The Families Behind the Badge: The Unseen Victims of Trauma

By Noelle Dodge

Published September 2026

When we talk about trauma and first responders, we picture the officer, the firefighter, the paramedic, the ER nurse. We rarely picture the people waiting at home.

Police officers, firefighters, EMS workers, and emergency personnel are routinely exposed to overwhelming violence, mass disasters, infectious disease, and bereavement — with the professional expectation that they remain unaffected, calm, and solution-focused. Inside that culture, any perceived weakness invites shame. So many cope the only ways the culture allows: emotional detachment, compartmentalization, and maladaptive coping that follows them through the front door.

The research

The numbers are difficult to look away from. A 2014 prospective study of 71 police recruits and their partners found that when a partner perceived PTSD symptoms in the officer, the partner experienced secondary traumatic stress — significantly associated with both total couple violence and partner-to-officer violence (Meffert et al., 2014). The study was small and its authors cautioned that the results need confirming in larger populations.

On domestic violence in police families, the most-cited figure comes with a long history. Advocates at the National Center for Women and Policing long cited 1990s surveys suggesting domestic violence is two to four times more common in police families than in the general population — a 1991

congressional testimony and a 1992 study of Tucson officers each found roughly 40% of officers reporting violence toward a spouse (archived fact sheet). But those figures are contested: a 2016 peer-reviewed systematic review found self-reported perpetration rates ranging from 4.8% to 40% across just seven qualifying studies, with inconsistent definitions and samples — and no nationally representative data exist.

Researchers analyzing Bureau of Labor Statistics and CDC data from 2003 to 2010 found the highest workplace suicide rates among protective service occupations — police officers and firefighters, at 5.3 deaths per million workers per year — a rate 3.5 times the overall U.S. worker average (Tiesman et al., 2015; CDC summary). Two important qualifiers: these were suicides occurring at work, not overall suicide risk in the occupation, and the study's discussion of access to lethal means and job stress summarized prior research rather than testing it directly.

The children absorb it too. In a 2006 study of more than 8,200 New York City public-school children six months after 9/11, 18.9% of children with EMT parents or relatives showed probable PTSD — the highest rate in the study — followed by children of police officers at 10.6% (Duarte et al., 2006). Having a family member exposed to the attack was an even stronger predictor of probable mental disorder than the child's own direct exposure. The researchers later extended the work to Tel Aviv, finding paternal occupational exposure among Israeli first responders likewise linked to children's posttraumatic stress and separation-anxiety symptoms (Kishon et al., 2020). "Probable" PTSD here means screening-scale symptoms, not a clinical diagnosis — and the researchers noted that socioeconomic differences between the responder groups partly explained the gaps.

And prior exposure to trauma increases the probability of developing PTSD after the next exposure — especially when the earlier trauma itself produced PTSD symptoms (Breslau et al., 1999).

Why families should come first

Here's the part that should reshape policy: when the first responder gets

support, the family's risk drops with it. A 2008 study of 1,481 firefighters across 144 companies found that units with adequate resources were less vulnerable to drinking to cope after critical incidents (Bacharach, Bamberger & Doveh, 2008) — and there is reason to think that reducing responder stress would also reduce families' secondary exposure, though that link was not directly tested in the study.

Trauma-specific programs should treat the primary and secondary victims together — the responder and the spouse, the responder and the kids. Mentoring programs inside those interventions could even rebuild respect between officers and fatherless youth in the communities they serve. And families of domestic violence who want to heal the relationship rather than dissolve the marriage, divorced parents trying to co-parent, single and widowed parents — all of them benefit from the same trauma-informed support.

The bottom line

It is the individual's perception of the event that determines whether it becomes trauma. But perception doesn't form in a vacuum — it forms in a household. If we want healthier communities, the families behind the badge can't remain invisible. Trauma is not a choice. Recovery and prevention are.

Sources: Meffert et al. (2014), Prospective study of police officer spouse/partners, PLoS ONE; National Center for Women and Policing, Police Family Violence Fact Sheet (archived); Mennicke & Ropes (2016), Estimating the rate of domestic violence perpetrated by law enforcement officers, Aggression and Violent Behavior; Tiesman et al. (2015), Suicide in U.S. workplaces, 2003–2010, Am J Prev Med; CDC NIOSH workplace suicide bulletin; Duarte et al. (2006), Posttraumatic stress in children with first responders in their families, J Traumatic Stress; Kishon et al. (2020), Parental occupational exposure and children's psychopathology: Israeli first responders, J Occup Environ Med; Breslau et al. (1999), Previous exposure to trauma and PTSD effects of subsequent trauma, Am J Psychiatry;

Bacharach, Bamberger & Doveh (2008), Firefighters, critical incidents, and drinking to cope, J Applied Psychology.