I were to say, 'Oh. My husband got into an accident, whatever,' and she goes back. That spouse goes back and tells her husband. There's a lot of like 'Oh, I heard, this is what happened.' I

wouldn't want to get together with the wives and if they needed somebody to talk to and someone to listen, I'd be there 100%. But to go and tell them our story. No (ID10).

Mistrust of other SSOs and her husband's employer has resulted in a more conservative approach to connecting with other SSOs in a social support context. Perhaps this mistrust of other SSOs developed as a result of past experiences where she and her partner were not effectively supported by the PSP's community in moments of crisis. Formal psychoeducation/PFA workshops for SSOs appear to be scarce; however, SSOs still actively seek methods to improve their well-being via therapy and connecting with other SSOs or reading literature relevant to their partner's career. This study has reinforced the phenomenon that SSOs of PSP are their first source of support, and the following section explores how SSOs provide said support.

Research Question 2: How do SSOs provide support to their PSP partners?

Table 5

How do SSOs Provide Support to Their PSP Partners?

Theme	Subthemes	Representative data extracts from SSOs
Reading the room	Gentle and direct	"I noticed that you know, you're pretty… distracted, or you know sad, or something after your shift. Is there something you want to talk about?" (ID02) "Would just try to ask him about it openly" (ID08) "As time passed. As I said before, we would say, you know, if you're having a difficult day, you've got to tell me. You gotta tell me, because otherwise I'm taking all this personally." (ID06)

Comfort in contacting the PSP supervisor	"Reach out to probably one of his sergeants. I know, I don't know them personally, but I feel like I could contact them." (ID01) "I'd reach out to his sergeant because I know him." (ID10) "Hypothetically, my next step would be to reach out to someone at his station, like in his crew. Because I'm fortunate that I'm friends with them." (ID03) "Because I felt like he had hit a rock bottom. I knew he was safe because I spoke with his captain." (ID12)

Theme 2: Reading the Room

Table 5 summarizes the results of this research question's inquiry by revealing a list of quotes that represent theme two and its two subthemes. (2.1) Gentle and direct, and (2.2) Comfort in contacting the PSP supervisor. If PSP partners of SSOs appear to be more withdrawn, angry, or experiencing any other red-flag behaviours, SSOs typically approach their partners in a gentle and direct manner. If red-flag behaviours persist or get worse, many participants expressed their comfort and trust in contacting their partner's supervisor for additional support.

Subtheme 2.1: Gentle and Direct

Participants described their approaches to their spouses as not being accusatory, yet being gently direct. For example, ID03 would notice a shift in her partner's mood and ask if he wanted to discuss anything. ID01 revealed this openness by reassuring her partner that she was there to listen or ask if there was anything she could do to help. ID09 and ID08 echoed this sentiment by

encouraging their partners to talk about things as well in a supportive manner. Additionally, many participants revealed how they would often notice a shift in their partner's mood before their PSP noticed, which offered them an opportunity to reflect on what they were noticing to their partners.

Instrumental Support. ID07 shared how she and her partner would check in with each other every once in a while, and how she would be mindful of the mood or state her partner was in:

> I usually give her time to decompress. She wants to talk about it, and then, if she doesn't, then I just be there for her, and let her relax and just help around the house more… Give her that space and time (ID07).

It is noteworthy that if ID07's partner does not have the capacity to talk about how she feels, then conducting house chores to compensate is a typical response. In other words, ID07 reads the room and identifies how she can support her partner. SSO instrumental support was found to be a prominent method of supporting their PSP partners, as not all PSPs have the capacity or interest to share their experiences of the day's shift when they arrive home.

Timing. ID02 and ID12 highlighted how timing also matters when discussing mental health-related topics with their partners. For example, waiting for one's partner to decompress before approaching them about their day. ID07 has had struggles with communicating with her partner in some of these moments.

> She doesn't open up. And sometimes she can't even talk about it right away, because she's so like traumatized from it, so there could be like months that go by, and she only tells me months later…what she's been dealing with because it's so hard… I don't know how

> to deal with her when she's in these certain types of states because I don't know what it's like to be in her position (ID07).

ID07 reveals that, at times, she does not know how to comfort or support her partner in moments of distress. It is within these moments that highlight the benefits of psychoeducation or PFA. Other SSOs had different strategies for these moments; for example, ID05 would wait until the house is quiet and for their kids to not be around to broach the subject if their partner is having an "off day."

PSP Partnered with Another PSP. Meanwhile, it appears that SSOs who are or have been PSPs themselves may experience greater ease with discussing occupational stress or mental health-related topics. For example, ID12 has a rule with her partner where if she or her partner has a bad day at work, they will talk about it, and occasionally they will have this conversation on the drive home. The purpose of this is so that when they arrive home, they do not discuss it anymore, so that work does not consume their time off together. ID04 shared a similar approach by stating that she and her partner would only speak about work for a little while, provide a summary of the call(s) as they do not want to relive the details again, and move on with their day.

There appears to be greater understanding or a sense of ease in communication between SSOs who have also been or are PSPs themselves. This greater ease perhaps arises from an understanding based on experience of what they themselves have needed in similar instances.

Openness to Discussing Mental Health-related Topics. ID05 stated that mental health topics have been discussed more openly in the past 10 years with her partner compared to earlier years in her partner's career, likely as a result of media attention. There appears to be growth in discussing mental health-related topics both publicly in Canada and at home. ID10's experience

is similar to this, in that ever since her partner's accident, mental health topics have been more consistently discussed at home. ID10 added that when her partner was on night shifts, they could speak to one another for about 15 minutes before the SSO had to leave for work. This was distressing for ID10 as she felt like her partner had no one to release his stress to.

> They have really no one to…release to in between the time of and after their shift. I kind of just sit and have to hear about what kind of goes on. It's not the greatest (ID10).

This was an example of openness from the SSO's perspective; however, it appears that connecting with one another in such a short amount of time – as a result of shift work was too rushed, and perhaps the SSO struggled with the capacity to hear about the PSPs' shift.

Struggles with Discussing Mental Health-related Topics. ID07 would occasionally hide as she does not always know how to respond to her partner's mental health challenges while ID06 struggled with her partner's red-flag behaviors.

> When the anger came out back then, I would cocoon in. I would be very quiet. I just let it go and sometimes we would talk about it sometimes you wouldn't…as time passed, as I said before, we would say, you know, if you're having a difficult day, you've got to tell me. You gotta tell me, because otherwise, I'm taking all this personally (ID06).

It appears that after some time and treatment of her partner's PTSD, ID06 was able to speak up more often to clarify if her partner had a bad day. Considering both ID07 and ID06's experiences in the past, perhaps a workshop dedicated to SSOs of PSP could include not only recognizing red-flag behaviours but also offering ways to respond to these behaviors. SSOs appear to provide emotional support by approaching their PSP partners gently and directly. SSOs also revealed comfort in finding support for their partners by communicating with their partner's coworkers or supervisors.

Subtheme 2.2: Comfort in Contacting PSP Coworker or Supervisor

Participants revealed comfort in reaching out to their partner's coworkers or supervisors if occupation stress and red-flag behaviours persisted or got worse. ID05 stated how she feels fortunate to be friends with her partner's coworkers as she can easily send them a message if needed to encourage them to spend some time with her husband.

ID01 also feels comfortable reaching out to her partner's coworkers and she's optimistic that they could provide her with additional resources if needed. ID01 also added that if something severe happened or she did not recognize her partner, she would connect with one of his supervisors. ID12 mentioned that she connected with one of her partner's supervisors when he hit "rock bottom," which reveals the SSO's comfort in reaching out to her partner's supervisor. ID09 would also encourage her partner to call in sick or speak with his co-workers and, as a last resort take him to the hospital; however, this has never been close to occurring. ID09 added that she's optimistic that her partner's supervisor would check in with her "out of the goodness of their heart," rather than them being mandated to do so.

ID10's partner experienced a crisis and her partner's supervisor came over to their home to check in on them. Despite ID10's mistrust of the local police department as well as her frustration that no one except one supervisor checked in on she and her partner, she still feels comfortable reaching out to the same supervisor if red-flag behaviours were to begin again.

> This is probably the only time I could actually tell you. I'd reach out to his sergeant because I know him. But any time before this, there was really nobody to reach out to. That I knew and trusted enough. That wouldn't you know what I mean? Like? Do anything (ID10).

ID10 fears that any other supervisor or coworker may divulge sensitive information, which may lead to career-related consequences for her partner; thus, the only individual that ID10 trusts with sensitive information is a supervisor who had previously supported she and her partner in a moment of crisis.

Psychoeducation Content: Signs and Symptoms. There may be a need for SSOs to experience a psychoeducation/PFA workshop that offers common signs and symptoms of red-flag behaviour and offers tools to support SSOs who struggle with communicating with their partner. There are a variety of ways that SSOs respond to their partner's red flag behaviours. The most common approach regarding opening up a dialogue was a general attitude of openness from both the SSO and PSP perspectives, according to SSOs. SSOs would often read the room and recognize a change of demeanour or mood in their PSP partner before their partner realizes themselves and approach them gently and directly. Meanwhile, at other times, SSOs may hide away or cocoon from the dysregulation that is being displayed by their partner. Many SSOs revealed that they are comfortable reaching out to their partner's supervisor or coworker if red-flag behaviours persist. There appears to be no mandate for supervisors or coworkers to connect with SSOs during a moment of crisis and yet SSOs largely feel comfortable in contacting their partner's colleagues. The need for SSOs to develop a greater understanding of signs and symptoms of red-flag behaviors is further solidified by the themes in the following section as expressions of occupational stress and its impact on SSOs are explored next.

Research Question 3: What would a psychoeducation/PFA workshop look like?

Table 6

What Would a Psychoeducation/PFA Workshop Look Like?

Theme	Subthemes	Representative data extracts from SSOs

Experiencing Occupational Stress	Police and paramedic stress: mix of specific calls and work demands Firefighter stress: specific calls A common thread to all: Calls involving children are the most impactful	"Can be very hard for somebody if you see, you know young kids die, and things like that and then there's just the workload" (ID10) "Because of the stuff that they go through and the stuff that they see like they're traumatized. She's been in the job in Ottawa for five years she has lot of PTSD" (ID07) "Going from a dead baby call to a broken toe...And trying to process that one thing, and then you're barely…have the patient off your stretcher. You're barely processing what happened?" (ID04)
Occupational Stress Spillover	Expressions of occupational stress symptoms/fatigue Impact on SSOs	"It's a friggin hard job, and you do take it home with you," (ID02) "If he didn't go for the outside help, we wouldn't still be together." (ID06) "Really jacked up, and then you drop, and then you kinda get a little moody and angry." (ID12) "I'd say many years dealing with anger. Frustration. He was better at work because it was kind of more of a controlled situation." (ID06) "He wouldn't bring in much at home, except being tired." (ID09)

	"If you have kids, you really feel like you're a single mom." (ID10)
Barriers to help-seeking behaviours: self-stigma and structural stigma	"You don't want to appear weak; you don't want to appear like you can't handle the job. 'Oh, I go to therapy.' Oh, really? Maybe we shouldn't put him into that into the fire next time. Well, now he's just not going to get put where he wants to be because he just admitted that he, you know, is working on his mental health." (ID02) "I feel more comfortable doing external [therapy] than I do internal, because I kind of have a feeling that even though everything they say is confidential, I feel like inside myself that it's not confidential. I feel like they can get whatever information they need to get." (ID10)
A need for future programming	"We have a much larger role we could be playing" (ID03) "As a spouse I want to be empowered to support my husband with his mental health and I need training and understanding to be able to do that." (ID03) "We need to look at what their [PSP] source…and if their support systems are mostly their spouses, then we need to prepare the spouses and other support people to be educated. They need to have their own

	tools. They need to be able to understand and orient to what kind of life they're going into when they're with a first responder." (ID04) "Program that provides kind of a foundation. Understanding, of like literally start soup to nuts of like what is mental health? What is mental wellness? What is mental illness? What does this mean? And then kind of build into the specifics, or like what our specific mental health issues, that. Firefighters and other first responders can face. Here's an understanding of what that means. Here are the signs and symptoms and then get into like. What can you do?" (ID03)

Table 6 reveals a summary of four themes that answer this question, along with five subthemes and related quotes. Themes (3) Experiencing occupational stress and (4) Occupational stress spillover complement one another as a PSP's experience of occupational stress influences its spillover into the home. Theme 3's subthemes include (3.1) Police and paramedic stress: mix of specific calls and work demands, (3.2) Firefighter stress: specific calls, (3.3) A common thread to all: Calls involving children are the most impactful, while theme four's subthemes include (4.1) Expressions of occupational stress symptoms/fatigue, and (4.2) Impact on SSOs. Theme five is (5) Barriers to help-seeking behavior: self-stigma and structural stigma, and finally, theme (6) A need for future programming concludes this section.

Theme 3: Experiencing Occupational Stress

PSPs respond to crises as part of their duties, which may include potentially traumatic events (PTEs). PSPs also tend to experience shift work, which entails working at all hours of a

24-hour day, depending on one's shift schedule or rotation. Spouses of police officers and paramedics shared similar perceived stressors. However, their experiences differed from spouses of firefighters. As such, the following sub-themes will be described: (3.1) Police officer stress: mix of specific calls and work demands and (3.2) Firefighter stress: specific calls.

Subtheme 3.1: Police Officer and Paramedic Stress: Mix of Specific Calls and Work Demands

Police Experiences. Participants were asked if their partner's occupational stress was predominantly caused by specific calls, work demands, or perhaps a mix of these two aspects of their careers. ID01, ID09, and ID10 happen to be SSOs of police officers, and they perceived their partner's occupational stress to be attributed to a mix of specific calls and work demands. ID01's partner stated that her partner's stress is typically a product of overthinking ways that he could have performed more effectively during his shift. Other stress arises from having many reports to complete, and perhaps ID01's partner couldn't complete them all in time. Meanwhile, police officers must also respond to crisis-related calls, as ID09 reported.

> Can be very hard for somebody if you see, you know, young kids die, and things like that. And then there's just the workload…It's a mix of everything. It's staff, its employees, it's the calls they get, it's the crap they have to put up with people (ID10).

Policing requires many demands out of individuals, and ID10 appears to be highlighting how responding to distressed people while working with coworkers or supervisors who are not looking for your best interest takes a toll. ID10 and her partner's experience with sanctuary trauma is what is being alluded to here and is explored in more depth later in this section.

Paramedic Experiences. ID04 and ID07 are partners of paramedics, and they appear to share similar understandings of their partners' sources of occupational stress. ID04 describes working as a PSP in the following excerpt.

> You're seeing things and smelling things and hearing things, and doing things, that can actually be contrary to our own moral codes and our own previous experiences. Going from a dead baby call to a broken toe...And trying to process that one thing, and then you're barely…have the patient off your stretcher. You're barely processing what happened? You don't even have time to finish your paperwork (ID04).

In both the perceived stressors from spouses of police officers and paramedics, it seems that a common thread relates to a busy workload with stressful calls, along with documentation responsibilities that may not be completed due to a lack of time. The heavy workload was also expressed by ID07, who revealed that her partner's stress at or from work may result from being denied break times and working lengthy hours. ID07 added that a lot of paramedics struggle to make it to retirement age.

> Because of the stuff that they go through and the stuff that they see like they're traumatized. She's been in the job in Ottawa for five years she has a lot of PTSD. And if you get, if you get stamped with that on your medical records, you can't be a paramedic, you can't work so, they just like live in silence a lot of the time…She can't say anything, but I can (ID07).

ID07 stated that her partner experiences cumulative trauma and that her partner can't share most things because ID07 struggles with hearing about her shifts. ID07 has noticed a lot of paramedics quit because they don't have the capacity to experience this cumulative trauma, and how only a special type of person can remain in this career. This excerpt also further revealed the blend of work stressors, which include more than just challenging calls. ID07 also referred to her ability to speak up for her partner while stating that her partner cannot. ID07's partner may be referring to several issues, which may include mistrust in the paramedic institution, complaints

falling on deaf ears, or fear of career-related consequences. ID07 continued stating that paramedics are burnt out, and driving while they're drowsy is another risky aspect of the career. Another gripe that ID07 shared about the paramedic career is that dispatch is apparently very unfair, and if you upset them, they will respond by giving you difficult calls back-to-back.

According to the qualitative results, police officers and paramedics appear to attribute their occupational stress to a mix of specific calls and general work demands. 2/2 (100%) of the SSOs of paramedics fit into this category, as well as 3/4 (75%) of SSOs of police officers. This topic of specific calls versus work demands was unfortunately not discussed with all four of the SSOs of police officers, hence only 3/4 of SSOs fit this category. Police officers and paramedics may have a less favourable work-life balance, which contributes to occupational stress attributed to both specific calls and work demands. After all, police, paramedics, and firefighters respond to similar crises. The difference between paramedics and police officers compared to firefighters may be in their work-life balance. 2/6 (33%) of SSOs of firefighters were included in this group as their partners also expressed work-related stress attributed to demands other than specific calls. Said work demands were both related to managerial tasks, such as managing people and helping their subordinates with paperwork.

Subtheme 3.2: Firefighter Stress: Specific Calls

SSOs of firefighters were almost all in agreement on what contributes to their partners' occupational stress. ID03, ID05, ID06, ID07, and ID11 stated that their partners' occupational stress resulted predominantly from specific calls. Thus, 5/6 (83%) of SSOs of firefighters believe that their partner's occupational stress is attributed to specific calls. ID05 and ID12 are partners of firefighters who happen to also share occupational stress unrelated to specific calls; however, they are distinctly different from the sources of stress shared by SSOs of police officers and

paramedics. ID05 shares how her partner's stress comes more from working with co-workers and more managerial work, as he's been promoted to a higher rank in the department. That said, ID05 did share how specific calls appeared to be more stress-provoking than the general demands of her partner's career. Similarly, ID12's partner has experienced more stress lately from managing coworkers as he's supporting many WSIB claims. What appears to be particularly challenging is his being privy to the experiences of his coworkers, as he must listen to them; however, it's been stressful for him because he has not been specifically trained for some of the demands of this new role.

As stated in the previous subtheme, SSOs of firefighters likely experience greater work-life balance than police officers and paramedics. There may be many other factors that are attributed to this, such as differences in employer culture, differences in work-related duties, or perceptions of the public. ID03's partner's mental health appears to be impacted by his inability to address long-term problems that a patient has, such as substance use issues, which are connected to societal-level problems.

> My spouse works in an area where there's a lot of poverty, a lot of drug overdoses, a lot of mental health issues. And having to go to those same apartments shift after shift, resuscitating the same people…a long-term stressor for him is not being able to like, solve someone's long-term mental health issues, and just being kind of… a band-aid solution. I think that is going to weigh on him more and more over the long term (ID03).

ID03's partner wants to create change to societal-level problems; however, as a first responder, he may feel that he's not making a significant enough impact. ID06 referred to one particular call during the interview that considerably impacted her partner involving children, while ID11 also referred to a particular call involving a child that appeared to bother her partner.

Calls involving children appear to impact PSPs the most, compared to other populations of patients, and this resulted in its own subtheme.

Subtheme 3.3: A common thread to all: Calls involving children are the most impactful

Children being involved in the calls appeared among six different participant stories; thus, it appears that scenarios involving children impact PSPs more significantly than other calls. This thread of occupational stress related to specific calls was never discussed purposefully during the interviews. Participants shared what calls were the most stress-provoking to their partners, and they happen to be relatively consistent, as 50% (n = 6) of participants disclosed the involvement of children in emergency scenarios. The collision of a child's innocence and death appears to be a particularly heart-wrenching experience for PSPs, which likely becomes exponentially traumatic the more maimed the child is. Additionally, if a PSP has children, especially similarly aged children as the deceased, this also appears to be considerably traumatic for PSPs. Other calls that impact PSPs include when people are significantly maimed, cumulative stress-provoking calls, when animals are involved, and when they are unaware of the outcome of a call. For example, ID03 stated that once the person they supported enters the ambulance and is on their way to the hospital, there is no resolution for her partner.

Psychoeducation Content: Adapting to Specific Audiences. PSPs appear to experience occupational stress in a multitude of ways – many that arise from specific calls that they respond to and many others that arise from general work demands like shift work, lack of resources, or managing people. Considering SSO responses, it appears that police officers and paramedics experience less optimal work-life balance than firefighters. Support for this reflection was revealed by SSOs of police officers and paramedics who experience occupational stress as a result of a mix of specific calls and general work demands. Meanwhile, most SSOs of

firefighters stated that specific calls, especially including children, were the main cause of occupational stress. This finding perhaps reveals a need to adapt psychoeducation/PFA workshops to their audience. For example, a workshop dedicated to SSOs of police officers and paramedics may include more information about the struggles of work-life balance, while this may not be discussed at length with SSOs of firefighters. It is important to adapt psychoeducational content to different audiences as different populations experience different hardships and express different needs. Offering relevant psychoeducation to its audience members may improve their understanding of their experience and improve their well-being. Understanding PSP's experience of occupational stress is important as they are the primary individual experiencing potentially traumatic events. Meanwhile, the stress of the primary trauma survivor may impact the SSO at home and family functioning.

Theme 4: Occupational Stress Spillover

Participants were asked about their experience of their PSP partner releasing occupational stress into the home and how they respond to this. Results indicated two subthemes related to occupational stress spillover: (1) Expressions of occupational stress symptoms/fatigue and (2) Impact on SSOs. PSPs' occupational stress does appear to influence the day-to-day experience at home for some participants. House chores and responsibilities like looking after children appear to, at times, be impacted by PSP work demands, which ultimately impact SSO's well-being. Responsibilities like making dinner, taking the dog out for a walk, cleaning the home, or supporting children's needs occasionally rest solely on the shoulders of SSOs. This added weight of responsibility impacts SSO well-being by, at times, developing resentment for their partner or feeling like their needs are not being met. Needs such as needing to take a break from making dinner, needing time to get physically active, or the need for more support in raising their

children. Unacknowledged resentment may erode a relationship, thus leading to reduced well-being, while unmet needs may also reduce one's well-being. ID06's experience highlights the prevalence of occupational stress spilling over into the home in the following quote: "If he didn't go for the outside help, we wouldn't still be together*"* (ID06). This excerpt also reveals the impact of occupational stress spillover on their relationship, as her partner's help-seeking behavior facilitated the continuation of their relationship. Expressions of occupational stress spillover often appeared as fatigue or in a more withdrawn mood.

Subtheme 4.1: Expressions of Occupational Stress Symptoms/Fatigue

PSP careers typically involve shift work, which impacts individuals within these careers as humans are predominantly diurnal beings. Participants' PSP partners appear to be no different, as a consistent symptom they experience is fatigue. ID02 expressed how she may need support with a chore or two when her partner comes home from a shift; however, he may not have the capacity to do said chore because he has been awake for 24 hours and working at multiple scenes. ID02's following quote captures this experience: "it's a friggin hard job, and you do take it home with you." ID12 speaks about her and her partner's experience of coming home feeling very elevated and excited, but then they experience a "drop" and feel moody and angry. ID12's experience reveals how her partner's shift may influence their affect or mental health when he returns home. Additionally, ID12's description reveals an increase in cortisol in a PSPs' body as they may have just left a scene to go home; therefore, they are filled with energy. Given some time at home with reduced life-or-death stakes, the PSP experiences a lull in their mood. ID12 refers to the experience as coming home with a "*trauma hard on*" because they are excited to share the story. As the PSP reflects more on the scene, they experience both highs and lows of internalizing what they experienced.

ID05 shared how she's noticed lately that because her partner has been a firefighter for 25 years, he gets tired more quickly, and she finds the shift work affecting him a lot. ID09 stated that her partner rarely releases occupational stress into the home, although if he's on a night shift, his window of tolerance appears to be smaller for daily stressors when he's more fatigued. Some PSPs may arrive home a little quieter or reflective, as ID03 shared about her partner, where sometimes he may be a little less upbeat but consistently communicative about his experience.

Compartmentalizing. ID08 stated that her partner does not release stress from work into the home and appears to be a "one-off" in terms of how he copes. ID08 stated that he would tell her how effective he is at compartmentalizing; however, ID08 is unsure if this is a good or bad thing. Meanwhile, later in the interview, ID08 reflected on this.

> If I do notice anything, where I've noticed that either he's a little bit more withdrawn or kind of on autopilot…just a little less talkative…. There has been one incident where I noticed it for a couple of months before he finally was like, yeah, maybe I have been on autopilot. And I was like, yeah, you think? It's been like three months (ID08).

What ID08 may be describing here is an example of her partner's ability to effectively compartmentalize what he sees and experiences on the road. ID08's partner is so effective at this and perhaps used to compartmentalizing that this defence spills over into his personal life. Other terms that ID08 used to describe this were less intentional regarding quality time in their relationship, and she also noted that being a police officer affected his craving to be social with people outside his police work. Whether ID08's partner is compartmentalizing or being less intentional, the theme here is the existence of occupational stress spillover. For example, ID08 states: "It [police work] just kind of makes you want to just not have any interactions."

This disinterest in engaging with the world outside of police work may be a result of developing mistrust in others, perhaps a cynical attitude towards others, or a generally reduced capacity to be outgoing due to stress. For example, if many social interactions that a police officer experiences during their shift are dedicated to supporting someone who is in distress or responding to someone causing distress in others, this may impact their interest in social interactions outside of work. The following subtheme is dedicated to the impact that a PSP's occupational stress has on SSOs at home.

Subtheme: 4.2: Impact on SSOs

Participants appear to have mixed experiences regarding the impact that their partner's occupational stress and schedule have on them. SSOs of police officers and paramedics appear to experience a greater impact on their lives at home than SSOs of firefighters related to their partner's occupation stress. As alluded to earlier, SSOs experience an impact from their partner's occupational stress (e.g., fatigue or social withdrawal) by contributing more to responsibilities at home. Taking on additional responsibilities also may occasionally contribute to the development of resentment and reduced well-being.

Police Experiences. ID01 shared how she also works full-time, and yet she still spends a lot of time with her daughter. ID01 refers to her partner's career being separate from his responsibilities at home, and these two separate domains of life should not conflict with one another.

> I have a daughter with me every day, all day. So, it's just like I feel sometimes it's just like it's not balanced like it's in their [PSP partner] mind…just because you have a job that requires a lot, it doesn't mean that you don't, you know, do your part, as you know a

> spouse or a partner, a father or you know, a householder…to me it's just your family and your home life is one thing, and work should be another kind of thing (ID01).

ID08 echoed these sentiments having stated that she absolutely feels like she takes on more duties and responsibilities at home and it's what she hears from every SSO of a PSP that she speaks with. ID08 appears to, at times, experience an imbalance regarding responsibilities at home such as cleaning, picking up groceries, and making dinner, day-by-day and week-by-week. This experience of imbalance appears to be amplified when ID08 is working from home as opposed to working in the office because she can readily clean a mess. ID08 added that even when her partner is home, it appears that he's not really home as he's so drained from work.

When ID08 was asked about her experience with resentment and giving grace to her partner, she revealed the presence of a cycle of resentment and grace.

> I find myself kind of going through… that kind of cycle on and off so often. I think I'll fall into the okay, this is getting a lot like dinner every single night this week, I'm also working two jobs, I'm also you know…going to the gym. I'm also going to all these things that, like you're also doing so. Then why, you know, if we're working the same amount of hours…Why does it still fall on me? And then I can definitely feel that resentment coming up for sure (ID08).

ID08 appears to be referring to her confusion regarding how is it that she and her partner work the same number of hours, yet she still conducts more responsibilities at home. ID08 continued:

> You want to provide so much to your partner and help them out as much as possible, knowing that…they are sleep deprived, or they're going into night shifts, or whatever else like you want to, or at least I do. I want to help as much as I can. But one thing at least

> that I try to do is try not to bend my own schedule. Because then I know that that just makes the resentment worse. Like, if I am going to the gym. And that's what my plan was but then he's not gonna have dinner for the night, because he slept in too long, or also was going to the gym. Then I just tried as hard as it is sometimes to just not bend on that and say, okay, well, he could have woken up a little bit earlier to make his own dinner (ID08).

ID08 appears to be cognizant of this cycle of grace and resentment and wants to support her partner as she is aware of how tiring shift work is for PSPs. Meanwhile, ID08 does not want to bend her schedule to the needs of her partner all of the time, as this would increase her resentment. An interest in finding the correct balance of supporting her husband while achieving her own needs appears to be taking place. Unrelated to additional responsibilities at home, some SSOs may worry more about their partner throughout the day, which may impact SSOs from being more present in their interests.

> If you have kids, you really feel like you're a single mom. Tell you the truth…You're doing everything around the house. You're cooking, you're doing everything. And then they get their two days off, and after night shift they're trying to recover. Their sleep is not the same, their eating patterns are not the same. So, it's like everything's off. So, you come home from work and they're sleeping. Because they're their shift, they're so off. So, you do have to pick up a lot more slack. You do have to do a lot more. Yes, 100% (ID10).

That said, when asked about her experience of resentment and giving her partner grace, ID10 responded by stating that she never resents her partner – they just work well together. ID10 added that her partner is up all night, and they go through a lot; therefore, she's not going to pile on more demands from him as her partner experiences enough in their day so that's when she

bites her tongue. During ID10's partner's crisis, she began using her partner's sleep medication to help her get some rest.

> Felt like I was alone. I started taking the pills he was taking because I couldn't sleep. You know, and I had nobody to say, okay, you know, like, just talk. Just have somebody talk to. You know what I mean. It takes a toll. Like his, his fluctuations. Up, down, up, down. You're only human (ID10).

When ID10 was asked about how she coped with the occupation stress that spilled into the home, she responded by saying that she did not know. There were days that it weighed heavily on her all day, especially when she would hear about the crises that he had had to respond to. ID10 revealed that she is always worried about her partner because he does not always share what is going on for him in his mind.

Paramedic Experiences. ID07 shared her experience at home with her partner who is a paramedic: "A lot of the time it did come to a point where, like I was kind of sick of cleaning and doing everything myself." ID07 stated that she would leave the house clean, be away for a few days, and then come back to an unkept home. When ID07 comes home from work she typically wants to decompress and relax so she's experiencing a reduced capacity to perform cleaning duties at home.

> She has a good head on her shoulders, so she's easy to communicate when it comes to that stuff. Fortunately, I have a good relationship…She goes to therapy to get help for that [stress spillover]. She's on medications for PTSD, helping her sleep at night. They have nightmares and stuff a lot. I have to wake her up a lot out of nightmares almost every night, sometimes…She changed in the last five years. I could tell you that much (ID07).

It appears that ID07 has, at times, had to carry a larger load of responsibilities at home, such as cleaning as a result of occupational stress spillover, while also supporting her partner through symptoms of PTSD. Additionally, ID07 revealed that in the past five years of working as a full-time paramedic, she has changed.

ID04 shared how she used to have to pick a fight with her partner to get him to discuss mental health-related issues; however, once she became a paramedic herself, she and her partner developed more effective ways of debriefing after shifts. There appeared to be a shift in how ID04 would approach her partner as a result of becoming a paramedic herself. As for responsibilities at home, ID04 shared how household chores were balanced as both she and her partner knew the demands of shift work.

Firefighter Experiences. Suicidal ideation was expressed by ID06's partner at one point in their relationship and this resulted in considerable concerns for her partner: "There's times where I'd come home…or you'd be worrying at work am I coming home to him, or his body kind of thing." ID06 shares a clear example of the impact that occupational stress may have in the home environment and with SSOs of PSP. Regarding responsibilities at home, ID03 stated that her partner is usually a high-energy person who needs a lot of projects to work on as healthy outlets. ID06 also shared that she was fortunate in that her husband still kept up with all the duties at home. ID12 revealed that house chores and responsibilities are effectively shared as both she and her partner understand the demands of shift work. ID12 may be shedding light on how couples who are both PSPs may have greater ease with dividing responsibilities at home as previously revealed in ID04's experience. ID12 added: "I do cut him some slack for sure, because I don't know what he's been through in that 24 hour*"* (ID12). ID12's perspective is aligned with ID11's perspective as she spoke about a balance at home regarding responsibilities

as there was a give-and-take. ID11 continued, stating that she is unsure if she took on more responsibilities at home than someone who had a partner who worked regular hours, such as nine to five, Monday to Friday.

Setting Expectations. There appears to be a relatively consistent thread of interest by SSOs to set expectations with their partner regarding responsibilities at home. For example, ID02 expressed how she needs support with a chore or two when her partner comes home from a shift; however, he may not have the capacity to do said chore because he's been awake for 24 hours and working at multiple scenes. ID08 reflected on conversations that she had with her partner before they got engaged and married. The following excerpt by ID08 referred to the additional responsibilities at home.

> Is this what I can expect? Am I okay with this? Am I okay taking on more…What does that balance look like? What can you do on your end? To try to like adjust things. What expectations are realistic? I don't know. Like, is it just kind of a frustration that there is not necessarily a solution? But at least like recognizing it makes it better (ID08).

ID05 revealed that the most challenging part of her relationship dynamic was expectations. ID05 expected that if her partner was home all day or home for three or four days in a row, the laundry be complete. ID05 and her partner would have conflicts about this at first but then they figured it out together. Communicating about each other's expectations appears to have been helpful for ID05 and her partner.

> Just as much as I need a break, so does he, and sometimes his breaks are longer than you would need, or you would think you need but because of…you know, not sleeping for 24 hours, it takes a toll after a while. So, yeah, there's a lot of compromises…you find a balance eventually (ID05).

ID05 referred to a need to find balance regarding responsibilities at home and although this fluctuates with her partner's schedule, it is ultimately balanced with the help of compromises.

SSO Reflections About the Interview. Participants were asked what the most important topic in the interview for them was. The purpose of this question was to uncover any additional needs or highlight any previously mentioned needs to inform future programming. ID01 shared how the most important thread to the SSO experience is the weight on the shoulders of the SSO. There appears to be a "fine line" as ID01 puts it, between wanting to be supportive of her partner while also needing to be supported by their partner.

ID08 stated that the most important part of the interview was just the fact that it focused on the experience of SSOs as they are often overlooked.

> Obviously, the first responder is the hero and the big person doing all the other things, and then you're just the one at home...Doing all the house stuff, and having all the responsibility, and having to take care of everything at home…you're just kind of like a forgotten one off to the side often and I've heard that repeated from like other spouses and friends, too where yeah, you just kind of are the one just with all the leftovers afterwards (ID08).

According to ID08, there appears to be more emphasis on mental health, especially on mental health-related experiences of PSPs but not on how those experiences impact SSOs. Finally, ID08 revealed how this interview is one of the only times that someone focused on the experience of SSOs of PSPs and how this topic is rarely discussed. ID12 echoed this sentiment by stating that PSPs need to be supported while the individuals who they are going home to shouldn't be forgotten.

Psychoeducation Content: Setting Expectations May Mediate Occupation Stress Spillover. SSOs, especially SSOs of police officers, appear to be impacted by their partner's work schedule and occupational stress. Meanwhile, SSOs of firefighters tend to have more balanced duties and responsibilities at home. SSOs of police officers appear to involve more "single-parenting" attitudes and feelings. Unfortunately, the sample of SSOs of paramedics was too small (n = 2) to provide concluding interpretations of this population's experience. SSOs appear to be impacted by the spillover of their PSP partner's occupational stress in several ways. SSOs may take on more duties and responsibilities at home, whether cleaning the house, walking the dog, picking up groceries, supporting the needs of their children, or making dinner. The stacking of these additional responsibilities at home may result in resentment for their partner. Resentment appears because there are needs, like not making dinner one evening, or an interest in getting physically active, that at times, go unmet. That said, this resentment conflicts with the SSO's compassion and grace they offer to their partner as they recognize how demanding their partner's career can be. SSOs may also experience additional worrying about their partner's well-being, especially if their partner does not share what's on their mind. Some SSOs view their role as important to their spouse's well-being; however, they feel left behind. Participants appear to recognize the challenges of PSP careers and want to support their partners; however, they feel like their needs may often be unmet. Setting expectations as a couple appears to be a helpful method of navigating the issue of occupational stress spillover. Perhaps a psychoeducation/PFA workshop involving the prevalence of occupational stress spillover and the benefits of setting expectations could be meaningful for SSOs of PSP. Unfortunately, barriers to PSP help-seeking behaviors such as self-stigma and structural stigma are still prevalent. The following section uncovers SSO appraisals of these common barriers in greater depth.

Theme 5: Barriers to Help-Seeking Behaviours: Self-Stigma and Structural Stigma

This section details this study's findings on the prevalence of PSPs seeking therapy while also detailing the barriers to help-seeking behaviour in this population. It appears that discussing PSPs' experience of seeing a therapist tends to be coupled with barriers such as stigma and pride. Eight of the twelve participants revealed that they have or are currently seeing a therapist, while the interest from PSPs is less enthusiastic, according to their SSOs. Three PSPs appeared to have engaged in couples therapy, and three PSPs have seen a therapist as an individual. ID06 revealed how helpful seeing a couple's therapist was for her marriage, and ID03 views seeing their couple's therapist more as a preventative measure. Meanwhile, ID08 has opened the conversation about couples therapy with her partner in hopes of balancing responsibilities at home; however, the PSP appears to be reluctant to participate. Participants were vocal about their opinions of PSPs regularly seeing a therapist.

> I've been actually encouraging him, I think he should just be going for like, monthly check-ins… to kind of just keep yourself regulated and keep yourself aware…of…how you're actually feeling (ID02).

ID02 appears to be referring to therapy as a method of developing insight into how one is feeling; thus, it begs the reflection that perhaps her partner experiences varying emotions related to occupational stress but struggles to articulate what he experiences. ID02 added that PSP seeing a therapist should be as natural as getting a haircut, which speaks to this participant's interest in normalizing therapy for PSPs. Both ID05 and ID06 highlight how pride and stigma are the leading barriers to PSPs seeking therapy because PSP feel weak if they admit to needing this support.

ID02 experienced a psychoeducation day dedicated to families of newly recruited firefighters and she stated that three well-respected firefighters shared that they all see a therapist, and this was a powerful moment for the SSO. ID02 appreciated this leading-by-example approach as she added:

> The problem is still that for people like my husband, who's very laid back, he's one guy. He's like, 'But I'm fine, but I'm fine, but I'm fine.' Yeah, you're fine until you're not. That's the problem, right? (ID02).

This opinion of not needing support until you need it, such as experiencing a crisis, appears to be a consistent theme for PSPs. According to participants, the greatest barriers for PSPs to seek mental health-related support were stigma and pride. Fear of career-related consequences appears to perpetuate the stigma of asking for help.

> You don't want to appear weak; you don't want to appear like you can't handle the job. 'Oh, I go to therapy.' Oh, really? Maybe we shouldn't put him into that, into the fire next time. Well, now he's just not going to get put where he wants to be because he just admitted that he, you know, is working on his mental health (ID02).

The previous excerpt also highlights structural stigma as the PSP culture appears to harmfully judge individuals seeking mental health support by limiting their participation in their career.

Barriers to Help-Seeking Behaviors for SSOs. ID05 highlighted how stigma does not apply to SSOs because most SSOs of PSP are female, as women are more open to receiving mental health support. According to ID08, barriers to SSOs seeking mental health support include how expensive therapy is for individuals. ID08 alluded to the necessity of therapy; however, if one cannot afford it, the well-being of their relationships may suffer. ID08 revealed

her gratitude for the insurance coverage that her partner's plan has for her, as her therapy sessions are fully covered. ID02 added that she would never have gone to therapy if she had to pay out of pocket for it; thus, she is also grateful for the insurance coverage with her partner's plan.

An additional barrier to seeking mental health-related support from an SSO's perspective was mistrust of the institution (i.e., local police department) that offers mental health support to police officers and their families.

> I go in for therapy and I speak about whatever, and then he for some reason gets investigated by something. They can go and request those notes…So it's like I would rather go outside of [local police department] for any help than be inside, entwined in that circle of them being able to access whatever they need. Because whoever they send you to is their people. That's what you feel like…I feel more comfortable doing external [therapy] than I do internal, because I kind of have a feeling that even though everything they say is confidential, I feel like inside myself that it's not confidential. I feel like they can get whatever information they need to get (ID10).

This participant's experience highlights that structural stigma regarding fearing career-related consequences occasionally reaches SSOs. As noted in an earlier section of this paper, PSPs fearing career-related consequences is one of the most often cited barriers to seeking mental health-related support. This participant would rather seek mental health support from an external source, rather than her partner's organization, in the interest of not risking her partner's career.

Mitigating Stigma. The local fire department appears to be mitigating barriers to help-seeking behaviours like pride and stigma by hosting a day dedicated to families. On this day,

they encourage both recruits and SSOs to seek mental health support and even offer experienced firefighters to share their experience of therapy. This leading-by-example approach appeared to resonate for ID02. The local fire department mitigates the expense of therapy by offering significant insurance coverage to its recruits and their SSOs. The local police department offers significant insurance coverage to its police officers and families; thus, this mitigates the barrier of affordability. The local police department may very well be attempting to reduce the stigma of seeking mental health support; however, discussions with participants about a psychoeducational day dedicated to families of police officers did not occur. As for the local paramedic service, discussions about insurance coverage for therapy or psychoeducational days dedicated to paramedic families were not discussed.

PSPs may find it more challenging to seek mental health support because they do not want to appear weak (e.g., pride, self-stigma, and structural stigma). Additionally, PSPs tend not to seek mental health support because they fear that if they speak up, they may endure career-related consequences. Meanwhile, the greatest barrier to help-seeking behaviours for SSOs is affordability.

Psychoeducation Content: Workplace Culture and Stigma. One SSO who experienced formal psychoeducation training valued the portion that explored PSP workplace culture as it facilitated her understanding of how and why stigma is so prevalent in this community. Therefore, PSP workplace culture and its derivatives (e.g., self-stigma and structural stigma) may be valuable content for SSOs to learn. Many SSOs expressed the need for both self-stigma and structural stigma to be reduced in PSP populations. SSOs have observed the benefits of seeking mental health-related support and encourage their partners to seek support. SSOs have acknowledged the great progress that has been made in the public's conversation about mental

health. There has been progress in reducing stigma; however, according to the majority of participants, there is still more progress to be made in normalizing seeking support from a mental health professional. Help-seeking behaviors of PSPs impact not only themselves but also SSOs; therefore, normalizing mental health support by discussing it in a psychoeducational context may improve SSOs' understanding of why seeking support can be a challenging prospect for many PSPs. This understanding may influence PSPs by increasing their openness to mental health support. This section has been dedicated to understanding what psychoeducation could look like in the future; therefore, the remaining theme unveils SSO attitudes regarding future programming.

Theme 6: A Need for Future Programming

Attitudes regarding the need for psychoeducation and PFA training were varied. One thread involved the idea that you don't know what you need, or you don't have the interest in participating in a psychoeducation/PFA workshop until you need it (i.e., a crisis occurs). A microcosm of this thread is ID10's experience of her and her spouse not discussing mental health-related topics at home until the PSP experienced a serious accident. ID09 alluded to this idea, having stated that if you have a strong social support network, she can see why SSOs don't feel the need to participate in psychoeducation/PFA workshops. Meanwhile, ID03 was especially vocal about their role in supporting their firefighter spouse:

> We have a much larger role we could be playing…as a spouse I want to be empowered to support my husband with his mental health and I need training and understanding to be able to do that…We all have busy lives. There's always a bunch of stuff competing for attention. But this is critically important. So, if it were offered absolutely, that would be an enthusiastic yes, and I would make the time to make that work (ID03).

ID03 suggests that SSOs of PSP should make time to learn about mental health symptoms and how to better support their partner, as she sees immense importance in this. ID03 also mentioned that SSOs need training, which sounds more formal than reading a book or listening to a podcast about psychoeducation. Perhaps ID03 believes that these other forms of psychoeducation are insufficient.

Practical Opinions on Psychoeducation/PFA. What future programming could look like was discussed with participants, and attitudes varied for this as well. Some opinions revealed that psychoeducation/PFA workshops could be delivered yearly to both SSOs of newly hired PSPs and SSOs with many years of experience. ID03 stated that psychoeducation/PFA could be akin to recertifying on first aid. ID09 also viewed the parallel between recertifying in first aid training and this idea of a psychoeducation/PFA workshop, not that one must conduct a "recertification," as this analogy is simply referring to the idea of refreshing forgotten skills or information. ID07 viewed psychoeducation/PFA workshops as being potentially delivered like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings and have meetings once a month; for example: "We could find community in that, and…relate to other people, and just feel like you're not alone" (ID07).

Another suggestion from ID07 was that if someone is uncomfortable with sharing their experience with the group, perhaps they could anonymously share the question or story with the presenter or mediator, and they may share this information with the group. ID05 called this psychoeducation/PFA workshop a "Family Day" where she can meet other SSOs, especially younger spouses, as ID05 has many years of experience to share with others. ID03 viewed this psychoeducation/PFA workshop as a method to provide SSOs with a basic understanding of their partner's career and the mental health risks associated with it.

> Program that provides kind of a foundation. Understanding, of like literally start soup to nuts of like what is mental health? What is mental wellness? What is mental illness? What does this mean? And then kind of build into the specifics, or like what our specific mental health issues, that. Firefighters and other first responders can face. Here's an understanding of what that means. Here are the signs and symptoms and then get into like. What can you do? (ID03).

A psychoeducation/PFA workshop was also described as a place where one can learn a menu of options or tools to add to their toolkit, and an opportunity to share "red-flag behaviours" such as signs and symptoms of mental health challenges. Delivering a workshop on psychoeducation/PFA may also find benefits from delivering it in both national languages (French and English) by a mediator and offering a "user-friendly" language that is easy for everyone to understand, no matter their background in mental health literacy. ID04 offered perspectives based on her extensive experience being a paramedic herself and being an SSO of a retired paramedic.

> As far as I know, and in my experience, there isn't a single service that invites spouses in to have a conversation as a psycho-educational component of the first responders becoming members (ID04).

ID04 continued stating that the tri-service organizations should include SSOs in psychoeducation processes during the hiring process:

> We need to look at what their [PSP] source…and if their support systems are mostly their spouses, then we need to prepare the spouses and other support people to be educated. They need to have their own tools. They need to be able to understand and orient to what kind of life they're going into when they're with a first responder (ID04).

ID04 also argued from the human resources perspective that if we increase the robustness of PSPs' main source of social support (i.e., SSOs), then perhaps there will be a cascade effect on reducing the risk of PSP mental health injury (i.e., sick leave), costing PSP organizations less money, which ultimately impacts the community as those funds could get allocated elsewhere.

Taking Advantage of SSO's Natural Interest in Mental Health. Eight of the twelve participants revealed that they have been or are currently seeing a therapist. The remaining four participants could be seeing a therapist, and it simply did not come up in the interviews. The purpose of raising the prevalence of participants' active participation in therapy is that this is a sign that SSOs of PSPs are a population that may be more open to participating in a psychoeducation/PFA workshop. This may result in the ease of recruiting participants for future psychoeducation programming. 10/12 (83.3%) of participants have not experienced a formal psychoeducation/PFA workshop dedicated to SSOs of PSPs. Participants expressed their need for a better understanding of mental health symptoms so that they can improve their ability to support themselves and their partners. Opinions did vary regarding this need; however, the majority of participants revealed that a psychoeducation/PFA workshop would be beneficial for their community. Participants also expressed what future programming could look like regarding psychoeducation/PFA, and there appears to be a need for education on signs and symptoms of mental health, an opportunity for connection and social support among other SSOs, the workshop being delivered in both official Canadian languages, the workshop being led by a mediator, the workshop offering opportunities to ask anonymous questions, and the workshop offering a vetted list of therapists who have worked with PSPs and their SSOs before. SSOs of PSP experiencing a workshop on psychoeducation/PFA may result in a cascade effect by bolstering their effectiveness in supporting themselves as well as supporting their partners. This

may, in turn, result in more first responders not needing sick leave, which results in more PSPs continuing to work, thereby reducing the impact of staff shortages.

Discussion

This study aimed to better understand the psychoeducation/PFA-related experiences of SSOs of PSPs. Additionally, this study aimed to identify how SSOs provide support to their PSP partners and understand SSOs' preferences related to psychoeducation/PFA-related workshops. To answer these research questions, the principal investigator conducted a qualitative study, involving an online demographic and background questionnaire as well as individual semi-structured interviews with participants. Six themes and seven subthemes were generated from the semi-structured interviews, which offer insight into the psychoeducation/PFA experiences of SSOs, provide clarity as to what needs this community has related to psychoeducation, and offer recommendations for future programming.

This study's main findings regarding the self-report survey include the significant prevalence of experiences of mental health issues in PSP (75%) – according to SSOs, while half of the participants expressed that they have experienced secondary traumatic stress. Additionally, SSOs' first source of support is a mental health professional followed by their PSP partner while SSOs reported that the first resources of support for the PSP would be SSOs followed by a mental health professional. Most participants (91.7%, $n = 11$) believe that psychoeducation dedicated to SSOs of PSP is needed, and an in-person psychoeducation/PFA workshop was the most requested format. Lastly, SSOs revealed that the content delivered in workshops should include education (e.g., signs and symptoms of mental health issues) while offering social support (e.g., local resources and group/peer support opportunities).

This study's main findings regarding the semi-structured interviews include scarce formal psychoeducation experiences, openness to discussing mental health-related topics with their PSP partner, and mixed experiences of occupational stress spillover. Additionally, there appeared to be differences in work-life balance between paramedics and police officers compared to firefighters, and a difference in terms of ease of communication (e.g., setting expectations) between SSOs who are/were PSPs themselves versus civilian SSOs. Lastly, stigma remains the greatest barrier to help-seeking behaviors for PSP; however, SSOs have revealed great improvements in this domain of PSP culture. The following section explores each theme and subtheme with greater detail as they relate to contemporary literature on this study's results. Similar to the results section, this study's research questions will be followed by the corresponding themes and subthemes that answer the questions.

Research Question 1: What psychoeducation-related experiences have SSOs had, and what are their perspectives on it?

Theme 1: Scarce Formal Support: Past Experiences of Psychoeducation

Theme one emerged as a concrete thematic answer to the question: What psychoeducation-related experiences have SSOs had, and what are their perspectives about it? This study found that only two participants out of the 12 participants experienced formal psychoeducation/PFA training. One SSO experienced this day many years ago, and this day consisted of more of a practical education (e.g., wearing firefighting equipment and putting out a fire in a mock-up kitchen). The other SSO experienced formal psychoeducation dedicated to families of firefighters, which included a similar practical education as well as a thorough presentation on mental health, firefighting culture, and stigma. Both SSOs enjoyed their time, while the SSO who participated in the recently developed formal psychoeducation day found it

meaningful and learned a lot of valuable information about expectations as an SSO. The results of this study align with contemporary literature on the matter of psychoeducation/PFA and SSOs of PSP. According to local data, gray literature review, and evidence-based journal search, peer support or psychoeducation/PFA-related workshops dedicated to supporting SSOs of PSPs are scarce. For example, a scoping review conducted by Hill and colleagues (2024) in Australia evaluated five qualitative studies and one quantitative study to better understand secondary traumatic stress (STS) in SSOs of paramedics. Hill and colleagues (2024) found that none of the studies included an evaluation of interventions that may decrease STS in SSOs of paramedics. As Hill and their team (2024) elaborated, formal interventions for SSOs of PSPs did not exist, due to STS literature focusing on its causes and prevalence instead of targeted interventions. Additionally, another narrative review was conducted by Tjin and colleagues (2022) in Ireland to understand how "trusted others" offer support to PSPs. Congruent with the findings from this thesis, Tjin and their team (2022) only found veteran-based psychoeducation; thus, no formal psychoeducation/PFA training was found dedicated to SSOs of police, firefighter, and paramedic occupations. Additionally, a systematic review conducted by a group of United Kingdom (UK) researchers found little to no formal support for the families of PSPs (Sharp et al., 2022). That said, PSPNET, located in Regina, Saskatchewan, Canada, offers PSP and SSOs either self-guided or therapist-guided internet-based cognitive behavioral therapy (ICBT) courses (PSPNET, 2023), which is a promising development as there appear to be positive treatment outcomes (Andersson et al., 2019a; Andersson et al., 2019b; Hadjistavropoulos et al., 2021; Hadjistavropoulos et al., 2023; Titov et al., 2018).

There appears to be a need for psychoeducation/PFA for SSOs of PSP, and yet globally, this formal support is scarce. Speculative reasons for why formal psychoeducation may not be as

abundant for SSOs as it is for PSPs include (1) SSOs have historically been seldomly recognized as providing significant support to their partners, (2) likewise seldomly researched, (3) recognition of their risk of secondary traumatic stress is not widely known in the public sphere, and (4) lack of funding (McCreary, 2019). Research-related solutions that may resolve the scarcity of formal psychoeducation/PFA training for SSOs may include continued implementation of current efforts of psychoeducation (e.g., the local fire department's event), evaluations of the effectiveness of current psychoeducation/PFA workshops, and evidence-based research on the development of future programming. Meanwhile, systemic changes that may resolve the scarcity of formal psychoeducation/PFA may include PSP organizations investing more time and funds into the creation of evidence-based training that includes SSOs.

Research Question 2: How do SSOs provide support to their PSP partners?

Theme 2: Reading the Room

The theme (2) Reading the room and its subthemes, (2.1) Gentle and direct and (2.2) Comfort in contacting PSP coworker or supervisor, offers insight into the second research question. SSOs provide support to their PSP partners in several ways. This thesis found that SSOs provide emotional support, practical support, support by encouraging them to seek mental health support via individual or couples therapy, and lastly, support by contacting the PSPs' supervisor or coworker. Three of these methods of supporting their PSP partner have been recognized in Tjin and colleagues' (2022) study on trusted others: emotional support, practical/instrumental support, and informational support. A fourth method of support, known as finding support (Tjin et al., 2022), was also found in this study, and this constituted its own subtheme - comfort in contacting the PSPs' coworker or supervisor. Emotional support involves creating a non-judgmental and caring space to discuss the behaviours that the SSO is noticing (Tjin et al., 2022) – after all,

SSOs often stated that they would notice changes in their partner's behaviours or mood before the PSP does, which further supports these previously noted phenomena (O'Toole, et al., 2022; Roth & Moore, 2009). Aligned with Tjin and their team's (2022) narrative review of trusted others providing social support to PSP, SSOs in this study would foster a safe space by gently and directly approaching their partner about what they are noticing. Practical/instrumental support included SSOs conducting extra duties like making dinner, walking the dog, picking up groceries, cleaning the house, or tending to the needs of their children. This instrumental support is also consistent with Tjin and colleagues' (2022) findings that female spouses would often manage household tasks to reduce the strain on their partners. Many SSOs sought informational support by reading books, listening to podcasts, reading a Road to Mental Readiness (R2MR) presentation, or participating in this study in hopes of becoming educated in mental health signs and symptoms. Thus, SSOs in this study are also consistent with Tjin and their team's (2022) findings regarding SSOs' interest in improving their knowledge about supporting their PSP partner. Many SSOs in the present study experience individual therapy, encourage their partners to seek individual therapy, and occasionally encourage couples therapy as a preventative measure. Some SSOs revealed their methods of informally coping by regulating their emotion by connecting with their partner, reaching out to family or friends, self-managing, and exercising, which fit intrapersonal and interpersonal methods of coping (Tjin et al., 2022). Lastly, most SSOs stated that they are comfortable with reaching out to their partner's supervisor or coworkers if distress or red-flag behaviours persist. This comfort in connecting with their partner's supervisors and colleagues was never discussed in Tjin and their team's (2022) analysis of help-seeking literature; therefore, more research investigating SSO comfort in this domain, as well as understanding PSP organization perspectives on this matter, may be beneficial.

PTSD/PTSS and Relationship Functioning. As revealed in theme (2) Reading the room, SSOs appeared to approach their PSP partners in an open, gentle, and direct manner. These findings align with the existing literature on how couples interact with one another when mental health-related challenges exist. The Couple Adaptation to Traumatic Stress (CATS) model and Dyadic Responses to Trauma (DRT) offer theoretical methods of situating this study's findings regarding the interactions between PSPs and SSOs (Goff & Smith, 2005; Marshall and Kuijer, 2017). 75% (n = 9) of SSOs in the present study revealed that their partner has experienced mental health challenges. Symptoms may involve dysregulation of biological, emotional, cognitive, and behavioral spheres of one's life (Goff & Smith, 2005). According to SSOs, various trauma symptoms were expressed by PSP, which impacted SSO daily living as secondary traumatic stress (STS) may result from a primary trauma survivor's dysregulation (Goff & Smith, 2005). For example, some PSPs experience chronic mental and physical injuries as a result of their careers (e.g., biological), some PSPs have expressed anger or are more withdrawn (e.g., emotional and/or cognitive), while many PSPs expressed disengagement from household responsibilities (e.g., behavioral). Regarding resources, according to the present study, PSPs tend to choose their SSO as the first resource they will connect with if facing mental health-related challenges. Fortunately, in well-functioning couples, the closeness of the SSO in the immediate aftermath of a potentially traumatic event (PTE) may increase, which mitigates the development of PTSD (Campbell & Renshaw, 2018). Role disruption appeared the most often in the relational functioning of participants' relationships, which has been noted in many other studies (Bolger et al., 1989; Sharp et al., 2022; Tjin et al., 2022; Watkins et al., 2021), which is consistent with the CATS model (Goff & Smith, 2005). Powling and colleagues (2024) found that partners living with someone with a PTSD diagnosis experienced an ongoing journey

of loss and gain, which found some resonance in this study's findings. For example, describing one SSO's relationship with a PSP who had been diagnosed with PTSD as a journey of loss and gain would be an accurate interpretation. Regarding DRT's model of PTSD/PTSS and couple functioning, this study's findings support the notion that individual vulnerabilities and resources mediate the impact of traumatic events as many SSOs believe that with improved psychoeducation/PFA skills (e.g., resources) they may feel more empowered and likewise more effective in supporting themselves and their partner (Marshall & Kuijer, 2017). For example, one of the SSOs who experienced formal psychoeducation with the local fire department found it to be valuable in improving her understanding of PSP culture, which may benefit her relationship. Meanwhile, another SSO revealed her own vulnerabilities with past trauma, which may improve or impair her capacity to support her partner.

PSP Partnered with Another PSP. According to Roth and colleagues (2009) USA study on the impact of PSP careers on the family system, participants who had previously worked in healthcare settings appeared to have had reduced concerns regarding the health and well-being of the PSP compared to participants without healthcare experience. This phenomenon was noticed in this study as PSPs who had SSOs who were PSPs or had been PSPs themselves had greater ease in understanding the experiences of their partners. If SSOs who are PSPs have reduced concern over the well-being of their PSP partners as well as experience greater ease in discussing work-related matters with their partner, then psychoeducation/PFA workshop training could be helpful for SSOs without healthcare or PSP experience. SSOs developing a greater knowledge of the risks involved in PSP occupations may result in greater outcomes, such as increased well-being for both PSPs and their SSOs.

Research Question 3: What would a psychoeducation/PFA workshop look like?

Theme 3: Experiencing Occupational Stress

Firstly, this study's findings on the self-reported prevalence of mental health symptoms are aligned with contemporary literature on the association of PSP careers and the experience of potentially traumatic events (PTE) (Carleton et al., 2018a; Galatzer-Levy et al., 2011; Komarovskaya et al., 2011). Additionally, this study's self-reported STS results also align with previous studies, as one person in a dyadic partnership experiencing trauma-related symptoms is associated with STS in the other (Henry et al., 2024). Occupational stress injury (OSI) is a term that is often discussed concerning military personnel and PSPs, which includes the experience of mental health symptoms like anxiety, depression, and PTSD, which appear in one's personal life because of one's occupation (Antony et al., 2020). In the present study, SSOs shared how their partners have experienced symptoms of PTSD/PTSS, experienced being more withdrawn, general fatigue, reduced capacity to conduct daily or weekly house chores, and disinterest in engaging in social activities outside of work. These behaviours and symptoms – expressions of PSP occupational stress may be influenced by repeated exposures to PTEs (Carleton et al., 2019; Flannery, 2015; Jones, 2017) or by the demands of shift work (e.g., fatigue) (Angehrn et al., 2020; Brown et al., 2020; Chaput et al., 2018; Wright et al., 2022). Although the PSP category encapsulates many careers, this group is not homogenous (Berger et al., 2012; Carleton et al., 2018a). PSPs in different PSP careers may have different sociodemographic backgrounds and experience different types of PTEs (Berger et al., 2012); therefore, the following two subthemes discuss these differences.

Subtheme 3.1: Police Officer and Paramedic Stress: Mix of Specific Calls and Work Demands

SSOs of police officers and paramedics appeared to claim that what caused stress in their partners was everything. The specific calls, the shift work, and the paperwork led to the following interpretation: firefighters may have a greater work-life balance than paramedics and police officers. This interpretation finds some support in Basinska and Wiciak's (2013) study in Poland on the differences in impact that police and firefighters face because of their occupation. The team found that firefighters had more positive assessments of the effects their occupation had on their life outside of work in addition to their overall well-being (Basinska & Wiciak, 2013). Meanwhile, police officers referenced work as having a negative influence on their life outside of work, including leisure and health domains. An evidence-based journal search revealed limited comparisons of occupation impacts between paramedics and other PSP-related careers. That said, Berger and colleagues' (2012) systematic review of 28 studies of PSP mental health prevalence rates found that ambulance personnel displayed greater estimated PTSD rates than both police officers and firefighters. Furthermore, a meta-analysis of 27 studies conducted by Petrie and colleagues (2018) in Germany found greater rates of mental health issues among paramedics than among the general population, which is consistent with Canadian rates (Carleton et al., 2018a). Differences in mental health issue rates across PSP careers are important to recognize, as this has salient implications for occupational stress spillover, which may impact SSOs.

Subtheme 3.2: Firefighter Stress: Specific Calls

This study found that SSOs of firefighters claimed that their partners experienced greater stress because of specific calls versus the general work demands of the job. However, it is important to note that two SSOs of firefighters also stated that stress from managing subordinates and the paperwork that entails are new stressors for them. All firefighters who are partnered with

SSOs of this study work at the same city-wide fire department; thus, work schedules are similar between the partners of the SSOs. Firefighters in the local city tend to work for a few days full-time (e.g., 24-hour shift), then have many days off. Meanwhile, the city's police have a completely different schedule, and so does the local city-wide paramedic department. Firefighters are called to the same calls that police officers and paramedics get called to so the PTEs between the tri-services are similar. Differences in work-life balance between the tri-service careers may be a prominent factor in this (Basinska & Wiciak, 2013). This result may impact future programming and the content that is delivered; for example, a psychoeducation/PFA workshop focused on SSOs of police officers or paramedics may find greater value in content that specifically pertains to their partner's career. Although SSOs were never asked to reveal what particular calls their PSP partners struggle the most with, calls involving children were often raised as examples of stress-provoking calls.

Subtheme 3.3: A Common Thread to All: Calls Involving Children are the Most Impactful

Calls involving children appeared to be one of the most impactful calls that PSPs can experience, as six of the twelve participants (50%) shared either a specific call about a child or referred to a call about children to be exceptionally challenging to process. Calls involving children who are the same age as their own children appear to be especially challenging. The participants' partners' experiences of calls align with Ricciardelli and colleagues' (2020) Canadian study on PSP interpretations of potentially traumatic events, where they found an apparent trauma hierarchy of calls. The death of a child was referred to by participants in Ricciardelli and their team's (2020) study as a specific call that is particularly challenging to respond to and process. How PSPs experience trauma was noted as having considerable influence on the processing of the PTE (Ricciardelli et al., 2020); however, any further

exploration into how participant partners experienced these specific calls was beyond the scope of this study. Witnessing PTEs is a common occurrence in PSP careers, and as one SSO put it, PSPs do take it home with them in the form of occupational stress spillover.

Theme 4: Occupational Stress Spillover

Theme four's occupational stress spillover was broken down into two subthemes: (4.1) Expressions of occupational stress symptoms/fatigue and (4.2) Impact on SSOs,

Subtheme 4.1: Expressions of Occupational Stress Symptoms/Fatigue

Many participants shared how their partners have experienced red flag behaviours such as changes in mood, being more withdrawn, having a smaller window of tolerance for daily stressors, a decrease in participation in social activities, and a decrease in participation in household responsibilities. These expressions of occupational stress symptoms are consistent with contemporary literature on the occupational demands of PSP careers (e.g., witnessing PTEs and experiencing shift work) (Brown et al., 2020; Carleton et al., 2018a; (Galatzer-Levy et al., 2011; Komarovskaya et al., 2011). As revealed by the CATS and DRT models of secondary traumatic stress, a primary trauma survivor's dysregulation may impact the secondary individual in a dyadic partnership.

Subtheme 4.2: Impact on SSOs

This study supported the notion that occupational stress does spill over into the home, and this aligns with Casas and Benuto's (2022) systematic review of 16 studies that found secondary traumatic stress (STS) as a common outcome in SSOs of PSP. Porter and Henriksen's (2016) and Landers and colleagues' (2020) studies also indicate the prevalence of occupational stress spillover. Lambert (1990) theorized that one's occupation and one's home life may have a bidirectional relationship wherein one's positive and negative experiences in either domain

influence one another. Lambert (1990) viewed the occupation and home life relationship as one that involves multiple processes, such as a process of segmentation – separating life at home and life at work, compensation or accommodation – increased time and energy involved with one life domain at the expense of the other, and occupational stress spillover (Casas & Benuto, 2022). Lambert (1990) further argued that these processes may occur because of direct issues such as shift work, occupational stress injury, or pay, while these processes may also occur because of indirect issues such as job satisfaction (Bolger et al., 1989; Casas & Benuto, 2022).

This study's results align with Lambert's (1990) theory of the three processes that occur in the occupation-home life relationship. Segmentation was noticed in a couple of the participants, where they would aim to discuss the content of their or their partner's shift on the way home from work, so that by the time they were home, the conversation about work would cease. Regarding the process of compensation, one SSO stated how their partner does not seek social activities outside of work as much anymore since they have become a police officer. Meanwhile, an SSO revealed an example of accommodation when they shared how their partner may reduce their involvement in family activities because of fatigue. This study found many examples of occupational stress spillover. Direct issues appeared to be the most often shared reason for occupational stress spillover in SSO's partners. Direct issues such as fatigue because of the shift hours and schedule, as well as the PTEs that the PSPs experience.

Differences in Instrumental Support Among the Tri-Services. Examples of instrumental support included increased cleaning of the home, tending to their children's needs, making dinner more often, and conducting other related house chores. That said, SSOs of firefighters often stated how house-related chores and the needs of their children were often met and arguably never experienced a lull or a reduction of attention. Meanwhile, greater responsibility

appeared to be felt by SSOs of police officers at home. Only two SSOs of paramedics were interviewed; thus, a comment about their experience is a challenge to generalize, although one of the SSOs of a paramedic often cleans their home by herself. Sacrifices of SSOs' well-being and emotional needs include SSOs biting their tongue when they would like to request additional support at home, sacrificing their physical activity to better support their partner (i.e., thus sacrificing their well-being), and an undertone of resentment expressed by some participants (Bolger et al., 1989; Watkins et al., 2021). SSOs appear to be mindful of the demands of their partner's work and reveal pride in this. SSO mindful and caring support for their partner may result in increased instrumental support for their partner and themselves as well as emotional compensation (Sharp et al., 2022; Tjin et al., 2022). This additional instrumental and emotional investment may result in the SSO resenting their partner (Watkins et al., 2021). Having said this, experiences of resentment did not appear in every interview. Stigma is a significant barrier that may perpetuate mental health symptoms of PSP and, therefore, their SSOs as well.

Theme 5: Barriers to Help-Seeking Behaviors: Self-Stigma and Structural Stigma

Although stigma-related barriers to help-seeking behaviours are associated with PSP, SSOs are impacted by the help-seeking decisions that PSPs do or do not make. For example, one SSO in this study stated how she and her partner would not be together today if her partner did not seek mental health support. Stigma has been recognized as a significant barrier preventing PSPs from seeking mental health support (Bikos, 2021; Henry et al., 2024; Miller & Silverman, 1995; Haugen et al., 2017). SSOs often cited self-stigma and structural stigma as reasons why their PSP partner or other PSPs refuse to seek help. Whether the PSP partner did not want to appear weak (i.e., self-stigma) (Corrigan & Anderson, 2004), or did not want to request sick leave because they may miss future opportunities as a result of cultural norms or policies of their

department (i.e., structural stigma) (Bikos, 2021; Corrigan et al., 2004; Hatzenbuehler, 2016). Haugen and colleagues' (2017) meta-analysis findings align with SSOs' perspectives about their partners, as SSOs often cited that PSPs view seeking support as a sign of weakness. Meanwhile, one SSO revealed that she also experiences concerns about confidentiality and fears of career-related consequences for her partner if she sought support from the organization that was created to support PSPs and their families. This was an example of structural stigma not only affecting the PSP but also their SSO, which has been noted in Hill and colleagues' scoping review (2024). Stigma is a harmful barrier to help-seeking behaviours as it may delay participation in mental health services, which may increase chronic mental health-related symptoms (Haugen et al., 2017). Haugen and colleagues' (2017) meta-analysis found that fears of confidentiality and career-related consequences were the most frequently cited reasons for not seeking mental health support. Ricciardelli and colleagues' (2020) study on 828 Canadian PSPs revealed pervasive structural stigma whereby PSPs may not pursue professional mental health support because they may be seen by their colleagues as individuals abusing the system. This suspicion has detrimental effects on PSP as individuals may choose not to seek support when they need it (Ricciardelli et al., 2020). The occurrence of staff shortages compounds structural stigma by decreasing PSPs' disinterest in seeking mental health support because if they are encouraged to go on leave by their mental health professional, their coworkers will have a greater burden to carry (Ricciardelli et al., 2020). SSOs revealed that stigma has improved among PSPs, which is associated with the general public's greater openness to mental health, as expressed by participants and noted by studies (Clement et al., 2013; Côté et al., 2021). That said, participants also expressed how it is still incredibly challenging to encourage their partners to seek mental health support. Considering the mountains that PSP culture still has to climb in reducing stigma,

bolstering PSP's current and more private source of support (e.g., their SSO) via psychoeducation/PFA may be an effective use of resources.

Theme 6: A Need for Psychoeducation

Psychoeducation/PFA training has been recognized in many different contexts that it can be an effective early intervention method in improving SSO understanding of their PSP partner's behavior (Fogarty et al., 2021), reducing self-criticism (Phoenix, 2007), reducing symptoms of PTSD (Ruck et al., 2013), reducing the impact of PTEs in individuals (Shultz & Forbes, 2013), improving adaptive responses to trauma (Watson et al., 2011), increasing help-seeking behaviors (Creamer et al., 2012), improving self-perceived competence in providing PFA to distressed individuals (Everly et al., 2014; Lee et al., 2017), and increasing personal resilience (Everly et al., 2014). This study's last question in the semi-structured interviews asked participants their opinion about immersive training (e.g., roleplaying) – whether they would be interested in participating or not. Participants were largely disinterested in this method of psychoeducation/PFA training; however, this immersive training may ultimately be beneficial for SSOs of PSPs (Everly et al., 2014; O'Toole et al., 2022) as simulated training is a recognized method of learning (Lioce et al., 2020; McNaughton et al., 2008; Rudolph et al., 2014). This study gained some insight into how SSOs would like to experience a psychoeducation/PFA workshop. For example, the most frequent response to the delivery of this workshop was in-person and would inform SSOs of two prominent topics: social support and education. Social support included a list of resources, the development of a stronger sense of community, and a group/peer support function. As for education, SSOs expressed that they wanted to improve their recognition of signs and symptoms of mental health issues, how to respond to these instances,

understand how critical incidents affect their partners, and understand how to more effectively set boundaries.

Limitations

The first limitation to report is the restriction of the sample to one local region. This study may have benefitted from revealing opinions from a variety of locations in Ontario or Canada-wide. That said, for purposes of studying a cohesive sample, the decision was made to recruit locally. One of the inclusion criteria was that the SSO and their partner had to be living together for at least the past year, which resulted in SSOs from separations, divorces, and widows not being included in the sample. SSOs who have experienced a separation, a divorce, or have been widowed may have revealed much richer data and further reveal the need for psychoeducation/PFA for SSOs. The results of this study may reveal experiences or coping methods by more resilient SSOs, as participants who experience greater STS or couple-related issues may not have volunteered to participate. The decision not to include SSOs who identify as one of these categories was seen as individuals who may not be sharing current experiences. Although it is helpful to understand patterns of behavior or experiences in people from relationships that are still together, it would be beneficial to explore what patterns of behavior or experiences resulted in separation or divorce within the PSP community. Volunteer bias is an additional limitation that must be reported; for example, individuals who are either open to psychoeducation or believe that there is a need for psychoeducation for members of their community may have been more open to participating in this study, which may have influenced the results. Related to this is the influence of the demographic questionnaire on participants. For example, the questionnaire began by asking demographic-based questions, followed by questions about their and their partner's experiences with mental health challenges and concluded by

asking about the need for a psychoeducation/PFA workshop for their community. The questionnaire may have influenced participants' interest in participating in a psychoeducation/PFA workshop. Using an online platform such as Zoom improved the ease of setting up interviews and likely increased participant interest. That said, conducting in-person interviews may have increased the depth that some participants could have reached, as there may have been concerns with discussing sensitive topics from home while other family members are in the adjacent room. Another limitation to report is the lack of participants who are SSOs of paramedics. Only two of the twelve participants were SSOs of paramedics; thus, this is a population that would benefit from additional participation in research. Furthermore, this study's sample size in general ($N = 12$) reduces its generalizability, and a larger sample size may result in improved internal validity. Additionally, no clinical oversight was provided regarding the self-report results; thus, the self-report data must be evaluated at face value. The lack of diversity in participants and their PSP partners is a significant limitation, as all participants were women, and only one PSP partner was female. Meanwhile, 10 of the 12 participants identified as white/Caucasian; thus, having a greater diversity of participants of both genders and ethnicities may have produced richer and more diverse results. For example, themes like reading the room, occupational stress spillover, and impact on SSOs may have resulted in different outcomes if more males had participated. Additionally, marginalized groups in PSP careers tend to experience more common experiences of institutional betrayal and/or sanctuary trauma. Thus, if more SSOs in the study had PSP partners who were women or were ethnically diverse, then results of comfort in contacting PSP coworkers or supervisors, occupational stress, and barriers to help-seeking behaviors may have resulted in different outcomes. The aforementioned issues in this study's sample do affect the generalizability of its findings, and including a broader range of

participants in future research could provide a more comprehensive understanding of the experiences of SSOs of PSP.

Implications

This study is an important addition to the first responder literature because it reveals the lack of formal support for SSOs and the need for formal support for SSOs of PSP. In theory, improving SSOs' knowledge about signs and symptoms of mental health-related issues, as well as improving their ability to effectively communicate with their partner about these topics, may improve the mental health and well-being of the PSP and decrease STS. This theory is supported by the current use of CISM, CISD, peer support, and related resilience training programs like R2MR, as these programs impact the mental health and well-being of their audiences. According to this study's findings, specific content that should be prioritized in training programs include signs and symptoms of mental health issues, setting expectations (e.g., with their PSP partner), and workplace culture and stigma, which should all be adapted to a homogenous group of SSOs (e.g., only to a room full of SSOs of paramedics). Furthermore, most SSOs in this study were interested in the in-person delivery of this training that focuses on educating participants while developing a sense of social support. For example, sharing resources such as a vetted list of therapists who work with the PSP community or simply offering participants a space to connect with other SSOs. Additionally, this study's sample lacked diversity; therefore, further research on understanding the experiences of male SSOs and SSOs with different ethnic backgrounds than white/Caucasian could provide valuable insights that this study was not able to attain. The research at PSPNET, which is a part of the Canadian Institute for Public Safety Research and Treatment (CIPSRT) located in Regina, Saskatchewan is promising as they are currently offering psychoeducation courses for both PSP and SSOs for individuals across Canada (PSPNET, 2023).

Applying these approaches to the context of SSOs may be in the best interest of SSOs, PSPs, the organizations and departments that employ PSPs, and the communities that PSPs serve. For example, improving SSO support may result in a stronger sense of community as SSOs may feel seen and recognized as a pivotal source of support for PSPs. If SSOs were to improve their understanding of the signs and symptoms of mental health issues, offer their PSP partner PFA if needed, set expectations in terms of roles and responsibilities at home, and improve their social service literacy (e.g., awareness of local resources), rates of STS may decrease and likewise rates of mental health disorder symptoms in PSP. PSPs connecting with their SSO most often occurs in private conversation, so increasing SSO social support may reduce help-seeking barriers like stigma so that PSPs can receive professional help earlier. Lastly, early treatment of PSP mental health issues may result in improved performance of their duties with less sick leave and overall, in a healthier manner. This study serves as a foundation for further research on developing an evidence-based psychoeducation/PFA workshop or training for SSOs of PSP.

Conclusion

There is a lack of early intervention programs (e.g., psychoeducation/PFA) for the individuals who provide the most support to PSP– their SSOs. PSPs are often referred to as "heroes" as they put their lives and limbs at risk to save both life and infrastructure. This study has further reinforced the notion that SSOs are the "unsung heroes" who have needs that are not being sufficiently met. This study reinforces that SSOs are typically the first source of support for PSPs and are in a convenient position to be offered psychoeducation/PFA training to further bolster their abilities to support themselves and their partners. SSOs appear to provide emotional support, instrumental support, informational support, and seek support for their partners. SSOs provide these various methods of support to their partner while potentially enduring STS

themselves. Given the high rates of therapy-seeking SSOs in this study, SSOs may have a greater openness to participating in psychoeducation/PFA workshops dedicated to their community. This study's results support the proposition of offering SSOs of PSP a psychoeducation/PFA-based workshop to bolster SSO capacities to improve their partners' mental health and well-being as well as their own. SSOs appear to naturally fill this role of being PSPs' most trusted source of support when compared to other support systems; therefore, organizations interested in limiting mental health leave (i.e., sick leave) have an opportunity to take advantage of this. In agreement with Marin (2012) and McCreary's (2019) attitudes of viewing this issue from a prevention lens, early investing in SSO psychoeducation/PFA may save the government and PSP organization spending in the long term. PSPs are integral to the functioning of communities and should be supported. A major factor that enables PSPs to provide their services is the partner at home and these unsung heroes require more attention and support.

References

Angehrn, A., Teale Sapach, M. J. N., Ricciardelli, R., Macphee, R. S., Anderson, G. S., & Nicholas Carleton, R. (2020). Sleep quality and mental disorder symptoms among Canadian public safety personnel. *International Journal of Environmental Research and Public Health*, *17*(8), 2708-. https://doi.org/10.3390/ijerph17082708

Alrutz, A. S., Buetow, S., Cameron, L. D., & Huggard, P. K. (2020). What happens at work comes home. *Healthcare*, *8*(3), 350. https://doi.org/10.3390/healthcare8030350

Alexander, D. A., & Klein, S. (2001). Ambulance personnel and critical incidents: Impact of accident and emergency work on mental health and emotional well-being. *British Journal of Psychiatry*, *178*(1), 76–81. https://doi.org/10.1192/bjp.178.1.76

Anderson, G. S., Di Nota, P. M., Groll, D., & Carleton, R. N. (2020). Peer support and crisis-focused psychological interventions designed to mitigate post-traumatic stress injuries among public safety and frontline healthcare personnel: A systematic review. *International Journal of Environmental Research and Public Health*, *17*(20), 1–20. https://doi.org/10.3390/ijerph17207645

Andersson, G., Carlbring, P., Titov, N., & Lindefors, N. (2019a). Internet interventions for adults with anxiety and mood disorders: a narrative umbrella review of recent meta-analyses. *Canadian Journal of Psychiatry*, *64*(7), 465–470. https://doi.org/10.1177/0706743719839381

Andersson, G., Titov, N., Dear, B. F., Rozental, A., & Carlbring, P. (2019b). Internet-delivered psychological treatments: from innovation to implementation. *World Psychiatry*, *18*(1), 20–28. https://doi.org/10.1002/wps.20610

Antony, J., Brar, R., Khan, P. A., Ghassemi, M., Nincic, V., Sharpe, J. P., Straus, S. E., & Tricco, A. C. (2020). Interventions for the prevention and management of occupational stress injury in first

responders: A rapid overview of reviews. *Systematic Reviews*, *9*(1), 121–121. https://doi.org/10.1186/s13643-020-01367-w

Arbona, C., Fan, W., & Noor, N. (2016). Factor structure and external correlates of posttraumatic stress disorder symptoms among African American firefighters. *Psychology Research and Behavior Management*, *9*, 201–209. https://doi.org/10.2147/PRBM.S113615

Armstrong, D., Shakespeare-finch, J., & Shochet, I. (2014). Predicting post-traumatic growth and post-traumatic stress in firefighters. *Australian Journal of Psychology*, *66*(1), 38–46. https://doi.org/10.1111/ajpy.12032

Badge of Life Canada. (2019) *Badge of Life Canada* https://badgeoflifecanada.org/

Bandura, A. (2012). On the Functional Properties of Perceived Self-Efficacy Revisited. *Journal of Management*, *38*(1), 9–44. https://doi.org/10.1177/0149206311410606

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does High Self-Esteem Cause Better Performance, Interpersonal Success, Happiness, or Healthier Lifestyles? *Psychological Science*, *4*(1), 1–44. https://doi.org/10.1111/1529-1006.01431

Basinska, B. A., & Wiciak, I. (2013). Impact of Work on the Well-Being of Police Officers and Firefighters. *Internal Security*, *5*(1), 247-. https://doi.org/10.5604/20805268.1059491

Bennett, P., Williams, Y., Page, N., Hood, K., & Woollard, M. (2004). Levels of mental health problems among UK emergency ambulance workers. *Emergency Medicine Journal: EMJ*, *21*(2), 235–236. https://doi.org/10.1136/emj.2003.005645

Ben-Zeev, D., Corrigan, P. W., Britt, T. W., & Langford, L. (2012). Stigma of mental illness and service use in the military. *Journal of Mental Health (Abingdon, England)*, *21*(3), 264–273. https://doi.org/10.3109/09638237.2011.621468

Beahm, J. D., Landry, C. A., McCall, H. C., Carleton, R. N., & Hadjistavropoulos, H. D. (2022). Understanding and addressing occupational stressors in internet-delivered therapy for public safety personnel: a qualitative analysis. *International Journal of Environmental Research and Public Health*, *19*(8), 4744-. https://doi.org/10.3390/ijerph19084744

Bercier, M. L., & Maynard, B. R. (2015). Interventions for Secondary Traumatic Stress with Mental Health Workers: A Systematic Review. *Research on Social Work Practice*, *25*(1), 81–89. https://doi.org/10.1177/1049731513517142

Berger, W., Coutinho, E. S. F., Figueira, I., Marques-Portella, C., Luz, M. P., Neylan, T. C., Marmar, C. R., & Mendlowicz, M. V. (2012). Rescuers at risk: a systematic review and meta-regression analysis of the worldwide current prevalence and correlates of PTSD in rescue workers. *Social Psychiatry and Psychiatric Epidemiology*, *47*(6), 1001–1011. https://doi.org/10.1007/s00127-011-0408-2

Berninger, A., Webber, M. P., Cohen, H. W., Gustave, J., Lee, R., Niles, J. K., Chiu, S., Zeig-Owens, R., Soo, J., Kelly, K., & Prezant, D. J. (2010). Trends of Elevated PTSD Risk in Firefighters Exposed to the World Trade Center Disaster: 2001-2005. *Public Health Reports, 125*(4), 556–566. https://doi.org/10.1177/003335491012500411

Bikos, L.J. (2021). “It's all window dressing:” Canadian police officers' perceptions of mental health stigma in their workplace." *Policing: An International Journal 44*(1)63-76. https://doi.org/10.1108/PIJPSM-07-2020-0126

Bikos, L. J. (2024). “When They Hand You Your Uniform, They Forget to Say, ‘Hand Me Your Soul’”: Incidents and Impacts of Institutional Betrayal in Canadian Police Services. *Social Problems, 71*(4), 1100–1117. https://doi.org/10.1093/socpro/spac062

Braun, V., Clarke, V., & Josselson, R. (2022). Conceptual and Design Thinking for Thematic Analysis. *Qualitative Psychology, 9*(1), 3–26. https://doi.org/10.1037/qup0000196

Braun, V. & V. Clarke. (2021) *Thematic Analysis – A Practical Guide*. SAGE Publications Ltd. https://us.sagepub.com/en-us/nam/thematic-analysis/book248481#description

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best Practices for Developing and Validating Scales for Health, Social, and Behavioral Research: A Primer. *Frontiers in Public Health*, *6*, 149–149. https://doi.org/10.3389/fpubh.2018.00149

Bolger, N., DeLongis, A., Kessler, R. C., & Wethington, E. (1989). contagion of stress across multiple roles. *Journal of Marriage and Family*, *51*(1), 175–183. https://doi.org/10.2307/352378

Bonde, J. P., Utzon-Frank, N., Bertelsen, M., Borritz, M., Eller, N. H., Nordentoft, M., Rugulies, R. (2016). Risk of depressive disorder following disasters and military deployment: systematic review with meta-analysis. *British Journal of Psychiatry*, *208*(4), 330–336. https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/risk-of-depressive-disorder-following-disasters-and-military-deployment-systematic-review-with-metaanalysis/A02087C940D902C0FFE702C4664186CF

Boots On the Ground Peer Support for First Responders (2021). *Anonymous Peer Support for First Responders, by First Responders.* https://www.bootsontheground.ca/

Brown, J. P., Martin, D., Nagaria, Z., Verceles, A. C., Jobe, S. L., & Wickwire, E. M. (2020). Mental health consequences of shift work: an updated review. *Current Psychiatry Reports*, *22*(2), 7–7. https://doi.org/10.1007/s11920-020-1131-z

Campbell, S. B., & Renshaw, K. D. (2018). Posttraumatic stress disorder and relationship functioning: A comprehensive review and organizational framework. *Clinical Psychology Review*, *65*, 152–162. https://doi.org/10.1016/j.cpr.2018.08.003

Canada Beyond the Blue (2024). *Committed to providing a community of support to police members and their families*. https://canadabeyondtheblue.com/

Canadian Institute for Public Safety Research and Treatment (2023) *CIPSRT Canadian Institute for Public Safety Research and Treatment* https://www.cipsrt-icrtsp.ca/en/glossary/public-safety-personnel-psp

Canevello, A., Michels, V., Hilaire, N., & Kendall-Tackett, K. (2016). Supporting Close Others' Growth After Trauma: The Role of Responsiveness in Romantic Partners' Mutual Posttraumatic Growth. *Psychological Trauma*, *8*(3), 334–342. https://doi.org/10.1037/tra0000084

Carleton, R. N., Afifi, T. O., Turner, S., Taillieu, T., Duranceau, S., LeBouthillier, D. M., Sareen, J., Ricciardelli, R., MacPhee, R. S., Groll, D., Hozempa, K., Brunet, A., Weekes, J. R., Griffiths, C. T., Abrams, K. J., Jones, N. A., Beshai, S., Cramm, H. A., Dobson, K. S., … Asmundson, G. J. G. (2018a). Mental disorder symptoms among public safety personnel in Canada. *Canadian Journal of Psychiatry*, *63*(1), 54–64.https://doi.org/10.1177/0706743717723825

Carleton, R. N., Afifi, T. O., Taillieu, T., Turner, S., Krakauer, R., Anderson, G. S., MacPhee, R. S., Ricciardelli, R., Cramm, H. A., Groll, D., McCreary, D. R., & Kelloway, E. K. (2019). Exposures to Potentially Traumatic Events Among Public Safety Personnel in Canada. *Canadian Journal of Behavioural Science*, *51*(1), 37–52. https://doi.org/10.1037/cbs0000115

Carleton, R. N., Afifi, T. O., Turner, S., Taillieu, T., LeBouthillier, D. M., Duranceau, S., Sareen, J., Ricciardelli, R., MacPhee, R. S., Groll, D., Hozempa, K., Brunet, A., Weekes, J. R., Griffiths, C. T., Abrams, K. J., Jones, N. A., Beshai, S., Cramm, H. A., Dobson, K. S., … Drapeau, M.

(2018b). Suicidal Ideation, Plans, and Attempts Among Public Safety Personnel in Canada. *Canadian Psychology / Psychologie Canadienne*, *59*(3), 220–231. https://doi.org/10.1037/cap0000136

Carleton, R. N., Afifi, T. O., Turner, S., Taillieu, T., Vaughan, A. D., Anderson, G. S., Ricciardelli, R., MacPhee, R. S., Cramm, H. A., Czarnuch, S., Hozempa, K., & Camp, R.D. (2020). Mental health training, attitudes toward support, and screening positive for mental disorders. *Cognitive Behaviour Therapy*, *49*(1), 55–73. https://doi.org/10.1080/16506073.2019.1575900

Carlier, I. V. E., Lamberts, R. D., & Gersons, B. P. R. (1997). Risk Factors for Posttraumatic Stress Symptomatology in Police Officers: A Prospective Analysis. *The Journal of Nervous and Mental Disease*, *185*(8), 498–506. https://doi.org/10.1097/00005053-199708000-00004

Carlsen, B., & Glenton, C. (2011). What about N? A methodological study of sample-size reporting in focus group studies. *BMC Medical Research Methodology*, *11*(1), 26–26. https://doi.org/10.1186/1471-2288-11-26

Casas, J. B., Benuto, L. T., & Kendall-Tackett, K. (2022). Breaking the Silence: A Qualitative Analysis of Trauma Narratives Submitted Online by First Responders. *Psychological Trauma*, *14*(2), 190–198. https://doi.org/10.1037/tra0001072 https://www.proquest.com/docview/2562586431?parentSessionId=i04vfVA38muG7lmMo9cNOHQlLhygO%2FWh6NSWKApu6hs%3D&pq-origsite=primo&accountid=14701&sourcetype=Scholarly%20Journals#s11

Casas, J. B., Benuto, L. T., & Kendall-Tackett, K. (2022). Work-Related Traumatic Stress Spillover in First Responder Families: A Systematic Review of the Literature. *Psychological Trauma*, *14*(2), 209–217. https://doi.org/10.1037/tra0001086

Chaput, J., Yau, J., Rao, D. P., & Morin, C. M. (2018). Prevalence of insomnia for Canadians aged 6 to 79. *Health Reports*, *29*(12), 16. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/prevalence-insomnia-canadians-aged-6-79/docview/2160688269/se-2

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*. https://doi.org/10.1177/2050312118822927

Clark, L. A., & Watson, D. (1995a). Constructing Validity: Basic Issues in Objective Scale Development. *Psychological Assessment*, *7*(3), 309–319. https://doi.org/10.1037/1040-3590.7.3.309

Clark, L. A., & Watson, D. (2019b). Constructing Validity: New Developments in Creating Objective Measuring Instruments. *Psychological Assessment*, *31*(12), 1412–1427. https://doi.org/10.1037/pas0000626

Clement, S., Lassman, F., Barley, E., Evans-Lacko, S., Williams, P., Yamaguchi, S., Slade, M., Rüsch, N., Thornicroft, G., & Clement, S. (2013). Mass media interventions for reducing mental health-related stigma. *Cochrane Database of Systematic Reviews*, *2013*(7), CD009453–CD009453. https://doi.org/10.1002/14651858.CD009453.pub2

Conference Board of Canada (2012). *Mental health issues in the labour force: reducing the economic impact on Canada* (Publication 13-037). Conference Board of Canada. https://publications.gc.ca/collections/collection_2018/bdp-lop/eb/YM32-5-2013-87-eng.pdf

Cooksey, R. W. (2020). Descriptive Statistics for Summarising Data. In: *Illustrating Statistical Procedures: Finding Meaning in Quantitative Data*. Springer, Singapore. https://doi.org/10.1007/978-981-15-2537-7_5

Corneil, W., Beaton, R., Murphy, S., Johnson, C., & Pike, K. (1999). Exposure to Traumatic Incidents and Prevalence of Posttraumatic Stress Symptomatology in Urban Firefighters in Two Countries. *Journal of Occupational Health Psychology*, *4*(2), 131–141. https://doi.org/10.1037/1076-8998.4.2.131

Corrigan, P., & Anderson, N. B. (2004). How Stigma Interferes with Mental Health Care. *The American Psychologist*, *59*(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural Levels of Mental Illness Stigma and Discrimination. *Schizophrenia Bulletin*, *30*(3), 481–491. https://doi.org/10.1093/oxfordjournals.schbul.a007096

Corrigan, P. W., & Rao, D. (2012). On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change. *Canadian Journal of Psychiatry*, *57*(8), 464–469. https://doi.org/10.1177/070674371205700804

Côté, D., Williams, M., Zaheer, R., Niederkrotenthaler, T., Schaffer, A., & Sinyor, M. (2021). Suicide-related Twitter Content in Response to a National Mental Health Awareness Campaign and the Association between the Campaign and Suicide Rates in Ontario. *Canadian Journal of Psychiatry*, *66*(5), 460–467. https://doi.org/10.1177/0706743720982428

Creamer, M. C., Varker, T., Bisson, J., Darte, K., Greenberg, N., Lau, W., Moreton, G., O'Donnell, M., Richardson, D., Ruzek, J., Watson, P., & Forbes, D. (2012). Guidelines for peer support in high-risk organizations: An international consensus study using the delphi method. *Journal of Traumatic Stress*, *25*(2), 134–141. https://doi.org/10.1002/jts.21685

Critical Incident Stress Management (CISM) (2024). Critical Incident Stress Management & Peer Training https://cism.ca/

Cox, M., Norris, D., Cramm, H., Richmond, R., & Anderson, G. S. (2022). Public safety personnel family resilience: a narrative review. *International Journal of Environmental Research and Public Health*, *19*(9), 5224. https://doi.org/10.3390/ijerph19095224

Declercq, F., Meganck, R., Deheegher, J., & Van Hoorde, H. (2011). Frequency of and subjective response to critical incidents in the prediction of PTSD in emergency personnel. *Journal of Traumatic Stress*, *24*(1), 133–136. https://doi.org/10.1002/jts.20609

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, *7*(2), e000057-. https://doi.org/10.1136/fmch-2018-000057

De Lyra, R. L., McKenzie, S. K., Every-Palmer, S., Jenkin, G., & Sar, V. (2021). Occupational exposure to suicide: A review of research on the experiences of mental health professionals and first responders. *PloS One*, *16*(4), e0251038–e0251038. https://doi.org/10.1371/journal.pone.0251038

Diagnostic and statistical manual of mental disorders: DSM-5 (Fifth edition.). (2013). American Psychiatric Association.

Donnellan, M. B., Trzesniewski, K. H., Robins, R. W., Moffitt, T. E., & Caspi, A. (2005). Low Self-Esteem Is Related to Aggression, Antisocial Behavior, and Delinquency. *Psychological Science*, *16*(4), 328–335. https://doi.org/10.1111/j.0956-7976.2005.01535.x

Everly, G. S., McCabe, O. L., Semon, N. L., Thompson, C. B., & Links, J. M. (2014). The Development of a Model of Psychological First Aid for Non–Mental Health Trained Public Health Personnel: The Johns Hopkins RAPID-PFA. *Journal of Public Health Management and Practice*, *20*(5), S24–S29. https://doi.org/10.1097/PHH.0000000000000065

Fetzner, M. G., McMillan, K. A., Sareen, J., & Asmundson, G. J. G. (2011). What is the association between traumatic life events and alcohol abuse/dependence in people with and without PTSD?

Findings from a nationally representative sample. *Depression and Anxiety*, *28*(8), 632–638. https://doi.org/10.1002/da.20852

Finlay, L., (2021). Thematic Analysis: The 'Good', the 'Bad' and the 'Ugly'. *European Journal for Qualitative Research in Psychotherapy*, *11*(103-116). https://ejqrp.org/index.php/ejqrp/article/view/136

Flannery, R. B. (2015). Treating Psychological Trauma in First Responders: A Multi-Modal Paradigm. *Psychiatric Quarterly*, *86*(2), 261–267. https://doi.org/10.1007/s11126-014-9329-z

Fogarty, A., Steel, Z., Ward, P. B., Boydell, K. M., McKeon, G., & Rosenbaum, S. (2021). Trauma and mental health awareness in emergency service workers: A qualitative evaluation of the behind the seen education workshops. *International Journal of Environmental Research and Public Health*, *18*(9), 4418. https://doi.org/10.3390/ijerph18094418

Fox, J. H., Burkle, F. M., Bass, J., Pia, F. A., Epstein, J. L., & Markenson, D. (2012). The Effectiveness of Psychological First Aid as a Disaster Intervention Tool: Research Analysis of Peer-Reviewed Literature From 1990-2010. *Disaster Medicine and Public Health Preparedness*, *6*(3), 247–252. https://doi.org/10.1001/dmp.2012.39

Freyd, J. J., & Birrell, P. (2013). *Blind to betrayal: why we fool ourselves we aren't being fooled*. Wiley.

Freyd, J. J. (1996). *Betrayal trauma: the logic of forgetting childhood abuse*. Harvard University Press.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Qualitative Report*, *20*(9), 1408–1416. https://doi.org/10.46743/2160-3715/2015.2281

Galatzer-Levy, I. R., Madan, A., Neylan, T. C., Henn-Haase, C., & Marmar, C. R. (2011). Peritraumatic and trait dissociation differentiate police officers with resilient versus symptomatic trajectories of posttraumatic stress symptoms. *Journal of Traumatic Stress*, *24*(5), 557–565. https://doi.org/10.1002/jts.20684

Goff, B. S. N., & Smith, D. B. (2005). Systemic Traumatic Stress: The Couple Adaptation to Traumatic Stress Model. *Journal of Marital and Family Therapy*, *31*(2), 145–157. https://doi.org/10.1111/j.1752-0606.2005.tb01552.x

Goodrick, D., & Rogers J. P. (2015). Qualitative Data Analysis. In Newcomer, K. E., Hatry, H. P., & Wholey, J. S. (Eds.), *Handbook of Practical Program Evaluation*. John Wiley & Sons.

Grace McKeon, Ruth Wells, Zachary Steel, Veronique Moseley & Simon Rosenbaum (2021). Self-reported physical and mental health of informal caregivers of emergency service workers. *Journal of Loss and Trauma*, *26*(6), 507-518, DOI: 10.1080/15325024.2020.1845020 https://www.tandfonline.com/doi/full/10.1080/15325024.2020.1845020

Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. *Educational Communication & Technology*, *30*(4), 233–252. https://doi.org/10.1007/BF02765185

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Guilaran, J., de Terte, I., Kaniasty, K., & Stephens, C. (2018). Psychological Outcomes in Disaster Responders: A Systematic Review and Meta-Analysis on the Effect of Social Support. *International Journal of Disaster Risk Science*, *9*(3), 344–358. https://doi.org/10.1007/s13753-018-0184-7

Gulliver, S. B., Pennington, M. L., Torres, V. A., Steffen, L. E., Mardikar, A., Leto, F., Ostiguy, W., Zimering, R. T., & Kimbrel, N. A. (2019). Behavioral health programs in fire service: surveying access and preferences. *Psychological Services, 16*(2), 340–345. https://doi.org/10.1037/ser0000222

Hadjistavropoulos, H. D., McCall, H. C., Thiessen, D. L., Huang, Z., Carleton, R. N., Dear, B. F., & Titov, N. (2021). Initial outcomes of transdiagnostic internet-delivered cognitive behavioral therapy tailored to public safety personnel: Longitudinal observational study. *Journal of Medical Internet Research*, *23*(5), e27610–e27610. https://doi.org/10.2196/27610

Hadjistavropoulos, H. D., Reiser, S. J., Beahm, J. D., McCall, H. C., Dena, I., Phillips, A. R., Scheltgen, M., Sekhar, S., Cox, M., Cramm, H., & Reid, N. (2023). Internet-delivered cognitive behavioral therapy tailored to spouses and significant others of public safety personnel: formative evaluation study. *JMIR Formative Research*, 7, e51088–e51088. https://doi.org/10.2196/51088

Hatzenbuehler, M. L. (2016). Structural Stigma and Health Inequalities: Research Evidence and Implications for Psychological Science. *The American Psychologist*, *71*(8), 742–751. https://doi.org/10.1037/amp0000068

Haugen, P. T., McCrillis, A. M., Smid, G. E., & Nijdam, M. J. (2017). Mental health stigma and barriers to mental health care for first responders: A systematic review and meta-analysis. *Journal of Psychiatric Research*, 94, 218–229.https://doi.org/10.1016/j.jpsychires.2017.08.001

Heber, A., Testa, V., Groll, D., Ritchie, K., Tam-Seto, L., Mulligan, A., Sullo, E., Schick, A., Bose, E., Jabbari, Y., Lopes, J., & Carleton, R. N. (2023). Glossary of terms: A shared understanding of the common terms used to describe psychological trauma, version 3.0. *Chronic Diseases in Canada*, *43*(10–11), S1–S999. https://doi.org/10.24095/hpcdp.43.10/11.09

Heinrichs, M., Wagner, D., Schoch, W., Soravia, L. M., Hellhammer, D. H., & Ehlert, U. (2005). Predicting Posttraumatic Stress Symptoms from Pretraumatic Risk Factors: A 2-Year Prospective Follow-Up Study in Firefighters. *The American Journal of Psychiatry*, *162*(12), 2276–2286. https://doi.org/10.1176/appi.ajp.162.12.2276

Helfers, R. C., & Nhan, J. (2022). A Qualitative Study: An Examination of Police Officers' Lived Experiences During the COVID-19 Pandemic. *International Criminal Justice Review*, *32*(3), 308–327. https://doi.org/10.1177/10575677211050427

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code Saturation Versus Meaning Saturation: How Many Interviews Are Enough? *Qualitative Health Research*, *27*(4), 591–608. https://doi.org/10.1177/1049732316665344

Henry, M. C., Burks, M. A., & Zoernig, E. L. (2023). PTSD, relationship satisfaction, and social support for EMS workers and their romantic partners. *The Family Journal, 32*(1). https://doi.org/10.1177/10664807231198866

Henry, M. C., Burks, M. A., & Zoernig, E. L. (2024). PTSD, Relationship Satisfaction, and Social Support for EMS Workers and Their Romantic Partners. *The Family Journal, 32*(1), 102–111. https://doi.org/10.1177/10664807231198866

Hill, M. A., Paterson, J. L., & Rebar, A. L. (2024). Secondary traumatic stress in partners of paramedics: A scoping review. *Australasian Emergency Care*, *27*(1), 1–8. https://doi.org/10.1016/j.auec.2023.06.002

Horn, E. E., Xu, Y., Beam, C. R., Turkheimer, E., & Emery, R. E. (2013). Accounting for the Physical and Mental Health Benefits of Entry into Marriage: A Genetically Informed Study of Selection and Causation. *Journal of Family Psychology*, *27*(1), 30–41. https://doi.org/10.1037/a0029803

Huang, E., Edgar, N. E., MacLean, S. E., & Hatcher, S. (2022). Workplace Assessment Scale: Pilot Validation Study. *International Journal of Environmental Research and Public Health*, *19*(19), 12408-. https://doi.org/10.3390/ijerph191912408

International Critical Incident Stress Foundation (ICISF) (2024) A Primer on Critical Incident Stress Management (CISM) https://icisf.org/a-primer-on-critical-incident-stress-management-

cism/#:~:text=Critical%20Incident%20Stress%20Debriefing%20(CISD,sense%20of%20post%2Dcrisis%20psychological

Issakidis, C., Sanderson, K., Corry, J., Andrews, G., & Lapsley, H. (2004). Modelling the population cost-effectiveness of current and evidence-based optimal treatment for anxiety disorders. *Psychological Medicine*, *34*(1), 19–35. https://doi.org/10.1017/S003329170300881X

Jebb, A. T., Ng, V., & Tay, L. (2021). A Review of Key Likert Scale Development Advances: 1995–2019. *Frontiers in Psychology*, *12*, 637547–637547. https://doi.org/10.3389/fpsyg.2021.637547

Jones, S. (2017). Describing the Mental Health Profile of First Responders: A Systematic Review. *Journal of the American Psychiatric Nurses Association*, *23*(3), 200–214. https://doi.org/10.1177/1078390317695266

Kaufman, R., & Triner, D. (1996). Planning and conducting needs assessment: a practical guide. *Human Resource Development Quarterly*, *7*(4), 384-387. https://login.proxy.bib.uottawa.ca/login?url=https://www.proquest.com/scholarly-journals/planning-conducting-needs-assessment-practical/docview/234904702/se-2

Komarovskaya, I., Maguen, S., McCaslin, S. E., Metzler, T. J., Madan, A., Brown, A. D., Galatzer-Levy, I. R., Henn-Haase, C., & Marmar, C. R. (2011). The impact of killing and injuring others on mental health symptoms among police officers. *Journal of Psychiatric Research*, *45*(10), 1332–1336. https://doi.org/10.1016/j.jpsychires.2011.05.004

Konnopka, A., Leichsenring, F., Leibing, E., & König, H.-H. (2009). Cost-of-illness studies and cost-effectiveness analyses in anxiety disorders: A systematic review. *Journal of Affective Disorders*, *114*(1), 14–31. https://doi.org/10.1016/j.jad.2008.07.014

Kostera, M., & Harding, N. (2021). *Organizational ethnography*. Edward Elgar Publishing.

Krueger, A. R., & Casey, A. M. (2015). Focus Group Interviewing. In Newcomer, K. E., Hatry, H. P., & Wholey, J. S. (Eds.), *Handbook of Practical Program Evaluation*. John Wiley & Sons.

Lambert, S. J. (1990). Processes Linking Work and Family: A Critical Review and Research Agenda. *Human Relations (New York)*, *43*(3), 239–257. https://doi.org/10.1177/001872679004300303

Landers, A. L., Dimitropoulos, G., Mendenhall, T. J., Kennedy, A., & Zemanek, L. (2020). Backing the Blue: Trauma in Law Enforcement Spouses and Couples. *Family Relations*, *69*(2), 308–319. https://doi.org/10.1111/fare.12393

Lane, J., Le, M., Martin, K., Bickle, K., Campbell, E., & Ricciardelli, R. (2022). Police attitudes toward seeking professional mental health treatment. *Journal of Police and Criminal Psychology*, *37*(1), 123–131. https://doi.org/10.1007/s11896-021-09467-6

Lee, J. S., You, S., Choi, Y. K., Youn, H. young, Shin, H. S., & Ito, E. (2017). A preliminary evaluation of the training effects of a didactic and simulation-based psychological first aid program in students and school counselors in South Korea. *PloS One*, *12*(7), e0181271–e0181271. https://doi.org/10.1371/journal.pone.0181271

Lewis-Schroeder, N. F., Kieran, K., Murphy, B. L., Wolff, J. D., Robinson, M. A., & Kaufman, M. L. (2018). Conceptualization, Assessment, and Treatment of Traumatic Stress in First Responders: A Review of Critical Issues. *Harvard Review of Psychiatry*, *26*(4), 216–227. https://doi.org/10.1097/HRP.0000000000000176

Lioce L., Lopreiato J., Downing D., Chang T.P., Robertson J.M., Anderson M., Diaz D.A., & Spain A.E., (2020). *Healthcare Simulation Dictionary – Second Edition.* Agency for Healthcare Research and Quality; September 2020. AHRQ Publication No. 20-0019. DOI: https://doi.org/10.23970/simulationv2.

Magnusson, E., & Marecek, J. (2015). *Doing interview-based qualitative research: a learner's guide*. Cambridge University Press.

Maia, D. B., Marmar, C. R., Metzler, T., Nóbrega, A., Berger, W., Mendlowicz, M. V., Coutinho, E. S. F., & Figueira, I. (2007). Post-traumatic stress symptoms in an elite unit of Brazilian police officers: Prevalence and impact on psychosocial functioning and on physical and mental health. *Journal of Affective Disorders*, *97*(1), 241–245. https://doi.org/10.1016/j.jad.2006.06.004

Marchand, A., Nadeau, C., Beaulieu-Prévost, D., Boyer, R., Martin, M., & Kendall-Tackett, K. (2015). Predictors of Posttraumatic Stress Disorder Among Police Officers: A Prospective Study. *Psychological Trauma*, *7*(3), 212–221. https://doi.org/10.1037/a0038780

Marciniak, M. D., Lage, M. J., Dunayevich, E., Russell, J. M., Bowman, L., Landbloom, R. P., & Levine, L. R. (2005). The cost of treating anxiety: the medical and demographic correlates that impact total medical costs. *Depression and Anxiety*, *21*(4), 178–184. https://doi.org/10.1002/da.20074

Marin, A. (2012). Ontario and OPP Failing to Support Police Officers Affected by Operational Stress Injuries: Ombudsman. (2012). *Marketwire*. https://ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports-on-Investigations/OPP-final-EN-accessible.pdf

Marmar, C. R., McCaslin, S. E., Metzler, T. J., Best, S., Weiss, D. S., Fagan, J., Liberman, A., Pole, N., Otte, C., Yehuda, R., Mohr, D., & Neylan, T. (2006). Predictors of Posttraumatic Stress in Police and Other First Responders. *Annals of the New York Academy of Sciences*, *1071*(1), 1–18. https://doi.org/10.1196/annals.1364.001

Marmar, C. R., Weiss, D. S., Metzler, T. J., Ronfeldt, H. M., & Foreman, C. (1996). Stress responses of emergency services personnel to the Loma Prieta earthquake Interstate 880 freeway collapse and

control traumatic incidents. *Journal of Traumatic Stress*, *9*(1), 63–85. https://doi.org/10.1007/BF02116834

Marshall, E. M., & Kuijer, R. G. (2017). Weathering the storm? The impact of trauma on romantic relationships. *Current Opinion in Psychology*, *13*, 54–59. https://doi.org/10.1016/j.copsyc.2016.04.013

McCann, I. L., Sakheim, D. K., & Abrahamson, D. J. (1988). Trauma and Victimization: A Model of Psychological Adaptation. *The Counseling Psychologist*, *16*(4), 531–594. https://doi.org/10.1177/0011000088164002

McCoy, S. P., & Aamodt, M. G. (2010). A comparison of law enforcement divorce rates with those of other occupations. *Journal of Police and Criminal Psychology*, *25*(1), 1–16. https://doi.org/10.1007/s11896-009-9057-8

McCreary, D. R. (2019). Veteran and first responder mental ill health and suicide prevention: A scoping review of prevention and early intervention programs used in Canada, Australia, New Zealand, Ireland, and the United Kingdom. British Columbia, Canada. https://uk.movember.com/uploads/files/2020/VFR%20Grants/Movember%20Executive%20Summary%20-%20Veterans%20and%20First%20Responder%20Scoping%20Review.pdf

McNaughton, N., Ravitz, P., Wadell, A., & Hodges, B. D. (2008). Psychiatric Education and Simulation: A Review of the Literature. *Canadian Journal of Psychiatry*, *53*(2), 85–93. https://doi.org/10.1177/070674370805300203

Mitchell, J. T., & Everly, G. S. (1996). *Critical incident stress debriefing-- CISD: an operations manual for the prevention of traumatic stress among emergency service and disaster workers* (2nd ed., rev.). Chevron Pub.

Miller, L., & Silverman, W. H. (1995). Tough Guys: Psychotherapeutic Strategies with Law Enforcement and Emergency Services Personnel. *Psychotherapy, 32*(4), 592–600. https://doi.org/10.1037/0033-3204.32.4.592

Monson, C. M., Fredman, S. J., Macdonald, A., Pukay-Martin, N. D., Resick, P. A., & Schnurr, P. P. (2012). Effect of Cognitive-Behavioral Couple Therapy for PTSD: A Randomized Controlled Trial. *JAMA: The Journal of the American Medical Association*, *308*(7), 700–709. https://doi.org/10.1001/jama.2012.9307

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education*, *8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

Newcomer, K. E., Hatry H. P., & Wholey J. S. (2015) *Handbook of Practical Program Evaluation, Fourth Edition.* Wiley.

Newton, J., Carpenter, T., & Zwicker, J. (2024). Exploring paramedic perspectives on emergency medical service (EMS) delivery in Alberta: a qualitative study. *BMC Emergency Medicine*, *24*(1), 66–66. https://doi.org/10.1186/s12873-024-00986-z

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, *16*(1), 1–13. https://doi.org/10.1177/1609406917733847

O'Toole, M., Mulhall, C., & Eppich, W. (2022). Breaking down barriers to help-seeking: preparing first responders' families for psychological first aid. *European Journal of Psychotraumatology*, *13*(1), 2065430–2065430. https://doi.org/10.1080/20008198.2022.2065430

Paulus, D. J., Gallagher, M. W., Bartlett, B. A., Tran, J., & Vujanovic, A. A. (2018). The unique and interactive effects of anxiety sensitivity and emotion dysregulation in relation to posttraumatic

stress, depressive, and anxiety symptoms among trauma-exposed firefighters. *Comprehensive Psychiatry*, *84*, 54–61. https://doi.org/10.1016/j.comppsych.2018.03.012

Pearson, C., Teresa, J., & Ali, J., (2013). Mental and Substance Use Disorders in Canada. *Health at a Glance.* Statistics Canada Catalogue no. 82-624-X. https://www150.statcan.gc.ca/n1/pub/82-624-x/2013001/article/11855-eng.htm

Perrin, M. A., DiGrande, L., Wheeler, K., Thorpe, L., Farfel, M., & Brackbill, R. (2007). Differences in PTSD Prevalence and Associated Risk Factors Among World Trade Center Disaster Rescue and Recovery Workers. *The American Journal of Psychiatry*, *164*(9), 1385–1394. https://doi.org/10.1176/appi.ajp.2007.06101645

Petrie, K., Milligan-Saville, J., Gayed, A., Deady, M., Phelps, A., Dell, L., Forbes, D., Bryant, R. A., Calvo, R. A., Glozier, N., & Harvey, S. B. (2018). Prevalence of PTSD and common mental disorders amongst ambulance personnel: a systematic review and meta-analysis. Social Psychiatry and Psychiatric Epidemiology, *53*(9), 897–909. https://doi.org/10.1007/s00127-018-1539-5

Pinto, R. J., Henriques, S. P., Jongenelen, I., Carvalho, C., & Maia, Â. C. (2015). The Strongest Correlates of PTSD for Firefighters: Number, Recency, Frequency, or Perceived Threat of Traumatic Events? *Journal of Traumatic Stress*, *28*(5), 434–440. https://doi.org/10.1002/jts.22035

Phillips, R., & Benoit, C. (2013). Exploring Stigma by Association among Front-Line Care Providers Serving Sex Workers. *Healthcare Policy*, *9*(SP), 131–151. https://doi.org/10.12927/hcpol.2013.23597

Phoenix, B. J. (2007). Psychoeducation for Survivors of Trauma. *Perspectives in Psychiatric Care*, *43*(3), 123–131. https://doi.org/10.1111/j.1744-6163.2007.00121.x

Platt, M. G., Freyd, J. J., & Kendall-Tackett, K. (2015). Betray My Trust, Shame on Me: Shame, Dissociation, Fear, and Betrayal Trauma. *Psychological Trauma*, *7*(4), 398–404. https://doi.org/10.1037/tra0000022

Porter, K. L., & Henriksen, R. C. (2016). The Phenomenological Experience of First Responder Spouses. *The Family Journal (Alexandria, Va.)*, *24*(1), 44–51. https://doi.org/10.1177/1066480715615651

Powling, R., Brown, D., Tekin, S., Billings, J., & Ptaszynski, M. (2024). Partners' experiences of their loved ones' trauma and PTSD: An ongoing journey of loss and gain. *PloS One*, *19*(2), e0292315–e0292315. https://doi.org/10.1371/journal.pone.0292315

Public Health Agency of Canada (2012). *Suicide in Canada: Key Statistics (Infographic).* Government of Canada. https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html

PSPNET (2023) *PSPNET.* https://www.pspnet.ca/

Rahimi, S., & khatooni, M. (2024). Saturation in qualitative research: An evolutionary concept analysis. *International Journal of Nursing Studies Advances*, *6*, 100174–100174. https://doi.org/10.1016/j.ijnsa.2024.100174

Raphael, B., & Wilson, J. P. (2000). *Psychological Debriefing: theory, practice, and evidence*. Cambridge University Press.

Regehr, C., Goldberg, G., & Hughes, J. (2002). Exposure to Human Tragedy, Empathy, and Trauma in Ambulance Paramedics. *American Journal of Orthopsychiatry*, *72*(4), 505–513. https://doi.org/10.1037/0002-9432.72.4.505

Ricciardelli, R., Czarnuch, S., Afifi, T.O., & Carleton, R.N. (2020). Public Safety Personnel's interpretations of potentially traumatic events. *Occupational Medicine*, *70*(3), 155-161. https://doi.org/10.1093/occmed/kqaa007

Ricciardelli, R., Czarnuch, S., Carleton, R. N., Gacek, J., & Shewmake, J. (2020). Canadian public safety personnel and occupational stressors: How PSP interpret stressors on duty. *International Journal of Environmental Research and Public Health*, *17*(13), 1–16. https://doi.org/10.3390/ijerph17134736

Ricciardelli, R., Carleton, R. N., Mooney, T., & Cramm, H. (2020). "Playing the system": Structural factors potentiating mental health stigma, challenging awareness, and creating barriers to care for Canadian public safety personnel. *Health*, *24*(3), 259–278. https://doi.org/10.1177/1363459318800167

Richmond, R., Ricciardelli, R., Dekel, R. (2024). Exploring the occupational lifestyle experiences of the families of public safety personnel. *Journal of Occupational Rehabilitation*, *34*, 895-912. https://doi.org/10.1007/s10926-024-10179-x

Roth, S. G., & Moore, C. D. (2009). Work-Family Fit: The Impact of Emergency Medical Services Work on the Family System. *Prehospital Emergency Care*, *13*(4), 462–468. https://doi.org/10.1080/10903120903144791

Ruck, S., Bowes, N., & Tehrani, N. (2013). Evaluating trauma debriefing within the UK prison service. *Journal of Forensic Practice*, *15*(4), 281–290. https://doi.org/10.1108/JFP-09-2012-0018

Rudolph, J. W., Raemer, D. B., & Simon, R. (2014). Establishing a Safe Container for Learning in Simulation: The Role of the Presimulation Briefing. *Simulation in Healthcare: Journal of the Society for Medical Simulation*, *9*(6), 339–349. https://doi.org/10.1097/SIH.0000000000000047

Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological First Aid. *Journal of Mental Health Counseling*, *29*(1), 17–49.

Sacchetti, E., Garozzo, A., Mussoni, C., Liotta, D., Novelli, G., Tamussi, E., Deste, G., & Vita, A. (2020). Post-traumatic stress disorder and subthreshold post-traumatic stress disorder in recent male asylum seekers: An expected but overlooked "European" epidemic. *Stress and Health*, *36*(1), 37–50. https://doi.org/10.1002/smi.2910

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179–183. https://doi.org/10.1002/nur.4770180211

Sandelowski, M. (2004). Using Qualitative Research. *Qualitative Health Research*, *14*(10), 1366–1386. https://doi.org/10.1177/1049732304269672

Sareen, J., Cox, B. J., Afifi, T. O., Stein, M. B., Belik, S.-L., Meadows, G., & Asmundson, G. J. G. (2007). Combat and peacekeeping operations in relation to prevalence of mental disorders and perceived need for mental health care: findings from a large representative sample of military personnel. *Archives of General Psychiatry*, *64*(7), 843–852. https://doi.org/10.1001/archpsyc.64.7.843

Sarkhel, S., Singh, O., & Arora, M. (2020). Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation. *Indian Journal of Psychiatry*, *62*(8), 319–323. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_780_19

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Senate Canada (2015). *Interim report on the occupational stress injuries of Canada's veterans*. Standing Senate Committee on National Security and Defence. https://sencanada.ca/content/sen/Committee/412/secd/rep/rep17jun15-e.pdf

Sharp, M. L., Solomon, N., Harrison, V., Gribble, R., Cramm, H., Pike, G., & Fear, N. T. (2022). The mental health and wellbeing of spouses, partners, and children of emergency responders: A systematic review. *Plos One*, *17*(6), e0269659–e0269659. https://doi.org/10.1371/journal.pone.0269659

Shultz, J. M., & Forbes, D. (2014). Psychological first aid: rapid proliferation and the search for evidence. *Disaster Health*, *2*(1), 3–12. https://doi.org/10.4161/dish.26006

Shultz, J. M., & Forbes, D. (2013). Psychological First Aid: Rapid proliferation and the search for evidence. *Disaster Health*, *2*(1), 3–12. https://doi.org/10.4161/dish.26006

Sinden, K., MacDermid, J., Buckman, S., Davis, B., Matthews, T., & Viola, C. (2013). A qualitative study on the experiences of female firefighters. *Work*, *45*(1), 97–105. https://doi.org/10.3233/WOR-121549

Smith, C. P., Freyd, J. J., & Anderson, N. B. (2014). Institutional Betrayal. *The American Psychologist*, *69*(6), 575–587. https://doi.org/10.1037/a0037564

Sprang, G., Ford, J., Kerig, P., & Bride, B. (2019). Defining Secondary Traumatic Stress and Developing Targeted Assessments and Interventions: Lessons Learned from Research and Leading Experts. *Traumatology, 25*(2), 72–81. https://doi.org/10.1037/trm0000180

Public Safety Canada (2019). *Supporting Canada's public safety personnel: an action plan on post-traumatic stress injuries.* Public Safety Canada. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2019-ctn-pln-ptsi/2019-ctn-pln-ptsi-en.pdf

Statistics Canada (2012). *Canadian community health survey–mental health, 2012: rates of selected mental or substance use disorders, lifetime and 12 month, Canada, household population 15 and older, 2012*. Statistics Canada. https://www150.statcan.gc.ca/n1/daily-quotidien/130918/dq130918a-eng.htm

Szeto, A., Dobson, K. S., & Knaak, S. (2019). The road to mental readiness for first responders: a meta-analysis of program outcomes. *Canadian Journal of Psychiatry*, *64*(1), 8-29. https://doi.org/10.1177/0706743719842562

Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., Monson, C. M., & Nezu, A. M. (2011). Posttraumatic Stress Disorder and Intimate Relationship Problems: A Meta-Analysis. *Journal of Consulting and Clinical Psychology*, *79*(1), 22–33. https://doi.org/10.1037/a0022196

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*, *15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01

Thorne, Sally (2016). *Interpretive Description: Qualitative Research for Applied Practice*. Routledge. https://doi.org/10.4324/9781315545196

Titov, N., Dear, B., Nielssen, O., Staples, L., Hadjistavropoulos, H., Nugent, M., Adlam, K., Nordgreen, T., Bruvik, K. H., Hovland, A., Repål, A., Mathiasen, K., Kraepelien, M., Blom, K., Svanborg, C., Lindefors, N., & Kaldo, V. (2018). ICBT in routine care: a descriptive analysis of successful clinics in five countries. *Internet Interventions: The Application of Information Technology in Mental and Behavioural Health*, *13*, 108–115. https://doi.org/10.1016/j.invent.2018.07.006

Tjin, A., Traynor, A., Doyle, B., Mulhall, C., Eppich, W., & O'Toole, M. (2022). Turning to 'Trusted Others': a narrative review of providing social support to first responders. *International Journal*

of Environmental Research and Public Health, *19*(24), 16492. https://doi.org/10.3390/ijerph192416492

Trautmann, S., Rehm, J., & Wittchen, H. (2016). The economic costs of mental disorders: Do our societies react appropriately to the burden of mental disorders? *EMBO Reports*, *17*(9), 1245–1249. https://doi.org/10.15252/embr.201642951

Ricciardelli, R., Carleton, R. N., Mooney, T., & Cramm, H. (2020). "Playing the system": structural factors potentiating mental health stigma, challenging awareness, and creating barriers to care for Canadian public safety personnel. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 24*(3), 259–278. https://doi.org/10.1177/1363459318800167

Rikkers, W., & Lawrence, D. (2021). Mental health help-seeking experiences and service use among Australian first responders. *Australian Journal of Psychology*, *73*(2), 125–133. https://doi.org/10.1080/00049530.2021.1882271

Robinson, H. M., Sigman, M. R., & Wilson, J. P. (1997). Duty-Related Stressors and PTSD Symptoms in Suburban Police Officers. *Psychological Reports*, *81*(3), 835–845. https://doi.org/10.2466/pr0.1997.81.3.835

Robinson, R. (2000). Debriefing with emergency services: Critical Incident Stress Management. In Psychological Debriefing (pp. 91–107). Cambridge University Press. https://doi.org/10.1017/CBO9780511570148.007

van der Ploeg, E., & Kleber, R. J. (2003). Acute and chronic job stressors among ambulance personnel: predictors of health symptoms. *Occupational and Environmental Medicine (London, England)*, *60*(suppl 1), i40–i46. https://doi.org/10.1136/oem.60.suppl_1.i40

Vasileiou, K., Barnett, J., Thorpe, S. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year

period. *BMC Medical Research Methodology 18*, 148. https://doi.org/10.1186/s12874-018-0594-7

Verhoef, M. J., & Casebeer, A. L. (1997). Broadening horizons: Integrating quantitative and qualitative research. *Canadian Journal of Infectious Diseases*, *8*(2), 65–66. https://doi.org/10.1155/1997/349145

Vernberg, E. M., Steinberg, A. M., Jacobs, A. K., Brymer, M. J., Watson, P. J., Osofsky, J. D., Layne, C. M., Pynoos, R. S., Ruzek, J. I., Vernberg, E. M., & Roberts, M. C. (2008). Innovations in Disaster Mental Health: Psychological First Aid. *Professional Psychology, Research and Practice*, *39*(4), 381–388. https://doi.org/10.1037/a0012663

Violanti, J. M., Mnatsakanova, A., Gu, J. K., Service, S., & Andrew, M. E. (2021). Adverse childhood experiences and police mental health. *Policing: An International Journal of Police Strategies & Management*, *44*(6), 1014–1030. https://doi.org/10.1108/PIJPSM-06-2021-0085

Waddell, E., Lawn, S., Roberts, L., Henderson, J., Venning, A., & Redpath, P. (2020). "Why do you stay?": The lived-experience of partners of Australian veterans and first responders with Posttraumatic Stress Disorder. *Health & Social Care in the Community*, *28*(5), 1734–1742. https://doi.org/10.1111/hsc.12998

Wagner, D., Heinrichs, M., & Ehlert, U. (1998). Prevalence of Symptoms of Posttraumatic Stress Disorder in German Professional Firefighters. *The American Journal of Psychiatry*, *155*(12), 1727–1732. https://doi.org/10.1176/ajp.155.12.1727

Watson, P. J., Brymer, M. J., & Bonanno, G. A. (2011). Postdisaster Psychological Intervention Since 9/11. *The American Psychologist*, *66*(6), 482–494. https://doi.org/10.1037/a0024806

Watkins, S. L., Shannon, M. A., Hurtado, D. A., Shea, S. A., & Bowles, N. P. (2021). Interactions between home, work, and sleep among firefighters. *American Journal of Industrial Medicine*, *64*(2), 137–148. https://doi.org/10.1002/ajim.23194

Wilson, S., Guliani, H., & Boichev, G. (2016). On the economics of post-traumatic stress disorder among first responders in Canada. *Journal of Community Safety & Well-Being*, *1*(2), 26. https://doi.org/10.35502/jcswb.6

Witkin B. R. & Altschuld J.W. (1995). *Planning and Conducting Needs Assessments, A Practical Guide*. Sage Publications, Inc.

Wings of Change (2023). *Wings of Change Peer Support* https://www.wingsofchange.ca/

Wounded Warriors (2019). *National Mental Health Service Provider*. https://woundedwarriors.ca/

Wright, H. M., Fuessel-Hermann, D., Pazdera, M., Lee, S., Ridge, B., Kim, J. U., Konopacki, K., Hilton, L., Greensides, M., Langenecker, S. A., & Smith, A. J. (2022). Preventative care in first responder mental health: focusing on access and utilization via stepped telehealth care. *Frontiers in Health Services*, *2*, 848138–848138. https://doi.org/10.3389/frhs.2022.848138

Yang, L., QI, L., & Zhang, B. (2022). Concepts and evaluation of saturation in qualitative research. Advances in Psychological Science, *30*(3), 511. 10.3724/SP.J.1042.2022.00511

Young, K. M., & Cooper, C. L. (1995). Occupational stress in the ambulance service: a diagnostic study. *Journal of Managerial Psychology*, *10*(3), 29–36. https://doi.org/10.1108/02683949510081356

UNIVERSITÉ SAINT-PAUL UNIVERSITY

APPENDIX A: Informed Consent Form

Study Title: The Partner at Home: Psychoeducation and Spouses of Public Safety Personnel

Principal Investigator:

William Jackson-Monroe
MA Student
Saint Paul University
223 Main Street, Ottawa, Ontario
K1S 1C4

Supervisor:

Dr. Stephanie Yamin, C.PSYCH.
Saint Paul University
223 Main Street, Ottawa, Ontario
K1S 1C4

Invitation to Participate

I am invited to participate in the abovementioned research study conducted by William Jackson-Monroe and their supervisor, Dr. Stephanie Yamin.

Introduction

I am invited to participate in the research study *The Partner at Home: Psychoeducation and Spouses of Public Safety Personnel*. The following information in this form relates to the study, which includes a brief overview of the purpose of the study, the risks and benefits involved with participating, and additional information that aims to help you decide whether or not participating in this study will be a good fit for you. If you have any questions about the study, we encourage you to contact the principal investigator. Please feel free to connect with your family or friends before deciding to participate to explore the risks and benefits. Participation in this study is voluntary and all identifying information that you share with the research team will be confidential.

This study has been reviewed by Saint Paul University's Research Ethics Board (add REB assigned # and date).

Purpose

The purpose of this study is to improve the public's knowledge about the experiences that spouses and significant others (SSO) of public safety personnel (PSP) (first responders) have had with psychoeducation. Psychoeducation is defined as an intervention or program that informs participants of mental health signs and symptoms, how to facilitate conversations about mental health in a safe environment, and resilience building (O'Toole et al., 2022). PSP encountering potentially traumatic events is a by-product of their careers and their experiences of mental health challenges have been largely reported. What is not reported nearly significantly enough is the experience of the partner at home – the SSO. This study aims to uncover what resources are available to SSOs of PSP and what psychoeducation-related programs would be helpful for them.

This study's findings may inform future psychoeducation programming for SSOs of PSP. Therefore, SSOs of PSP and their families may benefit from this study's findings in addition to first responder organizations as well as the Canadian public.

Procedure

This study aims to conduct interviews with a minimum of 10 participants using a virtual system to improve convenience and availability for participants. Therefore, each interview will last one hour. These virtual meetings will be recorded, transcribed, and analyzed for consistent patterns or themes. The principal investigator, Thesis Supervisor, and one Research Assistant will be the only individuals with access to the recordings. Interviews will be facilitated by the principal investigator, who will be responsible for asking the study's questions. The responsibilities of participants include sharing their experiences.

In addition to participating in an interview, participants will also be asked to complete a short demographic and background questionnaire. This document will be shared with participants prior to the interview and be asked to submit to the principal investigator. Participant identifying information will be confidential.

Participation

My participation will consist of arriving to one interview time slot, answering questions that the principal investigator asks, and completing a short demographic questionnaire that may take up to 15 minutes to complete. The interviews will be scheduled between August and September and will likely be set at 6 or 7 pm. The short demographic questionnaire is expected to be completed and submitted back to the principal investigator prior to the interview.

Risks

A known risk is the principal investigator's private laptop being breached and participant information being leaked. To mitigate this risk, the laptop will never be left alone in public spaces and will be password protected. Additionally, the recordings, transcripts of the recordings, and demographic questionnaires will be in password-protected folders. Lastly, participants may

be at risk of discomfort for speaking about challenging subjects. The level of risk participants have in participating in this study is deemed minimal by the principal investigator. Mental health resources for Ottawa and the surrounding areas will be shared at the end of the interviews to mitigate further distress. The following document, created by Ottawa Public Health will be shared with participants at the end of the interview: https://www.ottawapublichealth.ca/en/public-health-topics/resources/Documents/mental_health_resource_guide_en.pdf. This document details addiction support, crisis lines, walk-in mental health clinics, community health resources, hospitals, among many other resources.

My participation in this study will entail that I volunteer personal information about myself, which may be leaked by a fellow participant or a prohibited person accessing the password-protected laptop. Furthermore, by speaking and listening to sensitive topics, I am at risk of becoming emotionally or physically distressed. I have received assurance from the principal investigator that every effort will be made to minimize these risks, such as (1) briefing participants not to disclose sensitive information; (2) saving sensitive information in password-protected folders in a password-protected laptop; (3) sharing mental health resources for Ottawa and the surrounding areas.

Benefits

My participation in this study may have some benefits, such as connecting with people who have similar experiences to mine, improving public knowledge about my community's needs, and ultimately, having the opportunity to have my voice heard. The findings of this study may eventually support the participants, their families, PSP organizations, and the Canadian public. I may find great satisfaction in being one of the voices that helped improve the mental health and well-being of my community.

Confidentiality

I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the content in the interviews will be used only for developing themes, which summarize the most prominent data. Similarly, the demographic questionnaire that I will complete will be used to enhance the principal investigator and the public's understanding of the context of the participants. My confidentiality will be protected by the principal investigator by saving my sensitive data and recordings in a password-protected laptop and any identifying information will never be disclosed to the public.

Anonymity

Anonymity will be protected in the following manner: identifying information will not be shared publicly and participant answers to the interview and demographic questionnaire will be identified as a number (e.g., 1-20). Therefore, the identity of the participants will never be revealed in publications.

Conservation of Data

The recordings of interviews, transcripts, and demographic questionnaires will be stored on the principal investigator's password-protected laptop. Furthermore, these documents will be sealed within password-protected folders. Only the principal investigator and supervisor will have access to the recordings and demographic questionnaires. The original data or a copy of the data must be secured on Saint Paul University's campus during the full period of retention, which is five years. When the study's data is released to the public, no identifying information will be shared and once five years have passed since the study's completion, all recordings and data files will be deleted.

Conflict of Interest

There are no conflicts of interest within this study.

Compensation

Participants will not be compensated for participating in this research study.

Voluntary Participation:

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will not be analyzed or shared.

Acceptance:

I (*fill in your name here*), consent to participate in (*The Partner at Home: Psychoeducation and Spouses of Public Safety Personnel*) conducted by (*William Jackson-Monroe*). I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research and Ethics, Saint Paul University, 223 Main Street, Ottawa, ON K1S 1C4
Tel.: (613) 236-1393.

There are two copies of the consent form, one of which is mine to keep.

Signature _____ Date _____
Participant

Signature _____ Date _____

Principal Investigator

APPENDIX B: Interview Guide

Experiences of First Responder Spouses and Psychoeducation/Psychological First Aid

Preamble: Good evening, my name is William Jackson-Monroe, and I am the principal investigator of this study and will be conducting this interview with you tonight. Firstly, I would like to express my thanks for your participation. To remind you of the purpose of this study, the purpose is to better understand what the experiences of spouses or significant others regarding psychoeducation and psychological first aid have been like. Evidenced-based psychoeducation could include training programs that attempt to improve participants' knowledge of mental health-related topics and coping methods thereby reducing stigma and improving resilience. Psychological first aid is closely related to psychoeducation; however, it's more reactive than proactive.

I must remind you that everything shared in this interview is confidential; however, for data collection purposes, our conversation will be recorded. If you are uncomfortable answering any questions, please let me know and I will move on to another question. In the interest of time, I may have to end the discussion of a topic prematurely so that we may answer more questions. There are no wrong answers. Lastly, you may be sharing sensitive information, so I'd like to obtain verbal consent from you before we continue with the interview. You may withdraw at any time.

General questions about current resources:

- What psychoeducation or psychological first aid-related resources are available to you?
  Prompt: How did you become aware of these resources?

- Out of the psychoeducation and psychological first aid resources available to you, which have you found most useful?
  Prompt: How accessible are these resources to you?

- Which resources have you found least useful?
  Prompt: What factors contribute to their lack of usefulness?

- What has been particularly helpful about the resources you have received or experienced?
  Prompt: If you were to recommend a resource to a newly hired first responder's spouse, which resource would you encourage them to use?

- What are some barriers to accessing mental health-related resources?
  Prompt: How can these barriers be mitigated?

Questions about communication with spouse or significant other:

- Does your partner release stress from work into the home? If so, what does that look like?
  Prompt: Is the stress related to a recent call or was it due to demands of work? How do you cope with this stress?

- If you were to see a red flag in your partner's behavior, how would you respond?
  Example: Your partner comes home after a shift and gives one-word answers, is seemingly disinterested in speaking to you, and begins using substances. The red flag is not limited by this example as there are many different red flag behaviors.
  Prompt: What seems to be the most effective approach to communicating with your spouse in these moments?

- What has your experience been like with duties around the home? Do you find that there's additional weight on your shoulders?
  Prompt: In my research, it often appeared in the literature of spouses taking on more duties at the home than they expected to take on. Do you find that is the case?

- Are mental health topics brought up between you and your partner?
  Prompt: What approaches do you have in raising these topics? Does your partner open the conversation about mental health? How could you improve how you approach these topics with your partner?

- If you have children, how are mental health-related topics brought up?
  Prompt: What has that experience been like? How do you ensure the conversation is age-appropriate and supportive?

Questions about a psychoeducation/psychological first aid workshop/program:

- What seems to be missing in the support for first responders and their families?
  Prompt: Of all of the things we have talked about, what is most important to you?

- If someone or organization offered a program to improve psychological first aid in spouses and significant others of first responders, what would it look like?
  Prompt: How else would this ideal program look like? Would practicing role-plays of active listening be something you are interested in?

APPENDIX C: Demographics and Background Questionnaire

1) **What is your age?**
   - 18-25
   - 25-35
   - 35-50
   - 50+
   - Prefer not to say

2) **What is your gender?**
   - Male
   - Female
   - Non-binary/Transgender
   - Prefer to self-describe: _____
   - Prefer not to say

3) **What is your ethnicity?**
   - White or Caucasian
   - Black or African American
   - Asian
   - Indigenous
   - Hispanic or Latino
   - A race/ethnicity not listed here: _____
   - Prefer not to say

4) **What is your highest level of education?**
   - Less than a high school diploma
   - High school diploma or equivalent
   - Some college
   - College diploma
   - Bachelor's degree
   - Master's degree
   - PhD or higher
   - Trade school
   - Prefer not to say

5) **What is your employment status?**
   - Employed full-time
   - Employed part-time
   - Self-employed
   - Unemployed
   - Homemaker
   - Retired
   - Student
   - Prefer not to say

6) **How many years has your spouse or significant other worked as a first responder?**
   - Less than 5 years
   - 5-10 years
   - 10-15 years
   - 16-20 years
   - Over 20 years

7) **How many years have you and your spouse or significant other been together?**
   - Less than 5 years
   - 5-10 years
   - 10-15 years
   - 16-20 years
   - Over 20 years

8) **How many years have you and your spouse or significant other lived together?**
   - Less than 5 years
   - 5-10 years
   - 10-15 years
   - 16-20 years
   - Over 20 years
   - Prefer not to say
   - We do not live together

9) **How connected are you in the first responder community?**

   - 1 – Not at all connected
   - 2 – Somewhat connected
   - 3 – Moderately connected
   - 4 – Well connected
   - 5 – Very connected

10) **Are any mental health-related needs of yours not being met by the first responder community?**

   - Yes
   - No

11) **If yes, what mental health-related needs are not being met? Please specify below.**

_____

_____

_____

_____

12) **Do you have any dependents living with you under the age of 18?**

- Yes
- No

The following questions ask about mental health challenges, which can include anxiety, depression, stress, or a reduced sense of well-being, but are not limited to these.

13) **Has your partner experienced mental health-related challenges related to their work?**

- Yes
- No

14) **Do you believe you have experienced secondary traumatic stress OR mental health issues related to your partner's career? Secondary traumatic stress may include anxiety, mood changes, and intrusive thoughts amongst other symptoms (Casas & Benuto, 2022).**

- Yes
- No

15) **How comfortable do you feel discussing mental health issues with your spouse?**

- 1 – Not comfortable at all
- 2 – Slightly comfortable
- 3 – Moderately comfortable
- 4 – Very comfortable
- 5 – Extremely comfortable

16) **What resources do you prioritize for personal support if you have or were to face mental health challenges? Please rank from most to least likely.**

- Therapist (counsellor, psychotherapist, psychologist, psychiatrist)
- Colleague
- Friend
- Spouse or significant other
- Other family member
- Supervisor
- Mental health skills class
- Anonymous helpline
- Other: _____

_____
_____
_____

_____

17) How do you think your partner would prioritize the resources listed in question 14? Please rank from most to least likely.

- o Therapist (counsellor, psychotherapist, psychologist, psychiatrist)
- o Colleague
- o Friend
- o Spouse or significant other
- o Other family member
- o Supervisor
- o Mental health skills class
- o Anonymous helpline
- o Other: _____

_____
_____

_____
_

18) Would you be interested in participating in a workshop involving psychoeducation and/or psychological first aid?

- o 1 – Not at all interested
- o 2 – Slightly interested
- o 3 – Moderately interested
- o 4 – Very interested
- o 5 – Extremely interested

19) How satisfied are you with the current resources available to you regarding psychoeducation?

- o 1 – Very dissatisfied
- o 2 – Dissatisfied
- o 3 – Neutral
- o 4 - Satisfied
- o 5 – Very satisfied

20) Do you believe a psychoeducation/psychological first aid workshop/program is needed for spouses of first responders?

- o Yes
- o No

21) What do you think should be included to improve psychoeducation support for spouses of first responders?

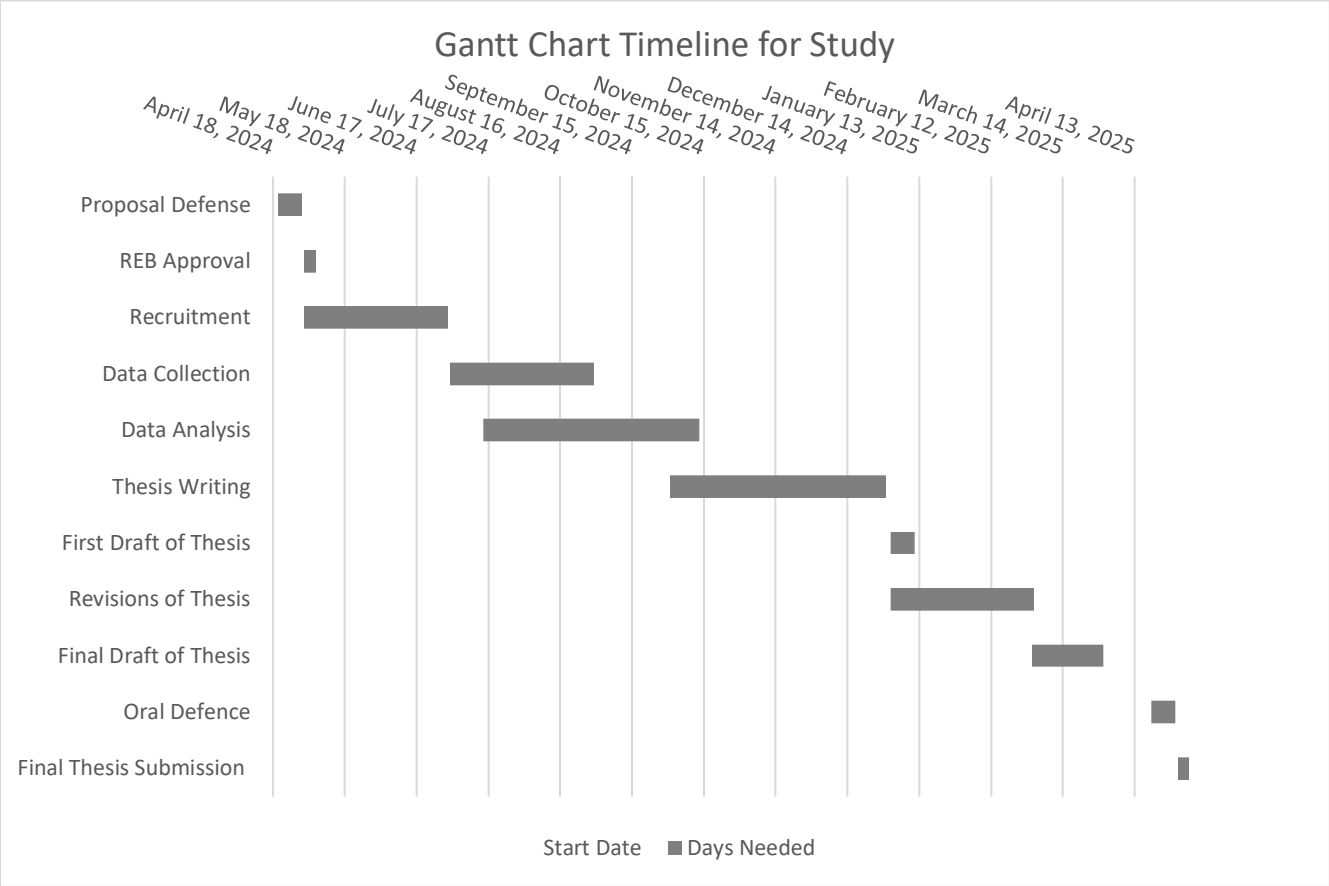
_____
_____

_____

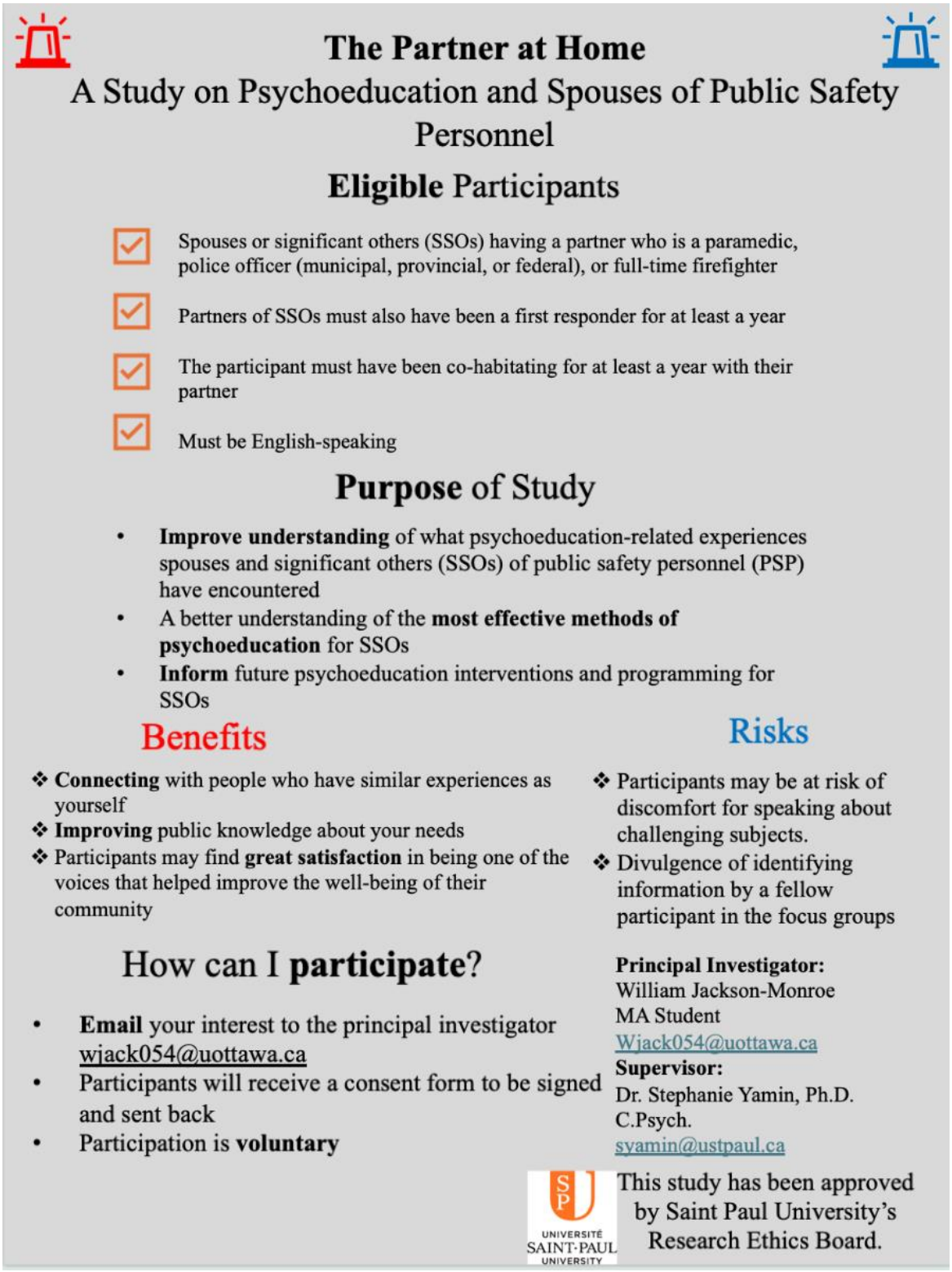
22) What modes of delivery for psychoeducation/psychological first aid resources would increase the likelihood of your participation? Please choose one.

- o In-person
- o Virtual
- o Individual
- o Group
- o Web-based modules (self-paced)

APPENDIX D: Timeline for Study



APPENDIX E: Study Poster



APPENDIX F: Recruitment Script

Good day,

Thank you for your interest in participating in the study: *The Partner at Home: Psychoeducation and Spouses of Public Safety Personnel*.

The purpose of this study is to acquire a better understanding of what psychoeducation and/or psychological first-aid experiences spouses or significant others of first responders have had. I am conducting interviews (1 hour in duration) throughout August-September 2024 with spouses of PSPs.

Attached to this email is the recruitment poster for this study, which offers a snapshot of eligibility for participation, risks, benefits, and how one may participate.

Thank you for offering to share this email with your network. If anyone is interested in participating or has any questions or concerns, please contact me.

William