Bringing the War Home: Redeployment Experiences of Spouses of Combat Veterans with Post-Traumatic Stress Disorder

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BRINGING THE WAR HOME: REDEPLOYMENT EXPERIENCES OF SPOUSES OF COMBAT VETERANS WITH POST-TRAUMATIC STRESS DISORDER

A Thesis
Submitted to the School of Graduate Studies and Research
In Partial Fulfillment of the
Requirements for the Degree
Master of Arts

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August 2012
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The purpose of this study is to better understand, through retrospection, how military spouses recognized the likelihood that their veteran needed to be evaluated for Post-Traumatic Stress Disorder. Existing research examines the role educating spouses of veterans with PTSD can play in the detection and diagnosis of PTSD but it does not identify specific educational needs of spouses. An online-survey was administered to spouses of combat veterans with PTSD. Themes between respondents were identified as need for self-care, avoiding self-blame, and tolerance and understanding for the veteran. Participants discussed lack of education on PTSD and redeployment issues as well as perceived lack of support by the military during deployment and redeployment processes.
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CHAPTER I: THE PROBLEM

“They say it takes a special woman to be a Military spouse- it takes an even tougher one to be a spouse of a Soldier who has never really come home. I love my husband unconditionally, in sickness and in health, and I remind myself of that every day. He came home- even if he isn’t exactly the same as he was when he left. I wouldn’t have left him if he came home with no legs, this is no different.” - Participant 2

There are many visible signs when a nation is at war: departures and homecoming, casualty statistics and military awards, media coverage and protests. Often times, however, the most deep seeded battles are at home long after the combat has ended. While soldiers are thousands of miles away fighting the war, spouses are left behind to hold together the lives of their families and loved ones. Often called the silent ranks, military wives face their own battles but often do not receive the support and resources they need to be successful.

Purpose of Study

The purpose of this study is to better understand, through retrospection, how military spouses recognized the likelihood that their veteran needed to be evaluated for Post-Traumatic Stress Disorder. A survey will be used to gather hindsight recollections of spouses of military combat veterans with a diagnosis of PTSD about the time leading up to the veterans’ diagnosis. Through collecting and analyzing hindsight recollections, it may be possible to incorporate this information into future educational programming for military spouses.

Statement of Problem

The rate at which combat veterans are being diagnosed with Post Traumatic Stress Disorder (PTSD) is rising at an alarming rate; despite this, spouses are receiving little or no additional education pertaining to the redeployment process or the possible presence of PTSD (Buchanan, Kemppainen, Smith, MaKain & Cox, 2011). Such education can potentially assist spouses with
identifying the warning signs for PTSD and avoiding negative consequences for the spouse and the veteran as a result of a missed diagnosis. Approximately one quarter of returning combat veterans will receive mental health care from the Department of Veterans Affairs (Kang & Hyams, 2005) with the most common diagnoses being PTSD (20%), anxiety (18%), depression (15%), and substance abuse (33%) (Erbes, 2007). While the number of diagnoses being made continues to rise, the number of veterans choosing to seek treatment following an Axis I diagnosis has remained stagnant at approximately 50% (Erbes, 2007). PTSD, especially, has a tendency to result in social and occupational problems which often detrimentally affect the family unit (Erbes, 2007). Although there are many potential risks to leaving PTSD untreated, there are also many barriers to seeking services, such as general attitudes pertaining to mental health care, fear and apprehension about the future, and how having a diagnosis may impact a military career (Sherman, Blevins, Kirchner, Ridener & Jackson, 2008).

The importance of the spouse is two-fold in the diagnosis and successful treatment of Post-Traumatic Stress Disorder in military combat veterans. Primarily, the spouse is able to witness changes in the veteran that occur after deployment. Spouses have knowledge of the veteran prior to deployment and are therefore able to identify changes in behavior and affect. The ability to identify and report symptoms in the veteran, however, is greatly affected by spouse’s psychological status (Gallagher, Riggs, Byrne & Weathers, 1998). If the spouse begins exhibiting symptoms of secondary traumatization, the likelihood of the spouse misconstruing normal behaviors of the veteran as potential symptoms of PTSD is high. Additionally, spouses of veterans with PTSD or other combat related mental health diagnoses are significantly more likely to experience symptoms of their own (such as somatization, obsessive-compulsive
problems, depression, anxiety, paranoid ideation, and psychoticism) than spouses of veterans without a PTSD diagnosis (Arzi, Solomon, & Dekel, 2000). Living with a veteran with PTSD poses a serious risk to the health and well-being of the spouse.

When left undiagnosed, PTSD has shown to be associated with a lower overall quality of life. Spouses can serve as a valuable tool in the diagnosis and treatment of this disorder. Through education, spouses can learn to detect possible warning signs in order to aid the veteran in seeking and receiving mental health treatment as well as potentially protecting their own emotional and physical well-being.

**Relevance to the Counseling Profession**

The counseling profession is at the forefront of providing treatment and support to individuals suffering from mental illness. Much support and information is available regarding the needs of combat veterans, but little research is available pertaining to the experiences and needs of the spouses of combat veterans (Military One Source, 2012). Military spouses experience many significant life-stressors throughout the course of the deployment process that can affect their own mental health as well as the health of their families and veterans. As clinicians, awareness of these stressors can be beneficial to provide the highest quality of care and to ensure the best outcomes for spouses and veterans.

A primary goal of the counseling profession is prevention. By equipping spouses of combat veterans with the knowledge and tools to identify possible warning signs of PTSD, it is possible to minimize the consequences of an undiagnosed disorder including secondary traumatization and domestic violence. PTSD can be a difficult disorder to diagnose: educating spouses and integrating them into the identification of PTSD may be beneficial in both the diagnostic and
treatment process.

Additionally, working with the military and military families has been an obstacle to the counseling profession. Currently, in all branches of the military, a degree and licensure in counseling is not sufficient to perform any mental health care duties within the military although it is beginning to be accepted by government sponsored insurances outside of military facilities. Most recently the American Counseling Association has advocated for and been accepted in the Veterans Administration and TriCare approved sites. The counseling profession provides a unique viewpoint that could be greatly beneficial to the diagnosis and treatment of mental disorders in the military that have yet to be explored.

**Previous Studies**

Research pertaining to combat induced PTSD has come in a biphasic response to the most recent military conflicts: Vietnam, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Recently, there has been increased interest in the impact of PTSD on marriage and the family unit. The concepts of incorporating the spouse into the diagnosis and treatment process as well as the impact the veteran’s disorder can have on the spouse’s health are relatively new.

Gallagher, Riggs, Byrne and Weathers (1998) investigated the accuracy at which a female spouse can estimate the severity of her veteran’s PTSD. This study indicated that spouses are moderately capable of estimating the severity of impact, but were unable to identify associated symptoms such as avoidance and exaggerated startle responses. It was noted that these behaviors are often times misinterpreted due to lack of understanding of PTSD on the part of the spouse. The present study aims to reframe this issue by using retrospection to understand
how spouses were able to identify sign and symptoms of PTSD in their spouse.

Sherman, Blevins, Kirchner, Ridener, and Jackson (2008) examined veterans’ and spouses’ views of education. This study indicated that whenever spouses are educated about the effects of PTSD, veterans are more likely to engage in treatment and feel supported by their spouse. Education helps to minimize veterans’ fears that spouses will not understand what is happening with their diagnosis and treatment. Additionally, spouses can serve to educate veterans and show their support through engaging in education and treatment surrounding PTSD. Increased level of understanding may facilitate and encourage communication between spouses and veterans in order to convey support and allow for growth while learning to manage PTSD.

In a 2011 study, Buchanan, Kemppainen, Smith, MacKain, and Cox presented preliminary findings on female spouses/intimate partners of combat veterans’ perceptions of Post-Traumatic Stress Disorder. This qualitative study explored spouses’ knowledge of PTSD, strategies to recognize PTSD symptoms, methods for determining veteran’s readiness to seek treatment, and behaviors that could lead to veterans accessing mental health care. Self-administered questionnaires based on critical incident technique were utilized to examine perceived barriers to PTSD treatment. The primary emphasis of this study was placed on barriers spouses face in identifying PTSD symptoms in veterans. The present study aims to use a similar technique in order to examine what information was helpful for the spouse to overcome these barriers to treatment and to increase understanding of PTSD.

Previous research has examined the spouse’s ability to identify PTSD symptoms in the veteran; the effect education has on the treatment process, and spouses’ perceptions of PTSD. While there is currently little research available in this area, it is clear that it is a current issue
and likely to be an even larger clinical issue in the future due to the large number of returning veterans. There is currently a wide array of informal resources available to spouses with a much lower number of empirically supported sources available. As mental health practitioners, it would be helpful to understand the information that is the most important and relevant to the population in order to establish best practice. The aim of this study is to continue to add to the literature particularly in the area of prevention and education.

**Definitions of Terms**

Combat Veteran – a member of the United States military who has been deployed to a theater of operations.

Spouse – a female who is legally married to a male combat veteran.

Predeployment – the time frame between receiving combat orders and being deployed.

Redeployment – The transition period after returning state-side following a combat deployment.

Military Service Commitment – period of obligated military service.
CHAPTER II: REVIEW OF RELATED LITERATURE

For military families, life can be full of stresses and strains unimaginable to civilians. At a time of war, these stresses are often amplified by the constant fear of deployment. With combat forces currently stationed in theaters across the world, millions of troops have been sent from their families to fulfill their military duty. The military places a strong emphasis on the value of preparation and readiness, yet little is being done to help prepare military spouses for the adversities of deployment and combat related injury. Education is often a secondary concern and very few families have knowledge of the warning signs and symptoms of PTSD that could play a pivotal role in the diagnosis and treatment of the disorder (Buchanan, 2011). The importance of preparation for redeployment is amplified in the presence of Post-Traumatic Stress Disorder exhibited through increases in divorce and intimate partner violence, decreases in marital satisfaction, and increased reported difficulties of children rearing in couples affected by PTSD (Galvoski & Lyons, 2004). Educating spouses about PTSD prior to redeployment can assist in the diagnosis and treatment of PTSD while helping to maintain the physical and psychological well-being of the spouse and the integrity of the marriage.

**Military Culture**

Since the commencement of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), military members are being exposed to a level of combat related stress not seen since the Vietnam War. The military instills within its soldiers a strong tradition of mental-toughness, discouraging individuals from seeking help for potentially life-threatening psychological disorders. In 2002, the rapid incline of incidents of domestic violence, homicide, and suicide by combat trained military members at Fort Bragg captured national attention and
began a mental health movement within the military (Biank, 2006).

Currently, there is recognition of the correlation between family readiness and mission readiness in all branches of the armed forces. Programs are being implemented to help prepare families for deployment and assist with basic needs throughout the deployment process, but many of the newly implemented family readiness programs end immediately after the tour of duty (Military OneSource, 2012). The days and weeks following redeployment can be filled with anxiety and turmoil as the family works to reintegrate the veteran back into daily civilian life. Combat deployments have a lasting effect on veterans and can manifest themselves in a variety of ways upon redeployment. As long as military members continue being deployed to combat zones, families will be left with the responsibility of coping with post-deployment anxiety and difficulties associated with reintegration into society that almost all combat veterans face. Homecomings are thought to be a happy reunion, but after the parades and celebrations, the real work begins helping the family reenter civilian life.

There are currently over 2 million active duty and reserve military members between the Army, Air Force, Marines, Navy, and Coast Guard; of these, approximately 50% of military members are married (IWCG, 2011). This population of military spouses works to maneuver their way through the military hierarchy while supporting their soldier and often times raising a family. With the number of troops returning from combat with mental health diagnoses on the rise, military spouses are also forced to manage through the difficult world of mental health care while facing the stigma and potential penalties of receiving a diagnosis. The transition from spouse to caregiver is often difficult and can threaten the integrity of the marriage.

There are numerous factors that influence a family’s experience with the military and
the services that are provided to them. Primarily, the type of service and branch of service has a significant impact on experience. There are five branches of service: Army, Air Force, Marines, Navy, and Coast Guard. Each branch has unique features that can affect the type of deployment as well as the types of services available to family members left at home. Each branch has its own set of services (e.g. family readiness, mental health, etc.); therefore, larger branches (such as the Army) are able to provide more assistance than smaller branches (such as the Coast Guard).

The type of commitment also strongly influences the type of services available to families and service members during and after deployment. There are three types of commitment: Active Duty, Reserve, and National Guard. Active duty refers to a full time military service commitment. Service members and families who are active duty live on or near the base or post at which the service member is stationed. This allows families to utilize services tailored especially to the needs of military families. For the spouse, this means being surrounded by a social support system that has insight into the experiences of deployment and military life. Access to resources pertaining to the deployment can aid in the adjustment process across the entirety of the tour of duty. Additionally, for Active Duty service members, the military is the primary source of income and benefits. Despite this, the concept of mental toughness is also expected of the spouse and family leaving little room to seek help on their own.

Reserve and National Guard members, however, are on part time military duty. The amount of time they dedicate to their commitment varies, with many serving approximately one month per year. This means that service members typically live at home and hold other
employment. Reservists serve on a national level whereas National Guard members are commissioned by the state. When National Guard and Reserve members are deployed, families of service members often do not have the support or resources allotted to Active Duty Families. This is particularly difficult for National Guard and Reservist families in which the soldier must leave other employment, greatly impacting the financial stability of the family unit. There are numerous resources available to aid in this process, however, the transition appears to be easier for those living on a post/base and surrounded by others in similar positions.

**OEF/OIF and PTSD**

Due to the current climate of the war, the occurrence of traumatic events is extremely high. Posttraumatic Stress Disorder occurs in individuals who have experienced or witnessed an event that involves actual or threatened death or serious injury of themselves or others (APA, 2000). The overall climate of the theaters of operations is allowing for the combat zone to spill into otherwise neutral zones through use of improvised explosive devices (IEDs) and difficulty differentiating civilians from enemy. This ambiguity forces OEF and OIF veterans to remain on high alert at all times leading them to experience the highest levels of PTSD of any other war (IWCG, 2011). After the traumatic event, symptoms include intense fear or feelings of helplessness manifested through re-experiencing events, avoidance of specific circumstances or increased arousal. In order for a diagnosis to occur, these symptoms must occur over a minimum of one month (APA, 2000). Symptoms may occur immediately after the occurrence of the incident or may be delayed to any time after.

**Deployment Process**

For military spouses, deployment marks the most noteworthy commitment of service
they will encounter throughout their service member’s career. Deployment affects the veteran and the family on psychological and practical levels (Erbes et al., 2008). The process begins when the military member receives notification of deployment but may not end for years or decades after redeployment. From the time a soldier receives deployment orders, the psychological, social and financial strains begin. Pre-deployment is a time filled with planning and fear surrounding the deployment process. The impending departure results in high levels of anxiety which is commonly coupled with changes in orders and overall uncertainty pertaining to the deployment experience (IWCG, 2011). The couple must prepare for the separation and rework the family structure. For both the soldier and spouse, this is the first event that may reveal warning signs for future psychological illness as manifested in their response to anxiety (IWCG, 2011).

The deployment experience continues to be filled with uncertainty and requires preparation as well as recovery. Much of the pressure and responsibility associated with the deployment is placed upon the spouse including reworking the structure and responsibilities of the household during the absence of the service member (IWCG, 2011). The family must learn to function in new ways while learning to cope with additional psychological burdens. During this phase, the marital relationship undergoes large amounts of change and often times serve as a catalyst for both parties to begin to question the strength of the relationship bond (Erbes et al, 2008). The spouse is left at home not only missing the soldier while he is away, but also facing the possibility that he may return injured or even be killed (Erbes et al, 2008). This worry can lead to high levels of anxiety and depression. Often times, spouses worry about the safety of their soldiers, while soldiers worry about how the family will run without them. While redeployment
is often filled with excitement and relief, it can also be filled with many stressors as the family structure is reworked to incorporate the veteran once again.

**Marital Relationships and PTSD**

The marital relationship is greatly affected by redeployment particularly when the returning veteran is suffering from PTSD. The transition from soldier to spouse is one that many veterans struggle with upon redeployment. This transition places an extremely large burden on the individuals responsible for reintegrating veterans back into families. Couples with a partner who is diagnosed with PTSD are more likely to report low marital satisfaction and be divorced or consider divorce than couples with no partner who is diagnosed with PTSD (Galvoski & Lyons, 2004). Increased understanding of PTSD by the spouse may help to maintain the marital bond when a veteran has a diagnosis. Spouses and veterans report higher levels of marital satisfaction in couples in which the veteran believes the spouse understands PTSD compared to their uneducated counterparts (Sherman et al., 2008). This level of understanding allows the couple to function better as a unit and also allows the spouse to educate and provide support to the veteran. In relationships in which the veteran is unaware of the spouse’s support and understanding, marital issues are more common. Spouses report suggesting treatment, issuing an ultimatum, taking action themselves, providing patience and support, working to acquire proof that PTSD treatment is needed, or feeling helpless as responses to PTSD symptomology (Buchanan, 2011). Providing spouses with the tools to understand PTSD may help to increase the positive responses leading to active treatment for the veteran.

Many individuals caring for a veteran with a PTSD diagnosis struggle with adjustment to life after deployment. The added stressors associated with being the caregiver of a veteran can
lead to decreased reports of happiness and life satisfaction, as well as increased level of anxiety and reports of depressive symptoms (Williamson, Miller & Schulz 2011). These challenges, in addition to the increased prevalence of veteran’s substance abuse and domestic violence, may contribute to the increases in divorce among combat veterans. Veterans with PTSD are more likely to become angry and act on the anger as a result of increased frequency of arousal, more hostile attitude toward others, and greater sensitivity to anger (McFall et al., 1999). Within the relationship, the occurrence of intimate relationship discord, intimate relationship aggression, and intimate relationship psychological aggression is significantly higher than that of non-PTSD relationships (Taft, Watkins, Stafford, Street, & Monson, 2011). There is an increase in interpersonal violence in partners with a PTSD diagnosis with 42% of Vietnam veterans engaging in at least one act of physical violence and 92% reporting an act of verbal aggression during the year preceding redeployment (Price & Stevens, 2010). The nature of PTSD is unpredictable but has the potential to contribute to serious harm to the veteran or the spouse. The negative effects of combat induced PTSD on the spouse can be intensified if left untreated.

**Spouses’ Health**

Secondary traumatization, or the similar physical and psychological responses in an individual who is closely associated with an individual who underwent the initial stressor (Arizi, Solomon, & Dekel, 2000), is becoming increasingly common in spouses of OEF/OIF veterans (Wilcox, 2010). A wide array of symptoms reflective of the veteran’s symptoms may manifest in the spouse including somatization, obsessive-compulsive problems, depression, anxiety, paranoid ideation, and psychoticism as manifested through irritability, alienation, guilt, and rage (Arzi, Solomon & Dekel, 2000). These symptoms are often coupled with additional
symptoms similar to those being experienced by the veteran as a direct result of PTSD including nightmares relating to traumatic event, feelings of shame, dread, horror, grief, and mourning (Calhoun, Beckham & Bosworth, 2002). Specific symptoms exhibited by the veteran, specifically numbing and withdrawal, appear to lead to the highest level in distress in the spouse as opposed to other symptoms (Renshaw & Campbell, 2011).

The health of the spouse and the veteran are largely reliant upon each other. It requires the proper treatment and understanding from both parties in order to create a balance ensuring the psychological and physical well-being of both parties. A spouse’s ability to report on the veteran’s progress and treatment is largely affected by the spouse’s psychological status (Gallagher, et al., 1998); therefore, in order to utilize this tool, it is necessary to maintain the spouse’s well-being as well as the veterans. The presence of interpersonal violence and the severity of symptoms are largely associated with increased experience of caregiver burden by the spouse (Calhoun, Beckham & Bosworth, 2002). Similarly, the greater the symptoms in the veteran, the greater the symptoms in the spouse (Renshaw & Campbell, 2011). There is a delicate balance required to ensure the well-being of the spouse and the veteran. Due to the severity of PTSD, it requires both parties to work to maintain their own psychological health to ensure the effects of their condition are not impacting the partner.

**Education and Treatment**

Education may be a viable tool in reducing the psychological strain placed on spouses of veterans with PTSD. Psychological adjustment for the spouse can often be inhibited when the veteran is experiencing PTSD and there are higher reports of increased perceived burden in spouses of veterans with PTSD (Calhoun, Beckham, & Bosworth, 2002). PTSD can be a difficult
disorder to diagnose and veterans are often unable or reluctant to share information pertaining to their symptomology (Gallagher, et al., 1998). The process can be greatly assisted by a spouse’s ability to report on how the veteran explains his symptoms as well as the spouse’s own observations about the veteran’s behavior (Gallagher, et al., 1998). This can include observations of changes in everyday habits and behaviors, physical manifestations (e.g. nightmares, inability to sleep, etc.), and mental state (Buchanan, 2011). The spouse often has awareness of changes that occurred from prior to deployment to the time the veteran returns home. This insight would otherwise be unavailable to mental health practitioners and can provide important information to assist in the diagnosis of PTSD. This additional empirical data is often more objective than veteran’s self-report of behaviors. Spouses can also serve as a source of emotional and social support to the veteran throughout the course of treatment. This additional support in the diagnosis process can lead to faster, more accurate diagnosis and a quicker turnover time to begin treatment.

Social support is proven to help serve as a buffer to protect against stress-related illness and disorders. While there are various types of social support (friends, coworkers, family, professional helpers, etc.), spouses/significant others may be the most beneficial and effective means of social support (Wilcox, 2010). Despite this, military divorce rates (particularly among combat veterans) are reaching record levels leaving traumatized veterans without a primary source of social support. There is growing evidence to support parallels between Vietnam and OEF/OIF veterans particularly in terms of relationship discourse prior to deployment. In Vietnam veterans, approximately 38% of individuals returning from combat divorced within six months of redeployment with the divorce rate for those with a PTSD diagnosis being two times
greater (Price & Stevens, 2010).

Due to the increasing number of service members returning from combat with PTSD, the media has taken an interest in covering the disorder; despite this, very few spouses of combat veterans receive any education on the symptoms of PTSD. In today’s culture, where popular media is equipping consumers with the information to self-diagnose, more people are turning away from formal education and training and are relying on informal sources such as television and the internet. The media is currently the most common source of education pertaining to PTSD for spouses of military veterans; this is followed by learning from family and peers (Buchanan, 2011). While these forms of informal education can help to provide basic knowledge, it cannot provide the resources needed to truly understand the disorder and prepare to live with a veteran suffering from PTSD.

Veterans often have their own perceptions on the value of education. Knowing the spouse has received education pertaining to PTSD can help open paths of communication between the veteran and the spouse as well as show the veteran support. When spouses are uneducated, many veterans fear that their spouses will not understand what is happening with the diagnosis and treatment of PTSD (Sherman et al., 2008). Additionally, veterans can identify benefits of having a spouse educated on PTSD including conveying understanding and decreasing the veteran’s anxiety about the disorder. Partners can also serve to educate the veteran and learn from the veteran about what specific needs are not being addressed. Ultimately, receiving education pertaining to PTSD shows veterans that their spouses are supportive of them and supportive of their treatment (Sherman et al., 2008). Similarly, if spouses are not engaged in education and treatment, they often have misconceptions about
the purpose and potential outcomes of treatment. This is often coupled with negative attitudes about the veteran’s ability to recover as well as how the spouse interprets how society and the military perceive the veteran (Sherman et al., 2008). These beliefs can lead the spouse to feel isolated from the veteran and society as a whole.

**Help Seeking Behavior and Perceived Barriers**

On a whole, society has negative views pertaining to mental health care; these negative beliefs are amplified within military culture and often dissuade veterans from seeking service. Negative stigma is viewed as the primary disadvantage of seeking treatment. A majority of service members fear repercussions that seeking help could have on their military career (Stecker et al., 2007). Many careers within the military require various levels of security clearance and it is a common fear that any type of treatment would have these clearances revoked, thus ending the member’s career. This fear is linked to denial of symptoms and refusal of treatment (Buchanan, 2011); despite this, service members cite finding a level of understanding between a client and counselor as a primary reason for seeking treatment and improving symptoms as the end result of receiving treatment (Stecker et. Al, 2007). There are clear differences in perceptions of stigma between Active Duty and National Guard veterans, which suggest that much of the stigma is based on organizational structure and military culture (Kim, Thomas, Wilk, Castro & Hoge 2010). This stigma is further explained through differentiating between the three types of service. For active duty personnel, it is easier to seek treatment due to the close proximity of providers (IWCG, 2010). In order to utilize these services, the member would have to take off work which could alert peers and supervisors of the member’s decision to seek treatment (Kim, et al., 2010). There is a common belief that
seeking mental health care is an excuse to avoid military duty (IWCG, 2010). There is a strong
dissonance between understanding the benefits of treatment and overcoming the barriers to
seeking treatment. By gearing education to the specific needs of spouses, it may be possible to
address these barriers and emphasize the potential benefits of seeking treatment for PTSD.

Conclusion

Anytime a nation is at war, there will be families facing the difficult battle of
reintegration after the soldier return home. The current conflicts veterans are facing are
resulting in increased reports of trauma and diagnoses of PTSD. From the time deployment
orders are received, military families begin experiencing countless stressors than affect their
psychological health. Spouses can be a unique tool in the diagnosis and treatment of combat
induced PTSD if they are aware of the signs and symptoms and are able to maintain their own
health throughout the process.
CHAPTER III: METHODOLOGY

The present study is a qualitative retrospective analysis of a self-report questionnaire modeled off techniques derived from critical incident theory. Critical incident technique allows for participants to reflect on significant events, incidents, processes, or issues resulting in an understanding of the thought process associated with the critical event (Flanagan, 1954). The purpose of this study is to examine the importance of educating spouses of combat veterans prior to redeployment, and how this education aids in the early detection and diagnosis of PTSD.

Target Population

The present study aims to address female spouses of male combat veterans with a diagnosis of Post-Traumatic Stress Disorder. Subjects must have been married to their spouse prior to a deployment. The current study is gender specific due to the large variances in experience between male and female combat veterans. While women are beginning to take on a combat role, there are still various sources of trauma (i.e. sexually related trauma) which a female veteran could experience that are less likely for males (IWCG, 2011). Male and female combat veterans experiences and stressors experienced in the combat zone are drastically different therefore to ensure a degree of consistency between subjects it would be necessary for sex to be constant. While these inclusion criteria limit the population size, utilizing constants will allow for more similar experience between male veterans and female spouses.

Instrument

Data collection was accomplished through the use of a survey constructed by the experimenter utilizing retrospections and based on critical incident technique. The survey
consisted of demographic questions, retrospections pertaining to spouses’ perceptions of veterans’ PTSD symptomology, and experiential retrospections. The survey contained multiple choices, short answer, and extended response questions. Sections included: demographic information, military service, education, symptoms, and retrospections.

Critical Incident Technique provides a flexible set of principles through which it is possible to understand behavior wherein the behavior is conducted in an environment in which the consequences are clearly defined (Flanagan, 1954). The present study examines retrospections about behaviors leading up to seeking a PTSD diagnosis. Understanding the event that caused the spouse to realize that their veteran may have PTSD can be used to identify areas in which spouses can be trained prior to redeployment for easier and fast identification of potential symptoms.

Demographic questions pertained to inclusion criteria and information pertaining to the marital relationship. It includes additional questions pertaining to the family unit. Education questions examine the amount of formal and informal education received by the spouse about PTSD prior to redeployment. These questions were derived from a previous study by Buchanan (2011) examining the type of information received and the source of the information.

Examining the level of PTSD education in the presence of retrospections of critical incidents may make it possible to gain insight into the effects education has on the ability to report veteran’s symptoms.

**Procedures**

An online survey was the means of data collection for the present study. Surveys provide the flexibility to target a large population and allow for complete anonymity and confidentiality.
The internet is becoming a widely utilized tool for gaining support and information. Social networking sites and blogs provide venues for individuals to share stories and advice with others in similar situations.

Potential participants were contacted through the use of social media and online support groups and forums utilized by spouses of combat veterans. Initial contact was made with administrators of eight social network/support groups in order to screen group for appropriateness and willingness to participate. The “Veteran Care Giver” and “Life After Homecoming” groups on Facebook are believed to be the two primary sources of participants. The survey was available on an online survey program, ESurveysPro. This allowed participants to access the survey via a link posted on the social media outlet.

**Data Analysis**

Initially data was analyzed on an individual basis. This was done in order to create a composite understanding of each participant’s situation. The present study aims to examine retrospections pertaining to the spouse’s experience from redeployment until her veteran received a diagnosis of PTSD. An individual response analysis was conducted to gain understanding into the individual circumstances that may affect their perceptions of being the spouse of a combat veteran with PTSD. Additionally, responses pertaining to retrospections were analyzed in order to identify reoccurring themes between respondents. Analyses were derived through the identification of key words and phrases reported in the retrospection portion of the questionnaire. These themes were also viewed in relation to existing literature in order to recognize specific areas of therapeutic need.
CHAPTER IV: DATA ANALYSIS

Participants for the present study consisted of six females between the ages of 24 and 63. All participants are female spouses of male combat veterans with a diagnosis of Post-Traumatic Stress Disorder as a result of a combat tour of duty. Four of the six respondents completed the survey in its entirety. Five of the six respondents are married to OEF/OIF veterans and have not been separated from their spouse since the time of redeployment. The sixth respondent (Participant 5) is the spouse of a Vietnam Veteran and had been separated from her husband since his redeployment.

All respondents reported having their veteran deployed to a combat zone. Two respondents reported their veteran being deployed to Operation Enduring Freedom and Operation Iraqi Freedom, one only to Operation Enduring Freedom, one only Operation Iraqi Freedom, one Vietnam, and one did not report the theater of her veteran’s deployment. All veterans were in the Army, with five being enlisted active duty and one National Guard. Four veterans are still under commitment with the Army. The number of deployments ranged between two and three with length of duration ranging from eight to 15 months with a mean of 12 months. Five of the six veterans served in mainly combat roles with the sixth being combat support.

Four of the six respondents received education pertaining to the redeployment experience. One of the six participants received education pertaining to Post-Traumatic Stress Disorder. Sources of education were primarily informal and included friends, other members of the veteran’s unit, and social media. Self-directed online research, non-profit organizations, and school were also cited as other sources of information. One respondent mentioned
“military” as a source of information but did not include in what capacity. Five of the six respondents reported that they did not believe that the military provided them with adequate resources and support while their spouses were deployed.

Five of the six respondents discussed their veteran seeking mental health services. One veteran still has not sought any type of mental health care. Of the other respondents, the time between redeployment to seeking service was between 6 months and 4 years with an outlier of 30 years. Five of the six respondents reported playing a large role in their veteran’s decision to seek mental health care. The sixth respondent’s veteran has not yet sought consistent care other than initial diagnosis.

**Individual Participant Response Analysis**

**Participant 1**

Participant 1 is a 47 year old spouse of combat veteran in the Army National Guard who is still under his commitment of service. She has known her spouse for 25 years and has been married for 12 years. The veteran has been deployed for three tours of duty but there is no report of which theater. His most recent deployment was 12 months in theater. Participant 1 received redeployment education but no formal education on PTSD. She does not believe that she received adequate resources and support while her spouse was deployed. The first things she noticed about her veteran upon return were increased anger, rage, jealousy, and memory loss. Symptoms noticed by the participant include: flashbacks, nightmares, unexplained fear/anxiety, unexplained agitation, loss of interest, distancing from family and friends, feelings of guilt, anger outbursts, little patience, overreacting, excessive alcohol use, and avoiding certain people and situations. Participant 1 provided no retrospections but reported “he made
me believe it is no big deal, but I’m afraid of him. He has gotten physical and violent.” The veteran has not sought mental health treatment.

**Participant 2**

Participant 2 is a 26 year old spouse of an active duty Army combat veteran who is still under his commitment of service. She has known her spouse for 11 years and has been married for 1 year. The veteran has been deployed for three for tours of duty to Operation Iraqi Freedom and Operation Enduring Freedom in a primarily combat role. His most recent deployment was 15 months in theater. Participant 2 received redeployment education but no formal education on PTSD. She does not believe that she received adequate resources and support while her veteran was deployed. The first things she noticed about her veteran were increased alcohol consumption, angry and violent outbursts, nightmares, and increased discomfort in large groups. Symptoms noticed by the participant include: flashbacks, nightmares, unexplained fear/anxiety, unexplained agitation, loss of interest, distancing from family and friends, wanting to be alone, feelings of guilt, anger outbursts, little patience, overreacting, excessive alcohol use, and avoiding certain people and situations. The veteran waited four years before seeking mental health care. The participant gave the veteran an ultimatum stating “he needed to get help, or I was leaving.” She believes she played a large role in his decision to seek treatment.

The participant recalls the veteran experiencing nightmares and talking in his sleep and that “he was drunk more than he was sober.” Looking back on her experiences since redeployment, she now recognizes that her veteran’s reactions to happy events were the result of his PTSD. She discussed that whenever a positive life event would occur (e.g. moving in
together, getting engaged, getting married, etc.), it would be followed by an episode of drinking and aggression. She noted: “I know now that he was not unhappy, he was HAPPY. And being happy was not allowed in his mind.” Through the experience, she wishes she would have known: “it isn’t my fault and I cannot fix him.” She recognizes that “trying to make it better” was enabling him to continue living with symptoms and causing them to be worse. Her biggest advice to other women in a similar situation is “get help! Even if he doesn’t want to, you should seek counseling for yourself,” “support him,” “make lots of good friends who are going through the same thing,” and “TALK about it.” The most important thing she wants to share is the importance of reminding herself of the vow “in sickness and in health” and to emphasize the importance of remembering “he came home” and that PTSD is a wound that they can overcome.

**Participant 3**

Participant 3 is a 24 year old spouse of an active duty Army combat veteran who is still under his commitment of service. She has known her spouse for 6 years and has been married for 4 years. The veteran has been deployed for two tours of duty to Operation Enduring Freedom in a primarily combat role. His most recent deployment was 14 months in theater. Participant 3 received redeployment and PTSD education prior to redeployment through military peers, friends, and online research. Her veteran began experiencing symptoms after his first tour of duty and those symptoms continued through the second tour. She does not believe that she received adequate resources and support while her spouse was deployed. After seeing him for the first time after his first deployment, she recalls immediately knowing something was wrong. The first thing she noticed about her spouse after his first tour of duty
was nightmares occurring on the first night. She noted that his best friend had died in front of him during this first tour of duty. After his second tour of duty she said that he did not hug her after getting off the plane and kept asking for his M16. He would not relax until he had his gun back. Symptoms noticed by the participant include: flashbacks, nightmares, unexplained fear/anxiety, unexplained agitation, crying spells, loss of interest, distancing from family and friends, wanting to be alone, feelings of guilt, anger outbursts, little patience, overreacting, excessive alcohol use, and avoiding certain people and situations. The veteran waited six months before seeking mental health care for the first time. He was seen once then waited another year before seeking care again. The event leading to a diagnosis was a flashback that resulted in hospitalization. The participant told the veteran that he needed to get help.

The participant recalls her veteran telling her about the death of his friend. She notes: “my husband’s best friend was killed in front of him….my husband is convinced he should have died because just minutes before the RPG my husband was standing in that spot.” Immediately after this, she began noticing major changes in her veteran which she has documented in online chat records and letters. Following this event she immediately became aware of the possibility that the veteran was expressing symptoms of PTSD. The veteran remained in combat almost a year after this event. Looking back, she wishes they would have immediately gotten help. For the year following the event and throughout the following deployment, the veteran was hospitalized numerous times while in theater for symptoms of PTSD. Her advice to other women is “get help for yourself,” “don’t try to protect your husband” “turn to other women,” and “take control of your own treatment.” Through her experiences she has learned that she is the best advocate for herself and her husband. They have experienced many hardships leading
up to her husband’s diagnosis, many of which she believes are the result of the Army’s reluctance to diagnose PTSD because of the Army’s history of “mental and physical resilience.”

**Participant 4**

Participant 4 is a 31 year old spouse of an active duty Army combat veteran who is no longer under commitment. She has known her spouse for six years and has been married for three years. The veteran has been deployed for two tours of duty to Operation Iraqi Freedom. His most recent deployment was 13 months in theater. Participant 4 did not receive redeployment education or PTSD education. She performed self-directed searches online, sought out non-profit organizations, and learned about PTSD in school. She does not believe that she received adequate resources and support while her spouse was deployed. The veteran was discharged from the military as a result of his diagnosis. Symptoms noticed by the participant include: flashbacks, nightmares, unexplained fear/anxiety, unexplained agitation, crying spells, loss of interest, distancing from family and friends, wanting to be alone, feelings of guilt, anger outbursts, little patience, overreacting, and avoiding certain people and situations. It took three years after redeployment before the veteran sought help. Participant 4 reported her veteran having a “breakdown” and recalls driving him to the hospital and giving him an ultimatum that she would only stay with him if he gets help.

**Participant 5**

Participant 5 is a 63 year old spouse of a retired Army combat veteran. She has known her spouse for 45 years and has been married for 42 years. The veteran has been deployed for two tours of duty to Vietnam in a primarily combat role. His most recent deployment was 12 months in theater. Participant 5 received no education on redeployment or PTSD. She does
not believe that she received adequate resources and support while her spouse was deployed.
The first things she noticed about her spouse were anger outbursts, “the need to control everything,” and an inability to share emotions and connect emotionally, particularly with her.

Symptoms noticed by the participant include: nightmares, loss of interest, distancing from family and friends, wanting to be alone, anger outbursts, little patience, and overreacting. The veteran waited 35 years before seeking mental health care. After experiencing frequent panic attacks and difficulty performing daily activities, he finally decided to seek treatment. The participant frequently recommended that the veteran seek counseling over the 30 years leading up to his diagnosis.

The participant does not recall a specific event that caused her to believe her spouse may have PTSD. Looking back, she recognizes that the changes in their relationship, his need to be in control, his inability to trust people, his mood swings, and his reaction to social events may have been the result of PTSD. She wishes she would have known “PTSD is an injury,” “PTSD behavior is not a personal attack on me,” and that she deserved to have help for herself to cope with living with the symptoms. Her advice to other women is to “get counseling therapy,” “understand that PTSD is an injury – not a personality disorder,” “try not to take PTSD behavior personally,” remember “they (the veteran) love you deeply; but are unable to express it,” and “try to have compassion for their plight.” She emphasizes the importance of counseling for both the veteran and spouse and to not be afraid of medication. She notes “you can get back the man you sent off to war. I did after living with PTSD for over 40 years.”

**Participant 6**

Participant 6 is a 37 year old spouse of an active duty Army combat veteran who is still
under his commitment of service. She has known her spouse for two years and has been married for one year. The veteran has been deployed for two tours of duty to Operation Iraqi Freedom and Operation Enduring Freedom in a combat support role. His most recent deployment was eight months in theater. Participant 6 received redeployment education but no formal education on PTSD. She does believe that she received adequate resources and support while her spouse was deployed. The first things she noticed about her spouse were emotional outbursts and crying. Symptoms noticed by the participant include: nightmares, unexplained fear/anxiety, unexplained agitation, crying spells, loss of interest, distancing from family and friends, wanting to be alone, feelings of guilt, little patience, overreacting, and avoiding certain people and situations. The veteran waited six months before seeking mental health care. The veteran was involved in a car accident which caused PTSD symptoms to increase. The primary things she noticed were nightmares that involved events from both deployments as well as the car accident. The participant encouraged her veteran to get help which eventually resulted in him receiving a service dog.

The participant recalls the veteran experiencing nightmares and distancing himself from people and activities he used to enjoy. Looking back on her experiences since redeployment, she now recognizes that her veteran’s distancing himself from things, crying episodes, and “becoming emotional to the extreme” may have been the result of his of PTSD. When asked what information she wishes she would have had she noted: “even a pamphlet with a warning would have at least helped.” The best advice she can give to other women is “to prepare themselves and seek out help at the first inkling there might be something PTSD related happening.” The participant works to help other women in similar circumstances by providing
them with education stating “I try to encourage and/or educate as many as possible to brace themselves when their soldier comes home. They have to learn to look for signs before they wake in the middle of the night being choked or something like that. They have to recognize this and they have to seek help ASAP.”

Identification of Key Concepts from Retrospection

Self-Care

A primary issue discussed by respondents was the importance of self care. Self-care encompasses both physical and psychological issues pertaining to safety and wellbeing. This would include respondents’ decisions to issue ultimatums to ensure their own safety, as well as the safety of their veteran. Additionally, this can be separated into social support and mental health care.

Literature suggests the importance of spouses seeking mental health care in order to ensure their own psychological wellbeing. Calhoun, Beckham, and Bosworth (2002) and Renshaw and Campbell (2011) examine how spouses often begin experiencing psychological symptoms similar to symptoms of PTSD if their own mental health needs are not met. This was reflected in the response of Participant 2:

Get help! Even if he doesn't want to, you should seek counseling for yourself... He may not want to go get help, and you can’t force him, but he can’t stop you from seeing someone for yourself. That is what I did, and it was the best decision I ever made.

In this case, Participant 2 addressed her veteran’s resistance to seeking treatment. When PTSD remains untreated, the spouse will continue to be exposed to the effects of the symptoms. This concept was further emphasized by Participant 3 who noted: “GET HELP FOR YOURSELF!!!
Don’t try to protect your husband you can’t do it turn to other women that have husbands who have PTSD.” This is contrasted with reports from Participant 5 who did not seek her own mental health treatment while coping with her veteran’s diagnosis. When asked, knowing what she now knows about PTSD, what she would have changed about the early stages of diagnosis she said: “I would have sought help for MYSELF to deal with the effects of living with a PTSD.” Additionally, her advice to other women in a similar situation would be “Get counseling therapy to help remain strong and confident in their own selves.”

In addition to professional help, participants emphasized the importance of peer support. Participant 2 responded:

Make lots of good friends who are going through the same thing- you will be each other’s support system, and its one you will need. Sometimes family and friends who have not been there just don’t understand why you have to cancel your plans AGAIN because your husband is having another anxiety attack.

This response emphasizes the importance of shared experience. While others may be supportive, this participant contends that it is difficult for others who have not been through a similar experience to understand what she is going through. Participant 6 also emphasizes the importance of peer support. She notes:

I offer that everyday to other wives on a few different forums on the internet. Mostly they need to prepare themselves and seek out help at the first inkling there might be something PTSD related happening.

Thanks to technologies such as social networking sites, it is now possible to connect with many others who are in a similar situation. These venues allow those who are currently living with
PTSD to share their stories in order to support those who are earlier in their journeys.

Participant 2 noted “...TALK about it. The more you talk about it like it is a normal thing, the more normal it will become.” Shared experience allows for spouses to help reduce feelings of isolation that often accompany living with a veteran with PTSD. Having the ability to talk about PTSD and share experiences can be beneficial to initially identifying signs of symptoms upon redeployment.

Avoiding Self-Blame

Many of the symptoms of PTSD can be traumatic to the spouse. Unexplained anger, avoidance, isolation, and reduced patience are common symptoms of PTSD but can often be viewed as personal attacks on those in contact with the veteran. Participant 2 notes “It is harder for him to see his troubles than it is for you to see them.” Separating the disorder from the veteran can be beneficial to gain insight into the symptoms displayed by the veteran. After years of coping with her veteran’s PTSD, Participant 5 learned “PTSD behavior is not a personal attack on me.” Additionally, she notes “Try not to take PTSD behavior personally. The sufferer is usually remorseful after an outburst; but due to the condition, is unable to confront their actions and thus can't / won't apologize (emotional disconnection).” Coming to this realization is a struggle for many spouses. In retrospect, Participant 2 discovered “it isn't my fault and I cannot fix him. I tried to make it better for him for years, but what I was doing was ENABLING him, and that just made things worse in the long run.”

Tolerance and Understanding

A level of tolerance and understanding pertaining to the veteran’s symptoms plays a large role in maintaining the integrity of the marriage as well as each partner’s psychological
wellbeing. Being supportive and present through the difficult diagnosis process may be beneficial for the couple to strengthen their bond. Participant 2 responds:

Support him... always be there for him, even when he doesn't make sense, most times he just needs someone to listen, not necessarily understand. And don't threaten to leave him. I did that, not realizing I was his BIGGEST fear- abandonment. I had no idea what I was dealing with. And try to be understanding when he doesn't want to go to the movies, or out to dinner, or a big concert or parade.

PTSD has the ability to drastically change the personality of the sufferer. The symptoms can cause the veteran to lose interest in many of the things the couple may have enjoyed prior to deployment. Being willing to work through these differences and understand the unique needs of the veteran may be more meaningful to the veteran than the spouse is aware. Participant 5 further notes on this subject by acknowledging that “PTSD is an injury and is not controllable by the sufferer.” She additionally notes “They (the veteran) love you deeply; but are unable to express it...Try to have compassion for their plight - they often are unaware of their behavior.”

When the veteran’s current behavior is not in line with how they are reporting they are feeling (e.g. say they are committed to the marriage but distances themselves from spouse) it can be difficult to remain invested in the relationship. Having tolerance and understanding pertaining to the effects of PTSD can allow spouses to begin separating the disorder from their veteran.
CHAPTER V: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The current study examined retrospections of spouses of combat veterans with PTSD pertaining to their experiences with the disorder. The original purpose of the study was to understand how military spouses recognized the likelihood that their veteran needed to be evaluated for PTSD. The responses provided by the participants, however, provided too few details to enable this purpose to be met. Questions pertaining to retrospections yielded a much richer response particularly pertaining to the personal coping strategies of respondents. Therefore, through an analysis of questions pertaining to retrospections of experiences leading to the diagnosis of PTSD was conducted in order to better understand the needs and experiences of spouses leading up to and following the diagnosis process. The study consisted of six participants who completed an online survey examining education received prior to redeployment, PTSD symptoms displayed by the veteran, and retrospections pertaining to the time leading up to the veteran’s diagnosis of PTSD. All six participants were female spouses of male Army combat veterans with a diagnosis of PTSD. Responses were analyzed on an individual basis and key themes were identified through analysis of retrospections.

Participant 5 reported demographic information that was inconsistent with the other participants in this study. She identified as being the spouse of a Vietnam veteran and was the only participant who had been temporarily separated from her veteran. Retrospections provided by this participant, however, were consistent with existing literature and other reports by participants in the current study. These similarities in experience between a Vietnam era respondent and OEF/OIF respondents imply potential consistencies in the psychological needs of spouses and coping styles implemented by spouses regardless of the
zeitgeist. While levels of social acceptance and available resources to diagnose and treat PTSD have changed between eras, the impact PTSD has on spouses may have remained a constant.

Reflective of previous literature, the level of education received by spouses prior to redeployment pertaining to the redeployment experience and PTSD was examined. The low levels of formal education resulted in perceived lack of support by the Army for spouses during the deployment process by the participants. The importance of social support, education, and receiving professional mental health support was emphasized in retrospections by participants.

The results of the present study support existing literature on the experiences of spouses of veterans with PTSD. The primary issues addressed in this study are the need for education and support for spouses before, during, and after the diagnosis process. Topics addressed include the need for self-care, the importance of avoiding self-blame, and the role of tolerance and understanding. These topics were derived from retrospections of spouses of combat veterans pertaining to the time leading up to their veteran’s diagnosis of PTSD.

This study supports the importance of maintaining the psychological health of the spouse when a veteran is suffering from PTSD. This is reflective of Sherman et al. (2008) and Gallagher et al. (1998) which emphasize the importance of psychological care due to increased susceptibility to psychological trauma as a result of living with a veteran with PTSD. The importance of self-care is further reflected in the work of Arzi, Solomon and Dekel (2000) which examined specific symptoms that frequently occur in spouses as a result of being exposed to an individual with PTSD. Wilcox (2010) additionally reflects the importance of peer support as a buffer against stress-related illness. Participants in the present study stress the importance of self-care in order to provide continued support for their veteran and to maintain their own
psychological health.

The issue of avoiding self-blame is closely tied to an understanding of PTSD. Calhoun, Beckham and Bosworth (2002) discuss how having a partner with PTSD can lead to higher perceived burden and poorer psychological adjustment for the spouse. This may be related to lack of understanding pertaining to the nature of the behavior (i.e. a response caused by PTSD versus a direct reaction to the spouse). An understanding of PTSD may allow spouses to better understand their current situation and alleviate some of the self-blame common to this type of relationship.

Tolerance and understanding were identified as critical aspects of maintaining personal psychological health. Sherman et al. (2008) examined how spouses who are educated on PTSD issues tend to convey a better sense of understanding and tolerance to veterans than uneducated spouses. Participants discussed how awareness that veteran’s behavior may be the result of PTSD makes it possible to view the behavior as a symptom rather than a personal attack on the spouse (e.g. violent outbursts, aggression, etc.) Ultimately, it appears the more the spouse is aware of the symptoms of PTSD, the more they are able to identify behaviors that are resulting from the symptoms thus leading to higher reports of tolerance of symptoms and decreases in overall anxiety pertaining to the veteran’s diagnosis.

There are several limitations to the present study. The number and demographics of the participants greatly diminished the ability to generalize results of this study. Participants were primarily active duty and all were members of the Army. This excludes members from other branches of service (Air Force, Navy, Marines, and Coast Guard) as well as other types of service (National Guard and Reserve). Understanding experiences of members from the various
types of service would be necessary to generalize the results of a study similar to the present study. Additionally, social networking sites specifically used as support forums for spouses of veterans with PTSD were used as the primary means of recruitment. These sites provide education and information as well as support to members. Because of their involvement in the group, it may have impacted participants’ perceptions of the importance of social/peer support. Members of the groups have sought peer support, which may not be representative of all spouses. As a result of utilizing an online social networking site for recruitment, spouses who do not utilize online networking were also excluded from the study. Improving recruitment techniques for participants would be beneficial to increase the power of the study.

As the role of professional counselors begins to extend into the realm of military culture, it is necessary to incorporate the unique features of the profession into the existing literature on the population. There are still many areas pertaining to the clinical considerations of spouses of combat veterans with PTSD that have not been addressed. Extending current research focusing on the importance of education prior to redeployment could be beneficial to the field. Education appears to be a form of prevention that is underutilized in the present situation. A better understanding of the specific needs of spouses of veterans with PTSD would make it possible to design and implement preventative and clinical programming to assist spouses prior to and following redeployment.
REFERENCES


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Appendix A: Questionnaire

Bringing the War Home: Redeployment Experience of Spouses of Combat Veterans with Post-Traumatic Stress Disorder
Answers marked with * are required

1. Informed Consent
As the wife of a combat veteran with a PTSD diagnosis, you are invited to participate in the current research study. The following information is provided in order to help you make an informed decision about choosing to participate in the study.

The purpose of this study is to take a retrospective look at the time and events leading up to your spouse's diagnosis of PTSD. Participation in this study will involve completing a questionnaire pertaining to your experience of redeployment and your decision to seek mental health care. Responses will then be analyzed by the researchers.

It is the hope of this study that insights you may find by examining your personal experiences will help you better understand your own process as well as allow the researchers to gain insight into ways mental health care could have better benefited you. If the recollection of any events pertaining to experience cause you any distress, we encourage you to seek professional help.

Your participation in this study is voluntary. You may choose to withdraw from the study at any time with no consequences. If you choose to withdraw, all of your information from the study will be destroyed. Your responses and experiences pertaining to the study will only be viewed in the context of the study and in relation to other participants. The information obtained in the study may be published or presented but your identity will be kept strictly confidential.

If you are willing to participate in this study, continue on to the survey. If you have any questions pertaining to the current study feel free to contact Ashley Rossi (ymm@iup.edu), or Dr. Laura Marshak (laura.marshak@iup.edu).
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This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: (724)357-7730).

2. Instructions
Please answer the following questions as thoroughly as possible. The purpose of this study is to better understand the experiences of military spouses and the role they play in the diagnostic process of Post-Traumatic Stress Disorder. Please answer these questions as thoroughly as possible keeping in mind that all information shared will remain confidential.
### Demographics

1. **Gender:**
   - Male
   - Female

2. **Age:**

3. **Are you married?**
   - Yes
   - No

4. **Does your spouse have a diagnosis of PTSD due to experiences from combat in either Operation Iraq Freedom or Operation Enduring Freedom?**
   - Yes
   - No

5. **How long have you known your partner? (in years)**

6. **How long have you been married? (in years)**

7. **Have you and your spouse been maritally separated since redeployment?**
   - Yes
   - No

8. **Do you have children?**
   - Yes
   - No
### 4. Military Service

The following questions pertain to your spouse's military service and deployment.

1. What branch of service was/is your spouse enlisted in?
   - [ ] Army
   - [ ] Air Force
   - [ ] Marines
   - [ ] Navy
   - [ ] Coast Guard

2. What type of service is/was your spouse enlisted in?
   - [ ] Active Duty
   - [ ] Reserves
   - [ ] National Guard

3. Is your spouse currently still under commitment with the military?
   - [ ] Yes
   - [ ] No

4. How many tours of duty was your spouse deployed to a combat zone?

5. In his most recent deployment, how long was your spouse deployed? (in months)

6. What type of military duty does your spouse perform?
   - [ ] Mainly combat
   - [ ] Combat support
   - [ ] Service support

7. In which theater of operations was your spouse deployed to?
## Bringing the War Home: Redeployment Experience of Spouses of Combat Veterans with Post-Traumatic Stress Disorder

**Answers marked with *[] are required**

### 5. Education

1. While your spouse was deployed, did you receive any education pertaining to the redeployment experience? (i.e. what to expect)
   - [ ] Yes
   - [ ] No

2. While your spouse was deployed, did you receive any education pertaining to Post-Traumatic Stress Disorder?
   - [ ] Yes
   - [ ] No

3. From whom did you receive your education? (i.e., military, friends, family, etc.)

4. Do you believe that the military provided you with adequate resources and support while your spouse was deployed?
   - [ ] Yes
   - [ ] No
### 6. Symptoms

#### 1. What did you first notice about your spouse that caused you to think there may be something wrong?

- [ ]

#### 2. Which of the following behaviors did you notice in your spouse upon his redeployment? (Select all that apply)

- [ ]Flashbacks
- [ ]Nightmares
- [ ]Unexplained fear/anxiety
- [ ]Unexplained agitation (“feeling jumpy”)
- [ ]Crying spells
- [ ]Loss of interest
- [ ]Distancing from family and friends
- [ ]Wanting to be alone
- [ ]Feelings of guilt
- [ ]Anger outbursts
- [ ]Little patience
- [ ]Overreading
- [ ]Excessive alcohol use
3. How long did your spouse wait after deployment before seeking mental health care?

4. What caused your spouse to finally seek mental health care?

5. What role (if any) did you play in your spouse’s decision to seek help?
7. Retrospection

1. Was there an event that occurred that caused you to believe that your spouse may have PTSD? Explain.

2. Now knowing that your spouse has PTSD, were there any events/behaviors that you NOW recognize as symptoms of PTSD? (i.e. things that were confusing at the time, things you didn’t understand, etc.) Explain.

3. If you could go back in time, what information do you wish you would have had about PTSD or the redeployment experience?

4. What advice would you give to other women in a similar situation?

5. Is there anything else you would like to share about your experience?
8. Thank You!

Your participation in this study is greatly appreciated. The purpose of this study was to investigate your personal experience of redeployment and the process of your spouse receiving a PTSD diagnosis. The current study attempts to further preexisting literature on this topic and gain insights into the lives of spouses of combat veterans.

If you have questions or comments about the study feel free to contact Dr. Laura Marshak or myself (ynpo@up.edu) and we would be more than happy to share any information with you.

Thank you again for your participation,
Ashley Rossi