

11-11-2025

Perspectives of Therapists Treating First Responders on the Role of Peer Support in Psychological Recovery and Development of PTSD Symptoms

Audrey Ramos
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>



Part of the [Psychology Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Allied Health

This is to certify that the doctoral dissertation by

Audrey Sierra Ramos

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Natalie Marr, Committee Chairperson, Psychology Faculty

Dr. Mario Tovar, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Abstract

Perspectives of Therapists Treating First Responders on the Role of Peer Support in

Psychological Recovery and Development of PTSD Symptoms

by

Audrey Sierra Ramos

BA, Southern New Hampshire University, 2021

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

November 2025

Abstract

First responders face an increased risk of posttraumatic stress disorder (PTSD) due to repeated exposure to traumatic events. While traditional treatments like cognitive-behavioral therapy and medication remain standard, peer support has become a supplementary strategy. However, limited research has investigated how licensed therapists view the role of peer support in clinical care. Therapists' perspectives on the effectiveness, limitations, and integration of peer support in first responder PTSD recovery were explored in this qualitative, phenomenological study. Guided by Lazarus and Folkman's transactional model of stress and coping and Masten's resilience theory, how peer support serves as both a coping mechanism and resilience-building intervention were examined. Semi-structured interviews were conducted with licensed mental health professionals experienced in treating first responders. The data were analyzed using thematic analysis and NVivo 15 software. In a review of the scientific literature, therapists identified peer support as emotionally validating and resilience-building but noted concerns about inconsistent implementation and lack of clinical oversight. Effectiveness varied depending on organizational structure, stigma, and confidentiality issues. Integration with formal therapy was inconsistent, highlighting the need for better collaboration. The findings support developing structured, evidence-based peer support models aligned with best practices. Implications for positive social change include reducing stigma, increasing access to interventions, and strengthening trauma recovery among high-risk occupational groups.

Perspectives of Therapists Treating First Responders on the Role of Peer Support in
Psychological Recovery and Development of PTSD Symptoms

by

Audrey Sierra Ramos

BA, Southern New Hampshire University, 2021

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

November 2025

Dedication

First and foremost, I dedicate this work to God. It was through His grace, guidance, and strength that I was able to walk this journey. In every challenge, He reminded me of my purpose and sustained me when I felt weak. This achievement was not mine alone but a reflection of His faithfulness.

To my husband, whose unwavering support, patience, and faith in me have been my foundation. Your encouragement reminded me that even on the hardest days, I was never walking this path alone. Thank you for loving me as profoundly as you do. I love you, Mi Amor.

To my children, who had been my greatest motivation and source of joy. May this accomplishment remind you that anything is possible with determination and resilience. Never stop dreaming, because your dreams were always within reach. To Infinity and Beyond.

To my Grandma Ginny, who departed this world before seeing this dream realized, but whose lessons continue to guide me every day. You taught me about love, safety, support, and the meaning of hard work. I carry your spirit with me daily, and I know this achievement honors your memory.

Finally, this was dedicated to my own journey—from a teenage mother with a GED to becoming a first-generation PhD holder. I hope my path serves as a testament to the power of perseverance, faith, and the belief that no dream is ever too big to pursue.

Acknowledgments

I want to express my deepest gratitude to those who have guided, supported, and encouraged me throughout this journey.

To my chair, Dr. Marr, thank you for your unwavering guidance, expertise, and patience. Your feedback and encouragement shaped this dissertation and helped me grow both as a scholar and as a professional. I am genuinely grateful for the time and dedication you invested in my success.

To my committee member, Dr. Tovar, thank you for your thoughtful insights and support throughout this process. Your perspective helped strengthen this work and pushed me to think more critically and deeply about my research.

To my internship site supervisor, Dr. Berry, and other mentors, I extend my sincere appreciation. Your commitment to my growth as a clinician and researcher has been invaluable. The knowledge, encouragement, and opportunities you provided have left a lasting impact on my professional development.

Finally, to all who believed in me during this journey, thank you for your love, support, and encouragement. To my friends, thank you for your kind words, understanding, and motivation, which carried me through long nights, early days, and many days of balancing school, work, and family life. This accomplishment was not mine alone but the result of the support, guidance, and encouragement I had been blessed to receive.

Table of Contents

List of Figures	vii
Chapter 1: Introduction to the Study.....	1
Introduction.....	1
Problem Statement	2
Purpose of the Study	2
Research Questions.....	3
Theoretical and/or Conceptual Framework for the Study.....	3
Nature of the Study	4
Summary of the Methodology	4
Definitions.....	5
Definition of Terms with Multiple Meanings.....	8
Assumptions.....	12
Scope and Delimitations	12
Limitations	12
Significance.....	13
Summary	13
Chapter 2: Literature Review	15
Introduction.....	15
Literature Search Strategy.....	17
Theoretical Foundation	20
Conceptual Framework.....	33

Literature Review Related to Key Variables and/or Concepts	40
Application of the Framework in Previous Research	40
Relevance of the Framework to the Current Study.....	41
Approaches to the Problem in the Discipline: Strengths and Weaknesses	41
Justification for Concept Selection	44
Review and Synthesis of Empirical Studies Related to Key Variables	46
Review and Synthesis Related to Research Questions and Rationale for Approach.....	50
Summary and Conclusions	53
Chapter 3: Research Method.....	63
Introduction.....	63
Research Design and Rationale	66
Research Questions.....	66
Central Concepts and Phenomena	67
Research Tradition	69
Rationale for the Chosen Research Tradition	70
Role of the Researcher	72
Role of the Participant	73
Researcher-Participant Relationship.....	75
Management of Researcher Biases and Power Dynamics	76
Methodology	77
Participant Selection Logic.....	77

Sampling Strategy	78
Participant Selection Criteria	80
Sample Size Justification	82
Participant Recruitment Procedures.....	83
Relationship Between Saturation and Sample Size	86
Instrumentation	87
Data Collection Instruments	87
Data Analysis Method.....	90
Sufficiency of Data Collection Instruments.....	90
Basis for Instrument Development	91
Basis for Instrument Development: Establishment of Content Validity	93
Establishing Instrument Sufficiency to Answer Research Questions.....	95
Procedures for Data Collection and Replicability	96
Participant Exit Procedures.....	98
Follow-Up Procedures	99
Data Analysis Plan.....	100
Connection of Data to Research Questions	100
Type of and Procedure for Coding.....	100
Software Used for Analysis	101
Manner of Treatment of Discrepant Cases	101
Issues of Trustworthiness.....	102
Credibility (Internal Validity).....	102

Peer Debriefing	102
Triangulation.....	103
Reflexivity.....	103
Saturation	105
Transferability (External Validity)	105
Thick Description.....	105
Variation in Participant Selection	106
Dependability (Qualitative Counterpart to Reliability)	106
Audit Trail.....	106
Confirmability (Qualitative Counterpart to Objectivity)	107
Ethical Procedures	108
Agreements to Gain Access to Participants or Data	108
Treatment of Human Participants	109
Ethical Considerations in Recruitment	109
Informed Consent Process	109
Ethical Considerations During Data Collection.....	110
Confidentiality and Data Security.....	110
Treatment of Data	111
Confidentiality and Protections.....	111
Data Dissemination and Access.....	111
Other Ethical Considerations	112
Summary	112

Chapter 4: Results	114
Introduction.....	114
Setting	115
Demographics	116
Data Collection	118
Data Analysis	119
Phenomenological Analytic Process.....	120
Treemap Visualization	125
Linguistic and Phenomenological Analysis.....	127
Semantic Domain Evolution.....	128
Conceptual Network Architecture	130
Evidence of Trustworthiness.....	132
Credibility	132
Transferability.....	133
Dependability	133
Confirmability.....	134
Results.....	134
Participant-Theme Network.....	135
Theme Cluster 1: Encountering Foundational Challenges in Peer Support	
Implementation	137
Theme Cluster 2: Developing Integration and Relational Foundations for	
Effective Practice	143

Summary	146
Chapter 5: Discussion, Conclusions, and Recommendations	149
Introduction.....	149
Interpretation of the Findings.....	150
Analysis Through Theoretical Frameworks.....	152
Resilience Theory Application	152
Transactional Model Integration.....	153
Novel Insights and Theoretical Contributions	154
Limitations of the Study.....	155
Recommendations.....	157
Implications.....	161
Positive Social Change	161
Methodological Implications	163
Theoretical and Empirical Implications.....	163
Implications for Practice	164
Conclusion	165
References.....	169
Appendix A: Recruitment Flyer.....	176
Appendix B: Semistructured Interview Protocol.....	177
Appendix C: Mental Health Support Referral List.....	179
Appendix D: Demographic Details.....	180

List of Figures

Figure 1	Theme Cluster 1A: Competency Gaps	122
Figure 2	Theme Cluster 1B: Systemic Barriers	123
Figure 3	Theme Cluster 2A: Integration Models	124
Figure 4	Theme Cluster 2B: Trust Foundations.....	125
Figure 5	Treemap.....	126
Figure 6	Dual-Panel Analysis	128
Figure 7	Four-Panel Semantic Analysis.....	129
Figure 8	Cluster's Experiential Landscape.....	131
Figure 9	Temporal Progression.....	132
Figure 10	Foundational Challenges in Peer Support	136
Figure 11	Integration and Relational Foundations.....	137

Chapter 1: Introduction to the Study

Introduction

Posttraumatic stress disorder (PTSD) is a psychiatric condition that can develop after exposure to traumatic experiences and is characterized by symptoms such as intrusive memories, hyperarousal, avoidance, and emotional numbing (Pietrzak et al., 2010). First responders—including police officers, firefighters, paramedics, and emergency dispatchers—are especially vulnerable to trauma because of the nature of their work. Repeated exposure to life-threatening events, human suffering, and high-stress environments increases their risk of developing PTSD and related disorders compared to the general population (Ge et al., 2020).

Recent studies show that the rate of PTSD among first responders differs by profession, with rates from 0% to 44% with a mean of 14.87% for law enforcement officers, 22% for emergency medical technicians and paramedics, and 57% for firefighters (Khazaei et al., 2021; Obuobi-Donkor et al., 2022; Wagner et al., 2020). Besides PTSD, these individuals also face higher risks of depression, substance use, and suicide (Lawn et al., 2020). Although evidence-based treatments like cognitive behavioral therapy (CBT) and medication are available, first responders often avoid seeking traditional mental health services because of stigma, concerns about confidentiality, and fear of professional repercussions (Alshahrani et al., 2022).

In this context, peer support has gained attention as a culturally appropriate, accessible, and effective complement or alternative to formal treatment. Peer support programs were usually built around mutual understanding, shared occupational identity,

and the delivery of emotional and informational support by peers with similar experiences (Auth et al., 2022). These programs were often started and maintained within fire departments, police agencies, and emergency medical services (EMS) organizations. While early research suggests that peer support might decrease psychological distress and boost resilience (Campos et al., 2023), little is known about how therapists understand its role in recovery or how they incorporate these programs into treatment planning.

Problem Statement

Although peer support programs have become more common in emergency services, there is still limited research on how licensed therapists view and assess these interventions. Most existing studies focus on first responders' experiences with peer support, with not enough attention to the role therapists have in interpreting, integrating, and supporting these models in clinical practice. As peer support is increasingly implemented alongside or within formal mental health services, the perspectives of therapists—who contribute clinical expertise, trauma-informed insight, and ethical oversight—are essential for understanding the intervention's effectiveness, risks, and contextual challenges (see Tjin et al., 2022; Papazoglou, 2023).

Purpose of the Study

The purpose of my qualitative, phenomenological study was to explore how licensed therapists who work with first responders perceive the role of peer support in reducing PTSD symptoms and aiding psychological recovery related to trauma. This includes understanding the benefits therapists see in peer programs, how peer support

might foster resilience, how peer models are combined with formal treatment methods, and the limitations or risks therapists note from their professional experience.

Research Questions

RQ1: What were therapists' perspectives on the role of peer support in the psychological recovery of first responder clients following trauma exposure?

RQ2: What were therapists' perspectives on the role of peer support in mitigating the development of PTSD symptoms in first responder clients with trauma exposure?

These research questions were guided by Lazarus and Folkman's (1984) transactional model of stress and coping and Masten's (2001) resilience theory. In Chapter 2, I discuss these frameworks and the conceptual assumptions that support the researchers study in more detail.

Theoretical and/or Conceptual Framework for the Study

My study was guided by two complementary psychological theories: the transactional model of stress and coping and resilience theory. Lazarus and Folkman's (1984) model emphasizes the role of cognitive appraisal and coping strategies in an individual's response to stress. Peer support might function as an emotion-focused coping mechanism that helps first responders manage trauma through shared understanding and emotional validation (Shalaby & Agyapong, 2020). Masten's (2001) resilience theory highlights adaptive functioning in the face of adversity and underlines the importance of social support in recovery. These frameworks help therapists interpret how peer support promotes psychological recovery, fosters emotional regulation, and supports long-term well-being.

Nature of the Study

I used a qualitative, phenomenological research design, which was ideal for exploring complex, context-dependent phenomena through participants' subjective experiences (see Creswell & Poth, 2018). I aimed to understand how therapists interpret the value, role, and results of peer support within the broader context of trauma recovery for first responders. I recruited eight licensed therapists with direct experience treating first responders. Data was gathered through semistructured interviews and analyzed thematically using NVivo 15 software. In Chapter 3, I detail procedures for participant selection, data collection, ethical considerations, and analytic strategies, including steps to ensure trustworthiness, credibility, and researcher reflexivity.

Summary of the Methodology

I used a qualitative phenomenological approach to examine how licensed mental health professionals view the role of peer support in the psychological recovery of trauma-exposed first responders. Data was gathered through semistructured interviews with eight licensed therapists who have direct clinical experience working with first responders. Participants were intentionally selected based on specific inclusion criteria, including licensure status, clinical experience with trauma populations, and familiarity with peer support frameworks. Recruitment was done through professional networks, mental health organizations, and online platforms targeting clinicians in trauma and emergency mental health care.

Interviews were conducted through a secure video conferencing platform and lasted between 45 and 60 minutes. They were audio-recorded, transcribed verbatim, and

analyzed using thematic analysis according to the procedures outlined by Moustakas (1994). NVivo 15 software was employed to facilitate systematic coding and to identify emerging themes. This method allowed me to capture the essence of participants' lived experiences, focusing on their meaning-making processes and professional perspectives on peer support interventions.

The phenomenological framework was appropriate for this inquiry because it emphasizes participants' subjective experiences and allows for an in-depth exploration of a complex, context-dependent phenomenon (see Creswell & Poth, 2018). Thematic patterns were analyzed across participants to identify both shared ideas and individual perspectives, ensuring a comprehensive interpretation of the data. This approach supported my study's goal of understanding how therapists view peer support as a way to build resilience and reduce PTSD during the recovery of first responders (see Donovan, 2022).

Definitions

Each of the following definitions was developed within the theoretical and conceptual framework of my study, aligning with the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) and Resilience Theory (Masten, 2001). These terms served as essential constructs for data collection, analysis, and interpretation in understanding therapists' perspectives on peer support in first responder PTSD recovery.

Burnout: A work-related syndrome characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Among first responders and therapists, burnout could result from chronic exposure to stress,

inadequate organizational support, and high workloads. Burnout might undermine the effectiveness of peer support interventions and impede recovery.

Coping Strategies: Cognitive and behavioral processes used to manage external and internal stressors. The Transactional Model of Stress and Coping distinguish between problem-focused coping—strategies aimed at addressing the source of stress—and emotion-focused coping, which involves regulating emotional responses to distress (Lazarus & Folkman, 1984). Peer support often serves as an emotion-focused strategy by providing validation, shared understanding, and emotional relief through connection (Ponder et al., 2024).

Mental Health Stigma in First Responders: A persistent cultural barrier within emergency service environments where expressions of psychological vulnerability were perceived as weakness, often leading to reluctance in seeking formal mental health support (Auth et al., 2022). Peer support programs were frequently leveraged to reduce this stigma by offering a trusted, confidential space for emotional disclosure and support among colleagues (Petrie et al., 2018).

Peer Support: A structured or informal system where individuals with shared occupational experiences provide emotional, psychological, and practical support to one another in response to work-related stress or trauma (Tjin et al., 2022). In first responder settings, peer support programs were used to foster resilience, normalize stress reactions, and reduce stigma associated with seeking mental health care (Donovan, 2022).

Posttraumatic Growth (PTG): Positive psychological change experienced as a result of the struggle with traumatic life events. PTG includes enhanced interpersonal

relationships, greater appreciation for life, increased personal strength, and spiritual development (Donovan, 2022). Peer support had been associated with fostering PTG by offering validation, connection, and shared narratives of overcoming adversity.

Posttraumatic Stress Disorder (PTSD): A psychiatric condition that could develop following exposure to a traumatic event, characterized by intrusive thoughts, avoidance behaviors, negative alterations in cognition and mood, and heightened arousal or reactivity (Pietrzak et al., 2010).

Posttraumatic Stress Disorder (PTSD) in First Responders: A psychiatric condition characterized by symptoms such as intrusive memories, hypervigilance, avoidance, and emotional numbing following exposure to traumatic events. Among first responders, PTSD frequently arises from cumulative trauma exposure and the chronic occupational stress of high-intensity work environments (Pietrzak et al., 2010).

Psychological Recovery: A holistic process involving the restoration of emotional regulation, cognitive function, and adaptive behavior following trauma exposure. In my study, psychological recovery was explored through therapists' perspectives on how peer support facilitates or hinders this process in first responders (Dolezal, 2021; Lawn et al., 2020). Recovery was seen not only as symptom reduction but also as regaining occupational functioning and resilience in high-risk roles.

Resilience: The capacity to recover, adapt, and grow following exposure to adversity or trauma, shaped by personal coping resources, external support systems, and contextual factors (Masten, 2001). In first responder populations, resilience was not merely an individual trait, but a dynamic process bolstered by peer support,

organizational culture, and structured interventions (Papazoglou, 2023; Campos et al., 2023).

Trauma Exposure: Repeated or acute exposure to events involving death, serious injury, violence, or overwhelming stress, which could lead to psychological impairment. For first responders, trauma exposure was cumulative, resulting from both direct involvement in emergencies and indirect experiences, such as witnessing suffering or fatal incidents (Lawn et al., 2020).

Vicarious Trauma: The emotional residue experienced by mental health professionals or peer supporters through empathetic engagement with trauma survivors. Over time, vicarious trauma might lead to changes in worldview, emotional exhaustion, and impaired functioning if not properly mitigated (Donovan, 2022; Ge et al., 2020).

Workplace Support: A multifaceted construct encompassing organizational infrastructure, leadership engagement, and cultural norms that promote well-being and buffer against the effects of occupational trauma (Campos et al., 2023). In first responder agencies, workplace support includes peer-led crisis intervention teams, trauma-informed policies, and accessible mental health services (Pihl-Thingvad et al., 2019).

Definition of Terms with Multiple Meanings

To ensure clarity and consistency in concepts, this section defines key terms used in the researchers study that may have different meanings across disciplines or contexts. Each definition is tailored to its relevance to trauma recovery, peer support, and clinical practice within first responder populations.

Clinical Judgment: The application of professional knowledge, ethical standards, and experience in assessing and responding to a client's psychological condition. This concept was central to the role of therapists in my study, who exercise clinical judgment when evaluating the role and appropriateness of peer support as a complement to formal treatment for PTSD and related symptoms (Donovan, 2022).

Cumulative Trauma: The progressive psychological impact resulting from repeated exposure to traumatic events over time. Unlike single-incident trauma, cumulative trauma was characterized by chronic stress symptoms, desensitization, or emotional dysregulation and was highly prevalent among first responders due to the ongoing nature of their exposure (Pietrzak et al., 2010).

First Responder: In my study, "first responder" refers specifically to individuals in frontline emergency roles, including law enforcement officers, firefighters, and emergency medical services (EMS) personnel, who were routinely exposed to traumatic incidents as part of their professional duties. This definition excludes military personnel and healthcare workers unless they were functioning in designated emergency response roles. The term was used to delineate the unique occupational risks, cultural norms, and resilience demands specific to civilian emergency services (Papazoglou, 2023).

High-Risk Occupation: A professional role that involves consistent exposure to physical danger or psychological threat, increasing the likelihood of adverse health or mental health outcomes. Within my study, first responders (law enforcement, firefighters, EMS) were considered high-risk due to routine involvement with life-threatening events, violence, or loss (Petrie et al., 2018; Campos et al., 2023).

Lived Experience: A phenomenological term referring to the subjective, first-person understanding of a particular phenomenon or context. In my study, lived experience applies to the firsthand insights of therapists who work with trauma-affected first responders and observe or integrate peer support into the recovery process (Creswell & Poth, 2018; Moustakas, 1994).

Mental Health Intervention: This term encompasses clinical approaches delivered by licensed professionals, such as cognitive-behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR), and trauma-focused interventions. In contrast, peer support—though psychologically supportive—is not categorized as a formal mental health intervention in my study, as it does not involve diagnosis or treatment by a licensed provider.

Moral Injury: A profound form of emotional or spiritual distress that occurs when an individual perpetrates, witnesses, or fails to prevent actions that violate deeply held moral or ethical beliefs. Among first responders, moral injury could occur in high-stakes decision-making contexts, often compounding trauma and complicating PTSD recovery (Papazoglou, 2023).

Organizational Culture: Within my study, organizational culture refers to the implicit values, norms, and expectations within first responder agencies that shape responses to mental health, trauma exposure, and peer support. This includes the degree to which mental health stigma was perpetuated or reduced, the supportiveness of leadership, and the prioritization of wellness resources (Papazoglou, 2023; Campos et al., 2023).

Peer Support Program: A peer support program refers to a structured initiative developed within an organization (typically a first responder agency) that trains selected personnel to provide psychological and emotional support to colleagues following exposure to traumatic events. Peer support in the researchers study excludes informal social interactions and was distinguished by its semi-formal framework, established protocols, and alignment with broader organizational wellness efforts (Tjin et al., 2022).

Supportive Relationship: While broadly defined in psychology, the researchers study uses the term “supportive relationship” specifically to describe interactions between trained peers and trauma-affected first responders that offer emotional containment, normalization of trauma responses, and validation. These relationships were shaped by shared experience rather than hierarchical dynamics and differ from clinical therapeutic alliances (Tjin et al., 2022).

Therapist: The term “therapist” was used to describe licensed mental health professionals (e.g., psychologists, licensed clinical social workers, licensed professional counselors, and marriage and family therapists) who provide trauma-informed psychotherapy to first responders. This excludes peer support personnel or non-licensed support staff. For the purposes of my study, therapists must have clinical experience treating trauma-exposed individuals in emergency services settings (Donovan, 2022; Campos et al., 2023).

Trauma Recovery: Trauma recovery in the researchers study was conceptualized as a dynamic, multidimensional process involving the restoration of psychological, emotional, and behavioral functioning following trauma exposure. It includes symptom

stabilization, enhanced coping, improved relational functioning, and reintegration into occupational roles. Recovery was understood to be non-linear and influenced by personal resilience, peer support, and systemic factors (Dolezal, 2021; Lawn et al., 2020).

Assumptions

In this study, I assumed that therapists possess sufficient experience and clinical insight to provide meaningful commentary on peer support programs. I assumed that participants would provide honest and reflective accounts of their experiences, and that their perspectives would offer valuable contributions to both clinical practice and the development of peer intervention programs.

Scope and Delimitations

I focused on therapists licensed to practice independently who have treated first responders. It was limited to participants with clinical experience in trauma recovery and familiarity with peer support frameworks. The findings do not necessarily apply to all mental health professionals, but they offer valuable insights into a specific and underexplored area.

Limitations

Potential limitations included a small sample size and reliance on self-reported data, which could be affected by individual biases, memory errors, or theoretical orientations. Additionally, I did not directly assess the effectiveness of peer support programs but instead explored therapists' perceptions of their impact.

Significance

By exploring how therapists interpret the value and function of peer support in first responder PTSD recovery, I aimed to enhance clinical understanding and support the development of peer programs. These findings could influence how mental health professionals work with peer teams, guide training, and assess trauma-informed interventions. The following chapters detail the empirical literature (Chapter 2) and the methodological approach (Chapter 3) used to address the research questions and fulfill the purpose of my study.

Summary

In Chapter 1, I established the foundational framework for this study, which examined licensed therapists' perspectives on the role of peer support in aiding PTSD recovery among first responders. The research problem was identified as a lack of empirical research on how mental health professionals assess the clinical usefulness, integration, and limitations of peer support—a gap that the researchers study addressed through a qualitative, phenomenological approach (see Auth et al., 2022). Rooted in Lazarus and Folkman's (1984) transactional model of stress and coping and Masten's (2001) resilience theory, the researchers study was positioned within a conceptual framework that sees peer support as both a coping mechanism and a resilience-building strategy.

I outlined my study's scope and boundaries, clarifying the population of interest—licensed therapists with direct experience treating trauma-exposed first responders—and excluding nonclinicians and first responders themselves. Key

assumptions were discussed, including the expectation that participants would offer honest and reflective insights, as well as the assumption that peer support programs were actively used in the field. Limitations inherent in my study's qualitative approach were also recognized, such as potential subjectivity, a small sample size, and different therapist viewpoints. Strategies like reflexive journaling, and data triangulation were used to improve reliability and reduce bias (see Creswell & Poth, 2018).

My study is important for advancing both theoretical knowledge and clinical practice. By focusing on therapists' interpretations of peer support interventions, the researchers study helped develop a more detailed understanding of how these programs work in real-world trauma recovery settings. It also offers practical benefits for improving peer support training, shaping mental health policy, and enhancing PTSD outcomes in high-risk occupational groups (Papazoglou, 2023).

In Chapter 2, I provide review of the relevant literature for my study, including empirical research on PTSD in first responders, peer support models, coping strategies, and the clinical roles of therapists in trauma-informed care. I also examined theoretical foundations and highlights gaps in the current knowledge, strengthening the rationale for my study.

Chapter 2: Literature Review

Introduction

In this qualitative study, I aimed to explore therapists' perspectives on the main factors affecting the psychological recovery of first responders and the therapeutic methods used to treat PTSD. I aimed to gain a comprehensive understanding of how resilience influences clinical interventions for this group, with a focus on strategies that promote long-term mental health. Because of the urgent need for effective mental health treatments, examining these viewpoints could help develop resilience-focused therapy approaches specifically designed for first responders (see Alshahrani et al., 2022). The motivation for reviewing the literature on first responder resilience, especially regarding the psychological effects of severe injuries and the lasting impacts of PTSD, arises from a growing public concern about the mental health and well-being of emergency workers (see Lawn et al., 2020). First responders, such as firefighters, paramedics, law enforcement officers, and emergency medical technicians, are often exposed to high-stress situations, traumatic events, and potentially deadly encounters (Wagner et al., 2020).

These individuals not only witness severe injuries and fatalities but may also experience physical harm while on duty. The cumulative exposure to occupational stressors faced by first responders is strongly linked to the development of behavioral health conditions, including PTSD and depression, with PTSD being among the most common (Pietrzak et al., 2010). Studies suggest that the prevalence of PTSD among first responders is significantly higher than in the general population, with estimates ranging

from 10% to 20%, depending on occupation and exposure severity (Wagner et al., 2020). Research shows that first responders—such as firefighters, paramedics, and law enforcement officers—experience much higher rates of PTSD and other mental health issues compared to the general population. For example, a scoping found that PTSD prevalence among firefighters ranged from 1.9% to 57%, highlighting the variability based on exposure and organizational factors. Similarly, there was a 30% PTSD prevalence among ambulance personnel, further underscoring the vulnerability of these occupational groups (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018).

Additionally, the prevalence of suicidal thoughts and attempts among first responders has been widely documented, further emphasizing the severe psychological toll of their occupational environment. For instance, Lawn et al. (2020) examined mental health risks among EMS workers. They highlighted higher rates of suicidal thoughts and poor mental health outcomes related to exposure to occupational trauma (Lawn et al., 2020). The mental health effects of exposure to both natural and human-made disasters are well established, pointing to increased risks of PTSD, depression, and anxiety in these groups (Office for Victims of Crime, 2020). Despite their vital role in public safety and crisis response, first responders often face many barriers to obtaining mental health care, such as stigma, a deeply ingrained culture of resilience that discourages admitting vulnerability, and limited access to specialized psychological services (Auth et al., 2022). These obstacles worsen the psychological strain from repeated trauma, increasing the likelihood of chronic conditions like substance use disorders and suicidal tendencies

(Pietrzak et al., 2010). Considering these issues, implementing resilience-building strategies prior to traumatic events has been suggested as an essential preventative step. Research stresses the value of pre-incident training programs aimed at improving stress management, emotional regulation, and coping skills suited to the specific challenges faced by first responders (Elbers & McCraty, 2020). Additionally, organizational support systems, such as peer networks and accessible mental health services, have proven effective in reducing PTSD symptoms and promoting better long-term mental health outcomes (Pihl-Thingvad et al., 2019; Campos et al., 2023). Addressing these systemic issues is critical, as PTSD and other mental health conditions can impair a first responder's ability to perform their duties effectively and safely, ultimately risking their well-being and public safety.

Literature Search Strategy

The Walden University Library and its associated databases were used to conduct this literature review. The databases accessed include PsycINFO, PubMed, CINAHL, Scopus, Web of Science, Google Scholar, ProQuest Dissertations & Theses Global, JSTOR, ScienceDirect, SAGE Journals, Taylor & Francis Online, and ERIC (Education Resources Information Center). These databases were chosen for their relevance to psychological research, trauma studies, and interdisciplinary scholarship on first responder mental health and resilience. The key search terms used to identify relevant literature included *first responder*, *resilience*, *long-term PTSD consequences*, *trauma in first responders*, *resilience in emergency personnel*, *posttraumatic stress disorder in first responders*, *mental health of first responders*, *coping mechanisms in emergency services*,

psychological resilience in high-stress professions, impact of trauma on emergency personnel, law enforcement mental health, firefighter resilience, paramedics and trauma, PTSD treatment and interventions, and occupational stress in first responders. Boolean operators (AND, OR) were used to refine searches, ensuring comprehensive results while maintaining focus on the research topic. Truncation (e.g., *resilien for resilience, resilient**) and wildcard searches were employed where appropriate to capture variations in terminology across studies. Only scholarly, peer-reviewed articles published from 2019 onward were included to ensure recent and relevant research findings. Foundational theoretical works (e.g., Lazarus & Folkman, 1984; Masten, 2001; Werner & Smith, 1982) were included to provide a conceptual framework for resilience and coping strategies in high-stress professions. Initially, I focused on studies of first responders; however, due to the interdisciplinary nature of trauma research, studies on occupational stress and resilience interventions in other high-risk professions were also considered when relevant. The selection process involved reviewing titles, abstracts, and keywords to assess relevance, followed by a full-text review. Systematic reviews, meta-analyses, and empirical studies on PTSD treatment, resilience training, and workplace support interventions were prioritized (Alshahrani et al., 2022). Citation tracking was used to identify additional sources from the reference lists of key articles. Studies on preincident training (e.g., Elbers & McCraty, 2020), peer support interventions (e.g., Auth et al., 2022), and workplace resilience programs (e.g., Campos et al., 2023) were especially valuable in establishing evidence-based methods for psychological recovery in first responders.

By employing a thorough, iterative search process, I established a solid foundation for understanding the psychological effects of severe trauma, PTSD recovery, and resilience-building strategies in first responders. When limited current research, dissertations, or conference proceedings were available on specific aspects of first responder resilience and PTSD recovery, a multifaceted approach was used to ensure a comprehensive review of relevant literature. First, foundational studies and theoretical frameworks were included to provide historical context and a basis for understanding resilience and coping mechanisms in high-stress professions. Seminal works, such as Masten (2001) on resilience as an adaptive process and Lazarus and Folkman (1984) on stress and coping, were incorporated to frame the researchers study within established psychological models. These sources remain widely cited and relevant, despite their age, due to their lasting influence on trauma and resilience research. Second, where recent empirical studies were limited, literature from related fields such as military psychology, disaster response, and occupational stress research was considered for applicable findings. For example, studies on workplace resilience interventions in law enforcement (Campos et al., 2023) and trauma exposure among emergency medical personnel (Lawn et al., 2020) were integrated to fill gaps in research specific to first responders. This approach ensured that resilience strategies and PTSD interventions remained informed by current scholarship, even when direct studies on first responder populations were scarce.

Additionally, citation tracking was used to identify emerging research trends and unpublished dissertations that might not yet be widely referenced in mainstream databases. Systematic reviews and meta-analyses, such as those conducted by Alshahrani

et al. (2022), were prioritized because they synthesize large bodies of research and often highlight gaps in existing studies. When dissertations and conference proceedings were limited, research from government reports and professional organizations, such as the Office for Victims of Crime (2020) and the SAMHSA (2018), was used to supplement peer-reviewed literature. These sources provided essential data on the mental health challenges faced by first responders and evidence-based intervention recommendations.

By employing this approach, I maintained academic rigor while ensuring that relevant literature informed the research, even in areas where direct empirical studies were limited. This strategy also allowed for the identification of research gaps, reinforcing my study's contribution to expanding knowledge on the role of resilience in the psychological recovery of first responders.

Theoretical Foundation

My study was based on two interconnected frameworks: resilience theory (Masten, 2001) and the transactional model of stress and coping (Lazarus & Folkman, 1984). These frameworks serve as theoretical perspectives through which therapists' views on peer support in PTSD recovery were explored. Resilience theory suggests that individuals can adapt and recover from adversity when supported by protective factors such as social support, self-regulation, and adaptive coping mechanisms (Masten, 2001). In the context of first responders, resilience was not only an individual trait but also a dynamic process influenced by organizational culture, leadership, and peer networks (Papazoglou, 2023; Werner & Smith, 1982). The theory distinguishes between protective and risk factors—protective factors buffer individuals from the adverse effects of trauma,

while risk factors increase vulnerability to psychological distress. Specific protective factors include secure attachment relationships, strong social support networks, positive self-image, emotional regulation, and access to responsive healthcare or supportive workplace structures (Masten, 2001; Werner & Smith, 1982). This theory supported my study's aim to explore how therapists perceive peer support as a protective factor that fosters psychological recovery from trauma.

The transactional model of stress and coping (Lazarus & Folkman, 1984) conceptualizes stress as a dynamic transaction between an individual and their environment, emphasizing the role of cognitive appraisal and coping strategies. In trauma-exposed populations like first responders, this model highlights how the interpretation of a traumatic event and the availability of coping resources (e.g., peer support) influence psychological outcomes (Ryu, 2024; Tjin et al., 2022). The integration of this model helps in understanding how peer support functions as both a coping resource and a buffer to PTSD symptom severity.

The transactional model of stress and coping, developed by Lazarus and Folkman (1984), provided a theoretical framework for understanding how people evaluate and respond to stressful situations. This model comes from cognitive appraisal theory, which indicates that the psychological effect of stress is not solely caused by the external event itself but also by a person's interpretation and coping methods (Lazarus & Folkman, 1984). The transactional model describes stress as a dynamic interplay between an individual and their environment, where stressors are assessed based on their perceived importance and the availability of coping resources. The model highlights two main types

of cognitive appraisals. The first, primary appraisal, happens when a person determines whether a situation is threatening, challenging, or irrelevant to their well-being (Lazarus & Folkman, 1984). The second, secondary appraisal, involves evaluating what resources are available to handle the stressor, such as personal resilience, social support, and coping strategies (Lazarus & Folkman, 1984). After appraisal, individuals choose one of two coping methods: problem-focused coping, which involves actively addressing the stressor through actions like seeking support, therapy, or acquiring new skills (Lazarus & Folkman, 1984) or emotion-focused coping, which involves managing emotional distress through avoidance, reframing, or seeking emotional support (Lazarus & Folkman, 1984). Ponder et al. (2024) discovered that finding opportunities for growth and relying on faith or a higher power were key predictors of resilience among first responders. These findings support resilience theory's claim that both personal and environmental factors help determine an individual's ability to adapt to trauma (Ponder et al., 2024).

Both resilience theory and the transactional model of stress and coping have been widely applied in previous research to study the psychological well-being and coping strategies of first responders (Dolezal, 2021; Papazoglou, 2023). Research has examined these theories concerning trauma exposure, stress management, and mental health interventions for professionals operating in high-risk environments (Oakes et al., 2024; Papazoglou, 2023). The selected articles provided empirical evidence of how these theories have been implemented in past studies, offering insights relevant to the current focus on therapists' perspectives on resilience-based interventions for PTSD recovery in first responders (see Dolezal, 2021; Papazoglou, 2023; Tjin et al., 2022).

Resilience theory, developed by Masten (2001) and Werner and Smith (1982) emphasize that resilience is a dynamic and adaptive process that enables individuals to recover from adversity. Research on first responders has consistently demonstrated that resilience is a critical factor in mitigating the psychological impact of repeated trauma exposure (Masten, 2001; Pietrantonio & Prati, 2008; Pink et al., 2021). Ponder et al. (2024) used network analysis to explore resilience in first responders, highlighting that posttraumatic growth and the ability to reframe stressors positively are key resilience factors. Similarly, Papazoglou (2023) examined the psychological resilience of first responders and emphasized the role of organizational culture and systemic support in enhancing resilience. I found that moral injury and ethical dilemmas could increase PTSD risk, reinforcing the need for resilience-building interventions at both the individual and institutional levels (see Papazoglou, 2023).

Similarly, Pink et al. (2021) emphasized the importance of organizational support and peer support integration for maintaining program sustainability. Their research, carried out during the COVID-19 pandemic, highlighted resilience as a key protective factor among first responders, who showed lower levels of psychological distress compared to the general population when supported by strong peer and organizational networks. Notably, first responders faced increased trauma exposure during this time due to higher workloads, more frequent encounters with death and suffering, and limited recovery time between crises. These stressors heightened the need for mental health support, and resilience—built through structured peer support—played a vital role in lessening the psychological impacts of prolonged crisis exposure. My research supported

the idea that resilience is not just an individual trait but is influenced by social support, structured interventions, and professional identity (Pink et al., 2021). A key element of resilience among first responders was the presence of protective factors such as social support and a sense of community (Pietrantonio & Prati, 2008; Tjin et al., 2022; Werner & Smith, 1982). Pietrantonio and Prati (2008) discovered that collective efficacy and self-efficacy were strong predictors of resilience in first responders, reinforcing the concept that resilience is developed through both internal and external resources (Pietrantonio & Prati, 2008).

The transactional model of stress and coping, developed by Lazarus and Folkman (1984) describes how individuals evaluate and respond to stress through cognitive appraisal and coping strategies. In first responder research, this model has been used to investigate how professionals handle occupational stress and trauma exposure. A recent theoretical expansion by Ryu (2024) enhanced the transactional model of stress by adding work-family conflict and role strain, showing how first responders manage occupational and personal stressors with adaptive coping mechanisms. I highlighted that problem-focused coping strategies, such as professional training and peer debriefing, are linked to better psychological outcomes, while avoidance strategies are connected to greater distress (see Ryu, 2024). Research by Modula et al. (2024) looked at coping strategies among police officers and found that adaptive approaches, like seeking support and resilience training, are more effective than maladaptive ones, such as emotional suppression and substance use. These findings support the transactional model's

distinction between problem-focused and emotion-focused coping, emphasizing the need for structured interventions for first responders (Modula et al., 2024).

Additionally, Dolezal (2021) carried out a dissertation study on posttraumatic cognitions and resilience among first responders, using the transactional model of stress and coping as a framework to examine how cognitive appraisals influence coping responses. I found that disengagement coping strategies, such as avoidance and emotional suppression, were strongly linked to lower resilience, whereas problem-focused coping, including therapy and structured interventions, improved resilience (see Dolezal, 2021). A comprehensive review by Oakes et al. (2024) on models of stress and coping in high-risk occupations discovered that problem-focused coping strategies were most effective for high-controllability stressors, while emotion-focused strategies were better suited for uncontrollable situations. The researchers study supports the transactional model's assertion that the effectiveness of coping strategies depends on how individuals perceive and respond to stressors (see Oakes et al., 2024).

Several studies have combined resilience theory and the transactional model of stress and coping to create resilience-based interventions for first responders. Tjin et al. (2022) conducted a narrative review on social support for first responders and found that trusted peer networks greatly increased resilience and lowered PTSD symptoms. These results emphasize the need for structured social support interventions, which align with both theoretical models (Tjin et al., 2022). Crane et al. (2022) examined psychoeducational resilience training programs for first responders and discovered that structured training in stress management and resilience-building significantly enhanced

mental health outcomes. My research underlines the importance of modifiable protective factors in resilience theory and the focus on adaptive coping mechanisms in the transactional model (see Crane et al., 2022).

The choice of resilience theory and the transactional model of stress and coping as the main frameworks for the researchers study was based on their practical importance and relevance to understanding how first responders recover psychologically after severe trauma. These theories offer a strong foundation for exploring how first responders deal with PTSD, the role of coping strategies in reducing psychological distress, and how structured interventions can improve resilience. Since I focused on therapists' views on peer support and its effect on reducing PTSD symptoms among first responders, these frameworks provide a comprehensive view of the individual and systemic factors that affect trauma recovery.

Resilience theory, as defined by Masten (2001) and Werner and Smith (1982), states that resilience is an adaptive process influenced by both internal and external protective factors. It suggests that individuals have the ability to recover from adversity through the interplay of cognitive, emotional, and environmental resources. This theory is especially relevant to first responders, who are routinely exposed to traumatic events, including life-threatening situations, violent incidents, and mass casualty events (Pietrantonio & Prati, 2008). Research shows that resilience acts as a protective factor against PTSD and other mental health issues in trauma-exposed populations. Ponder et al. (2024) used a network analysis approach to examine resilience in first responders, finding that posttraumatic growth and adaptive cognitive reframing were key elements in

psychological recovery. This aligns with resilience theory's idea that individuals can harness personal strengths and social resources to manage adversity, making it a valuable framework for studying PTSD recovery in first responders (Ponder et al., 2024).

Furthermore, Papazoglou (2023) emphasized that organizational culture and systemic support are crucial in fostering resilience among first responders. I discovered that peer support programs and structured resilience training significantly decreased the incidence of PTSD, reinforcing the relevance of resilience theory in identifying effective trauma recovery interventions (Papazoglou, 2023). Since I examined therapists' perspectives on the role of peer support in reducing PTSD, resilience theory served as a conceptual framework to analyze the effectiveness of peer-based interventions.

The Transactional Model of Stress and Coping, developed by Lazarus and Folkman (1984), offers a complementary framework by explaining how individuals assess and respond to stress. This model is especially helpful for understanding the coping strategies used by first responders after trauma. According to this model, stress outcomes are influenced by two cognitive appraisal processes: primary appraisal, where individuals determine if an event is a threat or a challenge, and secondary appraisal, where they evaluate their available coping resources (Lazarus & Folkman, 1984). Recent research supports the importance of this model in first responder populations. Ryu (2024) combined the Transactional Model of Stress and Coping with work-family conflict theory and found that problem-focused coping strategies, like seeking professional support and participating in structured debriefing sessions, are more effective in lowering PTSD symptoms than emotion-focused strategies such as avoidance or emotional suppression.

This finding highlights the importance of problem-focused coping in first responder groups and supports my study's goal of exploring therapists' views on effective PTSD recovery methods (Ryu, 2024). Additionally, Modula et al. (2024) conducted a scoping review on coping strategies among police officers. They found that adaptive coping mechanisms, such as seeking peer support and using mental health services, were strongly linked to lower PTSD severity. Conversely, maladaptive strategies, like substance use and emotional suppression, were associated with worse mental health outcomes. These findings emphasize the importance of understanding how therapists view and promote problem-focused coping within peer support programs, making the Transactional Model of Stress and Coping an essential framework for my research (Modula et al., 2024).

The integration of Resilience Theory and the Transactional Model of Stress and Coping provide a comprehensive framework for understanding how first responders recover from trauma and how therapists view the role of peer support in this process. Resilience Theory describes why some first responders recover from trauma more effectively than others, highlighting protective factors like social support, organizational resilience programs, and individual coping skills (Pink et al., 2021). Meanwhile, the Transactional Model of Stress and Coping offer insights into the cognitive and emotional processes that influence how first responders respond to trauma and engage in recovery efforts (Dolezal, 2021; Lazarus & Folkman, 1984; Oakes et al., 2024). Studies indicate that peer support programs bolster resilience by encouraging problem-focused coping and cognitive reappraisal strategies, supporting the importance of combining both

frameworks in the researchers study (Crane et al., 2022; Tjin et al., 2022). This approach also reinforces this approach, showing that psychoeducational resilience training significantly enhances mental health outcomes by providing first responders with adaptive coping skills. This supports my study's focus on how therapists perceive the role of structured peer support in fostering resilience and reducing PTSD symptoms (Crane et al., 2022).

The COVID-19 pandemic greatly changed the operational and emotional environment for first responders. Long-term exposure to high death rates, lack of resources, and emotionally draining decisions worsened trauma symptoms and increased burnout across emergency services. Law enforcement officers, firefighters, and EMS workers experienced relentless work demands, greater public scrutiny, and limited recovery time between critical incidents. These compounded stressors led to higher levels of anxiety, depression, and PTSD among first responders. In response, peer support programs and resilience-building efforts became even more important as departments aimed to address the pandemic's psychological impact.

Therapists and organizational leaders are increasingly turning to peer-led interventions to bridge the gap between overburdened clinical services and immediate support needs. This shift in mental health culture within emergency services emphasizes the normalization of trauma reactions, the value of shared lived experience, and the importance of accessible, non-stigmatizing support systems. The rapid implementation of peer support models during the pandemic revealed both the potential and the limitations of informal support networks in high-stress occupational environments. These

developments provide essential context for understanding how therapists now see peer support as a key part of trauma recovery and resilience.

My study aimed to examine therapists' perspectives on the role of peer support in the psychological recovery of first responder clients after exposure, as well as its effectiveness in reducing PTSD symptoms. My research was based on Resilience Theory (Masten, 2001; Werner & Smith, 1982) and the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), both of which offer a comprehensive framework for understanding how first responders cope with trauma and recover. The choice of these theories directly relates to my study's research questions, as they provide insight into how peer support acts as a protective factor in resilience and how cognitive appraisal and coping strategies influence trauma recovery. This section explains why these theories were selected, how they relate to the current study, and how the research questions build on, challenge, or refine existing theoretical models.

Resilience Theory suggests that individuals have adaptive abilities that enable them to recover from traumatic experiences, supported by protective factors such as social support, cognitive flexibility, and emotional regulation (Masten, 2001). This theory is especially relevant to first responders, who operate in high-stress environments where exposure to trauma is common (Pietrantonio & Prati, 2008). Research shows that resilience among first responders is not just an innate trait but is also influenced by external resources like peer support programs and organizational culture (Papazoglou, 2023). Evidence indicates that peer support is a vital resilience-building tool, offering emotional validation, shared coping strategies, and structured debriefings, which help

lower the risk of PTSD (Crane et al., 2022). A recent study by Ponder et al. (2024) used network analysis to identify key resilience factors, highlighting that opportunities for growth and cognitive reappraisal are central to resilience.

My study further found that peer support interactions often helped with this reframing process, highlighting the importance of social support in resilience-based interventions (Ponder et al., 2024). Since the first research question looks at therapists' views on how peer support affects the psychological recovery of first responders after trauma, Resilience Theory served as a framework for analyzing therapists' perspectives. The researchers study builds on existing research by specifically examining how mental health professionals see and implement peer support within resilience-based models. Previous research mostly focused on peer support from the perspective of first responders themselves (Tjin et al., 2022); however, little is known about how therapists understand, facilitate, or incorporate these peer strategies into trauma recovery interventions.

The Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) played a key role in understanding how first responders evaluate trauma exposure and use coping strategies that influence PTSD outcomes. This model suggests that stress responses are driven by two appraisal processes: primary appraisal, where a person judges whether a stressor is a threat, and secondary appraisal, where they assess their available coping resources (Lazarus & Folkman, 1984). This theory has been widely used in studies examining occupational stress and coping among first responders (Dolezal, 2021; Oakes et al., 2024; Papazoglou, 2023). Research by Modula et al. (2024) showed that problem-focused coping strategies, such as peer debriefing and structured

intervention programs, significantly lessen PTSD severity in police officers, while emotion-focused coping methods like avoidance and substance use were linked to worse outcomes (Modula et al., 2024). Likewise, Dolezal (2021) explored the connection between posttraumatic thoughts and resilience in first responders, finding that those who used disengagement coping strategies (e.g., avoidance and emotional suppression) showed lower resilience, whereas those engaging in problem-focused coping (e.g., therapy, peer support) experienced greater psychological recovery (Dolezal, 2021).

The second research question, which explores therapists' perspectives on how peer support mitigates PTSD symptom development in first responders, aligns with the Transactional Model's focus on coping strategies. The researchers study built on existing theoretical models by examining how therapists evaluate and use peer support within the cognitive appraisal and coping process. Although previous research has thoroughly documented how first responders handle trauma exposure (Ryu, 2024), the researchers study introduced a new aspect by analyzing how therapists view the role of peer support in shaping these coping mechanisms.

The present study contributed to Resilience Theory by exploring how therapists view and facilitate resilience-building interventions within peer support frameworks. Prior research has primarily focused on individual resilience factors in first responders (Papazoglou, 2023). Still, less attention had been given to the role therapists play in fostering resilience through peer-based interventions. The researchers study addressed this gap by examining therapists' conceptualizations of resilience, their strategies for integrating peer support, and the perceived effectiveness of these interventions in trauma

recovery. Similarly, the researchers study extended the Transactional Model of Stress and Coping by examining how therapists perceive and influence the coping strategies of first responders. Existing literature has predominantly examined how first responders themselves engage in coping mechanisms (Modula et al., 2024); however, the researchers study provides a therapist-centered perspective on the facilitation and effectiveness of peer support in shaping adaptive coping responses. Furthermore, the researchers study challenged existing theoretical assumptions by examining whether peer support could serve as both a problem-focused and emotion-focused coping mechanism. Traditional models often categorize peer support as an emotion-focused strategy; however, emerging research suggests that structured peer interventions also function as problem-focused coping mechanisms, providing first responders with actionable resilience-building skills (Crane et al., 2022).the researchers study sought to clarify whether therapists perceive peer support as a hybrid coping approach and how this influences their treatment strategies.

Conceptual Framework

The main idea I explored was peer support as a way to strengthen resilience in the psychological recovery of first responders after trauma exposure. My research aimed to understand this by gathering therapists' views on how peer support helps reduce PTSD symptoms in their first responder clients. The focus is on how peer support aids psychological resilience and trauma recovery, especially through structured interventions and coping mechanisms guided by mental health professionals. The researcher looked at how therapists view peer support in the recovery process of first responders from

workplace trauma, with the goal of helping future therapists incorporate peer support into treatment to prevent or lessen the development of PTSD symptoms.

Peer support refers to structured or informal social support systems among individuals with shared experiences, such as first responders who have faced occupational trauma (Auth et al., 2022; Campos et al., 2023; Tjin et al., 2022). It involves emotional validation, shared coping strategies, and practical guidance on trauma management, often facilitated through formal peer support programs or informal networks (Tjin et al., 2022). Research consistently shows that peer support boosts psychological resilience by reducing feelings of isolation, normalizing trauma responses, and encouraging adaptive coping mechanisms (Papazoglou, 2023). A study by Ponder et al. (2024) used network analysis to identify resilience factors in first responders, revealing that peer interactions help facilitate cognitive reappraisal, which is key to healthy processing of traumatic events (Ponder et al., 2024). Additionally, Crane et al. (2022) found that structured peer debriefing sessions lowered PTSD symptoms and increased help-seeking behaviors among first responders, supporting the idea that peer support is crucial for long-term psychological recovery (Crane et al., 2022).

Psychological resilience was defined as an individual's ability to adapt to and recover from adversity through cognitive, emotional, and social resources (Masten, 2001). Among first responders, resilience was critical in buffering against the long-term effects of trauma exposure, including PTSD, depression, and anxiety (Pietrantonio & Prati, 2008). While resilience was often discussed as a personal trait, emerging research suggests that external support systems, such as peer networks, workplace interventions,

and structured resilience training, play a crucial role in developing and sustaining resilience (Papazoglou, 2023). A study by Pink et al. (2021) examined the effects of resilience-based interventions on first responders and found that those who engaged in peer-led resilience programs exhibited lower rates of psychological distress and greater emotional regulation following trauma exposure (Pink et al., 2021).

Similarly, research by Dolezal (2021) found that first responders who relied on structured peer interventions reported a greater sense of self-efficacy in coping with occupational trauma, further supporting the idea that resilience is both an individual and systemic process shaped by environmental resources (Dolezal, 2021). The current study extends the researchers study by examining how therapists perceive and utilize peer support as a resilience-building intervention. While previous studies have explored how first responders engage in peer support, there is a significant gap in understanding how mental health professionals incorporate these strategies into trauma recovery programs (Modula et al., 2024).

PTSD is a psychological disorder characterized by intrusive thoughts, hyperarousal, avoidance behaviors, and emotional dysregulation following exposure to traumatic events (American Psychiatric Association, 2022). Among first responders, PTSD rates are significantly higher due to repeated exposure to life-threatening situations, witnessing fatalities, and experiencing moral injury (Substance Abuse and Mental Health Services Administration, 2018). The Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) offer a framework for understanding how peer support influences first responders' cognitive appraisal of trauma and subsequent coping

behaviors. Research suggests that problem-focused coping strategies, such as peer debriefing and structured support interventions, reduce PTSD risk. In contrast, emotion-focused coping, such as avoidance and suppression, is associated with increased PTSD severity (Modula et al., 2024).

A recent study by Ryu (2024) examined coping mechanisms among trauma-exposed police officers and found that peer support interventions were linked to more effective secondary appraisals of trauma exposure, leading to healthier coping responses and reduced PTSD symptom severity (Ryu, 2024). Similarly, Oakes et al. (2024) discovered that structured peer interventions were most effective when combined with psychoeducational strategies aimed at reframing trauma-related thoughts (Oakes et al., 2024). The researchers' study builds on existing research by exploring therapists' perspectives on implementing peer support in PTSD mitigation strategies. While earlier studies have focused on the effectiveness of peer support from the viewpoint of first responders, little is known about how mental health professionals integrate and evaluate these interventions (Tjin et al., 2022).

Both Resilience Theory and the Transactional Model of Stress and Coping offer a conceptual foundation for understanding how therapists develop, implement, and adapt peer support strategies for first responders. Resilience Theory explains why peer support promotes recovery, while the Transactional Model sheds light on how peer support affects stress perception and coping methods (Lazarus & Folkman, 1984; Masten, 2001). Research shows that peer support acts as both a problem-focused and an emotion-focused coping mechanism, depending on the intervention's structure and the individual's

resilience level (Crane et al., 2022). the researchers study aims to determine whether therapists view peer support as a hybrid coping approach and how this perception influences their treatment methods.

Integration of Resilience Theory and the Transactional Model of Stress and Coping Both Resilience Theory and the Transactional Model of Stress and Coping provide a conceptual foundation for understanding how therapists conceptualize, facilitate, and adapt peer support strategies for first responders. Resilience Theory explains why peer support promotes recovery, while the Transactional Model offers insight into how peer support affects stress appraisal and coping mechanisms (Lazarus & Folkman, 1984; Masten, 2001). Studies show that peer support acts as both a problem-focused and emotion-focused coping tool, depending on the intervention structure and the individual's resilience level (Crane et al., 2022). the researchers study aimed to clarify whether therapists see peer support as a hybrid coping approach and how this shapes their treatment strategies.

The concept of resilience as it relates to psychological recovery following trauma has its roots in developmental and clinical psychology. Norman Garmezy first introduced the concept of resilience as a protective factor in children exposed to adverse conditions, laying the groundwork for later longitudinal studies (Garmezy, 1974). Building on this foundation, Werner and Smith (1982) conducted one of the most influential longitudinal studies on resilience, identifying key protective factors—such as strong social bonds, adaptive problem-solving, and internal locus of control—that enabled high-risk youth in Kauai to thrive despite adversity. Their work was pivotal in reframing resilience as a

dynamic process rather than a static trait. Ann Masten (2001) further advanced this understanding with the concept of “ordinary magic,” emphasizing that resilience was a standard, naturally occurring capacity rooted in basic human adaptive systems such as attachment, cognitive competence, and self-regulation. Masten’s writings emphasized the interplay between individual, relational, and environmental factors—a view especially applicable to high-risk occupational groups, such as first responders (Masten, 2001).

In parallel, Lazarus and Folkman (1984) developed the Transactional Model of Stress and Coping, which focuses on how individuals appraise stressors and choose coping strategies. Their theory distinguishes between problem-focused coping, which aims to resolve the stressor itself, and emotion-focused coping, which seeks to manage the emotional response to the stressor (Lazarus & Folkman, 1984). According to Lazarus and Folkman (1984), stress was not an inherent quality of an event, but a result of the individual’s perception of their ability to cope. This model had been applied in numerous studies of trauma-exposed professionals, including healthcare workers, military personnel, and emergency responders (Lazarus & Folkman, 1984). Its emphasis on appraisal and coping provided a valuable lens through which to understand how peer support functions—not only as emotional validation but also as a means of equipping first responders with problem-solving tools and shared narratives that could reframe trauma (Lazarus & Folkman, 1984).

Together, these foundational theories provide a conceptual basis for understanding peer support as both a protective factor in resilience and a coping mechanism in response to trauma. They also inform the central aim of my study: to

explore how therapists understand and integrate these theoretical frameworks into peer-based interventions for PTSD recovery among first responders.

Both Resilience Theory and the Transactional Model of Stress and Coping had been widely applied in studies involving trauma-exposed populations, including military personnel, healthcare workers, and first responders (Dolezal, 2021; Oakes et al., 2024; Papazoglou, 2023). Previous research has utilized these frameworks to investigate how protective factors—such as social support, adaptive coping, and a sense of purpose—facilitate psychological resilience and recovery from PTSD (Lazarus & Folkman, 1984; Masten, 2001; Werner & Smith, 1982). For example, Papazoglou (2023) applied Resilience Theory to examine moral injury and ethical strain among law enforcement officers, emphasizing that systemic support and peer-based programs significantly reduced PTSD symptom severity. Similarly, Dolezal (2021) employed the Transactional Model to investigate how first responders cognitively appraise traumatic stressors and select coping strategies, finding that problem-focused interventions, such as therapy and peer debriefing, were associated with greater resilience and improved psychological outcomes.

My study benefited from the integration of these two frameworks by providing a dual lens through which to examine therapists' perspectives on peer support. Resilience Theory explains why peer support might buffer the effects of trauma and promote adaptive functioning (Masten, 2001), while the Transactional Model of Stress and Coping clarify how therapists assess and influence the cognitive processes underlying coping behaviors (Lazarus & Folkman, 1984). These theoretical insights enable a deeper

understanding of how peer support functions not only as a relational tool but also as a clinical mechanism embedded within trauma recovery work. This theoretical foundation enhances my study's capacity to identify evidence-informed strategies and clarify the processes by which therapists conceptualize, facilitate, and evaluate peer-based interventions for first responders navigating PTSD (Crane et al., 2022; Tjin et al., 2022).

Literature Review Related to Key Variables and/or Concepts

Application of the Framework in Previous Research

Both Resilience Theory and the Transactional Model of Stress and Coping have been widely applied in studies involving trauma-exposed populations, including military personnel, healthcare workers, and first responders (Dolezal, 2021; Oakes et al., 2024; Papazoglou, 2023). Previous research has utilized these frameworks to investigate how protective factors—such as social support, adaptive coping, and a sense of purpose—facilitate psychological resilience and recovery from PTSD (Lazarus & Folkman, 1984; Masten, 2001; Werner & Smith, 1982). For example, Papazoglou (2023) applied Resilience Theory to examine moral injury and ethical strain among law enforcement officers, emphasizing that systemic support and peer-based programs significantly reduced PTSD symptom severity. Similarly, Dolezal (2021) employed the Transactional Model to investigate how first responders cognitively appraise traumatic stressors and select coping strategies, finding that problem-focused interventions, such as therapy and peer debriefing, were associated with greater resilience and improved psychological outcomes.

Relevance of the Framework to the Current Study

My study benefited from the integration of these two frameworks by offering a dual perspective on how therapists conceptualize and respond to the needs of trauma-exposed first responders. Resilience Theory (Masten, 2001) informs how therapists understand peer support as a mechanism that fosters adaptive functioning and recovery despite adversity. Concurrently, the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) guides therapists in evaluating how first responders appraise stressors and engage in coping strategies, allowing them to tailor interventions that strengthen psychological recovery. These theoretical insights allow for a richer understanding of how peer support operates not only as a relational tool but also as a clinical mechanism embedded within trauma recovery work. This theoretical foundation enhances my study's capacity to identify evidence-informed strategies and clarify the processes by which therapists conceptualize, facilitate, and evaluate peer-based interventions for first responders navigating PTSD (Crane et al., 2022; Tjin et al., 2022).

Approaches to the Problem in the Discipline: Strengths and Weaknesses

Researchers within the fields of clinical psychology, trauma studies, and emergency mental health have employed a range of methodological approaches to address the complex issue of PTSD among first responders, particularly concerning the utility of peer support as a therapeutic intervention (Dolezal, 2021; Papazoglou, 2023; Tjin et al., 2022). Quantitative research has traditionally dominated this area, with numerous studies focusing on the prevalence, severity, and risk factors associated with PTSD in first responder populations (Pietrzak et al., 2010). These studies often employ

standardized measures, such as the PTSD Checklist for DSM-5 (PCL-5), to statistically assess the impact of trauma exposure and evaluate the effectiveness of interventions (Pietrzak et al., 2010). The strength of such approaches lies in their ability to produce generalizable findings and draw comparisons across large population samples. However, these studies often fail to capture the nuanced psychosocial and contextual factors that influence trauma recovery, particularly the subjective value of peer support as perceived by both recipients and clinical practitioners (Auth et al., 2022).

To address these limitations, qualitative research has increasingly been utilized to explore the lived experiences of first responders and the interpersonal dynamics of trauma recovery. Studies such as those conducted by Auth et al. (2022) and Papazoglou (2023) employed semi-structured interviews and phenomenological frameworks to gain deeper insights into how emergency personnel experience peer support. These investigations highlight the strengths of qualitative methods, which allow for a rich exploration of culturally embedded attitudes toward mental health, trust in peers, and resistance to traditional therapy models. Auth et al. (2022) found that peer support was viewed as more accessible and less stigmatizing than formal mental health services. In contrast, Papazoglou (2023) emphasized that peer-based interventions helped reframe trauma through shared narratives and moral grounding. Despite these strengths, qualitative research was often critiqued for its limited generalizability due to small sample sizes and contextual specificity. Inconsistencies in how peer support was defined and operationalized further challenge the synthesis of findings across studies (Tjin et al., 2022).

Another emerging approach involves mixed methods research, which combines both quantitative and qualitative elements to investigate trauma exposure and recovery. Dolezal (2021) employed a mixed methods design to investigate the relationship between coping strategies and resilience among first responders. Her work demonstrated that problem-focused coping, such as peer-led debriefings and therapy engagement, was positively associated with resilience. At the same time, emotion-focused or avoidance strategies were linked to poorer outcomes. This dual-method approach provided both statistical power and contextual richness, offering a more holistic understanding of the phenomenon. However, mixed methods design requires extensive resources, and integrating data across paradigms is methodologically challenging.

Despite these varied approaches, a notable gap remains in the literature regarding the perspectives of therapists who facilitate or work alongside peer support programs. Most existing studies prioritize the voices of first responders themselves, leaving unexamined the clinical reasoning, therapeutic adjustments, and treatment philosophies held by mental health professionals (Dolezal, 2021; Papazoglou, 2023; Tjin et al., 2022). This absence was significant, as therapists often serve as the bridge between evidence-based interventions and individualized care strategies (Auth et al., 2022; Campos et al., 2023). The current study addressed this gap by applying a phenomenological methodology aimed explicitly at uncovering how therapists conceptualize, evaluate, and implement peer support as a tool in PTSD recovery. This approach capitalizes on the strengths of qualitative inquiry—depth, flexibility, and contextual sensitivity—while

extending the literature to include perspectives that were central to the clinical application of peer support in first responder mental health.

Justification for Concept Selection

The selection of key concepts in my study—peer support, PTSD symptom severity, resilience, and therapists’ perspectives—is grounded in an extensive body of empirical literature and aligned with both theoretical and practical imperatives in trauma-informed care. Peer support has emerged as a salient and increasingly researched construct in the field of occupational mental health, particularly within high-risk professions such as emergency medical services, firefighting, and law enforcement (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022). Multiple studies have demonstrated that peer support interventions could reduce psychological distress, increase emotional regulation, and improve help-seeking behaviors among trauma-exposed professionals (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022). These outcomes were particularly critical for first responders, who were often embedded in organizational cultures that stigmatize vulnerability and discourage the use of traditional mental health services (Auth et al., 2022). Thus, peer support represents a culturally congruent, accessible, and scalable intervention that aligns with first responders’ relational values and need for trust-based interactions.

PTSD symptom severity remains a central concern in the literature, as it significantly impairs occupational functioning, interpersonal relationships, and quality of life among first responders (Pietrzak et al., 2010). While PTSD was widely studied using quantitative scales, there remains a need to explore how symptom trajectories were

influenced by context-specific interventions such as peer support. Resilience, another key concept in my study, serves as a theoretical bridge between exposure to trauma and long-term psychological recovery. Resilience Theory (Masten, 2001; Werner & Smith, 1982) posits that adaptive systems, such as social support, cognitive flexibility, and community connection, can mitigate the harmful effects of trauma and support recovery. Studies have shown that structured peer interactions facilitate resilience by normalizing traumatic experiences, promoting emotional validation, and encouraging adaptive reframing of stressors (Papazoglou, 2023; Ponder et al., 2024).

The inclusion of therapists' perspectives as a focal concept addressed a critical gap in the literature. While peer support had been examined from the standpoint of recipients—primarily first responders themselves—far less attention had been paid to how clinicians conceptualize and integrate peer support into trauma recovery frameworks (Dolezal, 2021; Modula et al., 2024). Therapists were uniquely positioned to evaluate the appropriateness, limitations, and clinical implications of peer-based interventions, particularly when working with clients with severe PTSD symptoms. Understanding how therapists perceive the interplay between peer support and resilience-building contributed not only to the empirical literature but also to the development of trauma-informed policies and intervention strategies (Modula et al., 2024; Campos et al., 2023). For these reasons, the selected concepts were well-justified, interconnected, and essential for advancing research, clinical practice, and public health approaches to supporting the psychological recovery of first responders.

Review and Synthesis of Empirical Studies Related to Key Variables

Extensive empirical inquiry has illuminated various facets of peer support, PTSD symptom severity, resilience, and therapist involvement in trauma recovery among first responders. Peer support has garnered increasing attention in recent years for its potential to serve as both a relational and therapeutic resource (Crane et al., 2022; Papazoglou, 2023; Tjin et al., 2022). Research has demonstrated that structured and informal peer support systems contribute to reduced psychological distress, enhanced emotional regulation, and improved engagement with mental health services (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022).

For example, Campos et al. (2023) found that peer support interventions within EMS organizations improved long-term psychological outcomes by fostering trust and emotional validation. Peer support was also shown to promote emotional safety, reduce stigma, and improve help-seeking behaviors in trauma-exposed professionals (Auth et al., 2022; Papazoglou, 2023).

The opportunities and challenges faced by individuals working to advance mental health policy and programming for first responders were examined. The researchers study employed qualitative content analysis and conducted interviews with firefighters, emergency medical services professionals, law enforcement officers, and other individuals involved in programming or policy, offering insights into the complexities of implementing effective mental health strategies within these professions.

Donovan's (2022) recent literature review identified five major themes that characterize both formal and informal peer support interactions as mechanisms for

promoting post-traumatic growth (PTG) among first responders. These themes included emotional validation, shared identity, normalization of trauma responses, mutual encouragement, and modeling of adaptive behaviors (Donovan, 2022). Donovan (2022) emphasized the importance of distinguishing between structured peer interventions led by trained individuals and informal peer interactions occurring among colleagues. Although both types of support could positively impact recovery trajectories, future research must explore whether formal peer training programs offer additional or superior therapeutic outcomes in PTSD prevention and treatment.

At the same time, studies such as those by Pietrzak et al. (2010) and Wagner et al., (2020) highlight the enduring psychological impact of trauma exposure in emergency personnel, emphasizing the prevalence of PTSD, depression, and suicidality. The Substance Abuse and Mental Health Services Administration (2018) further confirmed that PTSD symptom severity was consistently higher in first responder populations than in the general public. Although quantitative studies employing instruments like the PTSD Checklist for DSM-5 (PCL-5) have contributed to population-level understanding of mental health needs, they frequently lack the contextual detail needed to assess the experiential value of interventions such as peer support (Auth et al., 2022).

Resilience had been a central construct in the literature as well, with Resilience Theory offering a robust framework for understanding recovery trajectories in trauma-exposed populations (Garmezy, 1974). Foundational work by Masten (2001) and Werner and Smith (1982) posit resilience as a dynamic, adaptive process supported by protective systems, such as social support, cognitive flexibility, and emotion regulation. More recent

studies, such as Ponder et al. (2024) and Papazoglou (2023), build on this theoretical groundwork by identifying peer interaction as a catalyst for cognitive reframing, moral repair, and psychological stabilization. These studies affirm that resilience is not simply a trait, but a modifiable capacity that can be enhanced through interpersonal relationships and structured interventions (Masten, 2001; Papazoglou, 2023; Ponder et al., 2024; Werner & Smith, 1982).

Empirical investigations have also turned toward understanding coping mechanisms through the lens of the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), as applied to first responders. Ryu (2024) integrated this model with work-family conflict theory to examine how occupational and personal stressors were managed through adaptive and maladaptive strategies. Dolezal (2021) supported this framework in her study on posttraumatic cognitions, highlighting that disengagement coping strategies—such as avoidance or emotional suppression—were associated with lower resilience, while engagement with therapy and peer support promoted recovery. Modula et al. (2024) found similar patterns among police officers, concluding that structured peer support programs could improve mental health outcomes when aligned with problem-focused coping strategies.

A significant point of contention in the literature concerns the comparative effectiveness of peer support in relation to other psychological interventions. While peer support has gained popularity in mental health systems supporting first responders, few studies directly compare its efficacy to that of evidence-based trauma therapies such as cognitive behavioral therapy (CBT) or eye movement desensitization and reprocessing

(EMDR). Shalaby and Agyapong (2020) conducted a systematic review and meta-analysis that confirmed the effectiveness of psychological interventions in reducing PTSD, depression, and anxiety symptoms in first responders. However, recent reviews have noted the absence of long-term, high-quality randomized controlled trials (RCTs) focused on peer support, emphasizing the need for future studies to evaluate better how peer-based approaches perform either in comparison to or in conjunction with established clinical treatments.

Despite this growing body of evidence, several controversies persist. There was little consensus in the literature on how to define and operationalize peer support, leading to inconsistencies in program implementation and evaluation (Tjin et al., 2022). Some studies conceptualize peer support as informal check-ins or emotional validation, while others describe it as a structured, protocol-driven intervention akin to therapy (Papazoglou, 2023; Campos et al., 2023; Tjin et al., 2022). This variation complicates the evaluation of peer support as an evidence-based practice and introduces challenges in measuring outcomes across different settings. Additionally, although the experiences of first responders were frequently captured, the voices of therapists remain notably underrepresented. Therapists—who often design, facilitate, or recommend peer support interventions—are rarely consulted in empirical research (Dolezal, 2021; Modula et al., 2024; Papazoglou, 2023), representing a critical gap in understanding how clinical frameworks intersect with peer-led care.

Moreover, while many studies affirm the benefits of peer support, they often do so without longitudinal or comparative data (Crane et al., 2022; Papazoglou, 2023; Tjin et

al., 2022; Shalaby & Agyapong, 2020). For instance, few studies examine how peer support performs relative to or in combination with other trauma-focused interventions like EMDR or CBT. As a result, the field lacks clarity on when peer support was most effective, for whom, and under what conditions. Some research also suggests that peer support, if unstructured or improperly supervised, might inadvertently reinforce maladaptive beliefs or retraumatize participants (Papazoglou, 2023). This underscores the importance of integrating clinician oversight, therapeutic training, and trauma-informed frameworks into peer-based programs.

In sum, the literature reveals that peer support was widely regarded as a promising, culturally congruent intervention for first responders coping with trauma. Still, it also highlights considerable variation in implementation, theoretical framing, and research design. While resilience and coping theories provide strong justification for the utility of peer support, the field has yet to fully integrate therapists' perspectives or systematically evaluate peer support's long-term effects (Auth et al., 2022; Modula et al., 2024; Papazoglou, 2023; Campos et al., 2023; Tjin et al., 2022; Shalaby & Agyapong, 2020). The current study addressed these gaps by focusing on how therapists conceptualize, facilitate, and evaluate peer support within the broader scope of PTSD recovery. This contribution was vital to building evidence-based frameworks that inform both clinical practice and organizational mental health policy for first responders.

Review and Synthesis Related to Research Questions and Rationale for Approach

The research questions posed in the researchers study reflect a critical gap in the literature: how do therapists conceptualize and evaluate the role of peer support in the

psychological recovery of first responders experiencing PTSD? This line of inquiry was particularly salient given the strong empirical support for peer support as a culturally relevant and accessible intervention, paired with the underrepresentation of clinical voices in program evaluation and intervention design. Numerous studies have documented the effectiveness of peer-based programs in improving emotional regulation, encouraging help-seeking behaviors, and mitigating trauma-related symptoms in high-risk occupations (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022). However, while peer support has become a prominent intervention strategy across police, firefighting, and EMS systems, research has predominantly centered on the perspectives of first responders themselves, offering limited insight into how therapists—who often facilitate or supervise these programs—understand and apply them in practice (Dolezal, 2021; Modula et al., 2024).

My study's research questions aim to bridge this gap by investigating the dual conceptual and clinical roles that therapists occupy. The first research question focuses on how therapists perceive the psychological recovery of first responders in the aftermath of severe trauma, particularly in relation to peer support structures. The second research question explores how therapists believe peer support mitigates PTSD symptom severity, thus contributing to a deeper understanding of recovery trajectories and the operationalization of peer support within therapeutic frameworks. By focusing on these questions, the researchers study addressed a notable deficiency in trauma literature: the omission of provider perspectives in evaluating relational interventions (Papazoglou, 2023; Tjin et al., 2022).

The qualitative, phenomenological approach selected for my study was well-aligned with its research questions. Phenomenology offers a rigorous method for uncovering the lived experiences and interpretive frameworks of individuals—in this case, mental health professionals who treat trauma-exposed populations. Moustakas (1994) emphasized that phenomenological research allows for the examination of meaning-making structures and subjective realities, which was essential when evaluating how therapists integrate peer support into treatment plans. This approach contrasts with the more common quantitative studies in the field, which often utilize survey-based data (e.g., PCL-5, PHQ-9) to assess symptom severity but fail to contextualize interventions in relational, therapeutic, and organizational terms (Pietrzak et al., 2010).

Additionally, prior qualitative work supports the use of this methodology. Auth et al. (2022) employed interviews to investigate help-seeking behaviors among first responders, revealing cultural resistance to traditional therapy and a widespread reliance on peer support as a gateway to care. Papazoglou (2023) and Ryu (2024) applied similar interpretive methods to examine coping and moral injury, respectively, identifying key psychosocial factors that influence recovery outcomes. These studies validate the choice of a phenomenological design for eliciting rich, practice-based insights into trauma recovery. Moreover, Dolezal (2021) and Modula et al. (2024) have emphasized the importance of understanding provider perspectives in shaping trauma-informed care delivery, particularly for populations with high exposure to violence and occupational stress.

Thus, my study's research questions and methodological choices were directly informed by the empirical and theoretical gaps identified in current literature. The goal was not only to capture what therapists observe in their work with first responders, but also to examine how their perspectives on peer-based strategies to promote resilience and reduce PTSD symptomatology. This exploration might inform future training, policy, and clinical frameworks that center both empirical evidence and practitioner expertise in designing mental health interventions for first responders.

Summary and Conclusions

The literature on first responder mental health, trauma recovery, and peer support reveals several recurring themes that guide the current study. First, a consensus exists that first responders were disproportionately exposed to traumatic events and were at elevated risk for developing PTSD, depression, anxiety, and suicidality (Pietrzak et al., 2010). The chronic nature of trauma exposure in this population demands targeted, effective interventions that are sensitive to occupational culture and barriers to care. Peer support has emerged as a particularly relevant construct, offering a culturally congruent, accessible intervention that aligns with the relational values and communal identity of emergency personnel (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022). This form of support had been consistently associated with reductions in psychological distress and increased emotional regulation, particularly when it was structured and integrated within the organizational culture (Auth et al., 2022; Crane et al., 2022).

Another significant theme in the literature was the operationalization of resilience as a modifiable and dynamic process, rather than a fixed personal trait (Masten, 2001;

Ponder et al., 2024; Werner & Smith, 1982). Studies have shown that resilience was bolstered by protective factors such as cognitive reframing, social support, and organizational validation, with peer support playing a central role in facilitating these outcomes (Papazoglou, 2023; Ponder et al., 2024). This resilience-building process was especially relevant in the context of first responders, who benefit from interventions that normalize trauma responses and strengthen adaptive coping strategies.

In parallel, researchers have applied the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) to frame how first responders appraise and respond to stress. Adaptive strategies, such as problem-focused coping, have been linked to greater psychological resilience and recovery, while emotion-focused strategies, like avoidance, have been associated with worsened outcomes (Dolezal, 2021; Modula et al., 2024; Ryu, 2024). Studies have emphasized the role of peer support in promoting adaptive appraisals and reinforcing constructive coping mechanisms, providing theoretical justification for its implementation within trauma recovery frameworks.

Despite these advances, a recurring issue in the literature has been the variability in how peer support is defined and implemented. Some studies characterize it as informal emotional support, while others describe highly structured, protocol-driven interventions (Papazoglou, 2023; Campos et al., 2023; Tjin et al., 2022). This definitional inconsistency complicates cross-study comparisons and hinders the establishment of peer support as an evidence-based practice. Additionally, most existing research focuses on first responders' self-reported outcomes, leaving a critical gap in understanding how therapists—who facilitate, supervise, or refer to these interventions—conceptualize their

utility (Dolezal, 2021; Modula et al., 2024). This lack of integration of therapist perspectives represents a barrier to fully operationalizing peer support within clinical practice.

Finally, there has been limited longitudinal and comparative research on the efficacy of peer support relative to established trauma-focused therapies, such as CBT and EMDR (Crane et al., 2022; Papazoglou, 2023; Tjin et al., 2022). While peer support was widely valued, few studies systematically evaluate its long-term impact, optimal delivery models, or integration within multilevel treatment plans. Concerns have also been raised about unregulated peer interactions potentially reinforcing maladaptive narratives or retraumatizing participants, especially in the absence of clinical oversight (Papazoglou, 2023). This underscores the need for therapist-informed frameworks that incorporate peer support into comprehensive, trauma-informed care systems. Taken together, these themes underscore a robust yet evolving knowledge base on peer support, resilience, and trauma recovery among first responders. They also validate the significance of the current study's focus on therapists' perspectives, offering a unique and necessary contribution to literature that has, until now, largely prioritized the recipient experience over clinical application.

The existing literature on trauma recovery among first responders has established a strong foundation for understanding the psychological effects of occupational trauma and the potential of peer support to mitigate those effects. Research consistently shows that first responders were at heightened risk for PTSD, depression, and suicidality due to cumulative exposure to traumatic incidents (Pietrzak et al., 2010). Numerous studies have

validated peer support as a meaningful, culturally accepted, and accessible form of psychological support among this population (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022). These findings have led to the widespread implementation of peer support programs across EMS, law enforcement, and firefighting agencies, where they have been shown to enhance help-seeking behaviors, normalize trauma responses, and reduce stigma (Auth et al., 2022; Papazoglou, 2023).

The literature has also established the importance of resilience and coping in trauma recovery. Resilience Theory, as developed by Masten (2001) and Werner and Smith (1982), posits that resilience is a dynamic and modifiable trait shaped by social, cognitive, and environmental factors. Subsequent studies have confirmed the association between peer interaction and resilience-building, with evidence indicating that cognitive reframing, moral repair, and emotional validation are key mechanisms (Papazoglou, 2023; Ponder et al., 2024). The Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) has similarly informed research on how first responders manage trauma, emphasizing the significance of problem-focused coping in fostering adaptive recovery (Dolezal, 2021; Modula et al., 2024; Ryu, 2024). These models provide robust theoretical support for the implementation of peer support as a resilience-enhancing and coping-facilitating tool.

Despite these advancements, several gaps and uncertainties remain. There was no uniform definition or standardization for peer support programs, leading to inconsistencies in training, delivery, and outcome measurement (Papazoglou, 2023; Campos et al., 2023; Tjin et al., 2022). Some programs emphasize informal peer check-

ins, while others are highly structured and integrated into mental health systems. This lack of conceptual clarity complicates efforts to evaluate program effectiveness and develop evidence-based best practices. Another significant gap was the limited inclusion of therapist perspectives in empirical research. While peer support has been extensively explored from the standpoint of first responders, few studies have investigated how therapists conceptualize, apply, or assess peer support interventions in their clinical work (Dolezal, 2021; Modula et al., 2024; Papazoglou, 2023). This was a critical oversight, given that therapists often serve as facilitators, evaluators, or gatekeepers of these programs.

In addition, there was a lack of longitudinal and comparative research evaluating the sustained effectiveness of peer support over time or its efficacy relative to trauma-focused therapies, such as CBT and EMDR (Crane et al., 2022; Papazoglou, 2023; Tjin et al., 2022). While peer support has been endorsed for its accessibility and cultural congruence, questions remain about its long-term clinical value, scalability, and risks when implemented without clinical oversight (Papazoglou, 2023). Concerns had been raised that poorly regulated peer support might inadvertently reinforce maladaptive beliefs or contribute to retraumatization, particularly in high-stress occupational contexts. In summary, the literature confirms the utility and relevance of peer support, resilience, and coping frameworks in addressing the psychological needs of first responders. However, what remains underexplored is the role of therapists in shaping, evaluating, and delivering peer-based interventions. The current study addressed this gap by examining therapists' lived experiences and interpretive frameworks, offering novel insights that

might inform more coherent, clinician-informed models of peer support in trauma recovery.

My study makes a significant contribution to the discipline by directly addressing the persistent gap in research regarding therapists' perspectives on peer support for trauma recovery among first responders. While the extant literature strongly supports the psychological efficacy of peer support programs (Crane et al., 2022; Campos et al., 2023; Tjin et al., 2022), it has largely overlooked the insights of the clinicians who work most closely with these interventions in practice. Peer support was frequently evaluated from the perspective of its recipients—first responders themselves—but few empirical studies have examined how therapists conceptualize, implement, and assess these programs as part of broader clinical care (Dolezal, 2021; Modula et al., 2024; Papazoglou, 2023). The researchers study fills that void by centering the voices of therapists, whose professional expertise and clinical judgments were essential to understanding the therapeutic value and boundaries of peer-based interventions.

In doing so, the researchers study responds to calls within the field for a more integrated understanding of how trauma recovery unfolds within relational, organizational, and therapeutic contexts (Auth et al., 2022; Papazoglou, 2023). Therapists not only provide treatment but also influence how peer support was introduced, monitored, and evaluated in trauma-informed systems. By exploring therapists' views on how peer support mitigates PTSD symptom severity and fosters resilience, the researchers study contributed to the refinement of both theoretical frameworks—namely Resilience Theory (Masten, 2001; Werner & Smith, 1982) and the Transactional Model

of Stress and Coping (Lazarus & Folkman, 1984)—and applied practice. It operationalizes these models in a real-world context, demonstrating how concepts such as adaptive coping, cognitive appraisal, and emotional regulation are perceived and supported by mental health professionals working with trauma-exposed populations (Dolezal, 2021; Modula et al., 2024; Ryu, 2024).

Furthermore, the researchers study extended the literature by offering a phenomenological exploration of therapists' lived experiences, capturing the nuance and complexity that quantitative methods often miss. While survey-based studies had been invaluable in identifying prevalence rates and general outcomes (Pietrzak et al., 2010), they do not illuminate how therapists interpret and adapt peer support interventions based on the clinical, cultural, and ethical demands of their practice. Through this qualitative lens, the researchers study uncovers patterns in how therapists understand the dual role of peer support as both an emotional resource and a cognitive restructuring tool, reflecting the evolving nature of trauma care.

Notably, the findings from the researchers study may help organizations refine their training protocols, establish more precise boundaries for peer roles, and design interventions that are responsive to both client needs and clinical standards. This was particularly relevant given the definitional and implementation inconsistencies in peer support programs (Campos et al., 2023; Tjin et al., 2022). By integrating therapist insights, the researchers study aimed to support the creation of evidence-informed, trauma-responsive systems that blend relational support with professional oversight. In sum, the researchers study fills a significant empirical and conceptual gap in the literature

by focusing on therapists' perspectives on peer support for PTSD recovery in first responders. It deepens the field's understanding of how resilience and coping theories were applied in clinical practice and enhances the evidence base for peer support as a legitimate component of trauma-informed care. This advancement has implications for research, training, intervention design, and mental health policy, positioning the researchers study as a meaningful and necessary extension of current disciplinary knowledge.

Several recurring themes have emerged in the literature on PTSD recovery among first responders, providing a strong foundation for my study. First, peer support has been widely recognized as an effective coping strategy that could reduce PTSD symptoms and enhance resilience (Pietrzak et al., 2010; Tjin et al., 2022). Second, barriers to traditional mental health care—such as stigma, organizational culture, and limited access—continue to hinder help-seeking behaviors among first responders (Papazoglou, 2023). Third, research supports the importance of workplace social support and resilience-building as critical factors in trauma recovery (Masten, 2001; Campos et al., 2023).

However, contrasting viewpoints exist regarding how peer support should be structured and implemented. While some researchers advocate for informal, peer-driven check-ins, others emphasize the necessity of structured, clinically supervised programs to mitigate potential risks (Papazoglou, 2023; Tjin et al., 2022). These variations contribute to the lack of consensus on best practices, particularly regarding the integration of peer support into formal mental health treatment frameworks (Ponder et al., 2024).

What was known was that peer support could improve resilience, reduce psychological distress, and promote trauma recovery, especially in culturally congruent settings such as emergency services (Masten, 2001; Pietrzak et al., 2010). Nonetheless, what remains unknown—and critically understudied—is how therapists themselves perceive, evaluate, and clinically integrate peer support within therapeutic interventions (Auth et al., 2022). Therapists’ insights into the benefits, risks, and treatment implications of peer-based care were largely absent from the empirical literature. This gap significantly limits the field’s ability to generate clinician-informed, trauma-responsive models of care.

My study contributed to the discipline of clinical psychology by addressing this gap. It extends knowledge by capturing therapists’ professional insights into how peer support facilitates or complicates PTSD recovery, identifying clinical best practices for integrating peer support with established therapeutic modalities, and offering evidence-based recommendations to enhance peer support programs. The perspectives gathered might ultimately inform more effective training, policy, and clinical practices for mental health professionals who work with trauma-exposed first responders.

Given the lack of empirical documentation on therapists’ experiences, the researchers study employs a qualitative phenomenological methodology to explore their lived perspectives (Creswell & Poth, 2018). This approach enables the in-depth examination of therapists’ meaning-making processes and interpretive frameworks, which are essential for understanding how peer support is applied in real-world clinical contexts. Semi-structured interviews were particularly appropriate for this inquiry

because they allow participants to discuss the perceived benefits, limitations, and integration of peer support into treatment. These interviews also enable the identification of clinical patterns and interpretive themes that might not be captured through quantitative approaches.

To address the aforementioned gap in the literature, the following chapter outlines the research design, participant selection criteria, data collection process, and thematic analysis methods used to explore therapists' perspectives on the role of peer support in PTSD recovery among first responders.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to explore therapists' perspectives on the role of peer support in mitigating PTSD symptoms and facilitating psychological recovery among first responders. Given the unique occupational demands faced by emergency personnel—such as firefighters, paramedics, and law enforcement officers—who were routinely exposed to acute and cumulative trauma, peer support has emerged as a culturally congruent and accessible intervention strategy (Papazoglou, 2023; Tjin et al., 2022). However, while prior research has extensively examined peer support from the standpoint of recipients, namely first responders themselves, limited empirical attention has been devoted to the clinical insights of therapists who treat this population and often integrate or supervise such interventions (Dolezal, 2021; Modula et al., 2024).

During my study, I specifically sought to understand how therapists evaluate the effectiveness, limitations, and clinical integration of peer support programs within formal therapeutic models. This includes examining therapists' views on how peer support interacts with evidence-based treatments such as CBT and EMDR, as well as how these programs might promote—or in some cases, hinder—psychological recovery. Drawing from the theoretical foundations of Resilience Theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping (Lazarus & Folkman, 1984), I grounded the study in a conceptual understanding that peer support could function as both a protective mechanism and a coping facilitator in high-risk occupational settings.

By centering the lived experiences and interpretive frameworks of licensed mental health professionals, I aimed to contribute to an underdeveloped area of the literature with my study. The findings were expected to inform clinical best practices, enhance the design and delivery of peer support interventions, and generate evidence-based recommendations for therapists, mental health administrators, and first responder organizations. Ultimately, endeavored to bridge the empirical gap between theory, intervention design, and clinical practice in trauma-informed care for first responders.

In this chapter, I outline the methodological framework employed in my study, detailing each component of the research process to ensure transparency, academic rigor, and alignment with my study's purpose. I begin the chapter with a comprehensive explanation of the research design and rationale, justifying the use of a qualitative, phenomenological approach to explore therapists' lived experiences and professional perspectives on peer support in the treatment of PTSD among first responders. The selected design was intended to elicit rich, descriptive accounts that uncover meaning-making processes and clinical evaluations often overlooked in quantitative inquiry (see Creswell & Poth, 2018; Moustakas, 1994). Following the discussion of the research design, my role as the researcher was addressed, including considerations related to positionality, reflexivity, and steps taken to mitigate bias. Given my background in both law enforcement and clinical psychology, it was critical to examine the influence of professional experience on data interpretation and participant interaction (Patton, 2015).

The methodology section contains a detailed account of the participant selection process, including the use of purposive sampling to recruit licensed mental health

professionals with direct experience working with trauma-exposed first responders. I also define the inclusion and exclusion criteria, provides a rationale for the sample size, and outlines recruitment strategies. I continue with an overview of the data collection procedures, highlighting the use of semi-structured interviews as the primary method for gathering experiential data. This was followed by a description of the data analysis procedures, where I used Moustakas' (1994) modification of the Stevick, Colaizzi, and Keen method for phenomenological analysis. This approach supports the identification of emergent themes, patterns, and structures of meaning embedded within therapists' narratives.

The trustworthiness of the researchers study is then addressed through the discussion of strategies to ensure credibility, transferability, dependability, and confirmability, as recommended by Lincoln and Guba (1985). This section also includes considerations for researcher reflexivity and audit trails. Finally, the chapter concludes with an outline of ethical procedures, including informed consent, participant confidentiality, and institutional review board (IRB) compliance, ensuring that the researchers study adheres to ethical research standards in alignment with the American Psychological Association (APA, 2022) ethical guidelines. Together, these components form the foundation for a rigorous qualitative investigation, designed to illuminate how therapists understand, use, and evaluate peer support within the clinical care of first responders with PTSD. The chapter was conceptually anchored in both Resilience Theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping

(Lazarus & Folkman, 1984), which guide the interpretation of how therapists appraise coping processes and resilience-building strategies in the context of trauma recovery.

Research Design and Rationale

Research Questions

I grounded the study in resilience theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping (Lazarus & Folkman, 1984). I was guided by two central research questions. I designed these questions to explore the experiences and interpretive frameworks of therapists who work with first responders exposed to severe trauma and who were involved in peer-supported interventions for PTSD. The first research question was “How do therapists perceive the psychological recovery of first responders following exposure to severe trauma, particularly in relation to peer support?” With this question, I aimed to understand how therapists conceptualize recovery processes, identify resilience factors, and observe the relational and psychological dynamics that emerge through peer-based interactions. The second research question was “How do therapists perceive peer support as a mechanism for mitigating PTSD symptom severity among first responders?” This question emphasizes therapists’ insights into the functional role of peer support within clinical treatment—whether as a supplementary, adjunctive, or integrated approach—and how it might influence symptom reduction, coping behaviors, or treatment engagement. I framed both questions to elicit rich, qualitative data on therapists’ clinical reasoning, treatment philosophies, and observations of therapeutic outcomes related to peer support interventions.

By centering on the expertise of mental health professionals, I aimed to bridge a critical gap in the literature. While a growing body of research affirms the utility of peer support in promoting resilience and emotional regulation in high-risk occupations (e.g., Auth et al., 2022; Crane et al., 2022; Tjin et al., 2022), the clinical perspectives of those who facilitate or supervise these interventions remain largely absent from empirical discourse (Dolezal, 2021; Modula et al., 2024). These research questions were therefore not only aligned with the theoretical foundation of my study, but also with its practical implications. Still, they were also intended to yield practical insights that inform trauma-informed care, peer intervention development, and the integration of mental health services for first responders.

Central Concepts and Phenomena

The central phenomenon investigated in the researchers study was the role of peer support in the psychological recovery and symptom mitigation of PTSD among first responders, as perceived by licensed therapists. Peer support, within this context, refers to a structured or informal psychosocial intervention that draws upon shared lived experiences to provide emotional validation, mutual understanding, and practical coping strategies (Auth et al., 2022; Tjin et al., 2022). It was increasingly regarded as both a relational and therapeutic resource, particularly in high-risk professions such as law enforcement, emergency medical services, and firefighting, where cultural norms often discourage emotional vulnerability and create barriers to formal mental health care (Papazoglou, 2023; Campos et al., 2023).

The concept of peer support in trauma recovery encompasses a range of formats, from informal conversations between colleagues to protocol-driven, clinically supervised debriefings and resilience programs (Crane et al., 2022; Donovan, 2022). As such, it functions not only as a means of emotional co-regulation but also as a potential facilitator of posttraumatic growth, adaptive coping, and help-seeking behavior (Pink et al., 2021; Ponder et al., 2024). In my study, I focused on how therapists define, conceptualize, and evaluate peer support interventions in their clinical work with trauma-exposed first responders.

Another foundational concept was resilience, which was defined as a dynamic process involving the capacity to adapt positively in the face of adversity, trauma, or significant stress (see Masten, 2001). Resilience was influenced by multiple protective factors—both internal, such as cognitive flexibility and emotional regulation, and external, such as organizational support and peer relationships (Pietrantonio & Prati, 2008; Werner & Smith, 1982). From a therapeutic standpoint, peer support might serve as a resilience-enhancing mechanism that helps individuals reinterpret trauma, sustain recovery, and mitigate long-term psychological consequences (Papazoglou, 2023; Ryu, 2024).

The final central concept was coping, conceptualized through the lens of the transactional model of stress and coping (Lazarus & Folkman, 1984), which emphasizes the cognitive appraisal of stressors and the use of either problem-focused or emotion-focused strategies to manage psychological strain. Peer support might engage both mechanisms—providing emotional relief through shared experience and promoting

problem-solving through collaborative narrative construction and access to resources (Modula et al., 2024; Oakes et al., 2024). Understanding how therapists perceive and apply these frameworks to integrate peer support into clinical treatment was central to advancing trauma-informed care and policy for first responders.

Research Tradition

I grounded the study in the phenomenological research tradition, a qualitative approach that allows me to understand and describe how individuals perceive and make meaning of a particular phenomenon (see Moustakas, 1994; van Manen, 2016).

Phenomenology originates from the philosophical work of Husserl, who posited that knowledge emerges from the careful examination of conscious experiences as lived from the first-person perspective. Husserl emphasized the importance of epoché, or the intentional suspension of preconceived beliefs, to allow phenomena to emerge in their purest form through participants' descriptions (Moustakas, 1994). In psychological research, phenomenology has evolved into a rigorous methodological approach aimed at uncovering the essence of experiences that were often deeply personal, complex, and situated within specific cultural or occupational contexts.

The phenomenological tradition was especially appropriate for my study, which explores therapists' perspectives on peer support in treating PTSD among first responders. As these therapists possess unique insights derived from both professional expertise and clinical engagement, a phenomenological lens enables the examination of their interpretive frameworks and decision-making processes in a manner that quantitative or observational methods cannot capture (Creswell & Poth, 2018).

Moustakas' (1994) psychological phenomenology provided a structured foundation for this inquiry, using techniques such as horizontalization, clustering of meaning units, and textural-structural synthesis to arrive at the essence of participants' experiences.

This tradition aligned well with the goals of my study, as I sought not only to document what therapists do in relation to peer support, but also to understand how they perceive its effectiveness, limitations, and integration within broader clinical practice. Through this approach, I aimed to illuminate the nuanced and often overlooked dimensions of trauma recovery work, particularly in high-risk populations such as first responders, where cultural norms, systemic challenges, and psychological distress intersect in complex ways (see Dolezal, 2021; Papazoglou, 2023). In this way, phenomenology offers a deeply contextualized and humanistic method for contributing to theory, practice, and policy in clinical psychology.

Rationale for the Chosen Research Tradition

Phenomenology was used as the guiding research tradition for the researchers study because it aligns with both the ontological and epistemological foundations of my purpose: to explore the lived experiences and meaning-making processes of therapists who integrate peer support into their clinical treatment of first responders with PTSD. Phenomenology is uniquely suited for inquiries that aim to access how individuals interpret and engage with phenomena situated within complex psychological, relational, and occupational contexts (Moustakas, 1994; van Manen, 2016). Unlike quantitative methodologies, which were often constrained by predefined variables and structured instruments, phenomenology allows for the emergence of rich, subjective insights that

were essential to understanding deeply embedded professional perspectives, such as those formed through repeated therapeutic engagement with trauma-exposed populations.

This approach was particularly appropriate given the growing recognition of peer support as a dynamic and multifaceted intervention that lacks a standardized definition across clinical and organizational settings (see Papazoglou, 2023; Tjin et al., 2022). Therapists' interpretations of peer support might vary widely based on their training, theoretical orientation, and clinical experiences—factors that cannot be meaningfully captured through survey instruments alone. A phenomenological approach enabled me to delve into these interpretive layers, exploring not only what therapists observe but also how they understand, apply, and evaluate peer support as part of a broader treatment strategy (see Dolezal, 2021; Modula et al., 2024). Furthermore, phenomenology aligns well with the theoretical frameworks that underpin my study: resilience theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping (Lazarus & Folkman, 1984). These models emphasize the interaction between internal psychological processes and external support systems—concepts that were best explored through methods capable of capturing experiential nuance and context-specific interpretation. By prioritizing the subjective perspectives of therapists, phenomenology facilitates a deeper understanding of how peer support functions as both a clinical tool and a relational intervention. This approach also supported my goal of contributing to trauma-informed best practices and policy development by grounding the findings in the realities of those most intimately involved in treatment delivery (see Creswell & Poth, 2018). In summary, the phenomenological tradition offers the methodological depth and

flexibility I need to explore the complex, interpretive nature of therapists' experiences with peer support, making it the most appropriate and rigorously aligned approach for my research questions.

Role of the Researcher

In qualitative research—particularly within the phenomenological tradition—the role of the researcher is not only central but also inherently intertwined with the interpretive process (Creswell & Poth, 2018). I served as the primary instrument of data collection and analysis, engaging in meaning making alongside participants (see Creswell & Poth, 2018; Moustakas, 1994). As such, I recognize that acknowledging my positionality and its potential influence on the study is essential to ensuring methodological rigor, transparency, and trustworthiness. My background includes professional experience in both law enforcement and clinical psychology, including direct work with trauma-exposed populations such as first responders. This dual perspective provided a valuable lens through which participant narratives were understood with empathy and contextual accuracy; however, it also necessitates careful reflection on potential biases that could shape data interpretation.

To manage these influences, I was engaged in a process of reflexivity throughout my study, employing strategies such as reflective journaling, bracketing (*epoché*), and peer debriefing. Reflexivity allowed me to critically examine how my personal experiences, assumptions, and values might have affected my interactions with participants and the thematic analysis process (Patton, 2015). Bracketing was a core element of phenomenological inquiry, involving the conscious setting aside of prior

knowledge and expectations to focus on the lived experiences as described by participants (Moustakas, 1994). Additionally, I was maintaining a neutral stance during semi-structured interviews to ensure that participant responses were not shaped or influenced by my cues or interpretations. Open-ended questioning techniques were used to encourage rich, participant-led narratives, aligning with best practices for qualitative credibility and data integrity (Lincoln & Guba, 1985).

To further enhance objectivity, credibility, and confirmability, I employed triangulation using analytic memos, coding validation checks, and external auditing of the thematic framework. These methods helped ensure that emergent themes were grounded in participants' accounts rather than my own expectations. I acknowledge my proximity to the field as a strength that facilitates rapport-building with participants and depth of inquiry. Still, I was counterbalancing this with systematic efforts to maintain methodological transparency and analytic discipline (see Berger, 2015). By addressing these elements comprehensively, I aimed to uphold the ethical and epistemological standards of qualitative inquiry, ensuring that my findings are both authentic and analytically sound.

Role of the Participant

In phenomenological research, participants were not merely sources of data but were considered coconstructors of knowledge whose lived experiences form the foundation of thematic understanding (Moustakas, 1994; van Manen, 2016). The role of each participant in the researchers study was to provide in-depth, first-person accounts of their clinical perceptions, decision-making processes, and therapeutic experiences related

to the integration of peer support within treatment for first responders with PTSD. Participants were positioned as experts in their field, whose interpretive insights illuminate how peer support was conceptualized, implemented, and evaluated in real-world mental health settings. Their narratives serve to reveal the nuanced ways in which clinical reasoning intersects with relational dynamics and organizational culture in trauma recovery.

Given that the purpose of the researchers study was to explore the perspectives of licensed therapists with direct experience treating first responders, each participant was engaged in a semi-structured interview designed to elicit reflective and descriptive responses. These interviews were not intended to test hypotheses but rather to uncover patterns of meaning across participants' experiences—an essential component of phenomenological analysis (Creswell & Poth, 2018). The structure of the interview allows for depth, flexibility, and participant-led elaboration, aligning with qualitative best practices that prioritize authentic expression over prescriptive questioning (Kvale & Brinkmann, 2015). Participants were asked to share their perceptions of the benefits and limitations of peer support, how they have incorporated or recommended such interventions in their clinical work, and how peer support fits or challenges established therapeutic models.

Furthermore, participants in the researchers study play a crucial role in expanding the literature by offering insight into an underexplored aspect of trauma-informed care: the clinician's evaluation of peer-led interventions. While most existing research focuses on the perspectives of first responders themselves (Papazoglou, 2023; Tjin et al., 2022),

therapists who facilitate or supervise such care have been rarely consulted in empirical studies (Dolezal, 2021; Modula et al., 2024). By actively participating in my research, clinicians contribute their professional expertise to an evidence base that may ultimately inform clinical practice, peer support training models, and organizational mental health policies. In this way, participants were essential collaborators in both the construction of meaning and the advancement of applied psychological knowledge.

Researcher-Participant Relationship

In qualitative research, particularly in phenomenological studies where depth of engagement with participants was critical, transparency regarding the nature of any pre-existing relationships was essential to uphold ethical integrity and mitigate power imbalances (Creswell & Poth, 2018; Patton, 2015). In the context of my study, I had no personal, professional, supervisory, or instructional relationships with any of the participants. All participants were independently recruited through professional networks, clinician forums, and mental health associations to ensure there were no conflicts of interest or dual-role concerns that could influence participant responses or data interpretation. This separation safeguards against any perceived or actual coercion, particularly in relation to roles that might carry evaluative authority, such as supervision or academic instruction.

Maintaining this ethical boundary was particularly important given the sensitive nature of the research topic, which involves therapists' reflections on their clinical decision-making, treatment philosophies, and potential critiques of organizational practices. To promote open and honest disclosure, the study design intentionally excludes

individuals with whom I have had previous or ongoing professional relationships. This ensures that participant autonomy, confidentiality, and psychological safety were protected throughout the research process (APA, 2022). In alignment with best practices in human subject research, informed consent procedures included a clear statement affirming the absence of any hierarchical or evaluative relationships between the participants and me, further supporting the voluntary nature of participation and the credibility of my study's findings (Lincoln & Guba, 1985).

Management of Researcher Biases and Power Dynamics

In qualitative research, particularly within the phenomenological tradition, I play a central role in coconstructing meaning with participants, which necessitates intentional strategies to identify and manage potential biases. While no hierarchical or supervisory relationships existed between the participants and me in my study, the potential for implicit bias remains, particularly given my professional background in both law enforcement and clinical psychology. This dual expertise enhances the contextual understanding of the research topic, but also introduces the risk of interpretive bias, wherein prior experiences or beliefs may inadvertently shape the framing of questions or the analysis of data (Berger, 2015; Patton, 2015). To address potential biases and power dynamics, several strategies were employed throughout the research process. These include bracketing (*epoché*), reflexive journaling, and maintaining an audit trail. A more thorough description of these techniques, including their application during data collection and analysis, was found in the corresponding sections below.

Methodology

Participant Selection Logic

The population for the researchers study consists of licensed mental health professionals who provide psychological services to trauma-exposed first responders. This includes psychologists, licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), and licensed marriage and family therapists (LMFTs) with clinical experience treating first responders—such as firefighters, paramedics, emergency medical technicians, and law enforcement officers—diagnosed with or exhibiting symptoms of PTSD. These clinicians were situated within diverse therapeutic environments, including private practice, public safety wellness programs, outpatient trauma centers, employee assistance programs (EAPs), and nonprofit organizations specializing in trauma-informed care. The targeted population reflects the central aim of my study: to explore how therapists perceive and evaluate the integration of peer support within the treatment framework for first responders navigating PTSD recovery.

This population was purposefully selected due to their unique professional vantage point and experiential proximity to the phenomenon under investigation. Therapists serving first responders were often positioned at the intersection of clinical care, occupational culture, and organizational mental health policy, granting them a multidimensional understanding of how peer support interventions were perceived, utilized, and adapted within therapeutic contexts (Dolezal, 2021; Papazoglou, 2023). Their insights were critical for filling a gap in the literature, which has historically

prioritized the voices of peer support recipients while largely overlooking the clinical perspectives of mental health providers (Auth et al., 2022; Modula et al., 2024).

Additionally, the inclusion of licensed clinicians ensures that participants have met rigorous educational, ethical, and experiential standards required for independent clinical practice, thereby strengthening the credibility and applicability of the data generated (APA, 2022). The population was bounded by relevance to my study's guiding frameworks—resilience theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping (Lazarus & Folkman, 1984)—as these professionals were presumed to assess and engage with peer support interventions through the lens of adaptive coping and trauma recovery. By focusing on this population, the researchers study could contribute to a more comprehensive understanding of the role of peer support within evidence-informed trauma treatment for first responders. If any participants were known to me professionally, they were excluded from the researchers study to further ensure ethical boundaries were maintained. Snowball sampling was also employed, wherein existing participants were invited to share the opportunity with qualified colleagues who met the inclusion criteria (see Creswell & Poth, 2018).

Sampling Strategy

I employed a purposive sampling strategy, which is widely recognized in qualitative research for its effectiveness in selecting participants who possess specific knowledge, experiences, or characteristics directly relevant to the research phenomenon (see Creswell & Poth, 2018; Patton, 2015). In phenomenological research, the goal is not statistical generalizability, but rather to achieve depth of understanding by selecting

information-rich cases that offer profound insights into the lived experiences of a particular group (Moustakas, 1994). Accordingly, I sought to recruit licensed mental health professionals with direct clinical experience treating first responders who have experienced occupational trauma and/or PTSD. This sampling strategy ensured alignment with the purpose of my study, which is to explore how therapists perceive, use, and evaluate peer support in the treatment process.

The justification for purposive sampling lies in the conceptual and theoretical focus of my study. Because peer support varies widely in structure, delivery, and clinical oversight, it was essential to gather perspectives from therapists who have engaged with this intervention in real-world therapeutic settings. These participants were uniquely qualified to articulate how peer support functions within or alongside formal trauma-focused treatments and how it was perceived through the lens of evidence-based practice, resilience enhancement, and adaptive coping (see Dolezal, 2021; Modula et al., 2024; Papazoglou, 2023). Their experiential knowledge offers insights that were both context-specific and theoretically grounded, enabling the researchers study to advance understanding of how peer support was evaluated within clinical frameworks informed by resilience theory (Masten, 2001) and the transactional model of stress and coping (Lazarus & Folkman, 1984).

Purposive sampling also supports the inclusion of a diverse array of clinical backgrounds, settings, and treatment modalities to ensure variation in perspective while maintaining relevance to the central phenomenon (Patton, 2015). This strategy allowed me to select participants who were not only demographically diverse but also

professionally varied, including those practicing in urban, rural, institutional, and private settings. Such diversity enhances the transferability of findings by providing a broad representation of therapist perspectives across multiple systems of care. In sum, purposive sampling was methodologically appropriate and theoretically justified for this phenomenological investigation, enabling the researcher to gather rich, nuanced data from those most intimately involved in the psychological care of trauma-exposed first responders.

Participant Selection Criteria

In alignment with a phenomenological qualitative design, a purposive criterion sampling strategy was employed to recruit participants who have direct experience with the phenomenon under investigation (see Creswell & Poth, 2018). Inclusion criteria specify that participants must be licensed mental health professionals – specifically licensed psychologists, LPCs, LCSWs, LMFTs, or master’s-level social workers – practicing in the United States and currently in good standing with their licensing boards. Eligible clinicians were required to have a minimum of 2 years of post-licensure clinical experience providing psychotherapy to first responders (e.g., firefighters, emergency medical service personnel, law enforcement officers) who had been exposed to trauma or diagnosed with PTSD, ensuring that all participants possess first-hand professional knowledge of the issues being studied.

Participants must be English speaking and could work in either public-sector or private-sector settings, allowing for a breadth of professional contexts while maintaining the focus on direct clinical experience with first responder populations. Exclusion criteria

eliminate individuals who are not currently licensed, have no direct clinical experience with first responders, or have any known/documented professional complaints or ethical violations on record. These carefully defined criteria ensure that the sample comprises information-rich and credible informants, thereby enhancing the methodological coherence and trustworthiness of the study by including only those with relevant lived professional experience. This approach upholds ethical rigor by involving only practitioners who adhere to professional standards of practice (see APA, 2022; Creswell & Poth, 2018).

To ensure that participants meet the established inclusion criteria authentically, a systematic screening and verification process was used during recruitment. Interested individuals were first required to complete a prescreening questionnaire posted on the recruitment flyer (see Appendix A), designed to elicit essential information such as licensure type and status, geographic location, years of post-licensure clinical experience, and the scope of their work with trauma-exposed first responder populations. This instrument served as an initial eligibility filter, helping to confirm participants' alignment with the purposive sampling framework (see Patton, 2015).

To enhance credibility and transparency, licensure verification was conducted through state professional licensing boards, where feasible. These publicly accessible databases allowed me to confirm active licensure and check for any history of disciplinary action, thereby addressing exclusionary criteria related to ethical standing. This practice aligns with ethical research standards that call for the inclusion of qualified, professionally responsible individuals (APA, 2022). Furthermore, during the informed

consent process, participants were reminded of the eligibility requirements and prompted to disclose any information that might affect their qualification status, such as changes in licensure, disciplinary actions, or lack of clinical experience with first responders.

These layered safeguards—screening questionnaires, license verification, and consent confirmation—reflect a commitment to methodological transparency and ethical rigor. By carefully vetting participant eligibility, I ensured the credibility, relevance, and trustworthiness of the data collected, thus supporting the broader aims of phenomenological inquiry and adhering to the qualitative standards of dependability and confirmability (see Creswell & Poth, 2018; Lincoln & Guba, 1985).

Sample Size Justification

The proposed sample size for my phenomenological study ranged from five to 10 participants, with an upper limit of 15, should additional perspectives be needed to reach data saturation. This range was methodologically consistent with qualitative research best practices, where the objective was to achieve depth and richness of data rather than statistical generalizability (Creswell & Poth, 2018). In phenomenological inquiry, the goal was to reach data saturation, a point at which no new themes or insights emerge from additional interviews (Mason, 2010). Recent empirical studies provide updated guidance on sample sizes required to achieve data saturation in qualitative research. For instance, a systematic review analyzed multiple qualitative studies and found that saturation was typically reached within nine to 17 interviews or four to eight focus group discussions. This suggests that relatively small sample sizes were sufficient to achieve

saturation, particularly when participants were purposively selected for their specialized knowledge and relevance to the research phenomenon.

A sample of eight licensed clinicians provided sufficient variability to explore differences in setting, discipline, and treatment orientation, while still allowing for detailed thematic analysis and the development of meaningful, experience-based insights. This range also allows me to engage in intensive, iterative data analysis consistent with phenomenological methods, including horizontalization, clustering of meaning units, and the synthesis of textural and structural descriptions (see Moustakas, 1994). Moreover, this sample size was appropriate for ensuring analytic rigor while also accommodating the practical and ethical considerations of working with busy professionals in high-demand clinical roles. Saturation was achieved earlier with eight participants, and data collection concluded before reaching the maximum threshold.

Participant Recruitment Procedures

Participants were identified, contacted, and recruited through a combination of strategic outreach methods designed to access a diverse pool of qualified clinicians with direct experience treating first responders. First, recruitment notices and flyers (see Appendices A) were distributed through professional clinical networks and listservs, including the APA and the National Association of Social Workers (NASW). Access to post in these forums required active membership, compliance with organizational guidelines, and administrative approval or IRB documentation confirming ethical research practices. These platforms offer targeted access to credentialed professionals who are actively engaged in trauma-focused practice (APA, 2022).

Table 1*Summary of Intended Recruitment Platforms*

Organization / Platform	Method of distribution	Notes
American Psychological Association (APA)	Email / Listserv Post	Requires membership and IRB approval.
National Association of Social Workers (NASW)	Email / Listserv Post	Requires compliance with ethical posting guidelines.
Colorado Psychological Association (CPA)	Email / Post via Member Network	Membership required; access confirmed via CPA liaison.
National Register of Health Service Psychologists	Email / Post	May require confirmation of ethical oversight.
Walden University Research Participant Pool	Internal Email / Portal Post	Limited to Walden-affiliated professionals and faculty. Interested candidates will undergo eligibility screening before participation.

Second, outreach was conducted via professional social media platforms, such as LinkedIn and Facebook groups, and targeted emails to networks within trauma and emergency mental health communities.

Table 2*Summary of Social Media and Direct Outreach Platforms*

Platform/Network	Method of outreach	Notes
LinkedIn	Professional posts & messages	Posts in trauma-focused and clinician groups
Facebook groups (mental health/trauma)	Targeted group posts	Must follow group rules; posts subject to admin approval
Email – trauma psychology network	Direct email outreach	Based on pre-existing professional contacts

Email – emergency mental health listservs	Direct email outreach	Requires access or invitation to listserv community
---	-----------------------	---

Recruitment efforts initially conducted through social media and direct outreach did not yield the minimum number of eligible participants (anticipated to be five to 10 to achieve saturation). Therefore, outreach was expanded to include professional listservs, trauma-informed care forums, and clinician networks across the United States, where licensed mental health professionals regularly engage in peer consultation, continuing education, and clinical networking. These additional recruitment methods successfully resulted in participant saturation.

In accordance with Walden University’s research ethics policies, all posts clearly stated my study’s purpose, affirmed the voluntary nature of participation, and provided the researcher’s contact information (see Walden University, n.d.). Only IRB-approved content was posted in groups or forums where such recruitment was permitted. A social media post of the flyer, consistent with IRB recruitment guidelines, was provided in Appendix A. Posts were made in relevant forums such as clinician communities focused on trauma recovery, first responder mental health, and peer support implementation.

Third, email invitations were sent directly to trauma-focused clinicians identified through public directories and professional organization databases, provided their contact information was publicly accessible, and use was permitted under IRB guidelines. These email invitations adhered to ethical recruitment practices outlined by Walden University’s IRB and included details about my study, confidentiality protections, and voluntary participation. An email invitation of the flyer was provided in Appendix A.

Access to survey responses was restricted to me as the primary researcher, and I did not collect IP addresses to protect participant confidentiality further. Participation was entirely voluntary. Upon reading the flyer, individuals also received my direct contact information and chose to reach out via email with questions. I personally followed up with each eligible participant via email to review the study in greater detail, verify their eligibility, and address any questions related to informed consent prior to scheduling the interview.

This multi-channel approach ensured wide visibility among potential participants while maintaining ethical boundaries, transparency, and voluntary participation. By integrating digital platforms, professional associations, and peer networks, the recruitment strategy supported methodological rigor and maximized the likelihood of securing a well-qualified and diverse sample of clinicians with meaningful insight into the role of peer support in first responder trauma recovery (Creswell & Poth, 2018).

Relationship Between Saturation and Sample Size

In phenomenological qualitative research, the concept of data saturation serves as a foundational determinant for determining the sufficiency of sample size. Saturation refers to the point at which no new themes, categories, or insights emerge from additional data collection, indicating that the phenomenon under investigation has been adequately explored and represented (Saunders et al., 2018). Rather than adhering to a predetermined numerical threshold, saturation was achieved through an iterative and reflexive analytic process where each participant's contribution was examined for thematic redundancy and novelty (Creswell & Poth, 2018).

Recent studies provide updated empirical benchmarks for saturation. They found that saturation in individual interview-based qualitative studies is usually reached within nine to 17 interviews, depending on the complexity of the topic, participant homogeneity, and the interviewer's skill. This supports the rationale for the proposed range of five to 10 participants in this study, which focuses on a professionally homogeneous group—licensed mental health clinicians with experience treating first responders—discussing a shared conceptual framework (peer support and PTSD recovery).

When participants were purposefully selected for their direct relevance to the phenomenon, thematic saturation was often attained with fewer cases, particularly when data collection and analysis were conducted in parallel (Chen et al., 2020). This methodologically flexible approach allows me to terminate data collection once meaningful repetition and convergence are observed. The saturation-driven sampling logic not only supports analytic rigor but also safeguards against unnecessary participant burden and resource inefficiency.

Instrumentation

Data Collection Instruments

The primary data collection instrument for the researchers study was a researcher-produced semi-structured interview protocol consisting of open-ended questions designed to elicit participants' lived experiences, perceptions, and clinical insights regarding the role of peer support in first responder PTSD recovery (see Appendix D). The interview guide was constructed in alignment with my study's conceptual and theoretical framework (Lazarus & Folkman, 1984; Masten, 2001) and was reviewed by content

experts for clarity and alignment with phenomenological inquiry (see Appendix D) (Creswell & Poth, 2018). The interview guide was constructed in alignment with my study's conceptual and theoretical framework (Lazarus & Folkman, 1984; Masten, 2001) and was reviewed by content experts for clarity and alignment with phenomenological inquiry (Creswell & Poth, 2018). I solicited feedback from two doctoral-level clinicians with expertise in trauma-focused treatment and qualitative research design. These reviewers evaluated the interview questions for relevance, clarity, and appropriateness in eliciting rich, experiential data. Their suggestions were incorporated into a revised version of the protocol prior to implementation. Semi-structured interviews offer both consistency and flexibility: while all participants were asked a core set of questions to ensure thematic alignment across interviews, the format allowed for the exploration of emergent ideas, elaborations, and clarifications based on participant responses (Moustakas, 1994).

The protocol was structured around key domains such as participants' clinical observations of the interview protocol was structured around the four primary areas of inquiry outlined in Chapter 1: (a) therapists' perceptions of the effectiveness of peer support in addressing PTSD symptoms in first responders, (b) mechanisms through which peer support might facilitate resilience and posttraumatic growth, (c) how peer support integrates with existing clinical treatment models, and (d) the perceived limitations, risks, and contextual challenges of peer-based programs from a professional mental health perspective.

This approach ensures that rich, descriptive data were collected while respecting the phenomenological emphasis on individual meaning-making and subjective experience. Interviews were conducted via Zoom, depending on the participant's availability and geographical location. All interviews were audio-recorded and transcribed to ensure data accuracy and facilitate thorough analysis. Recordings were stored on encrypted, password-protected devices accessible only to me, in accordance with Walden University's research ethics and data protection requirements (Walden University, n.d.), as well as applicable data privacy laws such as the Family Educational Rights and Privacy Act (FERPA). Participants were informed of these protections during the consent process. All audio files and transcripts will be retained for five years following the completion of my study, after which they will be permanently deleted.

Transcripts served as the primary textual data for analysis, and analytic memos were also used to document researcher reflections and analytic decisions during the coding process. While no additional data sources, such as archival materials, artifacts, or observations, were collected in my study, the use of recorded and transcribed semi-structured interviews aligns with phenomenological methodology's emphasis on deep, first-person narrative accounts. The combined use of an interview guide, audio-recordings, and verbatim transcripts constitutes a robust and transparent data collection protocol, designed to support methodological consistency, data credibility, and analytic depth (Creswell & Poth, 2018; Lincoln & Guba, 1985).

Data Analysis Method

Thematic analysis, as described by Braun and Clarke (2006), was applied to identify, analyze, and report patterns (themes) within the qualitative dataset. This method aligns well with the goals of phenomenological research by enabling rich interpretation of how therapists understand and apply peer support in trauma recovery. It also allows flexibility in managing large textual data and offers a systematic framework for uncovering both latent and semantic meaning within participant narratives. Through iterative coding and theme development, I generated insights that reflect both shared and divergent experiences among participants. This analytic approach enhances the credibility and interpretive depth of the findings, supporting a comprehensive understanding of therapists' perspectives in this context.

Sufficiency of Data Collection Instruments

The sufficiency of the data collection instruments in the researchers study was grounded in their methodological alignment with the purpose and research questions. The researcher-produced semi-structured interview protocol was explicitly designed to generate rich, in-depth narratives regarding therapists' perspectives on peer support and its role in PTSD symptom mitigation and psychological recovery in first responders. The open-ended format enables participants to articulate their clinical observations, professional judgments, and nuanced interpretations—insights that were central to a phenomenological inquiry (Creswell & Poth, 2018; Moustakas, 1994).

This instrument supports comprehensive data collection by ensuring consistency across interviews while also providing the flexibility needed to probe emergent insights.

The core domains embedded in the interview guide reflect the research questions and theoretical foundations—Resilience Theory and the Transactional Model of Stress and Coping—which enhance content validity (Lazarus & Folkman, 1984; Masten, 2001). Because the phenomena under investigation involve subjective appraisals of therapeutic interventions and their integration into clinical practice, semi-structured interviews were an ideal means of exploring participants’ lived experiences and cognitive frameworks.

The interview protocol was further strengthened through the use of audio recording and verbatim transcription, both of which preserve data fidelity and facilitate robust qualitative analysis. To ensure the analytic process was rigorous, NVivo 15 software was employed to organize, code, and retrieve data during the thematic analysis phase. NVivo’s 15 capacity for handling complex, unstructured data enhances traceability and transparency in theme development, supporting the confirmability and dependability criteria of trustworthiness in qualitative research (Lincoln & Guba, 1985; Miles et al., 2020).

Taken together, the combination of a validated interview protocol, systematic data management tools, and a rigorous analytic strategy ensures that the data collection instruments were sufficient to address my study’s research aims. The design enables a nuanced exploration of therapists’ insights while adhering to the methodological standards of phenomenological research.

Basis for Instrument Development

The researcher-developed semi-structured interview protocol that was used and constructed through a synthesis of relevant literature, theoretical frameworks, and prior

empirical studies (see Appendix D). I grounded the development of the interview guide in two core theoretical models: Resilience Theory (Masten, 2001; Werner & Smith, 1982) and the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984). These frameworks informed the design of open-ended questions targeting clinicians' perspectives on stress appraisal, coping strategies, and resilience-building interventions among trauma-exposed first responders. Additional conceptual support was drawn from Braun and Clarke's (2006) thematic analysis approach and Moustakas's (1994) principles for phenomenological inquiry, which emphasize the importance of capturing subjective lived experiences through qualitative interviews.

I incorporated insights from contemporary literature on peer support interventions in clinical contexts (Auth et al., 2022; Ponder et al., 2024; Tjin et al., 2022), the psychological impact of trauma on emergency professionals (Pietrzak et al., 2010), and the role of therapists in trauma-informed care (Papazoglou, 2023). To ensure clarity, alignment with my study's purpose, and content validity, I followed best practices from qualitative research methodology (Creswell & Poth, 2018). I engaged two doctoral-level experts in trauma psychology and qualitative research to review the protocol for clarity, relevance, and comprehensiveness. Their feedback was used to revise and finalize the interview guide before initiating data collection.

Semi-structured interviews provided both consistency and flexibility: while I asked all participants a core set of questions to ensure thematic alignment across interviews, I was also free to explore emergent ideas and elaborations based on participant responses (Moustakas, 1994). The protocol was structured around key

domains, including participants' clinical observations of peer support, perceived benefits and limitations of peer interventions, and the integration of peer support into therapeutic settings. This approach enabled the collection of rich, descriptive data, respecting the phenomenological emphasis on individual meaning-making and lived experience.

I conducted the interviews via Zoom. All interviews were audio recorded and transcribed verbatim to ensure data accuracy and enable rigorous analysis. I stored recordings on encrypted, password-protected devices in accordance with Walden University's research ethics and data protection policies (Walden University, n.d.), as well as data privacy laws such as FERPA. Participants were informed of these protections during the consent process. Transcripts served as the primary data source for analysis, and I maintained analytic memos to document personal reflections and analytic decisions throughout the coding process.

While I did not collect additional data sources such as archival materials, artifacts, or observations, the use of recorded and transcribed semi-structured interviews was aligned with the phenomenological tradition's emphasis on first-person narrative accounts. The combined use of a structured interview guide, audio recordings, and transcripts supported methodological rigor, data credibility, and analytic depth (Creswell & Poth, 2018; Lincoln & Guba, 1985).

Basis for Instrument Development: Establishment of Content Validity

To ensure the content validity of the researcher-developed interview protocol (see Appendix D), a multi-phase process was employed prior to data collection. I began with an extensive review of literature addressing peer support, PTSD recovery, and trauma-

informed clinical practice among first responders (Papazoglou, 2023; Tjin et al., 2022). Based on this empirical foundation, I structured the protocol to reflect constructs relevant to the research questions, including perceptions of peer support efficacy, barriers to clinical integration, and decision-making surrounding resilience-based interventions (Creswell & Poth, 2018).

I grounded the development of the interview guide in two theoretical frameworks: Resilience Theory (Masten, 2001; Werner & Smith, 1982) and the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984). These models informed the construction of open-ended questions to capture clinicians' perspectives on stress appraisal, coping mechanisms, and trauma recovery. I also integrated concepts from Braun and Clarke's (2006) thematic analysis approach and Moustakas's (1994) principles of phenomenological inquiry to emphasize rich, lived experiences through qualitative interviews.

To ensure clarity and methodological alignment, I consulted two doctoral-level experts in trauma psychology and qualitative methodology. These experts reviewed the draft protocol and provided feedback on its clarity, relevance, and theoretical alignment. I used their input to revise and finalize the interview guide prior to launching my study. This expert validation step followed best practices in qualitative research for enhancing content validity through peer review (Creswell & Poth, 2018; Patton, 2015).

I structured the semi-structured interview protocol around key domains, such as clinicians' observations of peer support practices, their perceptions of peer intervention outcomes, and the integration of peer support into therapy. This approach ensured

consistency across interviews while allowing flexibility to explore participants' unique experiences and elaborations (Moustakas, 1994; Campos et al., 2022).

Establishing Instrument Sufficiency to Answer Research Questions

Establishing the sufficiency of data collection instruments was a critical component of ensuring the methodological rigor and credibility of qualitative research. In my study, the researcher-developed semi-structured interview protocol was intentionally aligned with the two central research questions to ensure the depth and breadth of responses necessary for phenomenological analysis. The protocol includes open-ended questions designed to explore therapists' experiences with peer support implementation, their evaluation of its effectiveness, and how such programs intersect with formal clinical treatment models. This design ensures that each research question was directly addressed through comprehensive participant narratives (Creswell & Poth, 2018).

The sufficiency of the instrument was further ensured through adherence to phenomenological traditions that emphasize the importance of first-person accounts and lived experiences (Moustakas, 1994). The interview questions were organized to reflect theoretical domains stemming from Resilience Theory (Masten, 2001) and the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), which guide the thematic structure of the protocol. This theoretical alignment ensures that the questions were not only relevant but also conceptually robust, facilitating rich and detailed data collection consistent with my study's epistemological stance.

Additionally, content experts reviewed the interview protocol prior to its use, offering feedback on its capacity to elicit responses relevant to each research question

and ensuring it captures the complexity of therapist-client interactions within trauma recovery contexts (Patton, 2015). These expert reviews helped establish content and construct validity and reduce the potential for instrument bias or omission.

Procedures for Data Collection and Replicability

Primary data for the researchers study was collected through semi-structured interviews conducted via Zoom or in person, depending on each participant's preference and availability. The data was collected from licensed mental health professionals who have direct clinical experience with first responders and familiarity with peer support interventions. Participants were identified and recruited through professional social media platforms, such as LinkedIn and Facebook groups, as well as targeted emails to networks within trauma and emergency mental health communities. I also distributed recruitment materials through professional organizations, including the American Psychological Association (APA), the National Association of Social Workers (NASW), and regional psychological associations, in accordance with their posting guidelines and with IRB approval. Once participants express interest, I will provide an electronic informed consent form and a brief eligibility screening questionnaire. Each participant was to participate in a one-time interview, scheduled at their convenience. The recruitment phase was expected to last between 30 and 60 days, allowing sufficient time for initial outreach, participant screening, and scheduling of interviews. Interviews were approximately 30 to 60 minutes long and were conducted one-on-one. I coordinated the scheduling of all interviews via email and maintained detailed records of participant

confirmations and session logistics. Interviews were audio-recorded using a secure, IRB-approved digital recorder.

All recordings were transcribed verbatim. These transcripts served as the primary data source, supported by field notes and analytic memos that I completed during and immediately following each session. All digital files were encrypted and stored on a password-protected device, with backup copies saved in secure cloud storage accessible only to me. Participants were identified and recruited through a combination of professional clinical platforms and organizational channels, including LinkedIn, Facebook groups, and targeted emails to networks within trauma and emergency mental health communities. I also distributed recruitment materials through professional organizations, including the American Psychological Association (APA), the National Association of Social Workers (NASW), and regional psychological associations, in accordance with their posting guidelines and with IRB approval. If initial recruitment efforts through social media and direct outreach did not yield the minimum number of eligible participants (anticipated to be five–10 to achieve saturation), I would expand outreach to include professional listservs, trauma-informed care forums, and clinician networks across the U.S. Additional IRB approval was sought if new recruitment venues were added. This process—identifying participants through professional networks, confirming eligibility through a screening form, obtaining informed consent electronically, and collecting data via audio-recorded, semi-structured interviews—ensures methodological transparency and replicability. Another researcher seeking to replicate the researchers study could follow a similar recruitment strategy, use a protocol

constructed in a manner aligned with my study's research questions and theoretical framework, and apply the same thematic analysis procedures outlined in the next section.

Participant Exit Procedures

At the conclusion of each interview, I engaged participants in a brief verbal debriefing process to ensure that they had the opportunity to reflect on their participation and ask any final questions. During this debriefing, I thanked participants for their time. I reiterated key points from the consent process, including their right to withdraw their data at any point prior to the final analysis. This closure helps to affirm participants' autonomy and reinforces ethical transparency (Creswell & Poth, 2018). Participants were also informed that they might request a summary of the research findings upon completion of my study. This offer serves both as a professional courtesy and as a method of participant engagement, aligning with ethical standards that encourage reciprocal communication between researchers and participants (Patton, 2015). I will provide this summary electronically once my study's results have been compiled and reviewed.

All participants were reminded that their identities would remain confidential, and that all data would be anonymized during the transcription process and in any subsequent reporting of the findings. There were no anticipated adverse consequences from participation, but if any emotional discomfort was noted during or after the interview, participants were encouraged to utilize their existing support systems or professional resources, and a referral list for mental health support was made available upon request (see Appendix C). This structured exit procedure ensures that participants leave the

researchers study with a clear understanding of their contributions and a full awareness of their rights and options, thereby supporting both ethical rigor and participant well-being (Lincoln & Guba, 1985).

Follow-Up Procedures

My study does not include plans for follow-up interviews as part of the core research design. Each participant was involved in a single, one-on-one, semi-structured interview lasting between 30 and 60 minutes. The aim was to collect rich, detailed data in a single session, consistent with phenomenological research methodology, which prioritizes depth of lived experience over repeated contact (Moustakas, 1994; Campos et al., 2022).

However, if clarification of interview content becomes necessary during data analysis—such as in cases of inaudible recordings, ambiguous statements, or the need for elaboration—I might contact participants via email to request brief clarifications, which might last 15 to 30 minutes. This approach was limited to resolving interpretive uncertainties rather than conducting comprehensive follow-up interviews, and it was communicated to participants during the consent process. This approach was limited to resolving interpretive uncertainties rather than conducting full follow-up interviews and was communicated to participants during the consent process.

Maintaining ethical and methodological transparency, I clearly documented any post-interview communications. I ensured that they did not alter my study's focus or introduce new lines of inquiry beyond the scope of the approved research protocol. This

limited, clarification-only follow-up supports analytic rigor without compromising the participants' time or autonomy (Creswell & Poth, 2018).

Data Analysis Plan

In my study, the data analysis plan was designed to ensure alignment between the collected data and each research question, utilizing rigorous procedures for coding, appropriate analytical software, and transparent treatment of discrepant cases. This section outlined the strategies applied for qualitative data, which constitute the core of this phenomenological investigation.

Connection of Data to Research Questions

Each qualitative interview transcript was analyzed in direct relation to the central research questions: How do therapists perceive the psychological recovery of first responders following exposure to severe trauma, particularly in relation to peer support? How do therapists perceive peer support as a mechanism for mitigating PTSD symptom severity among first responders? Supporting sub-questions guide the identification of recurring themes, such as the perceived effectiveness of peer support, key mechanisms of support, and contextual variables influencing recovery. Thematic patterns were examined in light of these research questions to ensure conceptual alignment and interpretive validity.

Type of and Procedure for Coding

Thematic analysis was conducted following Braun and Clarke's (2006) six-phase framework: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. An inductive

coding approach was used, allowing themes to emerge organically from the data.

Transcripts were read multiple times, and coding occurred iteratively using open coding methods. To enhance reliability, a second coder independently coded a subset of transcripts, and inter-rater reliability (IRR) was calculated using Cohen's κ (Cohen's Kappa; Cohen, 1960). Discrepancies in coding were discussed and reconciled through consensus.

Software Used for Analysis

NVivo 15, a Computer-Assisted Qualitative Data Analysis Software (CAQDAS), was used for data management and analysis. NVivo 15 facilitates the systematic organization, coding, and retrieval of large volumes of qualitative data. The software assisted in identifying themes, co-occurrence of codes, and pattern mapping, thereby strengthening analytical rigor and transparency.

Manner of Treatment of Discrepant Cases

Discrepant cases—data segments that do not align with emerging themes—will be deliberately examined to refine theoretical constructs and enhance the trustworthiness of findings. These outlier perspectives were critically explored to assess whether they represent unique variations or potential contradictions requiring modification of existing categories or the development of new ones. This form of deviant case analysis adds depth and credibility to the interpretive framework (Creswell & Poth, 2018; Patton, 2015).

By clearly connecting data to research questions, employing a rigorous thematic coding process, leveraging robust software tools, and transparently handling discrepant cases,

this data analysis plan supports a credible, replicable, and methodologically sound qualitative inquiry.

Issues of Trustworthiness

Credibility (Internal Validity)

To ensure the credibility—or internal validity—of this qualitative study, I implemented multiple strategies aligned with established best practices in phenomenological research. These strategies included triangulation, reflexivity, and ensuring data saturation. Together, these approaches were intended to enhance the trustworthiness of the findings by ensuring they authentically represent participants' perspectives.

Peer Debriefing

I was engaged in peer debriefing with colleagues who possess expertise in trauma-informed care and qualitative research but who were not directly involved in my study, in accordance with recommendations for enhancing credibility in qualitative research (Creswell & Poth, 2018). Peer debriefing occurred at multiple strategic points during the data collection and analysis process. Specifically, I initiated debriefing sessions after the completion of the first two interviews to obtain early feedback on the interview approach and emerging themes. Additional sessions were conducted after five interviews to reflect on analytic processes, explore alternative interpretations, and evaluate for potential researcher bias. This iterative process supported methodological transparency and helped ensure that thematic development remains grounded in

participant experiences (Lincoln & Guba, 1985). All feedback was documented and used to refine coding strategies and ensure consistency in data interpretation.

Triangulation

Methodological triangulation supports a more comprehensive and coherent understanding of the phenomena under investigation. To further enhance credibility, triangulation was used through the integration of multiple sources of data. These included interview transcripts, reflective field notes, and the reflexive journal maintained throughout my study.

Reflexivity

Throughout the research process, I maintained a reflexive journal to critically examine and document my positionality, assumptions, and potential biases. Reflexivity was essential in phenomenological research, particularly when the researcher has professional experience related to the study topic, as it promotes self-awareness and analytic transparency (Berger, 2015). Given my professional background as a retired law enforcement officer, I recognize that my lived experience might influence the way I engage with participants and interpret data related to first responders and trauma recovery. While this background provided meaningful context and insight into the occupational stressors, cultural dynamics, and support mechanisms within first responder communities, it also presents a potential source of bias. To uphold the integrity of my study, I was engaged in ongoing reflexivity to critically examine how my positionality shapes the research process.

Throughout data collection and analysis, I was maintaining a detailed reflexive journal to document my thoughts, assumptions, emotional reactions, and evolving interpretations. This journal served as a tool to identify and bracket preconceptions that could inadvertently color the analysis. For example, if I find myself identifying too closely with participant experiences or privileging certain narratives, I note these instances and revisit them during data interpretation to ensure that the themes remain grounded in participants' own words and perspectives.

Reflexivity also supported analytic triangulation. Journal entries were reviewed in parallel with coded transcripts and thematic summaries to cross-check interpretations and illuminate any researcher influence. Additionally, peer debriefing sessions with colleagues experienced in trauma-informed care and qualitative research—but not directly involved in my study—will provide an external perspective to challenge assumptions and strengthen interpretive validity. This layered approach to reflexivity was essential to preserving transparency and enhancing the trustworthiness of findings in phenomenological inquiry (Berger, 2015).

In conjunction with the audit trail, I used a reflexivity journal to record personal reflections, potential biases, and evolving thoughts throughout the data collection and analysis process. This practice promotes methodological integrity and helps mitigate the influence of the researcher's subjectivity on the findings (Berger, 2015). By employing these strategies, I aim to ensure a transparent and consistent research process that enhances the dependability of my study.

Saturation

Interviews were continued until thematic saturation was reached—that is, when no new patterns, themes, or insights emerged from the data. While the exact number of participants cannot be predetermined, it was anticipated that saturation would occur within five to 10 interviews, based on prior research involving similarly focused phenomenological inquiries (Creswell & Poth, 2018). Ensuring saturation was critical in qualitative research to support the comprehensiveness and credibility of the findings. By incorporating these credibility-enhancing strategies, I aim to produce findings that were methodologically sound, transparent, and reflective of the therapists' authentic perspectives on peer support and PTSD recovery in first responders.

Transferability (External Validity)

Transferability, or external validity, in qualitative research refers to the degree to which the findings can be applied or transferred to other contexts or populations (Lincoln & Guba, 1985). To support transferability, I implemented strategies such as thick description and variation in participant selection (Lincoln & Guba, 1985). These methods aim to provide readers with sufficient contextual detail to evaluate whether my study's findings might be relevant to their own settings.

Thick Description

Thick description enables readers to determine the extent to which the findings might be applicable to their own circumstances. I was employing thick, rich descriptions to contextualize the setting, participants, and emergent themes from my study. This

includes providing detailed accounts of participant demographics, clinical settings, and relevant experiences with first responder populations.

Variation in Participant Selection

To further enhance transferability, I sought a diverse range of therapists in terms of professional background, years of clinical experience, and the types of clients they treat as first responders. Purposefully sampling participants with varied perspectives was intended to support the identification of common themes across diverse contexts and strengthen the potential applicability of the findings (Malterud et al., 2016). By incorporating thick description and deliberately selecting a varied sample, I aim to ensure that readers are provided with sufficient detail to assess the potential relevance and applicability of the findings beyond the original study sample.

Dependability (Qualitative Counterpart to Reliability)

Dependability in qualitative research parallels reliability in quantitative inquiry, referring to the consistency and repeatability of the research process and findings (Lincoln & Guba, 1985). To ensure dependability, I employed strategies such as maintaining a detailed audit trail and engaging in ongoing reflexivity through journaling.

Audit Trail

I was maintaining a comprehensive audit trail that documents all stages of the research process, including decision-making rationales, methodological changes, data coding procedures, and theme development. This transparent record allowed other researchers to follow the progression of my study, thereby supporting its dependability and reproducibility. A parallel audit trail was maintained to capture methodological

decisions, analytic steps, and rationale for theme construction. This documentation provides an external path of verification, allowing others to trace the origins and development of findings from raw data through final interpretations. Together, reflexivity and audit documentation worked in tandem to promote objectivity and methodological transparency, supporting the confirmability of my study.

Confirmability (Qualitative Counterpart to Objectivity)

Confirmability in qualitative research refers to the degree to which the findings were shaped by the participants and not unduly influenced by researcher bias or personal motivation (Lincoln & Guba, 1985). To support confirmability, I implemented reflexive practices and maintained an audit trail that documents all analytic decisions throughout the research process. Reflexivity was integrated into all phases of the researchers study through continuous self-examination and documentation in a reflexivity journal. This journal served as a space to acknowledge personal assumptions, positionality, and evolving interpretations, thereby maintaining transparency in the analytic process (Berger, 2015). Regular engagement in reflexivity fosters a heightened awareness of how my background and experiences might influence data collection, interpretation, and theme development. Together, reflexivity and audit documentation worked in tandem to promote objectivity and methodological transparency, supporting the confirmability of my study. Ultimately, these combined strategies helped ensure that the research process remains grounded in participant narratives, and that the resulting interpretations were both credible and verifiable, reinforcing the integrity and trustworthiness of my study.

Ethical Procedures

Agreements to Gain Access to Participants or Data

In accordance with Walden University's research ethics policies, all necessary agreements to gain access to participants and data were obtained and submitted as part of the Institutional Review Board (IRB) application. Because the researchers study involves licensed mental health professionals as participants rather than clients or clinical records, formal agreements were not required from outside organizations to access protected health information (PHI). However, permission to post recruitment flyers on professional platforms (e.g., LinkedIn, Facebook therapist groups, and closed consultation networks) was documented through written communication (e.g., emails or platform-specific permissions).

Additionally, as required by Walden University, I was to upload signed copies of any relevant agreements—including email permissions or recruitment site approvals—into the IRB submission system. All documents clearly identified the purpose of access and the voluntary nature of participation, in accordance with APA ethical guidelines and institutional policy (American Psychological Association, 2022; Walden University Center for Research Quality, n.d.).

When applicable, professional group administrators were provided confirmation of their consent to share study information with potential participants. These agreements were retained with the IRB materials to ensure research transparency and compliance with ethical standards.

Treatment of Human Participants

My study complied fully with Walden University Institutional Review Board (IRB) requirements to ensure the ethical treatment of human participants. Prior to data collection, IRB approval was obtained from Walden University, and any necessary institutional permissions were submitted alongside the IRB application. All relevant documentation, including recruitment materials, consent forms, and site permissions, was reviewed and approved by the IRB prior to implementation (Walden University Center for Research Quality, n.d.).

Ethical Considerations in Recruitment

Recruitment was conducted through professional platforms and therapist-specific networks. To minimize coercion and ensure voluntariness, recruitment language emphasized that participation was entirely optional, with no consequences for declining. Individuals self-identified their interest and contacted the researcher directly, thereby limiting the influence of any hierarchical or power relationships.

Informed Consent Process

Participants received an IRB-approved informed consent form via email prior to their scheduled interview. The form described my study's purpose, procedures, potential risks and benefits, the voluntary nature of participation, and confidentiality protections. Participants were asked to review the form carefully and reply to the email with the words "I consent" if they agreed to participate. This email reply served as written documentation of informed consent, in accordance with Walden University IRB approval and ethical research standards. All consent emails were stored in a password-protected,

encrypted cloud storage system accessible only to me. All signed consent forms were securely stored in a password-protected, encrypted cloud-based storage system accessible only by me. These documents will be retained for a period of five years following the completion of my study, after which they will be permanently deleted.

Ethical Considerations During Data Collection

To protect participant confidentiality, no identifying information was recorded in the transcripts or published findings. Participants were assigned pseudonyms or selected one, and all files were stored on encrypted, password-protected devices. No institutional affiliations or client information were disclosed. The researchers study involves licensed therapists and does not include discussion of specific clients to prevent any breach of therapist-client confidentiality (Elbers & McCraty, 2020).

Confidentiality and Data Security

All interview data, including audio recordings and transcripts, were de-identified and stored separately from consent forms. Digital files were encrypted and stored in compliance with Institutional Review Board (IRB) data management policies. In accordance with Walden University guidelines, all research data—including audio recordings and transcripts—will be securely retained for a period of five years following the Chief Academic Officer's (CAO) approval of my final study. After this period, the data will be permanently deleted (Walden University, n.d.).

NVivo 15 software was used for analysis, with secure, password-protected access restricted to me only. The researchers study adhered to the Belmont Report's ethical

principles of respect for persons, beneficence, and justice. Compliance with all IRB standards ensures the protection of participants and the integrity of the research process.

Treatment of Data

The treatment of all research data adhered to strict ethical and institutional protocols to safeguard participant confidentiality and maintain data integrity. In my study, all data collected from participants were considered confidential rather than anonymous, as some demographic or contextual information (e.g., years of experience, therapeutic background) might have the potential to indirectly identify individuals despite the absence of names or direct identifiers.

Confidentiality and Protections

To maintain confidentiality, participants were assigned pseudonyms, and all identifying details were removed from transcripts. Consent forms were stored separately from research data to prevent linkage. Data—including audio recordings, transcripts, analytic memos, and NVivo 15 project files—will be stored on an encrypted, password-protected computer accessible only by me. All digital files were backed up to a secure, encrypted external drive.

Data Dissemination and Access

Only I had access to raw data; however, members of the dissertation committee and representatives of the Institutional Review Board (IRB) might request access for auditing or verification purposes, which was granted in accordance with ethical and institutional protocols. Aggregated findings, de-identified quotations, and thematic summaries might be presented in the final dissertation or related scholarly presentations

and publications. At no point were identifying details shared. All research data—including audio recordings, transcripts, consent forms, and analytic documents—will be retained for a period of five years following the completion of my study, as required by Walden University policy. After this retention period, all digital and physical data were securely destroyed to protect participant confidentiality (Walden University Center for Research Quality, n.d.).

Other Ethical Considerations

No archival data or existing datasets were used in my study. Additionally, I did not conduct the study within my own place of employment, thereby reducing the risk of role-based coercion, dual relationships, or conflicts of interest. No incentives or compensation were offered, as participation was entirely voluntary and posed minimal risk to participants. This decision also supports the principle of justice by ensuring that participation was not influenced by financial need or coercion.

Summary

This chapter outlined the methodological framework for the proposed qualitative phenomenological study exploring therapists' perspectives on the role of peer support in mitigating PTSD symptom severity and promoting psychological recovery among first responders. The chapter described the research design, research questions, my role as the researcher, participant selection criteria, data collection and analysis procedures, and strategies to ensure credibility, transferability, dependability, and confirmability. Ethical considerations related to participant recruitment, informed consent, data treatment, and

confidentiality were also addressed in accordance with IRB standards and APA ethical guidelines.

By employing reflexive thematic analysis and rigorous qualitative methods, the researchers study aimed to yield rich, nuanced insights into how licensed therapists perceive and utilize peer support in clinical work with trauma-exposed first responders. The next chapter, Chapter 4, was present the findings that emerge from my study, including key themes and interpretive insights derived from participants' narratives.

Chapter 4: Results

Introduction

In my qualitative phenomenological study, I explored licensed therapists' perceptions of the role of peer support in mitigating (PTSD symptoms and facilitating psychological recovery among first responders following trauma exposure. My research was guided by two central questions: (a) What were therapists' perspectives on the role of peer support in the psychological recovery of first responder clients following trauma exposure? and (b) What were therapists' perspectives on the role of peer support in mitigating the development of PTSD symptoms in first responder clients following trauma exposure?

Through semistructured interviews with eight licensed mental health professionals, I examined how clinicians experience, conceptualize, and integrate peer support interventions within therapeutic frameworks informed by resilience theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping (Lazarus & Folkman, 1984). Following Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method for phenomenological analysis, as outlined in Chapter 3, the analysis revealed the essential structure of therapists lived experiences with peer support, organized into two overarching theme clusters that collectively illuminate the temporal development of clinical understanding and integration practices.

In this chapter, I present the findings of the study in four primary sections. The data analysis section described the systematic phenomenological process used to identify meaning units and develop textural and structural descriptions of the phenomenon. The

results section presents the two major theme clusters that emerged, organized to demonstrate the temporal progression from encountering foundational challenges to developing sophisticated integration approaches. Each theme cluster addressed elements of both research questions while revealing the experiential dimensions of therapists' evolving understanding of peer support effectiveness. The chapter concludes with a summary of key findings and their relationship to the essential structure of the phenomenon.

Setting

At the time I conducted this study, participants were practicing across diverse professional and organizational contexts that fundamentally shaped their lived experiences with peer support integration. All eight participants were licensed mental health professionals actively treating clients of first responders. However, their practice environments and organizational conditions varied significantly, creating distinct experiential landscapes that influenced their phenomenological understanding of peer support.

Participants practiced across multiple states, including one in Colorado, two in Florida, one in Georgia, two in Texas, one in Tennessee, and one in Virginia, representing rural, suburban, and urban environments. Their practice settings included private practice, community mental health centers, inpatient hospital programs, and dual-diagnosis treatment facilities. These varied organizational contexts created different experiential realities for participants as they encountered and worked with peer support programs. Several participants described experiencing systemic conditions—such as

leadership engagement levels, resource availability, and cultural stigma within agencies—that fundamentally shaped their understanding of peer program effectiveness and their own role in facilitating integration.

My study was conducted within the broader context of heightened post-pandemic demand for mental health services and increased national attention to the wellness of first responders. These macrolevel conditions influenced how participants experienced and made sense of peer support's role in trauma recovery, as their clinical perspectives developed not only through direct therapeutic encounters but also through the organizational and cultural climates in which they practiced.

Demographics

The sample consisted of eight licensed mental health professionals with direct clinical experience in treating first responders. The demographic composition reflected both professional diversity and geographic representation, contributing to varied experiential perspectives on integrating peer support. The group represented individuals ranging in age from 34 to 62 years, with the majority identifying as female ($n = 6$) and two identifying as male. Most participants self-identified as White/Caucasian ($n = 6$), with one participant identified as Asian.

Participants demonstrated varied professional backgrounds and credentials, including LCSW, LMFT, LMHC, and one participant holding dual licensure as an LCSW and licensed addiction counselor (LAC). Educational backgrounds ranged from master's degrees to doctoral-level training. Clinical experience spanned from five years to more

than 24 years, with most participants reporting between six and nine years of direct experience treating first responders.

Practice settings reflected both organizational diversity and geographic variety. Three participants reported working primarily in private practice, two practiced in community mental health clinics, two in inpatient or hospital-based programs, and one in a dual-diagnosis treatment facility. Geographic representation included urban ($n = 3$), suburban ($n = 3$), and rural ($n = 2$) environments across Colorado, Florida, Georgia, Tennessee, Texas, and Virginia.

The type of practice setting appeared to influence participants' perspectives on integrating peer support. For example, clinicians in private practice reported more limited opportunities to observe peer support structures directly and instead encountered them indirectly through client reports. By contrast, the participant in the dual-diagnosis facility emphasized the unique role of peer support as a formalized part of substance use treatment, noting both benefits and challenges tied to confidentiality and role clarity. Clinicians working in inpatient or hospital settings described systemic factors, such as leadership policies and liability concerns, as particularly salient to the effectiveness of peer support. At the same time, those in community mental health emphasized cultural stigma and access barriers within first responder organizations.

The participants represented a diverse group of licensed mental health professionals who have experience treating first responders exposed to occupational trauma. In addition to their clinical work, several participants described involvement in professional and community-based initiatives aimed at improving access to care and

increasing awareness of mental health challenges within this population. Notably, a few participants reported active engagement in advocacy efforts, including lobbying for legislative or policy changes within their respective states to strengthen mental health resources and peer support infrastructure for first responders. These activities reflect the participants' commitment to effecting systemic change beyond the therapeutic setting and underscore their broader dedication to advancing the well-being of those they serve.

This distribution highlights that while all participants engaged with peer support through their clinical work, the specific setting shaped how they encountered challenges and integration possibilities. Thus, differences in organizational context contributed to variation in emphasis across themes, particularly regarding systemic barriers and the role of peer support in recovery from substance use compared to trauma-only presentations.

Data Collection

Data collection involved eight licensed mental health professionals with direct clinical experience in treating first responders. The primary data source consisted of semistructured interviews conducted via Zoom, each lasting between 45 and 60 minutes. While each participant was interviewed only once, the phenomenological interviews generated rich, detailed experiential narratives that provided sufficient depth to address the research questions thoroughly and explore the essential structure of therapists' lived experiences with peer support.

The virtual interview format, necessitated by participants' geographic distribution across multiple states, allowed participants to join from private offices, homes, or other confidential spaces of their choosing. This format not only ensured accessibility and

convenience but also appeared to foster the openness and trust essential for phenomenological inquiry, particularly given the sensitive nature of discussing clinical decision-making and organizational dynamics. Conducting interviews in familiar environments seemed to enhance participants' willingness to share detailed experiential accounts and reflect deeply on their lived experiences with peer support integration.

With participant consent, each interview was audio-recorded and subsequently transcribed verbatim. Consistent with phenomenological methodology, I maintained detailed reflective notes during and after every interview to capture contextual nuances, emotional undertones, and preliminary interpretive insights that emerged during the meaning-making process. These field notes complemented the transcripts by preserving experiential details about tone, emphasis, and relational dynamics that were not always evident in text alone, supporting the later development of textural and structural descriptions.

Data Analysis

The interview data were analyzed using Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method for phenomenological analysis, as outlined in Chapter 3, rather than basic thematic analysis (see Dolezal, 2021; Modula et al., 2024). This approach provided a systematic framework for identifying the essential structure of therapists' lived experiences with peer support while maintaining fidelity to the phenomenological tradition emphasized in the study's design. The analytic process focused on uncovering not merely what therapists think about peer support, but how they experience it as a lived phenomenon within their clinical practice.

Phenomenological Analytic Process

The analysis began with the epoché process, which involved systematically bracketing my own assumptions and experiences to approach participants' narratives with a fresh perspective. Following Moustakas' (1994) framework, I engaged in multiple readings of each transcript while simultaneously reviewing audio recordings to immerse myself in the lived texture of participants' experiences. This immersion phase was crucial for developing sensitivity to the temporal and experiential dimensions of how therapists' understanding of peer support evolved through clinical encounters.

The next phase involved identifying significant statements and meaning units within each transcript. This process focused on extracting experiential descriptions that captured the essence of how therapists lived through their encounters with peer support. Across the eight interviews, 847 meaning units were identified and subjected to horizontalization, treating each unit as equally valuable for understanding the phenomenon. These meaning units were then clustered into thematic categories that reflected common experiential structures.

Through iterative analysis and synthesis, the essential structure of therapists' lived experience with peer support emerged as two interconnected theme clusters representing a temporal progression in understanding and integration:

- Theme Cluster 1: encountering foundational challenges in peer support implementation
 - Subtheme 1A: experiencing competency gaps and professional development tensions

- Subtheme 1B: navigating systemic implementation barriers and organizational dynamics
- Theme Cluster 2: developing integration and relational foundations for effective practice
 - Subtheme 2A: discovering therapeutic integration and treatment synergy possibilities
 - Subtheme 2B: cultivating cultural competency and trust-based implementation

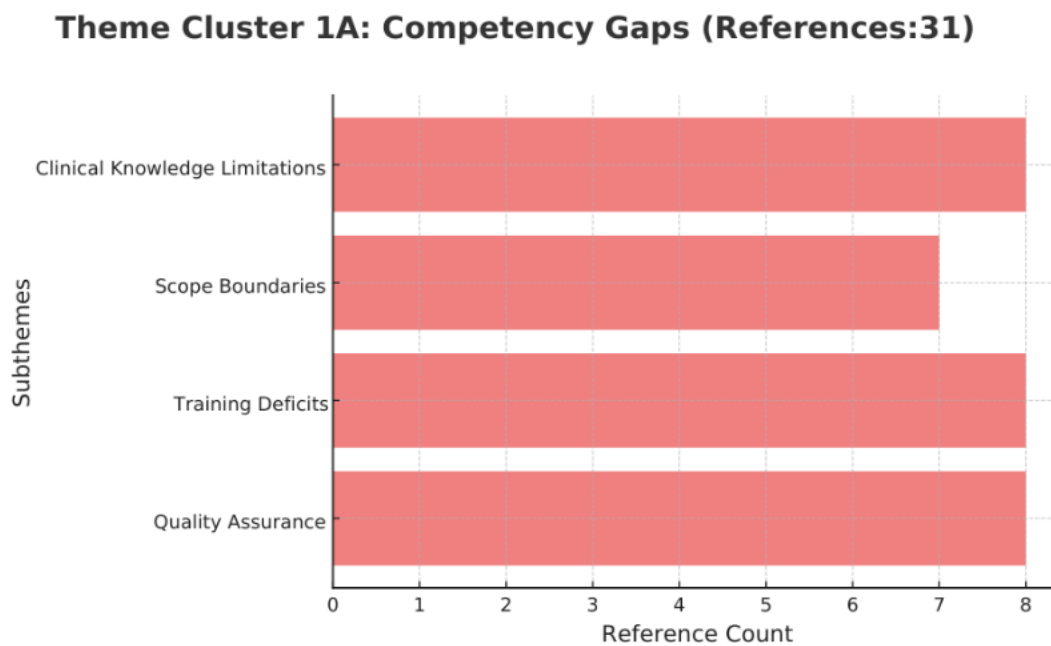
Figure 1*Theme Cluster 1A: Competency Gaps*

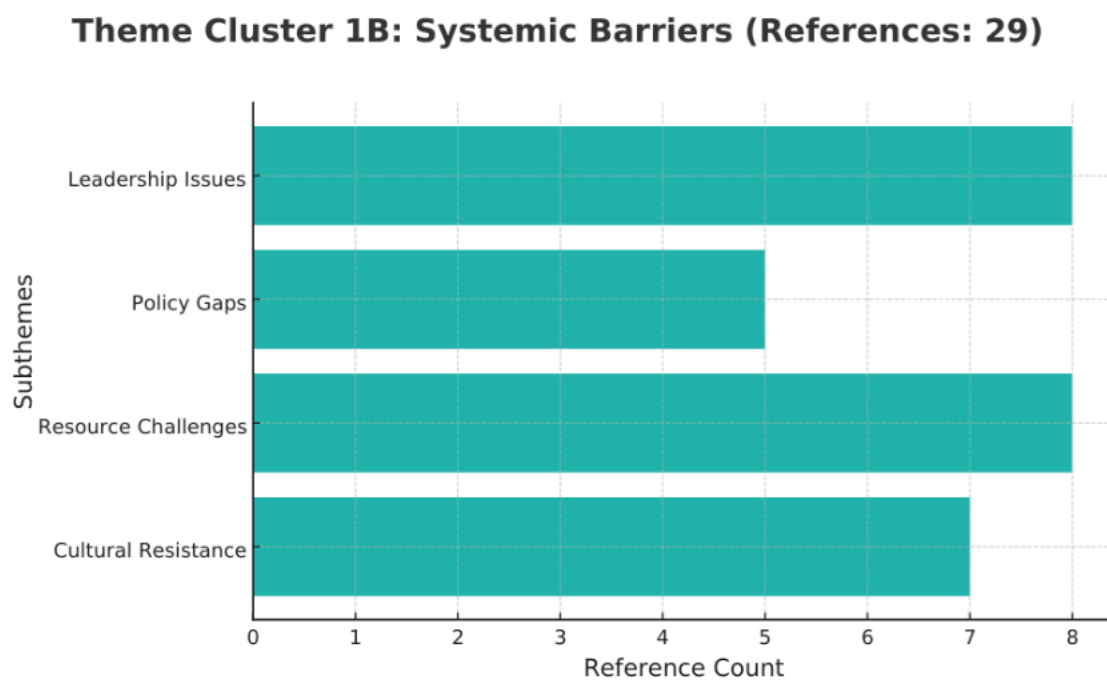
Figure 2*Theme Cluster 1B: Systemic Barriers*

Figure 3

Theme Cluster 2A: Integration Models

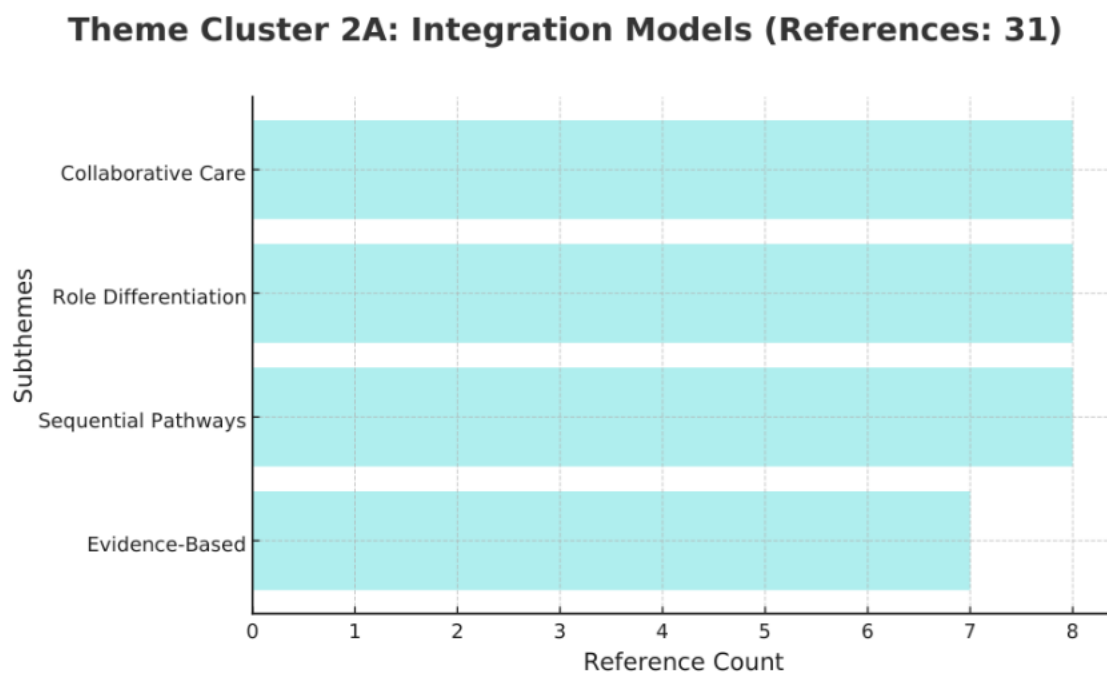
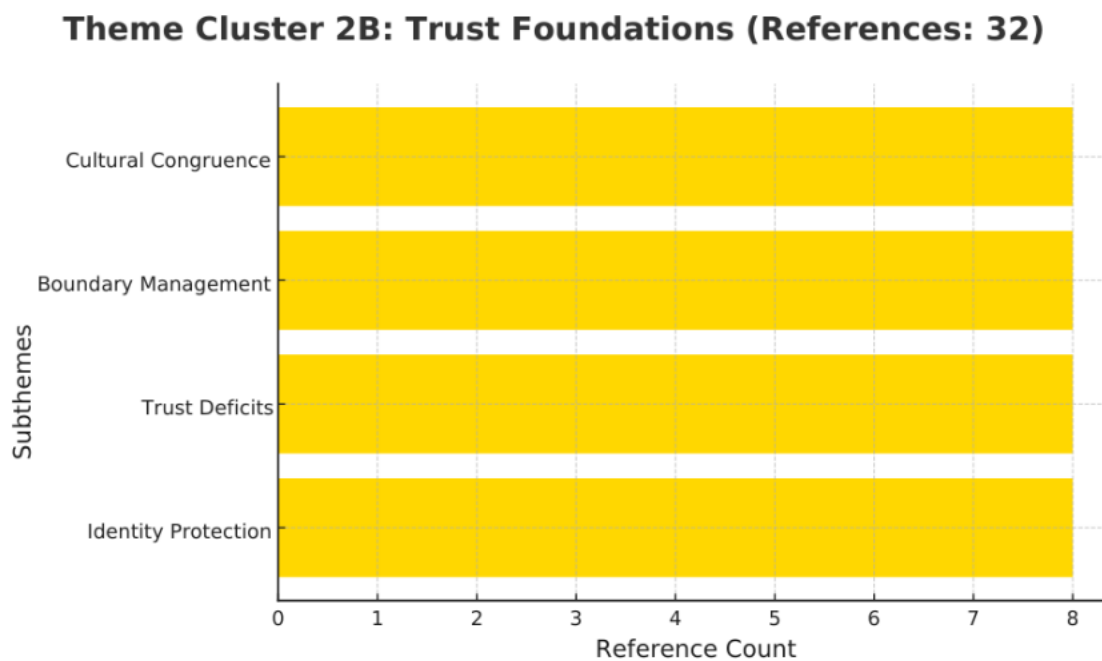


Figure 4

Theme Cluster 2B: Trust Foundations

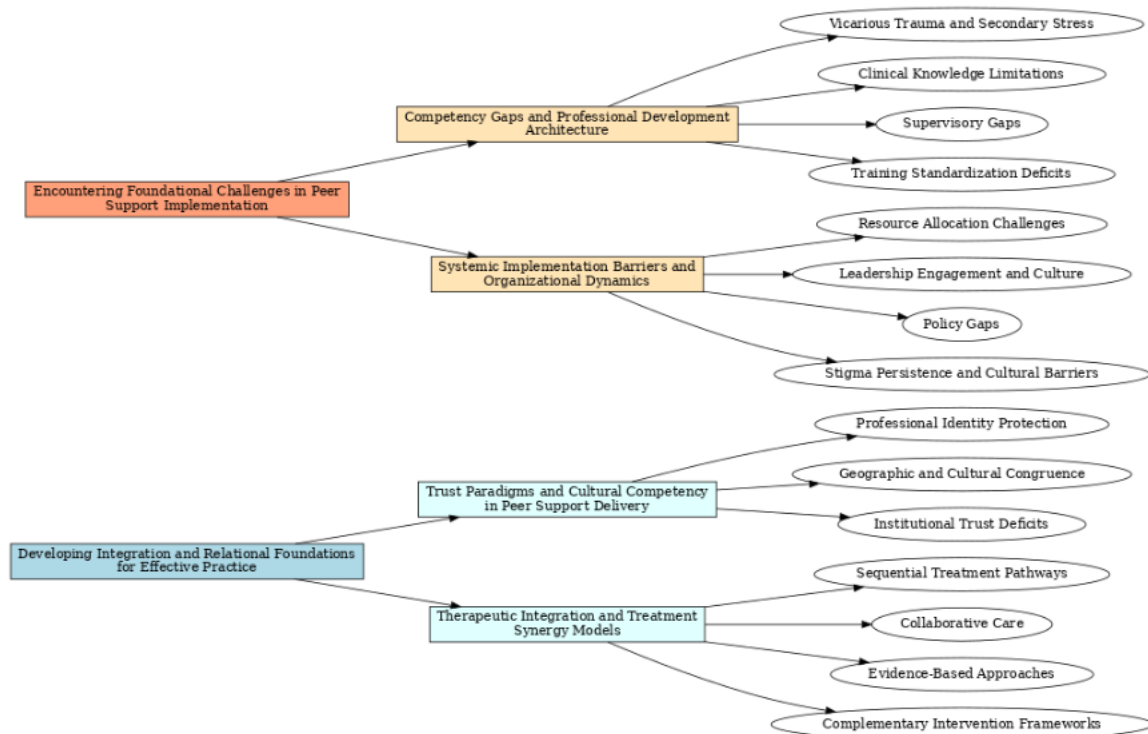


Treemap Visualization

The systematic organization of meaning units into theme clusters was illustrated through the hierarchical structure that emerged from the phenomenological analysis.

Figure 5

Treemap



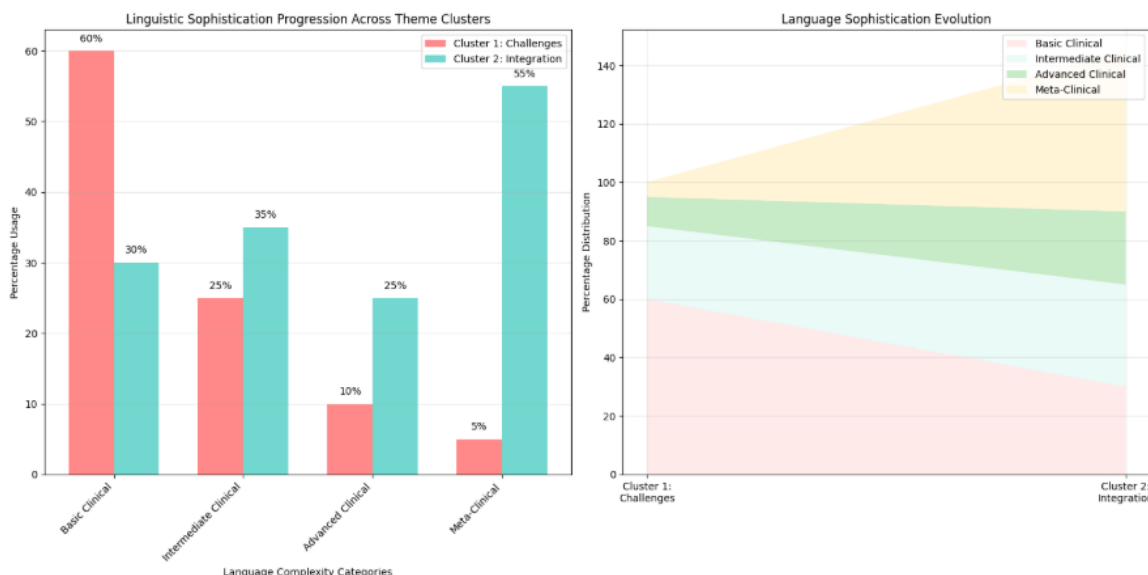
This hierarchical flow diagram illustrates the organization of major theme clusters and their sub-themes within the phenomenological analysis. The diagram branches into two overarching clusters: encountering foundational challenges in peer support implementation (orange) and developing integration and relational foundations for effective practice (blue). The first cluster includes competency gaps and professional development architecture, along with systemic implementation barriers and organizational dynamics. The second cluster encompasses sub-themes of trust paradigms and cultural competency, as well as therapeutic integration and treatment synergy models. Each subtheme further expands into detailed elements, visually representing the

structured relationships and balanced thematic distribution that emerged from the 847 meaning units across eight participant interviews.

Linguistic and Phenomenological Analysis

The phenomenological analysis revealed a notable evolution in clinical discourse complexity across theme clusters, demonstrating how therapists' experiential understanding developed through lived encounters with the integration of peer support.

This dual-panel analysis demonstrates the phenomenological evolution of clinical language sophistication across theme clusters. The left bar chart reveals that Cluster 1 (foundational challenges) predominantly utilized basic clinical terminology (60%) with minimal meta-clinical discourse (5%), whereas Cluster 2 (integration foundations) demonstrated a notable sophistication, with 55% of the language being meta-clinical. The right stacked area chart illustrates this temporal progression, with basic clinical language decreasing from 60% to 30%. In comparison, meta-clinical discourse increased eleven-fold from 5% to 55%, indicating therapists' deepening analytical engagement with the complexity of peer support through lived experience. This linguistic evolution reflects the expansion of the horizon of meaning as therapists moved from initial problem identification to sophisticated integration and understanding.

Figure 6*Dual-Panel Analysis***Semantic Domain Evolution**

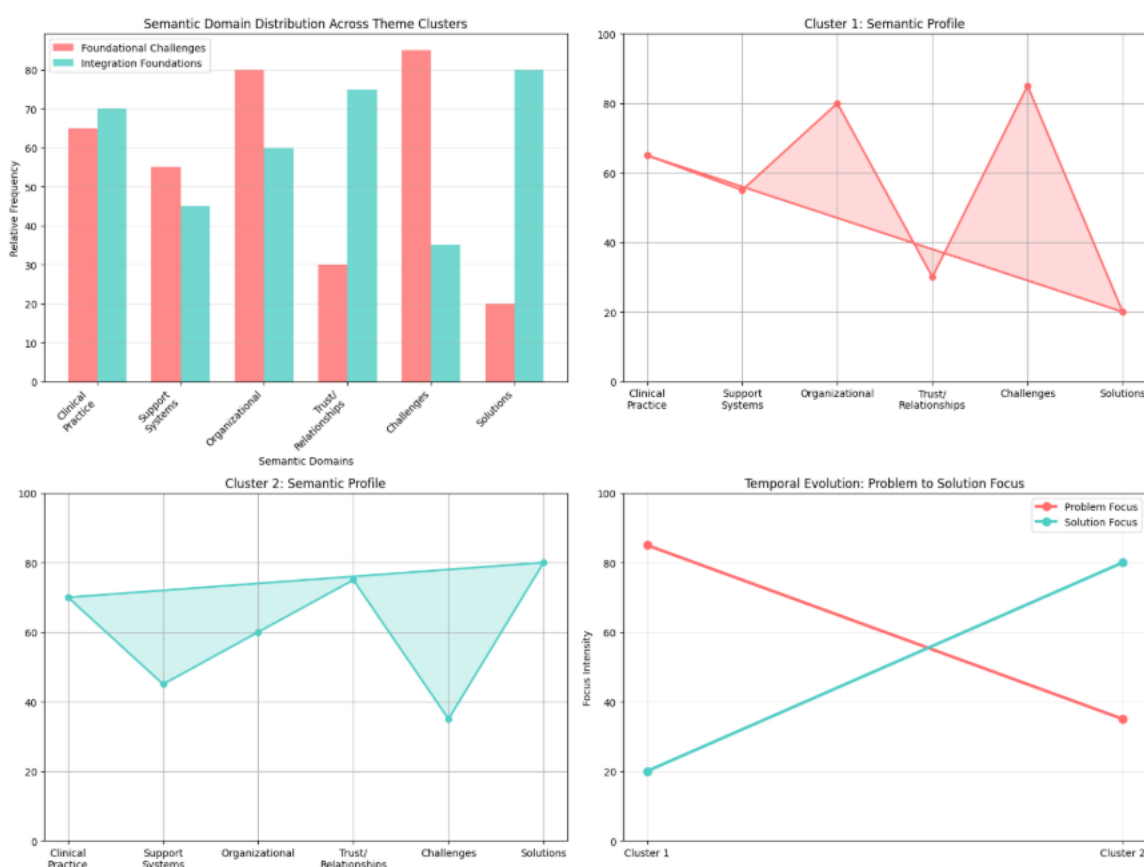
Analysis of semantic domains revealed distinct shifts in priority across theme clusters, demonstrating how therapists' experiential focus evolved from concerns about technical competency to relational and cultural considerations through their lived experiences with peer support.

This four-panel semantic analysis reveals the phenomenological shift in therapists' focus on meaning-making. The top-left bar chart illustrates domain distribution, with organizational concerns peaking in Cluster 1 (80%) and trust/relationships culminating in Cluster 2 (75%). The top-right radar chart displays Cluster 1's experiential profile, which was heavily weighted toward challenges (85%) and organizational issues (80%), with a minimal focus on Solutions (20%). The bottom-left radar chart shows Cluster 2's transformed profile, emphasizing solutions (80%) and trust/relationships (75%) while

challenges decreased dramatically (35%). The bottom-right temporal evolution chart illustrates the phenomenological progression, showing that problem focus declined from 85% to 35%. In comparison, solution focus increased fourfold from 20% to 80%, confirming therapists' experiential journey from problem identification to implementation of integration.

Figure 7

Four-Panel Semantic Analysis



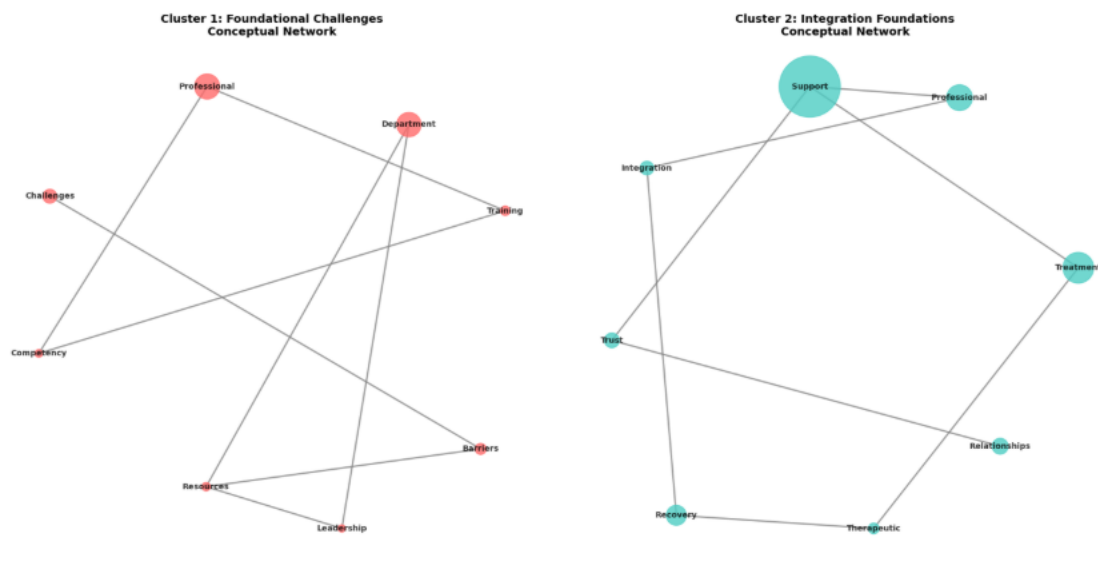
Conceptual Network Architecture

The therapeutic discourse network analysis revealed the conceptual architecture underlying therapists' experiential understanding of peer support integration, showing how meaning-units clustered around essential phenomenological themes.

These network diagrams illustrate the essential relationship structures within each theme cluster's experiential landscape. The left network (Cluster 1: Foundational Challenges) displays problem-focused relationships, with professional, department, and challenges as central nodes, connected to peripheral concerns such as training, competency, barriers, and resources. The interconnections reflect therapists lived experience of encountering multiple interdependent obstacles. The right network (Cluster 2: Integration Foundations) demonstrates a solution-oriented architecture with support as the dominant central hub, connecting to treatment, professional, and integration nodes. At the same time, trust, relationships, recovery, and therapeutic form a supportive constellation. This structural transformation reflects the essential shift from experiencing fragmented challenges to discovering integrated solutions through lived clinical encounters.

Figure 8

Cluster's Experiential Landscape

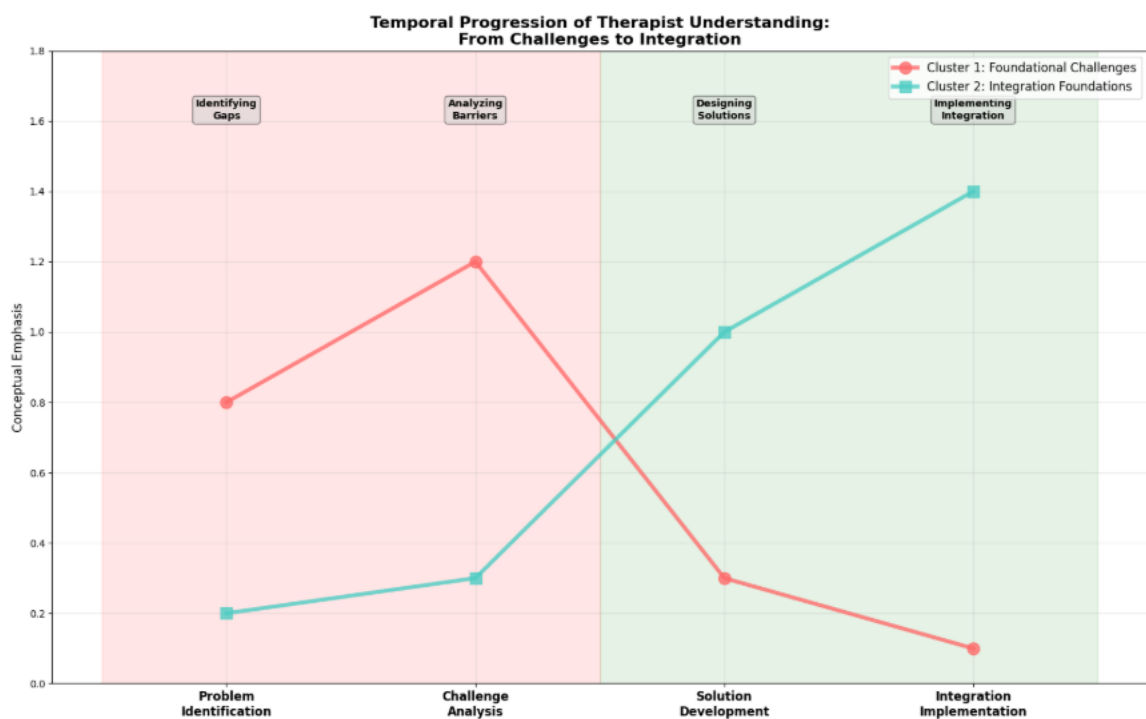


This temporal progression visualization illustrates the phenomenological development trajectory of a therapist's understanding, from challenges to integration. The timeline shows four developmental stages: problem identification, challenge analysis, solution development, and integration implementation. Cluster 1 (Foundational Challenges) shows the highest emphasis during the early stages (0.8-1.2 intensity), then diminishes, while Cluster 2 (Integration Foundations) starts at a minimal level (0.2-0.3) but culminates at peak intensity (1.4) during the implementation of integration. The crossing trajectories at the solution development phase represent the phenomenological turning point at which therapists' lived experience shifts from a problem-focused to a solution-oriented understanding. Background shading distinguishes the problem phase (red) from the solution phase (green), with annotations indicating the experiential focus

of each stage: identifying gaps, analyzing barriers, designing solutions, and implementing integration.

Figure 9

Temporal Progression



Evidence of Trustworthiness

Credibility

Credibility was strengthened through strategies consistent with the principles of phenomenological inquiry. Semistructured, open-ended interviews allowed participants to describe their lived experiences in their own words, producing authentic accounts of peer support integration. I audio-recorded each interview with the participant's consent and transcribed verbatim, with the transcripts cross-checked against the recordings to ensure accuracy. Reflexive journaling throughout the data collection and analysis process

further enhanced credibility by helping me remain attentive to my own assumptions and biases and ensuring that interpretations were grounded in participants' perspectives rather than the researcher's expectations.

Transferability

Transferability was supported by providing thick descriptions of participants, settings, and the essential structure of the phenomenon. The eight licensed therapists in the researchers study represented diverse demographics, professional backgrounds, and geographic practice settings. By situating their narratives within varied organizational and cultural contexts, I provided sufficient experiential detail for readers to assess the applicability of findings to other clinical settings where therapists encounter peer support programs.

Dependability

I established dependability by maintaining consistency in data collection and analysis. All participants were interviewed using the same semistructured protocol, with each session following a uniform format that allowed for flexibility in pursuing unique experiential narratives. Detailed documentation of the analytic process—including coding decisions, category development, and the progression from meaning units to subthemes and themes—ensured transparency and accountability. NVivo 15 software preserved coded data, thematic structures, and analytic queries, creating a clear audit trail that allows another researcher to follow and replicate the process.

Confirmability

Confirmability was enhanced through reflexive practices and systematic documentation designed to minimize researcher bias. Reflective notes and analytic memos recorded observations, decision-making processes, and potential sources of bias, which were reviewed throughout the coding and theme development process. Discrepant cases were deliberately included to avoid presenting only data that aligned with dominant patterns. For example, while most participants emphasized the benefits of peer support when properly structured, some cautioned that peer support without adequate clinical training could cause harm, particularly if peers attempted to move beyond their supportive role and offer therapy. Including these divergent perspectives demonstrated that the findings were grounded in participants lived experiences rather than my own assumptions. By combining reflexivity, transparent documentation, and NVivo 15-based audit trails, I ensured that study results reflect the voices of participants rather than researcher influence.

Results

The phenomenological analysis revealed two major theme clusters that collectively address both research questions while demonstrating a clear temporal progression from encountering foundational challenges to developing sophisticated integration approaches. The theme clusters reflect the essential structure of therapists' lived experience, revealing how their understanding evolved through direct clinical encounters with peer support implementation. The purpose of this phenomenological study was to explore licensed therapists' perceptions of the role of peer support in

mitigating PTSD symptoms and facilitating psychological recovery among first responders following trauma exposure. Two research questions guided the study:

RQ1: What were therapists' perspectives on the role of peer support in the psychological recovery of first responder clients following trauma exposure?

RQ2: What were therapists' perspectives on the role of peer support in mitigating the development of PTSD symptoms in first responder clients following trauma exposure?

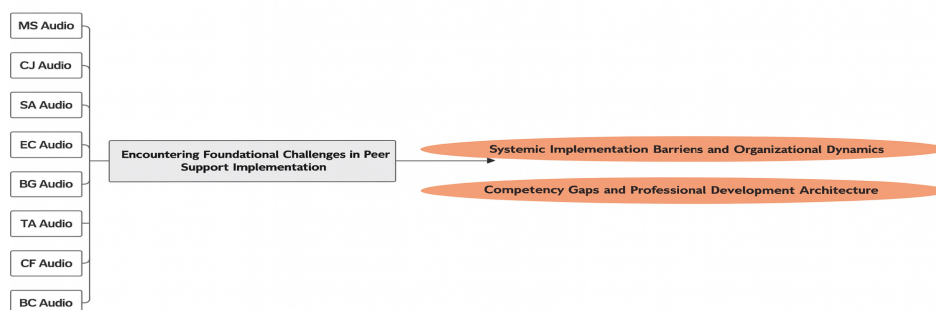
Participant-Theme Network

The phenomenological analysis systematically captured experiential data from all participants across both theme clusters, ensuring a comprehensive representation of the lived experience phenomenon.

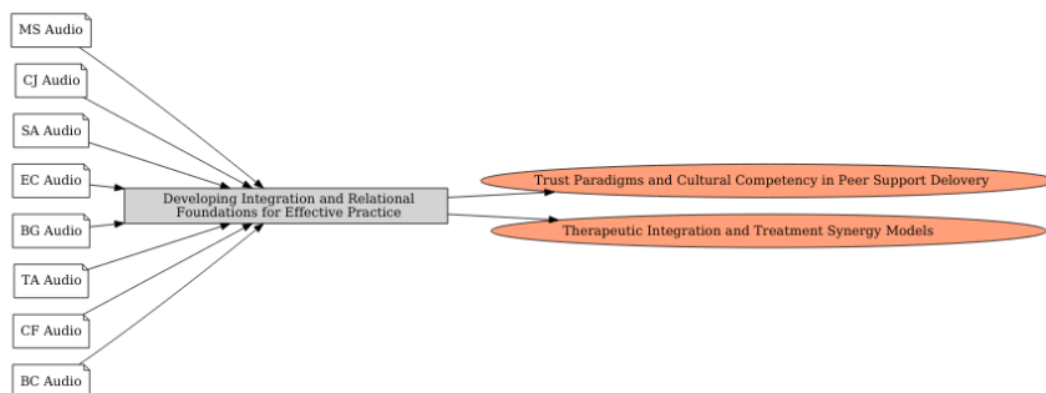
This network diagram depicts how all eight participant audio sources connected to the theme cluster encountering foundational challenges in peer support implementation. Two major sub-clusters emerged: competency gaps and professional development architecture and systemic implementation barriers and organizational dynamics. The converging lines from participants reflect the shared challenges therapists identified in delivering peer support, including knowledge limitations, training deficits, resource barriers, and organizational issues. These connections emphasize that foundational challenges were not isolated, but collectively experienced, underscoring their central role in shaping the phenomenological structure of peer support implementation.

Figure 10

Foundational Challenges in Peer Support



This network diagram illustrates how all eight participant audio sources contributed to the theme cluster developing integration and relational foundations for effective practice. The diagram highlights two interconnected sub-clusters: Trust Paradigms and Cultural Competency in Peer Support Delivery and Therapeutic Integration and Treatment Synergy Models. The balanced linkage across participant sources demonstrates that every therapist's lived experience informed the development of integrative and relational frameworks, emphasizing both trust-building and treatment synergy as essential dimensions of effective peer support practice.

Figure 11*Integration and Relational Foundations***Theme Cluster 1: Encountering Foundational Challenges in Peer Support****Implementation**

This theme cluster captured therapists' initial and ongoing encounters with fundamental obstacles that shaped their lived experience of integrating peer support. The phenomenological analysis revealed that therapists did not simply observe these challenges objectively but experienced them as sources of professional tension, uncertainty, and ethical concern that required ongoing navigation and meaning-making.

Subtheme 1A: Experiencing Competency Gaps and Professional Development***Tensions***

Therapists' lived experiences with peer support revealed fundamental tensions around peer supporter preparation and ongoing professional development. These weren't simply observed deficiencies but deeply felt concerns that shaped clinical decision-making and collaborative relationships. What emerged as particularly significant was

how participants distinguished first responder peer support from general peer support models. The unique occupational culture and shared exposure to critical incidents created implementation requirements that differed substantially from civilian peer support contexts.

The Unique Nature of First Responder Peer Support

First responder peer support operates within a distinct cultural framework that therapists consistently identify as fundamentally different from civilian models. The occupational identity creates both opportunities and constraints that do not exist in general peer support. Participant 6, who was herself married to a law enforcement officer and deeply embedded in that culture, captured this dynamic: "Cops trust cops, paramedics trust paramedics, firefighters trust firefighters... when I go to debriefings, peer support leads it, not me. To hear that there were others who had been through it was everything." This cultural specificity wasn't just background context—it was central to understanding how peer support functions in this population.

What differentiates first responder peer support most clearly was the importance of shared critical incident experience. During debriefings, one therapist explained, "The people who were allowed into that debriefing were peers who had been through a similar incident and who get it... It helps them to be informed, also to be understood." Another therapist emphasized how this experiential foundation creates connection: "Peers that I work with... they've had thoughts of suicide, or I used to have a substance problem. They're very open. And in some ways, it might model like a sponsorship... but the playing field becomes very equal." The shared occupational trauma becomes the basis for

trust in ways that differ from general peer support, where common struggles might be less specific or intense.

However, this occupational specificity creates paradoxes rarely seen in civilian peer support. One therapist who works as both a licensed social worker and an active police officer described the disconnect between theory and reality:

Would you go and trust one of your other fellow officers to talk about confidential stuff and they said, hell no... that whole brotherhood... people think that cops have got their back... was one of the most backstabbing professions I've ever come across."

The hierarchical nature of public safety agencies, combined with fears of professional retaliation, creates trust barriers that don't typically exist in general peer support contexts. Unlike civilian peer support, where participants might never see each other again outside the group, first responders work alongside their peers daily, creating complex relational dynamics around disclosure and vulnerability.

Competency Gaps Within First Responder-Specific Contexts

The training inadequacies became particularly apparent when viewed through the lens of first responder-specific needs. One therapist who went through peer support training herself described the experience: "When I went through the training for a peer support team member... They don't even teach that... It's like really glazed over... they don't talk about workman's comp or any of that. I really feel that they need to." This gap matters more for first responders than for general populations because of the unique occupational stressors—cumulative trauma exposure, shift work disruption, line-of-duty

injuries, administrative investigations, and complex benefits systems that civilian peer supporters rarely encounter.

The cultural context of first responder work also shapes how competency gaps manifest. One therapist observed: "A lot of times, peer support was giving them feedback or advice, like, just keep grinding it out... peer support isn't fully educated on different tools or techniques that were helpful." This observation highlights a concerning pattern. The culturally sanctioned stoicism within first responder culture—the expectation to be tough and push through—can be inadvertently reinforced by peer supporters who haven't been trained to recognize when this coping mechanism becomes maladaptive. This differs from general peer support, where the occupational culture doesn't inherently promote emotional suppression as a professional virtue.

Therapists experienced these competency gaps as creating clinical complications beyond what they'd encounter with other populations. One therapist's frustration was evident: "Oftentimes the people working in peer support... have not yet cleared their own stuff up... they're trying to offer support, but it doesn't feel that great because they still were working through a lot of their own stuff." This concern carries different weight in first responder contexts. Unlike civilian peer supporters who typically don't face ongoing exposure to the same stressors as those they support, first responder peer supporters continue working in high-trauma environments themselves. They're attempting to provide support while simultaneously managing their own cumulative trauma—a dual burden that distinguishes this model from general peer support.

Training Deficits in First Responder-Specific Content

The specialized knowledge required for first responder peer support extends beyond standard peer support training. While general peer support focuses on active listening, empathy, and resource connection, first responder peer support requires understanding occupational trauma patterns, critical incident stress responses, administrative processes, workers' compensation systems, and complex departmental politics. These aren't supplementary topics—they're core competencies.

One therapist's client experience illustrated the consequences of these training gaps:

"Nobody ever told my clients about workmen comp and applying for disability. Nobody told him to go ahead and get an attorney. It was until he saw me in May after a December incident of a shooting that he got that."

Six months passed between a line-of-duty shooting and the first time anyone provided guidance on basic administrative processes. This isn't a gap that would typically appear in general peer support, where occupational injury protocols and disability systems aren't relevant concerns. For first responders, these administrative issues could determine whether someone loses their career, pension, and livelihood.

The lack of standardization compounds these problems in ways specific to first responder contexts. One therapist noted: "There's not even a national curriculum that was out there... some of them were doing it in house and having their peer support person just training based on whatever information they have." First responders transfer between agencies, work mutual aid calls across jurisdictions, and move between specialties—

mobility patterns that make inconsistent training particularly problematic. In general, participants in peer support typically remain within one program or community, so local variations matter less.

The structural demands placed on first responder peer supporters also differ substantially from civilian models. One therapist explained: "Many departments, if not probably 99% of the departments, do not give that peer support person less duty time than a normal patrol officer." First responder peer supporters maintain full operational duties—responding to calls, working patrol, fighting fires—while simultaneously providing peer support. This dual role doesn't exist in most civilian peer support programs, where volunteers typically do not simultaneously perform high-stress operational work. The cumulative burden creates both capacity limitations and potential boundary complications that training programs rarely address.

Subtheme 1B: Navigating Systemic Implementation Barriers and Organizational Dynamics

Therapists' experience of peer support was profoundly influenced by their encounters with organizational resistance, policy inadequacies, and cultural barriers that shaped the context within which peer support operated. These systemic factors were experienced as frustrating constraints that limited their ability to integrate peer support into comprehensive treatment approaches effectively.

A therapist described experiencing organizational resistance: "You still have a lot of administrators that had been police for 30 years who were like, nah, we don't need

that... guys could just talk to each other car to car... going forward, peer support was going to be a standard, but right now it's still waiting for changing the guard."

Policy framework gaps created legal and liability concerns that hindered program development. A therapist explained:

"One of them said that they had to get rid of their entire program because the person broke confidentiality. So out of all of them that I've had, only probably about two or three had used their peer support prior to coming to me."

These regulatory ambiguities were experienced as significant impediments to program expansion and institutional support.

Theme Cluster 2: Developing Integration and Relational Foundations for Effective Practice

This theme cluster represented therapists' evolving experiential understanding of how peer support was effectively integrated into comprehensive treatment approaches. The phenomenological analysis revealed that this understanding developed through lived encounters with successful integrations and the gradual recognition of peer support's potential when properly supported and implemented.

Subtheme 2A: Discovering Therapeutic Integration and Treatment Synergy

Possibilities

Therapists lived experience revealed a developmental process of discovering how peer support could complement and enhance their therapeutic work rather than competing with it. This discovery often occurred through witnessing unexpected client breakthroughs that followed peer support encounters.

A therapist described experiencing this integration:

"The people that I've seen that have gone through peer support... they tell me about an incident or problems they're having, and then it's like, yeah, the peer said, 'Hey man, you need something more.' That's when they get to me."

Another therapist reflected on discovering synergistic possibilities: "An important part of PTSD recovery was just being able to talk... talking helps the brain process emotionally what happened and reconnects the mind and body." The phenomenological analysis revealed that therapists' understanding of integration developed through lived experience rather than theoretical knowledge, as they witnessed firsthand how peer support could facilitate therapeutic engagement.

Subtheme 2B: Cultivating Cultural Competency and Trust-Based Implementation

Therapists' lived experience demonstrated that effective peer support implementation required a deep understanding of first responder culture and the cultivation of trust relationships that honored occupational identity while promoting help-seeking behavior.

A therapist described experiencing cultural dynamics: "Cops trust cops, paramedics trust paramedics, firefighters trust firefighters... when I go to debriefings, peer support leads it, not me. To hear that there were others who had been through it was everything." The importance of shared occupational identity and cultural understanding was emphasized across multiple interviews.

Another therapist reflected on witnessing trust development challenges: "They had to get rid of their entire program because the person broke confidentiality... They

don't trust anybody." The phenomenological analysis revealed that therapists' appreciation for cultural competency and trust-based approaches developed through lived encounters with the unique dynamics of first responder culture.

Professional identity protection represented a critical consideration in peer support engagement. A therapist explained: "There was still kind of that hesitancy of I'm not tough enough... I should be able to handle this... they look at themselves as the helper. And so many of them was tell me that if I'm the helper, I shouldn't need to get help." This tension between professional identity and vulnerability was identified as central to the successful implementation of peer support.

The centrality of trust emerged as a unifying concept across all themes. Whether discussing competency concerns, systemic barriers, integration strategies, or cultural factors, participants consistently returned to trust as the fundamental prerequisite for adequate peer support. This finding suggests that trust operates simultaneously at interpersonal, organizational, and cultural levels, making it both essential and complex to establish and maintain. Professional identity emerged as another cross-cutting theme that influenced all aspects of peer support implementation. The tension between maintaining professional competence and acknowledging vulnerability affected both first responders' willingness to seek support and peer supporters' ability to provide practical assistance while managing their own professional identities. The linguistic analysis revealed increasing theoretical sophistication across themes, with meta-clinical language dominating the final theme, suggesting that therapists develop increasingly complex

frameworks for understanding peer support integration as they move from problem identification to solution implementation.

Summary

The phenomenological analysis revealed that therapists' lived experiences with peer support in first responder PTSD recovery encompassed both significant challenges and evolving opportunities for integration. Two major theme clusters addressed the research questions while illuminating the temporal and experiential dimensions of how therapists developed an understanding of peer support effectiveness through clinical encounters.

An important dimension emerged regarding therapists' experiences with different first responder populations. While participants worked across multiple disciplines—including law enforcement, emergency medical services (EMS), paramedics, and firefighters—several therapists noted distinct cultural dynamics affecting peer support implementation. One therapist explicitly described the discipline-specific trust paradigm: "Cops trust cops, paramedics trust paramedics, firefighters trust firefighters," suggesting that occupational identity operates within rather than across first responder categories.

Therapists working primarily with law enforcement personnel more frequently encountered institutional barriers related to confidentiality concerns and departmental politics, with multiple references to officers' hesitancy to utilize peer support due to career implications. Those with experience treating EMS personnel and firefighters noted different organizational structures, with some fire departments demonstrating more openness to mental health interventions. However, the essential structure of challenges

and integration needs remained consistent across disciplines, suggesting that while implementation contexts vary by first responder type, the fundamental phenomenological experience of navigating competency gaps, systemic barriers, and trust dynamics transcended specific occupational categories. Participants treating clients from multiple first responder disciplines emphasized the importance of discipline-specific peer matching, noting that cross-discipline peer support rarely achieved the cultural congruence necessary for effective engagement.

For the first research question, findings indicated that therapists perceived peer support as potentially valuable but limited in its current form. The progression from encountering challenges to discovering integration possibilities suggested that peer support was most effective when embedded within professionally informed frameworks rather than functioning independently. For the second research question, the analysis emphasized that effectiveness depended heavily on the context in which peer support operated. Organizational support, cultural congruence, and trust dynamics emerged as central conditions shaping whether peer support contributed to symptom reduction or remained underutilized.

Although these clusters reflected dominant patterns, some participants voiced concerns that diverged from the majority. A minority cautioned that peer support without sufficient clinical training could become harmful, particularly when peers attempted to move beyond their supportive role into providing therapy. Others noted tensions when peer and professional responsibilities overlapped. Including these discrepant perspectives

strengthened the analysis by acknowledging variation across participants' experiences rather than presenting a uniform account.

Overall, the temporal progression from problem identification to solution implementation reflected therapists' increasing experiential sophistication in integrating peer support. The centrality of trust across both theme clusters suggested that relational and cultural dynamics might be more fundamental to successful peer support than procedural or technical elements. These findings enhance understanding of how mental health professionals phenomenologically experience peer support and offer insights for improving trauma-informed care through enhanced integration models. Chapter 5 discusses the implications of these findings for theory, clinical practice, and future research, with particular attention to how the essential structure of therapists' lived experience could inform comprehensive models of first responder mental health care.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I explored licensed therapists' lived experiences and perspectives regarding the role of peer support in mitigating PTSD symptoms and facilitating psychological recovery among first responders following trauma exposure. Grounded in resilience theory (Masten, 2001; Werner & Smith, 1982) and the transactional model of stress and coping (Lazarus & Folkman, 1984), I sought to understand how mental health professionals phenomenologically experience, conceptualize, and integrate peer support interventions within therapeutic frameworks for this high-risk population. The need for this investigation arose from a critical gap in the literature. While peer support programs have proliferated across emergency service organizations, therapists' clinical perspectives on these interventions have remained largely unexplored.

Through semistructured interviews with eight licensed mental health professionals across five states, the phenomenological analysis using Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method revealed two interconnected theme clusters that shed light on the core structure of therapists' lived experiences with peer support in first responder mental health care. These theme clusters—showing a progression from facing basic challenges to developing advanced integration strategies—demonstrate that while therapists see the potential benefits of peer support through their clinical experiences, significant gaps in implementation still exist between current practice and ideal integration. Most notably, trust emerged as the central organizing principle across both theme clusters, functioning at interpersonal, organizational, and cultural levels throughout

therapists' phenomenological journeys. These findings challenge simple views of peer support as just an add-on service, instead highlighting its role as a complex intervention that demands careful coordination of training, supervision, organizational backing, and cultural understanding, as experienced through therapists' evolving clinical insights.

Interpretation of the Findings

The phenomenological findings both confirm and significantly extend current understanding of peer support in first responder mental health care through the lens of therapists' lived experiences. Consistent with Tjin et al.'s (2022) narrative review, participants' experiential accounts emphasized the value of peer support in providing emotional validation and reducing the stigma associated with help-seeking. This was clearly reflected in Participant 2's phenomenological description: "An important part of PTSD recovery is just being able to talk... talking helps the brain process emotionally what happened and reconnects the mind and body." This aligns with research demonstrating that peer interactions facilitate trauma processing through shared understanding and normalization of stress responses (Donovan, 2022; Pink et al., 2021).

However, the phenomenological analysis extends beyond these established benefits to reveal profound systemic challenges that previous research has inadequately addressed through the unique experiential lens of therapists' lived encounters. While Auth et al. (2022) documented barriers to help-seeking among trauma-exposed emergency personnel, the present findings illuminate how these barriers persist within peer support structures themselves. Participant 4's lived experience revealed: "They had to get rid of their entire program because the person broke confidentiality," exposing

vulnerabilities in peer support implementation that the literature has largely overlooked. This experiential finding suggests that trust—which Tjin et al., (2022) identified as crucial for mental health engagement—can be catastrophically undermined by a single breach, with lasting implications for entire departments.

The theme cluster addressing competency gaps particularly extends current knowledge by revealing the inadequacy of existing training models through therapists' direct observations and lived experiences with peer supporters. While there were examined opportunities for advancing first responder mental health programming, participants identified specific deficits in peer supporter preparation through their professional encounters. One participant's frustration was evident in their report: "They don't even teach that... It's like really glazed over. They say, 'know your resources,' but they don't talk about workman's comp or any of that." This phenomenological finding challenges assumptions in the literature that brief training programs adequately prepare peer supporters for their complex roles (Papazoglou, 2023).

My phenomenological findings fundamentally challenge several prevailing assumptions about the effectiveness of peer support through the essential structure of therapists' lived experiences. Contrary to the literature suggesting that shared occupational identity automatically facilitates trust (Crane et al., 2022), multiple participants described scenarios in their clinical practice where intradepartmental peer support heightened anxiety. Participant 6 captured this paradox: "cops trust cops," and asked clients, "would you go and trust one of your other fellow officers to talk about confidential stuff?" The clients responded, "hell no." This contradiction suggests that

occupational solidarity, although culturally valued, may be insufficient to overcome fears of professional consequences and interpersonal betrayal.

Additionally, the phenomenological analysis challenges the assumption that peer support uniformly reduces barriers to professional mental health services. While Ponder et al. (2024) found that peer interactions facilitate help-seeking, therapists' lived experiences revealed that poorly trained peers might impede recovery. One participant's observation from clinical practice warned: "A lot of times, peer support will give them feedback or advice of like, just keep grinding it out." This experiential finding suggests that without adequate clinical grounding, peer support may inadvertently reinforce maladaptive coping strategies that the literature associates with poorer outcomes (Modula et al., 2024).

Analysis Through Theoretical Frameworks

Resilience Theory Application

Analyzing the phenomenological findings through resilience theory reveals both the promise and limitations of current peer support implementation as experienced by therapists in their clinical practice. Masten's (2001) conceptualization of resilience as a dynamic process involving protective factors aligns with participants' lived experiences of peer support as a potential protective factor. One participant's experiential account exemplified this understanding: "When they see other people struggling, and then they hear other people's stories and hear how they got through it. It gives them a little bit of hope."

However, the phenomenological analysis also reveals that protective factors can transform into risk factors when improperly implemented. The absence of supervisory structures and systemic barriers identified in Theme Cluster 1 actively undermines resilience-building processes as experienced by therapists. This aligns with Werner and Smith's (1982) emphasis on environmental supports but extends their framework by demonstrating how organizational failures can convert potential protective mechanisms into sources of additional stress. Therapists' lived experiences with trust violations illustrated how these breaches can compound existing trauma, contradicting resilience theory's assumptions about social support as uniformly protective.

Transactional Model Integration

The transactional model of stress and coping provides crucial insights into how peer support influences cognitive appraisal and coping strategies as observed through therapists' phenomenological experiences. According to participants, peer support played a role in secondary appraisal by affecting how first responders sized up their coping resources—building confidence when support was constructive but sometimes undermining it when support was negative or poorly managed. One participant's lived experience articulated this process: "The people that I've seen that have gone through peer support... they tell me about an incident or problems they're having, and then it's like, yeah, the peer said, hey man, you need something more."

My phenomenological findings extend Lazarus and Folkman's (1984) model by revealing the unique position of peer support in the appraisal process. Unlike therapists who may be perceived as outsiders, peers can influence appraisal through shared cultural

understanding, as witnessed in clinical practice. However, the phenomenological data also reveal concerning patterns where peer supporters inadvertently promote emotion-focused avoidance strategies rather than problem-focused coping. Participants' lived observations of peers advising to "keep grinding it out" exemplify how culturally sanctioned stoicism may perpetuate maladaptive coping patterns that Dolezal (2021) associated with lower resilience.

Novel Insights and Theoretical Contributions

My phenomenological study offers several novel insights that advance the theoretical understanding of peer support in trauma recovery by examining the essential structure of therapists' lived experiences. First, the identification of trust as a meta-principle operating across both theme clusters represents a significant theoretical contribution derived from the temporal progression of therapists' experiential understanding. While previous research has acknowledged the importance of trust (Tjin et al., 2022), my phenomenological findings revealed its multidimensional nature, encompassing interpersonal trust, organizational trust, and cultural trust paradigms that must align for effective intervention.

Second, the progression from encountering foundational challenges to developing integration foundations suggests a developmental model of peer support integration that has been previously unrecognized in the literature. This phenomenological finding implies that organizations and clinicians must navigate predictable stages of implementation, each with distinct challenges and requirements as revealed through the essential structure of the participants' lived experiences. The linguistic analysis, revealing

increasing theoretical sophistication across theme clusters, further supports this developmental perspective, suggesting that adequate peer support requires evolutionary growth in conceptual understanding.

Third, the phenomenological findings introduce the concept of "role boundary permeability" as a critical factor in peer support effectiveness derived from therapists' lived clinical observations. Participants described scenarios where peer supporters must fluidly navigate between peer and para-professional roles, a complexity not adequately addressed in current theoretical models. One participant's experiential description of peers who "can confront them and challenge them while also having them feel supported" illustrates this delicate balance, suggesting the need for theoretical frameworks that account for role flexibility while maintaining appropriate boundaries.

Limitations of the Study

Several limitations emerged during the execution of my phenomenological study that warrant acknowledgment. First, despite efforts to recruit a diverse sample, the participant pool demonstrated limited ethnic and racial diversity, with six of seven participants who provided demographic data identifying as White/Caucasian. This homogeneity limits the transferability of the phenomenological findings to more diverse therapeutic contexts and may not capture culturally specific perspectives on the implementation of peer support. The first responder population itself is increasingly diverse (Office for Victims of Crime, 2020); however, the sample may not reflect the full spectrum of lived clinical experiences necessary to serve this changing demographic.

Second, the geographic concentration of participants in certain regions, despite representation across five states, may have introduced regional biases that affect the essential structure of the experiences captured. One participant specifically acknowledged, "that's here in Tennessee and experience in central Tennessee," recognizing that peer support implementation varies significantly by location. State-specific legislation, funding mechanisms, and organizational cultures likely influence peer support models in ways the phenomenological analysis could not fully capture.

Third, the reliance on therapists' experiential accounts, while appropriate for phenomenological inquiry, means that the lived experiences described could not be triangulated with objective program outcomes or first responder perspectives. Therapists' phenomenological understanding of peer support effectiveness may differ substantially from measurable clinical outcomes or the lived experiences of first responders themselves. This limitation is particularly relevant, given participants' reports of limited direct collaboration with peer support programs, which may indicate a selection bias toward therapists with specific types of experiential encounters.

Fourth, the cross-sectional nature of data collection captured perspectives at a single temporal point, potentially missing the evolution of peer support programs and therapists' changing lived experiences over time. The field of first responder mental health has evolved rapidly, particularly following high-profile incidents and the COVID-19 pandemic; therefore, the phenomenological snapshot may not accurately reflect current experiential trajectories.

Finally, while data saturation was achieved for the identified theme clusters, the sensitive nature of discussing programmatic failures and professional criticisms may have led to response bias affecting the essential structure captured. Despite assurances of confidentiality, participants may have moderated their critiques, particularly regarding specific programs or colleagues. My phenomenological approach relied on authentic experiential sharing; however, subtle self-censorship remained possible despite the generally open responses observed.

Recommendations

Based on the phenomenological findings and limitations, several critical areas warrant further investigation to extend understanding of the essential structure revealed. First, longitudinal phenomenological research tracking therapists' evolving lived experiences with peer support programs from inception through maturation would illuminate the developmental progression suggested by the temporal analysis. Such studies should examine how experiential understanding navigates the evolution from encountering challenges to achieving sophisticated implementation, documenting specific turning points and critical success factors through extended phenomenological engagement.

Second, comparative effectiveness studies are urgently needed to evaluate peer support outcomes in relation to and in combination with established trauma treatments, incorporating both phenomenological perspectives and quantitative measures. While therapists valued approaches such as EMDR, no rigorous trials have compared peer support to evidence-based psychotherapies for first responder PTSD. Mixed-methods

designs could capture both quantitative symptom changes and qualitative experiential dimensions of integrated care models. As Shalaby and Agyapong (2020) noted in their systematic review, the absence of high-quality randomized controlled trials limits evidence-based decision-making.

Third, research should examine cultural and demographic factors influencing peer support effectiveness through a more diverse phenomenological lens. My study's limited diversity highlights the need for investigations that specifically explore how race, ethnicity, gender, and sexual orientation intersect with lived experiences of peer support utilization and outcomes. One therapist commented on noticing “a lot of character disorder with the females” in their first responder clients, highlighting gendered patterns that may merit further phenomenological exploration. Culturally adapted peer support models may be necessary for increasingly diverse populations of first responders.

Fourth, organizational ethnographies examining peer support within different departmental cultures could identify the barriers that hinder implementation as well as the practices and conditions that make it more effective. The observation that "administrators that have been police for 30 years who are like, nah we don't need that" suggests generational and cultural dynamics requiring systematic investigation. Such research should examine how organizational leadership, funding structures, and cultural norms shape the essential structure of peer support program success.

Fifth, the development and validation of standardized peer supporter competency assessments represent a critical need informed by the competency gaps revealed in this phenomenological analysis. The findings revealed substantial training inconsistencies,

with observations of programs where " They don't want to be a whistleblower on anything because the retaliation is extremely probable." Empirically validated competency standards can guide the development and quality assurance of training, based on essential competency structures.

Finally, investigations of innovative delivery models, such as "regional peer teams" for rural communities, suggested by one of this study's participants, could address geographic and resource limitations. Research examining technology-enhanced peer support, inter-agency collaborations, and hybrid professional-peer models could expand access to care while maintaining its quality. The experience with "rural, suburban, and urban environments" underscores the need for adaptable approaches informed by diverse phenomenological contexts.

My phenomenological findings generate several immediate implications for clinical practice and program implementation derived from the essential structure of therapists' lived experiences. Based on the temporal progression identified in this study, mental health professionals working with first responders should actively assess clients' peer support experiences, understanding that these may be harmful when they remain problem-focused but become more beneficial as they evolve toward solution-focused support. Therapists should be prepared to address peer support-related trust violations and help clients navigate complex departmental dynamics. As demonstrated through lived experience, "only two or three have ever used their peer support before coming to therapy," suggesting therapists may be the first to hear about negative experiences.

The results of the researchers study suggest that training programs for peer supporters require fundamental restructuring to address competency gaps. Current brief training models appear wholly inadequate for the complex roles peers assume. Based on the findings, comprehensive curricula for peer support should include advanced communication skills, boundary management, crisis intervention protocols, ethical decision-making frameworks, trauma-informed approaches, and systems navigation (including workers' compensation and disability processes). The experience with programs combining "peer counseling and clinical counseling" offers a promising model for enhanced preparation.

Organizations implementing peer support should prioritize systemic changes addressing the barriers identified in the foundational challenges theme cluster of this study. This includes developing clear confidentiality policies with explicit exceptions, creating promotional incentives for peer support roles, establishing regular supervision structures for peer support specialists, and fostering leadership buy-in through education about the evidence-based benefits of peer support. The lived experience with programs having "multiple approaches to help them" suggests the value of comprehensive, multi-modal approaches.

Integration protocols between peer support and clinical services require formalization based on the integration foundations revealed through phenomenological analysis. My findings suggest that optimal outcomes occur when peer support functions as a bridge to professional treatment, rather than a substitute. Clear referral pathways, collaborative treatment planning, and regular communication between peers and

clinicians can maximize the benefits of both interventions. The experience where peers brought clients to sessions exemplifies effective collaboration.

Quality assurance mechanisms must be established to prevent the competency and ethical issues revealed in this study. Regular program evaluation, peer supporter performance reviews, client feedback systems, and adverse event tracking could identify problems before they undermine entire programs. The catastrophic failure, where confidentiality breaches led to the elimination of a whole program, underscores the importance of proactive quality management based on the essential trust structures identified.

Implications

Positive Social Change

My phenomenological findings carry profound implications for positive social change across multiple system levels based on the essential structure of therapists lived experiences. At the individual level, improving peer support programs could dramatically enhance psychological recovery for thousands of first responders who have PTSD and related conditions. When effectively implemented through the integration approaches revealed, peer support can transform isolation into connection, shame into acceptance, and hopelessness into recovery. The powerful testimony—"Cops trust cops, paramedics trust paramedics, firefighters trust firefighters... to hear that there are others who have been through it is everything"—captures this transformative potential.

At the family level, enhanced peer support could mitigate the cascading effects of first responder trauma on loved ones based on the relational dynamics observed through

therapists lived experiences. Multiple participants described how PTSD symptoms manifest primarily in home environments, straining marriages and parent-child relationships. By facilitating earlier intervention and more effective coping through the pathways revealed in the phenomenological analysis, improved peer support could preserve family systems that might otherwise fracture under trauma's weight. The observation of first responders who "don't feel connected to their kids" illustrates the family-level stakes involved.

Organizationally, the phenomenological findings suggest that properly implemented peer support can fundamentally shift emergency service cultures from stigma-based silence to a recovery-oriented dialogue. This cultural transformation could lead to fewer disability claims, lower turnover, increased operational effectiveness, and better community service delivery. As revealed through lived experience, adequate peer support helps responders "continue to do what they want to do... without exacerbating more symptoms," indicating organizational benefits of supporting employee wellbeing.

At the societal level, enhancing first responder mental health through improved peer support serves critical public safety functions, based on the essential structures revealed. Traumatized first responders may exhibit impaired judgment, increased aggression, and diminished capacity for community engagement—factors with direct public safety implications. The reference to problematic officers potentially linked to "burnout" and untreated trauma underscores how individual suffering can manifest as community harm. Adequate peer support represents an upstream intervention protecting both responders and the communities they serve.

Methodological Implications

The phenomenological approach revealed methodological insights applicable to future investigations of sensitive professional practices. The effectiveness of semi-structured interviews in eliciting candid critiques of existing programs—despite potential professional risks for participants—validates the use of phenomenological methods for studying systemic failures. The identification of trust as a meta-principle through Moustakas' inductive analysis highlights phenomenology's ability to capture overarching essentials that standardized approaches might miss.

The study also illustrates the value of researcher positioning in accessing hard-to-reach populations for phenomenological inquiry. My self-disclosed background in law enforcement likely facilitated recruitment and rapport, as evidenced by appreciation for someone who "took time to find out what it's like to be us." This suggests that insider-outsider positioning can be strategically leveraged in phenomenological research with closed professional communities.

However, the experience also reveals methodological challenges in studying interventions with inconsistent implementation through phenomenological lenses. The wide variation in peer support models complicated cross-case analysis and required flexible analytical approaches. Future mixed-methods designs might better capture this heterogeneity while still identifying common essential structures.

Theoretical and Empirical Implications

My findings suggest we need to rethink how peer support is understood within trauma recovery, based on the patterns that emerged in this study. The multidimensional

nature of trust, as revealed through lived experience analysis, underscores the need for more sophisticated theoretical models that recognize trust's operation across interpersonal, organizational, and cultural levels. Current applications of Resilience Theory and the Transactional Model of Stress and Coping fail to adequately account for these multilevel dynamics, as revealed through my investigation.

The developmental progression from encountering challenges to achieving integration, as revealed in the temporal structure, suggests that peer support follows predictable implementation stages—a finding with significant theoretical implications. This challenges static conceptualizations of peer support as a uniform intervention, suggesting instead that programs evolve through identifiable phases that require different supports and face distinct challenges.

The phenomenological findings indicate that peer support research should move beyond conceptual discussions and incorporate implementation science to ensure that evidence-based strategies are effectively integrated into practice. The gap between peer support's theoretical promise and practical failures suggests that implementation factors may be more determinative of outcomes than intervention content itself. This aligns with emerging recognition in healthcare that evidence-based practices require equal attention to implementation processes.

Implications for Practice

The practice implications of my findings extend beyond the specific recommendations offered earlier. At a fundamental level, the researchers study suggests that mental health professionals must reconceptualize their relationship with peer support

programs based on the essential integration structures that have been revealed. Rather than viewing peer support as a separate, parallel intervention, therapists should understand themselves as part of an integrated care ecosystem requiring active collaboration and mutual support.

This reconceptualization necessitates new competencies for therapists working with first responders, informed by the insights gained from my study. These include understanding peer support models and their variations, assessing clients' experiences with peer support and their therapeutic impact, navigating complex organizational dynamics that affect treatment, and advocating for systemic improvements in peer support delivery. As noted through participants' interviews in the researchers study about combining professional and peer perspectives, clients can "receive the absolute best care."

Training programs for mental health professionals should incorporate content on peer support collaboration informed by these phenomenological findings. In contrast, peer supporter training must include basic mental health literacy and appropriate referral processes. This bi-directional capacity building could address the competency gaps identified in the foundational challenges while facilitating the integration described in the developmental foundations.

Conclusion

My phenomenological exploration of therapists' lived experiences with peer support in first responder PTSD recovery reveals a complex landscape of promise constrained by systemic failures as understood through the essential structure of clinical

encounters. While the theoretical foundations of peer support remain sound—offering culturally congruent, accessible interventions grounded in shared experience—implementation realities fall far short of this potential. The two theme clusters emerging from the phenomenological analysis chart in the researchers study show a clear trajectory from encountering fundamental preparation failures through systemic barriers to aspirational visions of integrated care, all mediated by trust dynamics operating across multiple levels, throughout the temporal progression of understanding.

The central message emerging from this investigation is that peer support represents neither a panacea nor a problem, but rather a complex intervention that requires sophisticated implementation to achieve its full potential. The trust violations, competency gaps, and organizational barriers documented in the foundational challenges are not inherent limitations of peer support itself but rather failures of current implementation models. When therapists described successful peer support through their lived experiences—peer support specialists who facilitate treatment engagement, provide sustained encouragement, and bridge cultural divides—they illustrated what becomes possible with adequate training, supervision, and systemic support.

My study's unique contribution lies in elevating therapists' phenomenological voices in a discourse dominated by organizational perspectives and recipient experiences. These clinical professionals, positioned at the intersection of peer and professional interventions, offer crucial insights into both current failures and future possibilities. Their experiential perspectives reveal that adequate peer support requires more than good intentions and shared experience; it demands systematic preparation, ongoing support,

organizational commitment, and integration with professional services as understood through the essential structure of successful implementations.

As first responder mental health needs intensify amid societal upheaval and occupational stressors, the stakes for improving peer support have never been higher. My phenomenological findings suggest that realizing the potential of peer support requires fundamental shifts in how these programs are conceptualized, implemented, and evaluated. Half-measures—brief trainings, unfunded mandates, and unsupervised volunteers—not only fail to help but may cause active harm by betraying trust and reinforcing stigma.

The path forward requires courageous leadership willing to invest in comprehensive training, establish robust quality assurance, and foster genuine integration between peer and professional services based on the developmental model revealed through phenomenological analysis. It requires movement beyond simplistic either-or debates about peer versus professional support to embrace both-and solutions honoring each intervention's unique contributions as understood through the essential structure of effective integration. Most critically, it requires centering trust—interpersonal, organizational, and cultural—as the foundation upon which all effective intervention builds, as revealed through the meta-principle in this study.

The first responders who risk their lives protecting communities deserve nothing less than evidence-based, culturally competent, integrated support for the psychological wounds they sustain in service. The researchers study suggests that peer support, implemented adequately, could play a vital role in providing such support. The question

is not whether peer support can contribute to healing, but whether the collective will exist to implement it with the sophistication, resources, and commitment it requires. The voices of the therapists in this study, drawn from their years of lived clinical experience and professional wisdom, chart a clear path forward. The challenge now is to follow it.

References

- Alshahrani, K. M., Johnson, J., Prudenzi, A., & O'Connor, D. B. (2022). The effectiveness of psychological interventions for reducing PTSD and psychological distress in first responders: A systematic review and meta-analysis. *PLOS ONE*, 17(8), e0272732. <https://doi.org/10.1371/journal.pone.0272732>
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Publishing.
- Auth, N. M., Sensky, T., Booker, C. L., & Brewer, N. (2022). Mental health and help-seeking among trauma-exposed emergency service staff: A qualitative evidence synthesis. *BMJ Open*, 12(2), e047814. <https://doi.org/10.1136/bmjopen-2020-047814>
- Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15(2), 219–234. <https://doi.org/10.1177/1468794112468475>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Chen, J. A., Chung, W. J., Young, S. K., Tuttle, M. C., Collins, M. B., Darghouth, S. L., & Dimeff, L. A. (2020). COVID-19 and telepsychiatry: Early outpatient experiences and implications for the future. *General Hospital Psychiatry*, 66, 89–95. <https://doi.org/10.1016/j.genhosppsy.2020.07.002>
- Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and*

Psychological Measurement, 20(1), 37–46.

<https://doi.org/10.1177/001316446002000104>

Campos, F. D., Ferreira, A. I., & Gomes, A. R. (2023). Work social support and PTSD in police officers. *Sustainability*, 15(24), 16728.

<https://doi.org/10.3390/su152416728>

Crane, M. F., Falon, S. L., Kho, M., Moss, A., & Adler, A. B. (2022). Developing resilience in first responders: Strategies for enhancing psychoeducational service delivery. *Psychological Services*, 19(Suppl. 2), 17–27.

<https://doi.org/10.1037/ser0000439>

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications.

Dolezal, M. J. (2021). *Predicting first responder resilience: Investigating the indirect effect of posttraumatic cognitions through coping processes* (Publication No. 28322191) [Doctoral dissertation, Seattle Pacific University]. ProQuest Dissertations Publishing.

Donovan, N. (2022). Peer support facilitates post-traumatic growth in first responders: A literature review. *Trauma*, 24(4), 277–285.

<https://doi.org/10.1177/14604086221079441>

Elbers, J., & McCraty, R. (2020). HeartMath approach to self-regulation and psychosocial well-being. *Journal of Psychology in Africa*, 30(1), 69-79.

<https://doi.org/10.1080/14330237.2020.1712797>

Garmezy, N. (1974). The study of competence in children at risk for psychopathology. In

- E. J. Anthony & C. Koupernik (Eds.), *The child in his family: Children at psychiatric risk* (pp. 77–97). Wiley.
- Ge, F., Yuan, M., Li, Y., & Zhang, W. (2020). Posttraumatic Stress Disorder and Alterations in Resting Heart Rate Variability: A Systematic Review and Meta-Analysis. *Psychiatry Investigation*, 17(1), 9.
<https://doi.org/10.30773/pi.2019.0112>
- Khazaei, A., Navab, E., Esmaeili, M., & Masoumi, H. (2021). Prevalence and related factors of post-traumatic stress disorder in emergency medical technicians: A cross-sectional study. *Archives of Academic Emergency Medicine*, 9(1), e35.
<https://doi.org/10.22037/aaem.v9i1.1157>
- Kvale, S., & Brinkmann, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). SAGE Publications.
- Lawn, S., Roberts, L., Willis, E., Couzner, L., Mohammadi, L., & Goble, E. (2020). The effects of emergency medical service work on the psychological, physical, and social well-being of ambulance personnel: A systematic review of qualitative research. *BMC Psychiatry*, 20(1), 348.
<https://doi.org/10.1186/s12888-020-02752-4>
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>

- Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 11(3), Article 8. <https://doi.org/10.17169/fqs-11.3.1428>
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227–238. <https://doi.org/10.1037/0003-066X.56.3.227>
- Miles, M. B., Huberman, A. M., & Saldaña, J. (2020). *Qualitative data analysis: A methods sourcebook* (4th ed.). SAGE Publications.
- Modula, M. J., Mathapo-Thobakgale, E. M., Nyoni, C. N., & Jansen, R. (2024). Strategies for coping with occupational trauma: A scoping review of the police officer context. *International Journal of Environmental Research and Public Health*, 21(7), 921. <https://doi.org/10.3390/ijerph21070921>
- Moustakas, C. (1994). *Phenomenological research methods*. SAGE Publications.
- Oakes, H., Millett, G., Hudson, A., Davis, S., & Thomson, M. H. (2024). *Models of stress and coping in high-risk professions*. Defence Research and Development Canada. <https://pubs.drdc-rddc.gc.ca/BASIS/pcandid/www/engpub/DDW?W%3DSYSNUM%3D818971%26M%3D1%26R%3DY%26U%3D1>
- Obuobi-Donkor, G., Oluwasina, F., Nkire, N., & Agyapong, V. I. O. (2022). A scoping review on the prevalence and determinants of post-traumatic stress disorder among military personnel and firefighters: Implications for public policy and practice. *International Journal of Environmental Research and Public Health*, 19(3), 1565. <https://doi.org/10.3390/ijerph19031565>

- Office for Victims of Crime. (2020). *Mental health responses to mass violence and terrorism: A field guide*. <https://ovc.ojp.gov/library/publications/mental-health-response-mass-violence-and-terrorism-field-guide>
- Papazoglou, K. (2023). Stress, prevention, and resilience among first responders. *International Journal of Environmental Research and Public Health*, 20(24), 7174. <https://doi.org/10.3390/ijerph20247174>
- Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). SAGE Publications.
- Petrie, K., Milligan-Saville, J., Gayed, A., Deady, M., Phelps, A., Dell, L., Forbes, D., & 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://pubmed.ncbi.nlm.nih.gov/29869691/>
- Pietrantonio, L., & Prati, G. (2008). Resilience among first responders. *African Health Sciences*, 8(Suppl 1), S14–S20.
- Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2010). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: Results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Anxiety Disorders*, 25, 456–465. <https://doi.org/10.1016/j.janxdis.2010.11.010>
- Pihl-Thingvad, J., Andersen, L. L., Brandt, L. P. A., & Elklit, A. (2019). Are frequency and severity of workplace violence etiologic factors of posttraumatic stress

disorder? A 1-year prospective study of 1,763 social educators. *Journal of Occupational Health Psychology*, 24(5), 543–555.

<https://doi.org/10.1037/ocp0000148>

Pink, J., Gray, N. S., O'Connor, C., Knowles, J. R., Simkiss, N. J., & Snowden, R. J.

(2021). Psychological distress and resilience in first responders during COVID-19. *Journal of Occupational and Organizational Psychology*, 94(4), 789–807.

<https://doi.org/10.1111/joop.12364>

Ponder, W. N., Beattie, E., Yockey, R. A., Cassiello-Robbins, C., & Carbajal, J. (2024).

First responder resilience: A cross-sectional network analysis. *Traumatology*.

Advance online publication. <https://doi.org/10.1037/trm0000510>

Ryu, G. (2024). A theoretical integration of work–family studies with the transactional model of stress. *Journal of Family Theory & Review*, 16(1), 45–60.

<https://doi.org/10.1111/jftr.12423>

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>

Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer support in mental health: Literature review. *JMIR Mental Health*, 7(6), e15572. <https://doi.org/10.2196/15572>

Smith, J., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.). SAGE Publications.

Substance Abuse and Mental Health Services Administration. (2018). *First responders:*

Behavioral health concerns, emergency response, and trauma.

<https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf>

Tjin, A., Traynor, A., Doyle, B., Mulhall, C., Eppich, W., & O'Toole, M. (2022). Turning to "trusted others": A narrative review on providing social support to first responders. *International Journal of Environmental Research and Public Health*, 19(16492), 1–15. <https://doi.org/10.3390/ijerph192416492>

van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). Routledge.

Wagner, S. L., White, N., Fyfe, T., Matthews, L. R., Randall, C., Regehr, C., White, M., Alden, L. E., Buys, N., Carey, M. G., Corneil, W., Fraess-Phillips, A., Krutop, E., & Fleischmann, M. H. (2020). Systematic review of posttraumatic stress disorder in police officers following routine work-related critical incident exposure. *American Journal of Industrial Medicine*, 63(7), 600–615.

<https://doi.org/10.1002/ajim.23120>

Walden University. (n.d.). *Research ethics and compliance: Policies and procedures.*

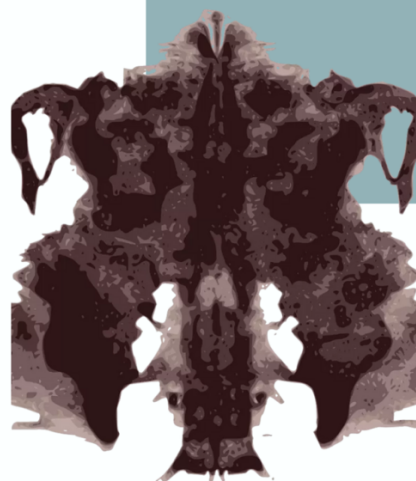
<https://academicguides.waldenu.edu/research-center/research-ethics>

Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth.* McGraw-Hill.

Appendix A: Recruitment Flyer

PARTICIPANTS NEEDED

Interview for study
of peer support in
PTSD recovery



OBJECTIVE

This study aims to explore therapists' perspectives on the role of peer support in the recovery from PTSD among first responders.

INTERVIEWS

- Will be via Zoom
- Will last 30-60 minutes
- Will be audio-recorded

For more information,
email:

✉ XXX@waldenu.edu

Volunteers must be:

- A licensed mental health professionals (e.g., psychologist, LCSW, LPC, LMFT)
- Have experience providing services to first responders with PTSD or trauma
- Have been providing clinical services post-licensure for at least two years
- Experience with peer support for first responders

Appendix B: Semistructured Interview Protocol

Introduction Script:

“Thank you for participating in this interview. The purpose of my study is to explore how licensed mental health professionals perceive and experience the role of peer support in the recovery of first responders who have been affected by PTSD. Your insights will contribute to the understanding of how peer support complements clinical treatment. You are free to skip any question, and you may stop the interview at any time. I will audio-record this interview for transcription and analysis. Do you have any questions before we begin?”

Primary Interview Questions & Follow-Up Prompts

1. Can you describe your professional experience working with first responders?

Follow-up prompts:

- What types of trauma-related concerns do you most frequently address with first responders?
- How long have you been working with first responders?

2. In your clinical experience, how have you observed PTSD manifest in first responders?

Follow-up prompts:

- Are there common patterns, symptoms, or challenges you've noticed in your work with first responders?
- How do these symptoms affect the daily functioning or treatment engagement of first responder clients?

3. What does peer support look like in the context of your work with first responders?

Follow-up prompts:

- Can you describe any structured or informal peer support systems your first responder clients have?
- How have clients described their peer support experiences to you?

4. What is your clinical perception of the impact of peer support on a first responder's recovery from PTSD?

Follow-up prompts:

- Please share examples where peer support made a noticeable difference in treatment outcomes for first responder clients?
- In your view, what specific elements of peer support are most effective for first responder clients?

5. Are there any challenges or limitations you've encountered when integrating peer support into treatment planning for your first responder clients?

Follow-up prompts:

- Have there been any ethical considerations or boundary issues related to integrating peer support with your first responder clients?

- Do some first responder clients reject or disengage from peer support options? What is your clinical perspective as to why this occurs for first responder clients or why it does not occur?

6. How do you incorporate discussions about peer support during therapy sessions with your first responder clients, if at all?

Follow-up prompts:

- Do you refer first responder clients to peer-led groups or organizations?
- Do you assess peer relationships during intake or treatment planning with your first responder clients?

7. In your opinion, how does peer support align with or differ from professional mental health treatment in supporting PTSD recovery for first responders?

Follow-up prompts:

- Do you view peer support as complementary, supplementary, or potentially conflicting with professional mental health treatment?
- In your opinion, can peer support serve therapeutic purposes that clinical treatment does not for first responder clients?

8. Is there anything else you would like to share about the role of peer support in the psychological recovery of first responders?

Follow-up prompt:

- Is there a question I should have asked that would help illuminate this topic further?

Closing Script:

“Thank you so much for your time and valuable insights. If you have any follow-up thoughts after this interview, please don’t hesitate to reach out. Do you have any final questions or comments?”

Appendix C: Mental Health Support Referral List

1. National Alliance on Mental Illness (NAMI) – www.nami.org / 1-800-950-NAMI (6264)
2. Substance Abuse and Mental Health Services Administration (SAMHSA) Helpline – www.samhsa.gov / 1-800-662-HELP (4357)
3. Psychology Today – Therapist Directory – www.psychologytoday.com/us/therapists
4. Open Path Collective – www.openpathcollective.org (Affordable therapy options for individuals and families)
5. Local Employee Assistance Programs (EAPs) – Available through many employers

This list was not exhaustive, and participants were encouraged to contact providers in their region or through their health insurance network.

Appendix D: Demographic Details

• What is your age?

- Under 30
- 30–39
- 40–49
- 50–59
- 60 or older

• What is your gender identity?

- Female
- Male
- Non-binary / Third gender
- Prefer to self-describe: _____
- Prefer not to say

• What is your race/ethnicity? (Check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Prefer to self-describe: _____
- Prefer not to say

• What type of license do you currently hold as a mental health professional?

- Licensed Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Other (please specify): _____

• How many years of clinical experience do you have post-licensure?

- 2–5 years
- 6–10 years
- 11–15 years
- 16–20 years
- More than 20 years

• Have you ever provided clinical treatment to first responders (e.g., law enforcement, firefighters, EMTs)?

Yes

No

• **Do you have any specialized training related to trauma or PTSD?**

Yes (please describe briefly): _____

No

• **What is your primary practice setting?**

Private practice

Community mental health center

Hospital or medical center

Government agency or military setting

Academic or university clinic

Other (please specify): _____

• **Have you had professional experience with peer support programs for first responders?**

Yes

No

• **If yes, how many years of experience do you have working with peer support programs?**

Less than 1 year

1–3 years

4–6 years

7–10 years

More than 10 years