

EXPERIENCES OF SECONDARY TRAUMA AMONGST SPOUSES OF EMERGENCY SERVICE PERSONNEL

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This article explored the secondary trauma experiences of the spouses of medical emergency service personnel (ESP). Eight spouses of ESP were interviewed and this produced five themes. Some of the EMS personnel bring their caring and supportive nature into the relationship and use the insight learnt in their role to benefit the relationship. Negative impacts of emergency work on relationships were increased arguments, decreased quality time, distancing from spouses, communication breakdown and fewer social activities. Secondary trauma is characterised by fears about safety of their spouse, behaviour changes from living with their spouses' emotional reactivity, and social withdrawal from family members.



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### **INTRODUCTION AND PROBLEM STATEMENT**

South African emergency service personnel (ESP) regularly face traumatic, stressful and life-threatening situations which influences them physically, emotionally and psychologically. They are exposed to an unpredictable work environment and traumatic situations such as witnessing on a regular basis the human pain and suffering of individuals who have been seriously injured or dying. Because of the unpredictability of calls, ESP are required to make quick decisions and administer effective aid, often without support or reassurance (Fjeldheim, Nöthling, Pretorius, Basson, Ganasen, Heneke, Cloete & Seedat, 2014). As a result of stressful work circumstances EMS personnel often experience sleep disturbances, trauma, organisational stress, stressed reaction to alarm bells, as well as the overall mental demands of the job, which are all significant determinants of stress levels among EMS personnel (Calhoun & Tedeschi, 2006). “Given all of these factors, the inherent occupational stress of this type of work can take a significant toll on the physical and emotional health of paramedics themselves” (Porter, 2008:1). The images and feelings that are associated with being exposed to continuous traumatic situations are not limited to the paramedics who are primarily exposed to the event, but these events can also have an effect on the significant others in their environment, such as their spouses.

Trauma can be viewed as a systemic entity which is interpersonal by nature as traumatic experiences create memories that are often co-constructed through interpersonal interaction with others (Figley & Figley, 2009). Family members share overlapping and intertwining relationships, so that trauma exposure by one member can have a negative influence on the family system as a whole (Becvar & Becvar, 2006). The traumatic events that ESP personnel may therefore discuss with their family or friends could cause secondary trauma and have an impact physically and emotionally on their loved ones. Secondary trauma is characterised by changes in memory and perception, alterations in an individual’s sense of self-efficacy, a depletion of personal resources, and disruptions in an individual’s perceptions of safety (National Child Traumatic Stress Network, 2011). Kail (2014) found that some EMS personnel choose not to talk about traumatic events with their families or partners – preferring to ‘protect’ them – consequently denying themselves an outlet to process their experiences and appearing detached to their partners. Conversely, others are more unguarded about their experiences, which could create an emotional burden for their partners and families, causing strain and, possibly, secondary trauma (Kail, 2014). A large proportion of previous research studies have focused on investigating the experiences of secondary trauma and PTSD among paramedics, but little research has been done on the impact of paramedic work and secondary trauma on their spouses (Porter, 2013). This study aimed to explore and describe the experiences of secondary trauma amongst the spouses of emergency service personnel in different emergency service organisations in Gauteng.

## Theoretical framework

Bowen's family systems theory (Goldenberg & Goldenberg, 2000) formed the theoretical underpinning of this study; it concentrates on the underlying concept that each family member is connected to the others as a unified whole. This theory further asserts that if one family member is experiencing challenges, such as secondary trauma, other family members, and the system as a whole, could be impacted.

## METHODOLOGY

### Research approach and design

The current study adopted a qualitative approach as it allows for the provision of detailed and in-depth descriptions of the experiences of the participant(s) and their associated meanings (Babbie & Mouton, 2003). An exploratory descriptive design was used to understand experiences of secondary trauma reported by spouses of ESP and to gain a richer and more accurate description of their experiences in daily life, social settings and in relationships (De Vos, Strydom, Fouché, & Delpont, 2011; Rubin & Babbie, 2001).

### Selection of participants

Purposive, non-probability sampling was used to select participants; this refers to the selection of participants from a particular population relevant to the purpose of the study by the researcher (Rubin & Babbie, 2007). Eight spouses of two private emergency service companies, ER24 and Netcare911, and a non-profit emergency service company, Hatzolah Emergency Services, were selected. The EMS staff member was approached first for permission to contact their spouses. The criteria for selection included: (1) the spouse was required to be in a relationship with an EMS personnel member who had been working for the emergency service company for a minimum of two years; (2) the spouse was required to be in a relationship with an EMS personnel member, who worked in a position where s/he is exposed to trauma on a regular basis; (3) and the spouse was required to be married or cohabiting with the EMS personnel member for a minimum of two years. Table 1 gives a summary of the participants.

**TABLE 1**  
**SUMMARY OF PARTICIPANTS**

Participant	Gender	Age	Ethnicity	Language	Marital status	Duration of cohabitation	Spouse's duration in EMS field
1	F	20	White	English	Engaged	2.5 years	2 years
2	M	28	White	English	Married	4 years	3 years
3	M	32	White	English	Married	6 years	5 years
4	F	45	White	Afrikaans	Married	20 years	10 years
5	F	27	White	English	Married	2 years	2 years
6	M	40	White	Afrikaans	Married	15 years	9 years
7	F	30	White	English	Married	3 years	4 years
8	F	34	White	English	Married	9 years	6 years

## Data collection

A pilot study was conducted before the commencement of data collection with a sample of 2 participants who did not form part of the study's sample population (De Vos *et al.*, 2011). The pilot study was conducted to: (1) identify any potential problems with the research design; (2) review any shortcomings and the trustworthiness of the interview guide; (3) to bring about adjustments where necessary (Terre'Blanche, Durrheim & Painter, 2006). The spouses responded to individual in-depth semi-structured interviews to non-directional open-ended questions, which addressed major concerns and perplexities to be explored around secondary trauma experienced by the spouses of ESP (see Table 2) (Creswell, 1998). Relevant data were gathered from the eight participants, or until data saturation was reached (De Vos *et al.*, 2011). Interviews were audio-recorded with the permission of the participants.

**TABLE 2**  
**INTERVIEW GUIDE QUESTIONS**

<b>Interview Guide: Questions</b>	
1.	How long has your spouse been working in the emergency service field?
2.	How do you feel about your spouse working in the emergency medical services field?
3.	How often is your spouse exposed to traumatic incidents at work?
4.	Does your spouse discuss any traumatic incidents he/she may have been exposed to at work? If yes: <ul style="list-style-type: none"> <li>- Does it impact your relationship?</li> <li>- How has it impacted your relationship?</li> </ul>
5.	How do you feel if your spouse describes a traumatic incident he/she may have witnessed at work?
6.	Have you noticed any behavioural changes in your spouse since he/she has been working in the emergency medical field?
7.	What changes have you noticed and how does this behaviour influence your relationship?
8.	What type of impact does your spouse working in the emergency medical services field have on your relationship?

## Data analysis

Data were transcribed and analysed according to steps proposed by Creswell (2009). The general meaning and tone conveyed by participants were determined through coding, descriptions and the themes that emerged.

## Ethical aspects

Permission was granted by the University of the Western Cape and emergency service organisations. Participants consented to participate in the study and were informed that participation is voluntary as well as of their right to withdraw at any time. Cognisance was given to any physical or emotional harm which could result from this research.

Information that might harm the participants' employment or embarrass them was not disclosed and will remain confidential (Babbie, 2010). Provision was made for participants experiencing distress as a result of negative feelings emerging during the interview process. Distressed participants were referred to a social worker at the Independent Counselling Advisory Services (ICAS) for debriefing, where they were afforded the opportunity to address any negative feelings (De Vos, Strydom, Fouché, & Delport., 2002).

### **Trustworthiness**

Neuman (2006), Lincoln & Guba (1985) and Krefting (1991) suggest various criteria for ensuring data verification and trustworthiness, i.e. credibility/truth value, transferability/applicability, dependability/consistency and conformability/neutrality. **Credibility**, which seeks to answer the question of how compatible the findings are with reality (Babbie, 2010), was ensured by including the direct words spoken by the participants, which are a true reflection of the participants' lived and perceived experiences. By using the same interview guide for all the participants, thus taking into account contextual differences (D'Cruz & Jones, 2004; Ross, 2010), **dependability** was achieved. The use of an independent coder further enhanced dependability. **Applicability** was achieved by providing enough rich data for comparisons to be made with the findings of existing or future studies (Krefting, 1991), as illustrated in the discussion of the findings. **Consistency** of data ensures that "the findings would be consistent if the enquiry was replicated with the same subjects or in a similar context" (Krefting, 1991:2). Coding and recoding during the analysis phase enhanced consistency. The researcher obtained consistency by ensuring that any variability in replicating the research could be tracked to identifiable sources, using the same sampling procedure. **Neutrality** was ensured by remaining free from bias, focused on learning from the participants' lived experiences and not trying to control or manipulate them (Krefting, 1991). Analysing the data independently by an independent coder furthermore ensured neutrality.

## **RESEARCH FINDINGS**

Several themes emerged from the transcribed data: (1) traumatic events at work; (2) impact of secondary trauma on marital relationships; (3) behavioural changes; (4) impact of emergency service work on marital relationships; (5) social support for EMS personnel and spouses; and (6) coping mechanisms. However, only two themes were discussed in relation to the purposes of this study namely, the impact of (i) emergency service work and (ii) secondary trauma on marital relationships.

### ***Theme 1: Impact of emergency service work on marital relationship***

Emergency service work has a profound influence on marital relationships. To understand the development of secondary trauma, the impact of emergency medical service work on marital relationship is explored in the discussion to follow. This theme focuses specifically on the way in which emergency service work, which is characterised by long working hours, inflexible shift times, high stress levels and communication challenges, may impact on marital relationships. High stress levels and fatigue that result from long shifts requiring a great deal of physical, emotional and cognitive energy,

reduce the quality of marital interactions, creating negative feelings about the marital relationship. High stress levels associated with the job can reduce the quality of marital interactions, creating negative feelings about their relationship (Regehr, 2005). Two participants confirmed the negative impact of emergency work on relationships, as they reported increased arguments, decreased quality time because of working hours, distancing from their spouses, poor communication and fewer social activities as a result of shift work.

*“We have more arguments because I’m pushing him to talk. On Sunday he goes in to do paperwork and I get upset because it could be family time. The hours are a big problem as they are difficult hours for a normal relationship. I often can’t go to functions, or I go alone, because he’s working. It does take a toll on our relationship. It’s difficult for him and I, and it’s frustrating for him too because he sends message to say I wish was there with you.”*(Participant 1)

*“It can impact our relationship negatively because I expect her to be sympathetic to me like she is with her patients, but at times she’s not and this frustrates me.”* (Participant 6)

The daily frustrations of emergency work; the inopportune calls from work, the changes to schedule, changing co-workers, dealing with shift work and the unpredictability of overtime all negatively impact on both the marital relationship and the family (Porter, 2013). Familial dysfunction may occur as a result of stress and work shifts affecting social life, which increases the strain on family life. (Kail 2014). There is also a concern, related to shift work, that family time is compromised and family responsibilities are not equally shared (Porter, 2013). The relationships may be impacted by the degree to which EMS personnel are able to share the emotional stressors of their role with their spouses (Kail, 2014). Some ESP personnel choose not to talk about traumatic events, preferring to protect their spouses while simultaneously denying themselves an outlet to process their experiences, and appearing closed off to their partner (Kail, 2014). This view is evident in the following comment:

*“It impacts our relationship because there are times when he pushes me away and becomes distant, and this upsets me because I like to have open communication and to be able to support him.”* (Participant 8).

In contrast, other ESP personnel are more open about their experiences, creating an emotional burden and possible secondary trauma for the partner, causing more strain (Porter, 2013).

Some of the spouses indicated that they were amazed by the work that their partners do and were proud of the risks they take to save people’s lives. Some spouses and children also viewed their family member as a hero (Regehr, 2005). Five of the participants agreed with this and felt that their spouse working in the ESP field had a positive impact on their relationship, and were proud of their spouse and respected the work they do:

*“It has a positive impact because of the way she helps people and she also brings that caring nature into our relationship and helps me as a person.”*  
(Participant 6).

From the findings it has also been illustrated that some of the ESP personnel bring their caring and supportive nature into the relationship. They constructively utilise the insight learnt in their professional role to benefit the interpersonal relationship with their spouse.

### ***Theme 2: Impact of secondary trauma on marital relationship***

Because of the close, emotionally intense nature of marital relationships, spouses are usually at high risk of experiencing the effects of secondary trauma (Klarić, Kvesić, Mandić, Petrov, & Frančišković, 2013). In contrast to the direct experience of trauma, secondary trauma stress results from the spouse’s need to make sense of, and emotionally connect with, their spouse, who had experienced trauma (Klarić *et al.*, 2013). This also indicates that the consequences of traumatic events are not limited to the persons primarily exposed to the event, as these events often affect significant others in their environment, namely family, friends or caregivers (Dekel & Monson, 2010) as suggested in the comment below:

*“Depending on the incident, I can feel traumatised myself, but sometimes I feel really sad for the patient, or really upset if a child is involved in any way. He doesn’t often talk about the death of a patient, but if he does, it can be hard to hear and make me worry about his wellbeing. I also tend to then think of my own death or if something had to happen to him.”* (Participant 5)

Secondary trauma can start with spouses’ efforts to support their troubled partners emotionally, attempting to understand their feelings and experiences and, ultimately, empathise with them (Dekel & Monson, 2010). During this process spouses could internalise the traumatised person’s feelings, experiences and even memories as their own, which could trigger similar symptoms (Dekel & Monson, 2010). This was evident from the participants’ responses that at some point during or after the discussion of the traumatic incidents, their emotions were compromised and they were, most probably, experiencing secondary trauma as the following comment indicates:

*“When he tries to explain an incident I don’t understand all the terms he is using. He talks about p1 and p4 and has to explain all the time what this means. It does affect me if he describes an incident that involves children, like a young child in a car accident and the child has passed away. He told a really terrible story about a patient that was a child and I cried when he told me.”* (Participant 7)

These responses reflect that spouses do experience symptoms of secondary trauma, such as feeling traumatised, helpless, sad, confused and worried, after hearing of incidents their spouses had seen or experienced. Bowen (1950, cited in Goldenberg & Goldenberg, 2000) asserts that every family member is connected to the others through a system of overlapping and intertwining relationships, therefore, if one of the family



members is regularly exposed to trauma, the family system as a whole could be negatively impacted (Becvar & Becvar, 2006).

The discussion of traumatic incidents that ESP personnel are exposed to with their spouse is important and is viewed in a positive way. As this demonstrates open communication, it can also impact on the relationship negatively and/or traumatise their spouse depending on the content shared. Evidence of communication is evident:

*“My wife does discuss some calls that she attends to, because I think it helps her to debrief, but I can see there are times when she wants to talk more about work, but may feel like it will burden me or cause me to worry about her.”* (Participant 2).

*“We both work in the ESP field and we thus talk to each other about incidents we may experience and this helps bring us closer, because as we understand what the other person may be feeling.”* (Participant 6).

Emotional numbing is one behavioural change that may occur and is used as coping strategy when confronted with stressful events. However, this can further isolate family members as “research has suggested that numbing, related to traumatic stress reactions, is significantly associated with negative feelings of family members toward the relationship” (Regehr, 2005: 4). Research by Dekel and Monson (2010) has found that partners of ESP personnel have indicated that their spouses returned home moody, closed off (emotionally), or emotionally distant, which had a tremendous impact on the family (Dekel & Monson, 2010).

## CONCLUSION AND RECOMMENDATIONS

Evidently secondary trauma affects both ESP personal and their spouses, negatively impacting on their interpersonal relationships, particularly the couples’ quality time, communication and social activities. But there was also a finding of a positive impact, as some participants expressed being proud of their spouses and gaining insight into their relationships. Further research could consider a more enlarged population, comprising ESP personnel and their spouses from several provincial facilities in South Africa, as well as an equal number from different ethnic groups. This will yield more comprehensive and insightful results, validating the findings of this study. Comparative studies between the experiences of secondary trauma among the spouses of ESP personnel in South Africa, as well as other countries in Africa, should be conducted for further expansion of the research on co-habiting families. Quantitative studies are also recommended on this subject to generate statistical data, empirical analysis and more generalised findings. Implications of the family-work interface could be further explored.

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