LIVING WITH PTSD AND ITS IMPACT ON LIFE, AN INTIMATE PARTNER'S PERSPECTIVE

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

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DENTON, TEXAS

DECEMBER 2016

DEDICATION

I would like to dedicate my dissertation to my deceased military mentor, LTC Daniel O'Rourke. You changed my life with your continuous unsolicited support of my pursuit for higher education. You encouraged me multiple times when my educational goals were put on hold due to multiple military tours of duty. You are truly missed. I hope to make a difference in others' lives the way that you have done in mine. Rest in peace dear friend.

ACKNOWLEDGMENTS

Doctoral education is not for the faint of heart. It takes perseverance, discipline, and a love for higher education. Achieving this final step in my nursing academic journey is greatly due in part to the help and support of key individuals. I am grateful to God for giving me a vision and allowing this vision to come to fruition. I could not have completed this doctoral journey without the help from selfless, understanding, and supportive people. I would first like to thank all of the wonderful faculty at Texas Woman's University who provided advice and guidance during this journey. I would especially like to thank Dr. Lene Symes for her continuous support, counseling, and guidance during the stressful semesters of this dissertation. She kept me focused on the end goal throughout my multiple military deployments and breaks from the doctoral program. Without her support, this doctoral journey would have been mentally unreachable. She was pivotal to my success and I will strive to carry on her legacy of research on PTSD.

I want to thank my dissertation committee members, Dr. Sandra Cesario and Dr. Anne Young, for their knowledge, guidance, and expertise. They are great role models and mentors who have demonstrated exceptional scholarship, patience, and leadership. I am forever grateful for having such an outstanding committee.

I am grateful to my fellow doctoral students who made this long journey bearable and interesting. I have grown tremendously with your support and understanding. We have cried together, laughed together, and traveled the world together. I am privileged to know all of you and I can hardly wait for your great contributions to the body of nursing science.

Lastly, I would like to express my gratitude to my family and friends that have been my foundation of support throughout this long journey. Thanks for understanding my numerous absences from events due to school obligations. I love you all. And a special thanks to the intimate partners of veterans with PTSD who shared their experiences; their strength is a force to be reckoned with.

ABSTRACT

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DECEMBER 2016

This mixed-method, phenomenological study explored the lived experience of intimate partners of veterans with post-traumatic stress disorder (PTSD). PTSD was reported by 20% of the veterans from the Iraq/Afghanistan wars. PTSD symptomatology has far-reaching effects that can extend to intimate partners of veterans with PTSD. Although intimate partners often bear the burden of caring for veterans with PTSD, there is only a small body of research on the effects of PTSD on them. The purpose of this study was to obtain an in-depth understanding of the lived experience of intimate partners of veterans with PTSD. Such an understanding will help nurses and healthcare providers develop effective strategies for providing care to these individuals. Using a Web-based questionnaire, responses were obtained from 27 participants about their experiences with veterans' PTSD. Husserl's descriptive phenomenology was the philosophical underpinning for the study and Colaizzi's (1978) method was used for data analysis. The 27 intimate partners described their experiences, providing information that led to identification of an overarching theme, *It Has*

Affected Every Aspect of Our Lives, and six themes: *My Partner's PTSD Takes a Mental and Physical Toll on Me*, *My Partner Has a Tendency To Be Highly Aggressive and Violent*, *Financial Life is a Struggle*, *Family Life is Hard*, *I Am More Cautious*, and *I Seek Out Help and Resources*. The themes provided a deeper understanding of the lives of intimate partners of veterans with PTSD, specifically their commonalities and concerns. The findings from this study have implications for increasing nurses' and the public's awareness of the effects of PTSD on the intimate partners of veterans. Awareness serves in the identification of these individuals and it serves to facilitate the development of strategies to effectively care for these individuals.

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CHAPTER I

INTRODUCTION

Focus of Inquiry

Post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur after one has been exposed to a traumatic event, such as military combat, natural disasters, terrorist attacks, serious accidents, or violent personal assaults. The impact of PTSD and its long-term consequences are a major concern nationally and internationally. Approximately 20% of the veterans from the Iraq and Afghanistan wars reported symptoms of PTSD (Insel, 2008). PTSD was ranked as the highest mental disorder among veterans from the Iraq/Afghanistan wars (Gibbons, Hickling, & Watts, 2012). PTSD is not only a problem among male veterans. In 2013, the Defense Department ended the direct ground combat exclusion rule for female service members leading to the opening of 237,000 combat positions (Roulo, 2013). With the increasing numbers of women in combat roles, PTSD among female veterans is steadily increasing. In 2013, women made up 14.6% of the armed forces, 19.5% of the reserves, and 8% of the veteran population. Statistics show that more than 150 women have been killed and approximately 800 were wounded in Iraq and Afghanistan wars (National Center for Veterans Analysis and Statistics, 2011). Lifetime prevalence

rates of PTSD reported among Vietnam veterans were as high as 30.9% (Kulka et al., 1990).

PTSD symptomology and its effects are not limited to the veterans. Early research findings have shown that PTSD negatively impacts those around the PTSD sufferer and the symptoms of PTSD can extend from one generation to the next (Pearrow & Cosgrove, 2009; Pfefferbaum, Tucker, North, Jeon-Slaughter, & Nitiéma, 2014). Individuals around PTSD sufferers are at risk for developing PTSD symptomology also known as secondary traumatic stress disorder. Figley (1999) coined the term "secondary traumatic stress disorder" and defined it as the "natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other" (Figley, 1999, p. 10). Secondary traumatic stress symptomology manifest emotionally, socially, and physically. Research on Holocaust survivors has shown the transmission of PTSD symptomology and maladaptive behaviors to the spouses and the children of the PTSD sufferers (Baranowsky, Young, Johnson-Douglas, Williams-Keeler, & McCarrey, 1998; Degloma, 2009; Kellermann, 2001). Other research findings have shown persons most affected by PTSD are the wives and female partners of the veterans (Williams & Williams, 1987). In 1999, the Australian Institute of Health and Welfare surveyed Vietnam veterans and found that 40% of the veterans reported physical or psychological problems in their partners that they attribute to their Vietnam military service (Commonwealth

Department of Veteran Affairs & Australian Institute of Health and Welfare, 1999).

Intimate partners of veterans with PTSD have received little attention regarding their partners' PTSD experiences and the impact of PTSD on their lives. Lack of adequate research on this vulnerable population can lead to silencing and invisibility in healthcare. Herman (1992) noted that psychological trauma is a field where effort is continually given to prove that psychological trauma is real and not a figment of the victim's imagination. An Australian study by Westerink and Giarratano (1999) was conducted to explore the effects of PTSD on Vietnam veterans' partners and children. The findings of the study show that the partners suffered from high levels of psychiatric symptoms; children suffered from stress symptoms comparable to the veterans. Social awareness, healthcare interventions and political movements are needed to bring legitimacy and awareness to the suffering that intimate partners of veterans with PTSD endure (Herman, 1992).

Studies have shown that intimate partners of veterans with PTSD, often the primary caregivers of the veterans, have firsthand experiences of the veterans' PTSD symptomatology, and bear the responsibility of maintaining the family (Calhoun, Beckham, & Bosworth, 2002; Galovski & Lyons, 2004; Solomon et al., 1992). Dekel, Goldblatt, Keider, Solomon, and Polliack (2005) noted that wives of PTSD veterans depict themselves as the strong partners whose must

constantly give to maintain the marital relationship in the presence of an ill partner. Their lives have been shown to revolve among their spouses' illnesses leading the partners into a struggle to maintain their independence, autonomy, and sanity (Dekel, Goldblatt et al., 2005). Expectations by the family, the military, and society are placed on the intimate partners to care for the veterans. Given the strain placed on the intimate partners, their well-being and experiences need to be taken into consideration and explored.

Statement of Purpose

In this descriptive, phenomenological mixed-method study, the experiences of intimate partners of veterans who have post-traumatic stress disorder (PTSD) were explored and the impact of the veterans' PTSD on their intimate partners assessed. The purpose of the study is to increase knowledge about the experiences and perceptions of intimate partners of veterans with PTSD in order to develop effective strategies for providing care to these individuals.

Rationale for the Study

Significance to Nursing

Research has shown that intimate partners of veterans with PTSD experience emotional numbing, shifting spousal roles, and relationship distress When caring for the veterans, the intimate partners may experience self-neglect, loss of identity, social isolation, and increasing health problems (Dekel, Solomon,

& Bleich, 2005; Galovski & Lyons, 2004; Ray & Vanstone, 2009). Dekel, Goldblatt et al. (2005) noted that PTSD is a systemic problem whereby the veteran's PTSD navigates the partner's and the family's lives.

Intimate partners are at risk for the development of caregiver burden which encompasses the emotional, physical, and financial toll of care provision (George & Gwyther, 1986). The strain of caregiver burden can lead to self-neglect among the intimate partners of veterans with PTSD. Furthermore, assuming the role of primary caregiver might make it difficult for the intimate partners of veterans with PTSD to seek treatment for themselves (Dekel, Solomon, & Bleich, 2005). Nurses have a vital role to play in identifying barriers to healthcare, creating educational programs, interventions, and developing or implementing policy that can benefit the intimate partners of veterans with PTSD.

Within the past three decades, researchers have examined the negative effect of PTSD on the intimate partners of veterans using standardized, self-report measures. These quantitative measures presented data as static and invariant. Quantitative data show that variables are related but may fail to provide insights about "why" they are related (Frederikson, Chamberlain, & Long, 1996; Polit & Beck, 2008). Qualitative research provides insights about phenomena by addressing the "why" and are vital to gain understanding and more global and dynamic views of lived experiences (Polit & Beck, 2008). Given

that growing evidence shows the adverse effect of PTSD on intimate partners, their experiences and perceptions are needed.

Researcher's Relationship to the Topic

The author's interest in the topic developed while on active duty at Fort Meade, Maryland in 2008. While serving as an Army Nurse Anesthetist, the author was afforded the opportunity to talk to veterans and their intimate partners during the pre-surgical, anesthesia interview. During the interview, she gathered medical, social, surgical, and psychiatric history from the veterans to develop an anesthesia plan best suited to their surgery and their health history. At the completion of the pre-surgical interviews, the researcher opened the dialogue for any questions that the intimate partners might have concerning surgery. A common concern among the intimate partners, not related to the veterans' surgeries, was the need for support for the family members of veterans with PTSD.

The intimate partners' questions included: What resources are available to family members of veterans with PTSD? How does the spouse or significant other deal with the veteran's transition from the warzone to family life? What effect does the veteran's PTSD have on the spouses or the significant others?

The writer's inability to adequately address the family members' concerns and her empathy for their stressful lives led her to this research focus on the intimate partners of veterans with PTSD. As an advanced practice nurse in the

U.S. Army who continues to work with veterans and their partners, the author is committed to providing research-based knowledge that can be used by nurses to develop protocols that nurses can use to provide support, education, and treatment for the intimate partners of veterans who experience PTSD.

Assumptions

The following assumptions were made in this study.

1. Intimate partners of veterans with PTSD are at risk for the development of psychological, physical, and social problems.
2. Intimate partners of veterans with PTSD can benefit from knowledge gained about the lived experiences of other intimate partners of veterans with PTSD.
3. Subjective experiences can inform researchers about the lived experience phenomenon that is not well understood or documented.
4. Descriptive, phenomenological, research methodology can provide knowledge about the lived experiences of intimate partners of veterans with PTSD that will improve the care of these individuals.

Research Questions

The research questions answered in this study are:

1. What is the lived experience of the intimate partner of a veteran with PTSD?

2. Are intimate partners of veterans with PTSD at risk for the development of secondary traumatic stress?
3. What coping mechanisms do the intimate partners of veterans with PTSD develop?

Philosophical Underpinnings

Descriptive phenomenology was used to explore the lived experience of intimate partners of veterans with PTSD. The term "experience" refers to living through an event, situation, or circumstance. Experience is a valid and fruitful source of knowledge and is the basis for behavior. The term "phenomenon" refers to objects, events, situations, and circumstances as they appear to a partcipant in orginal perception, prior to any interpretation; the aim of phenomenology is to disclose lived experience (Oiler, 1982). To obtain a better understanding of the lived experience of intimate partners of veterans with PTSD, this study draws upon Edmund Husserl's phenomenological, descriptive approach.

Edmund Husserl, the founder of phenomenology, rejected the position of positivism and naturalism as the final truths in natural and social sciences research and posited that everyday experiences are valuable sources of knowledge which give meaning to the human existence (Husserl, 1960). The natural scientific approach uses reductionism to explore discreet variables acting in a causal way to produce effects in human experience and behavior; human experience and behavior truths are reduced to variables that identify causes and

effects which are not holistic in nature. Holism encompasses all aspects of an individual including interactions between individuals; it is important to understanding an individual's mind and behavior (Ashworth, 2006, p. 28-29; McLeod, 2008; Polit & Beck, 2008). Natural science, a fact-based science, creates fact-minded people leaving questions regarding the meaning of human existence (Husserl, 1936/1970).

Husserl's solution to dehumanized science was the development of descriptive phenomenology which involves the careful description of ordinary conscious experiences of everyday life that is inclusive of hearing, seeing, believing, evaluating, and acting (Polit & Beck, 2008). Husserl viewed human experience as the basic building block of science (Husserl, 1913/1982). He proposed that human experiences be described instead of being explained or having its causal relations searched for; human meanings are the key to understanding the lived experience, not causal variables (Ashworth, 2006, p. 29; Husserl, 2000).

Husserl's goal was to establish descriptive phenomenology as a rigorous science through his systematic method of studying human consciousness and experiences (Husserl, 1962). Using Husserl's systematic method, a researcher describes human experience as it is rather than the preconceived propositions of the natural sciences (Martins & Bicudo, 1989). All efforts are directed exclusively towards the human experience with the understanding that all consciousness is

consciousness of something. The first tenet of Husserl's phenomenology is that consciousness is intentional. A phenomenon (an intentional object), exists when an individual perceives it (Husserl 1913/1982). The researcher's goal is to describe the phenomenon using the individual's perception through the concept of intentionality. Intentionality of consciousness gives meaning to all human objects, gestures and actions (Husserl, 1970). Through analysis of the intentionality of consciousness, the researcher identifies how the phenomenon is given meaning leading to its essences (Sadala & Adorno, 2002).

Husserl posited that essences of phenomenology could be obtained through a phenomenological reduction process which is a method of inquiry that deepens understandings of lived experiences. In order to achieve unbiased description of the phenomenon, the researcher should strive for transcendental subjectivity. Transcendental subjectivity is achieved when the researcher describes the phenomenon in its pure sense minus the researcher's personal bias (Husserl, 2001).

This first step in the reduction process is the *epoché,* which is the suspension of beliefs. The *epoché* is important in examining the phenomenon free from the introduction of the researcher's interpretation (Husserl, 1960). Achieving *epoché* is accomplished through bracketing which involves the identification of the researcher's preconceived beliefs and opinions about the phenomena under study. Even though it is impossible to suspend all pre-study

beliefs, bracketing affords the researcher the opportunity to explore the data in its pure form (Polit & Beck, 2008). The purpose of bracketing is to obtain phenomena in the everyday, unreflected attitude of naïve belief (Husserl, 1960).

The second step in the reduction process is *eidetic reduction* which consists of constructing general essences of the phenomena from facts presented by the study participants. The construction of general essences is also known as intuiting of essences. The term "essence" is derived from the Greek word "ousia" which means the true being of a thing; it is the inner essential nature of a thing that makes it what it is (van Manen, 1990). Essences provide insight into a lived experience being investigated to yield a concrete, descriptive analysis. This process discloses the eidetic structures of consciousness, meaning, and experience and it involves analysis through observation, comparison, and examination of variations in the data (Cohen & Omery, 1994). The last step in the reduction process is *transcendental* or *phenomenological proper,* which uncovers the universal essences of the lived experience which Husserl (1960) described as the common features of a lived experience.

Phenomenology is best fitted for use to gain an understanding of a phenomenon that is poorly understood and researched. Husserl's descriptive phenomenology provides a systematic method for discovering common essences among the intimate partners to develop scientific knowledge. His phenomenological framework is best suited for exploring their participants' lived

experiences while separating the researcher's preconceived notions regarding the phenomena under investigation.

Summary

Since the official diagnosis of PTSD was established by the American Psychological Association in 1980, there has been slow growing concern regarding the effects of PTSD among intimate partners of veterans with PTSD. Literature findings, although sparse, note that the negative effects of PTSD extend beyond the individual with the diagnosis to their intimate partners and suggest the need for more research on this vulnerable population. A mixed-method, phenomenological study based on the philosophical underpinnings of Husserl has been undertaken to explore the lived experiences of intimate partners of veterans with PTSD and its impact on life. The findings may contribute to the development of interventions that address the needs of the intimate partners of veterans with PTSD.

CHAPTER II

REVIEW OF LITERATURE

The purpose of this chapter is to synthesize what is currently known about the experiences of partners of veterans with post-traumatic stress disorder (PTSD). There is only a small body of literature on the experiences of partners of veterans with PTSD despite PTSD being the most prevalent psychiatric diagnosis among veterans returning from the Iraqi and Afghanistan wars. In 2011, 476,515 veterans with a diagnosis of PTSD received treatment at Department of Veterans Affairs (VA) medical centers (Blades, Presta, & Royster, 2014). Research has shown that traumatic events affect the victim's significant others (Figley, 1995). This review includes both quantitative and qualitative studies that identify psychological, psychosocial and physical effects of veterans' PTSD on their intimate partners.

Whittemore and Knafl (2005) literature review method was used to conduct the review of literature. Whittemore and Knafl's (2005) research process for literature reviews modified Cooper's (1998) process for synthesizing research. Cooper's (1998) process and Whittemore and Knalf's (2005) process for synthesizing research consist of the following five steps: (a) problem formulation, (b) data collection (literature search), (c) data evaluation, (d) data analysis, and (e) presentation.

Problem formulation was discussed in depth in Chapter 1. Intimate partners of veterans with PTSD are likely to experience difficulties and there is a lack of knowledge about their experiences and effective interventions to lessen the difficulties. Therefore the aim of this paper is to determine what is currently known about the experiences of partners of veterans with post-traumatic stress disorder (PTSD).

Data collection began with accessing the electronic database Published International Literature on Traumatic Stress (PILOTS) from 1985 to 2014. PILOTS is an electronic database provided by the National Center for PTSD which includes worldwide literature on PTSD. Academic Search Complete online database from 1985 to 2014 was also searched to identify sources on PTSD. The search included peer-reviewed articles and case reports. Dissertations and unpublished manuscripts were excluded from the database search. Search terms used were *veterans*, *PTSD*, *stress*, *secondary traumatic stress, marital problems*, *history, coping, mental health, physical health*, *partners*, and *spouses* alone and in combination.

Data evaluation included determining that inclusion criteria were met. Inclusion criteria included (a) peer-reviewed publications in English; (b) intimate partners as research participants; (c) primary and secondary studies of the psychosocial and physical effects of veterans' PTSD on their intimate partners; and (d) interventions and treatments that have been successful in treating the

intimate partners. An intimate partner of a veteran refers to a married or unmarried significant other of the veteran regardless of gender or present relationship status. Inclusive of the intimate partner definition are boyfriends/girlfriends, spouses, ex-spouses, widows, common-law, and same-sex partnerships. All articles that met the inclusion criteria were retained.

Two hundred and sixty-three references were identified in the initial computerized search. Studies that primarily focused on veterans with PTSD were excluded. In all, 24 research articles were located that met the inclusion criteria: 19 quantitative studies and 5 qualitative studies. The studies took place in the following countries: United States (*n* = 14), Israel (*n* = 3), Croatia (*n* = 2), The Netherlands (*n* = 1), Iran (*n* = 1), and Australia (*n* = 3). Data analysis resulted in organizing the review into six major interconnected topics: (a) caregiver burden, (b) secondary traumatic stress disorder/ compassion fatigue, (c) manifestations of psychological distress and physical distress, (d) marital and relationship distress, (e) overall functioning and well-being, and (f) treatments and interventions.

Results

Caregiver Burden

The spouse or intimate partner of a veteran with PTSD faces many stresses when caring for the veteran which may lead to caregiver burden. Caregiver burden, a term originally used to describe the burden experienced by

those caring for people with dementia, is defined as alterations in caregivers' emotional and physical health that occurs when care demands outweigh available resources (Dunkin & Anderson-Hanley, 1998; Given et al., 1992).

Caregiver burden among intimate partners of veterans with PTSD was a central finding in the following four studies. Beckham, Lytle, and Feldman (1996) conducted a study that examined intimate partners' caregiver burden over time in relation to the veterans' PTSD severity. The partners completed the Burden Interview, the Symptom Checklist-90-Revised, the Beck Depression Inventory, and the Spielberger State and Trait Anxiety Inventory. Multiple regression analysis was significant. There was a significant positive correlation between caregiver burden among the partners and PTSD severity among the veterans. Caregiver burden was significantly related to PTSD symptom severity and it was an important factor in predicting caregiver adjustment. Partners with increased caregiver burden experienced increases in psychological distress, dysphoria, and anxiety (Beckham et al., 1996).

Calhoun, Beckham, and Bosworth (2002) examined the association between PTSD symptom severity, caregiver burden, and psychological adjustment in partners of Vietnam combat veterans (N = 71). The partners of the veterans with PTSD completed the Burden Interview and the Symptom Checklist-90-Revised Scale. Multiple regression analysis results were significant. The

partners of veterans with PTSD (*n* = 51) experienced greater burden and poorer psychological adjustment compared with partners of veterans without PTSD (*n* = 20). Increases in caregiver burden were positively associated with the severity of the veterans' PTSD and negatively associated with the partners' psychological adjustments. Increases in interpersonal violence were also associated with the partners' poorer psychological adjustment (Calhoun et al., 2002).

Dekel, Solomon, and Bleich (2005) examined the association between the veterans' emotional and physical impairment and their wives' sense of burden (*N* = 215). The wives completed the Dyadic Adjustment Scale and the Caregiver Burden Inventory. The wives' caregiver burden was positively correlated to the husbands' severity of PTSD impairment. The wives also exhibited more emotional distress and marital problems than wives in the general population (Dekel, Solomon, & Bleich, 2005). The findings were similar to the findings in Calhoun et al. (2002).

A more recent study by Klaric, Franciskovic, Pernar, Moro, Milicevic, Obrdalj, and Satriano (2010) explored caregiver burden and burnout in partners of war veterans with PTSD (*N* = 154) and partners of war veterans without PTSD (*N* = 77). The partners completed the Caregiver Burden Questionnaire and the Maslach Burnout Inventory. The partners of veterans with PTSD scored significantly higher on these instruments, indicating they experienced greater

caregiver burden than the partners of veterans without PTSD. The authors concluded that partners of veterans with PTSD are exposed to greater burden of life and suffer from stronger cumulative physical, emotional, and behavioral effects of prolonged stress compared to wives of veterans without PTSD (Klaric et al., 2010). These findings were consistent with the findings of Calhoun et al. (2002) and Dekel, Solomon, and Bleich (2005).

Secondary Stress Disorder/Compassion Fatigue

Secondary Traumatic Stress, a term coined by Charles Figley (1995), is the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other. Figley further defines it as the stress resulting from helping or wanting to help a traumatized or suffering person. He used this term interchangeably with compassion fatigue (Figley, 1995). Four studies were identified that provide a better understanding of contributing factors leading to the development of secondary traumatic stress in partners of veterans with PTSD.

In a historical study, Waysman, Mikulincer, Solomon, and Weisenberg (1993) investigated the association of family environment on the degree of secondary traumatization among wives of combat stress veterans (N = 127) and wives of non-combat stress veterans (N = 85) from the 1982 Lebanon War. Family environment was determined using the Family Environment Scale which categorized families as expressive structured, expressive unstructured,

rigid/moral, midrange, and conflict-oriented. The findings shown that family environment was significantly related to wives' physical and psychiatric symptomatology. Wives from expressive families reported minimal levels of physical and psychiatric symptomology followed by wives from midrange families who reported low levels. Wives from rigid-moral families reported moderate levels of physical/psychosocial symptomology and wives from conflict-oriented families reported the highest levels of physical/psychosocial symptomology (Waysman et al., 1993).

Bramsen, van der Ploeg, and Twisk (2002) explored the presence of secondary traumatic stress in Dutch couples (*N* = 444) that lived through World War II. The aim of the study was to determine if either partner's secondary traumatic stress symptoms were predictable from their individual war experiences, the war experiences of their partners, and the posttraumatic symptoms of their partners. Data were collected using the Dutch version of the Impact of Event Scale and nine events based on the American Psychiatric Association (1987) Criterion A for PTSD. The presence of secondary traumatic stress symptomology among the couples was predicted by both the individual war experiences and the presence of PTSD symptoms in one partner. PTSD symptomology in one partner was shown to predict the presence of secondary traumatic stress symptoms in the other partner (Bramsen et al., 2002).

Franciskovic, Stevanovic, Jelusic, Roganovic, Klaric, and Grkovic (2007) conducted a study on Croatian wives of veterans with PTSD (*N* = 56) to assess the presence of secondary traumatic stress symptomology among the wives and to determine if the types of demographics and socioeconomic status predisposed the wives to the development of secondary traumatic stress. Secondary traumatic stress symptomology was obtained through an Indirect Traumatization Questionnaire. Regression analysis was significant and shown that unemployment status and duration of marriage were significant predictors of secondary traumatic stress symptomology among the wives. Unemployed wives were found to experience more symptoms of secondary traumatic stress than employed wives which is consistent with financial dependence on the husbands, smaller social networks, and feelings of uselessness. The findings also shown that 39% of the wives' symptomology met the criteria for secondary traumatic stress (Franciskovic et al., 2007).

Ahmadi, Azampoor-Afshar, Karami, and Mokhtari (2011) conducted a study to determine if the severity of veterans' PTSD was associated with the degree of secondary traumatic stress in their spouses (*N* = 120). The severity of PTSD was assessed using the Mississippi Scale for Combat-Related PTSD and the PTSD-Checklist Military. Thirty percent of the veterans experienced severe symptoms, 57% experienced moderate symptoms, and 17% experienced mild symptoms. One hundred percent of the spouses reported symptoms of

secondary traumatic stress, with 51% reporting severe symptoms and 49% reporting moderate symptoms. The authors attributed the 100% presence of secondary traumatic stress in the spouses to the Iranian culture in which wives are expected to meet the emotional and physical needs of the veterans with little or no support from outside sources (Ahmadi et al., 2011).

Psychological Distress/Physical Distress

Wives of veterans with PTSD have been shown to report higher levels of psychological and symptoms compared to wives of veterans without PTSD (Waysman et al., 1993). Psychological distress is defined as the unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent (Knapp, 1988). The five defining attributes of psychological distress are: (a) perceived inability to cope evidenced by failure to verbalize ways to address problem, dependence on others to make decisions, hopelessness and avoidance of issue; (b) change in emotional status evidenced by anxiety, irritability, depression, withdrawal from others, hyperactivity, tearfulness, and inappropriate laugher; (c) discomfort evidenced by sadness, aches, pain, anger, and hostility; (d) communication of discomfort evidenced by expressing lack of hope for the future, fearfulness, complaining of pain, insomnia, silence, facial scowling, frowning, restlessness, neglect of appearance, and avoiding eye contact; and (e)

harm evidenced by pain, change in vital signs, and suicide gesture (Ridner, 2004). Psychological distress can lead to physical distress.

Coughlan and Parkin (1987) identified an unmet need in nursing in Maine where women partners of Vietnam veterans did not have a voice in healthcare. To address the unmet need, the authors created a weekly group session for these women with the focus on assessing psychological distress and coping strategies. During the group sessions, the authors observed that the women exhibited PTSD symptomatology that included neglect of personal appearance, hostility, withdrawal, lack of concentration, and indecisiveness. Physical symptoms exhibited consisted of tachycardia, headaches, sleep disturbances, and sexual dysfunction. Physical abuse, substance abuse, self-abuse and eating disorders were also prevalent (Coughlan & Parkin, 1987).

Solomon, Waysman, Levy, Fried, Mikulincer, Benbenishty, Florian, and Bleich (1992) examined the implications of combat-related psychopathology among Israeli war veterans on the psychosocial status of their wives (N = 205). Data were obtained using a PTSD Inventory, the Symptom Checklist-90-Revised, a somatic self-report questionnaire, the Family Environment Scale, the Dyadic Adjustment Scale, the UCLA Loneliness Scale, and the Social Support Questionnaire based on Mueller's (1978) Social Network Inventory. The wives were found to display social dysfunction that included feelings of loneliness. The wives' perceptions of the veterans' PTSD were significantly related to their own

symptoms. The wives' perceptions of their spouses' PTSD severity was associated with wives having greater psychiatric symptoms, more somatization, depression, obsessive-compulsive problems, anxiety, interpersonal sensitivity, and hostility (Solomon et al., 1992).

Westerink and Giarratano (1999) explored the impact of PTSD on partners (*N* = 47) and children (*N* = 36) of Australian Vietnam veterans diagnosed with PTSD using the Lifestyle Questionnaire, the Family Environment Scale, the Coopersmith Inventory, and the General Health Questionnaire. They found that the partners of Australian veterans reported symptoms of anxiety, depression, and insomnia. Social dysfunction, poor family environment, low expressiveness, and high family conflict were also prevalent (Westerink & Giarratano, 1999).

Dekel (2007) examined the associations between the veterans' PTSD, their wives' attachment style, and the wives' level of distress among combat veterans (*N* = 74) and prisoners of war (*N* = 87) of the 1973 Yom Kippur War. Data were obtained using the Brief Symptom Inventory, the Posttraumatic Growth Inventory, and the PTSD Inventory. The wives of prisoners of war veterans (POW) reported higher levels of distress, depression, anxiety, hostility, and obsessive-compulsive disorders than the wives of combat veterans. The wives of POWs distress positively correlated with the veterans' severity of PTSD symptomology (Dekel, 2007).

Manguno-Mire, Sautter, Lyons, Myers, Perry, Sherman, Glynn, and Sullivan (2007) explored psychological distress and partner burden among female partners (*N* = 89) of veterans undergoing PTSD treatment. Multiple regression analysis was significant revealing a positive correlation of perceived threat, PTSD treatment, and partner caregiver involvement on partner psychological distress. The partners of veterans with PTSD reported significant levels of emotional and psychological distress inclusive of suicidal ideation, and depression (Manguno-Mire et al., 2007). These findings were consistent with earlier findings by Westerink and Giarrantano (1999).

Marital and Relationship Distress

There is growing evidence that PTSD disrupts marriages and intimate relationships in families resulting in impaired intimate and social relations. Partners of veterans with PTSD have been shown to report less satisfaction with life and marriage than partners of veterans without PTSD (Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough, & Weiss, 1992). Alt (2006) proposed that deployment and PTSD symptoms may affect marriages by creating feeling of neglect in the spouses at home. Other research has shown that veterans with PTSD were less self-disclosing, more hostile, and more aggressive towards their partners that veterans without PTSD (Carroll, Rueger, Foy, & Donahoe, 1985).

Riggs, Byrne, Weathers, and Litz (1998) examined the quality of intimate relationships of Vietnam veterans with PTSD and their partners (*N* = 26) in

comparison to Vietnam veterans without PTSD and their partners (*N* = 24). Levels of distress, quality of the relationships, propensity to end the relationship, and degree of intimacy among the veterans and their partners was obtained using the Dyadic Adjustment Scale, the Marital Status Inventory, the Relationship Problems Scale, the Fear of Intimacy Scale, and the PTSD Checklist Military Version. Seventy percent of the partners of veterans with PTSD reported high levels of relationship distress compared to 30% of the partners of veterans without PTSD. The degree of relationship distress positively correlated with the severity of PTSD symptoms which is indicative of the difficulties that veterans with PTSD and their partners face in sustaining a healthy, functional relationship (Riggs et al., 1998).

Allen, Rhoades, Stanley, and Markman (2010) explored the effects of recent deployment and PTSD on marital functioning. Allen et al. (2010) administered the PTSD Symptom Checklist, the Kansas Marital Satisfaction Scale, the Confidence Scale, the Positive Bonding Scale, the Parenting Alliance Inventory, the Dedication Scale, the Satisfaction with Sacrifice Scale, and the Communication Danger Signs Scale to army couples separated (*N* = 434) by deployment. Veterans with recent deployments were found to have higher levels of PTSD symptoms; the partners of veterans with PTSD reported lower levels of communication and marital satisfaction (Allen et al., 2010).

Although relationship and marital distress have a high likelihood of occurring among veterans with PTSD and their partners according to the above studies, little is known about the factors that led to the relationship distress. Renshaw and Caska (2012) sought out factors leading to relationship distress through their exploration into the role of the veteran partners' perceptions (*N* = 258) of PTSD symptomology and the effect of these perceptions on relationship distress. Partners of veterans of Operation Enduring Freedom and Iraqi Freedom (*N* = 258) and partners of veterans in the National Vietnam Readjustment Study (*N* = 465) completed interviews, the PTSD Checklist, the Depression Anxiety Scale, and the Relationship Assessment Scale. Bivariate correlations were significant with the partner perception variables and the partner distress variables. The partners' perceptions of PTSD symptomology were positively associated with greater levels of relationship distress. In particular, the PTSD symptom (cluster) of withdrawal/numbing was positively associated with relationship and psychological distress (Renshaw & Caska, 2012). The findings were similar to the findings from an earlier study by Klaric, Franciskovic, Stevanovic, Petrov, Jonovska, and Moro (2011) where the veterans' PTSD symptoms of avoidance contributed to decreased marital satisfaction for their partners.

Overall Functioning/Well-Being

Research has shown that veterans with PTSD experience psychological and physiological problems that often prohibit the veterans from maintaining employment and functioning in the roles of husband and father. This lack of functioning may lead to partners of these veterans assuming emotional and financial burdens thus affecting their overall functioning and well-being (Beckham et al., 1996).

Outram, Hansen, MacDonell, Cockburn, and Adams (2009) conducted a qualitative study that explored the perceptions and experiences of partners of Australian Vietnam veterans (*N* = 76) regarding their health and well-being 40 years post the Vietnam War. Data were obtained using 10 focus groups. The following themes emerged from the data: (a) the feeling of being in a continuous warzone; (b) heavy dependency from the veterans leading to their lives being consumed with PTSD; (c) deterioration in health and the development of an altered sense of self; and (d) social isolation and feelings of worthlessness. (Outram et al., 2009).

Hayes, Wakefield, Andresen, Scherrer, Traylor, Wiegmann, Denmark, and DeSouza (2010) conducted a qualitative study that explored the experiences of seven partners of veterans with PTSD with the goal of enhancing support systems within the Veteran Administration. Partners play important roles in the treatment of veterans with PTSD and their involvement in the veterans'

treatments can lead to exposure to the veterans' trauma and stress. This study provided an insight to the experiences of partners of veterans with PTSD. Measures consisted of focus group interviews and expert panel discussions. Findings showed that partners of veterans with PTSD experience financial hardships, substance abuse, psychological symptoms, role ambiguity, parental conflict, marital dissatisfaction, and lack of social support (Hayes et al., 2010).

Evans, Cowlishaw, Forbes, Parslow, and Lewis (2010) examined the relationship of PTSD and family functioning across a 9-month time span of veterans with PTSD (*N* = 1,822) and their partners (*N* = 702). The study specifically focused on the PTSD symptom clusters of intrusion, hyper-arousal, and avoidance. Measures used were the PTSD Checklist-Military Version, the McMaster Family Assessment Device 12-Item General Functioning Scale, the Hospital Anxiety and Depression Scale, and the Alcohol Use Disorders Identification Test. Findings showed that decreased family functioning at three months post-treatment served as precursors to the veterans' symptoms of intrusion, hyper-arousal, and avoidance. These findings suggest that positive family functioning is vital to a veteran with PTSD who is undergoing treatment (Evans et al., 2010).

Interventions and Treatments

Appropriate interventions are needed to decrease PTSD symptomatology among veterans and their partners. A growing trend is the institution of couple-

based treatment for veterans with PTSD based on research findings that have shown PTSD's negative effect on the family unit (Jordan et al., 1992). Couple-based therapy provides a support system that can help veterans overcome the negative social stigma associated with the diagnosis and treatment of PTSD. A negative social stigma still associated with PTSD is weakness. Soldiers are expected to be strong in the mind and the body. Through research, education, and treatments, this sigma is slowly decreasing (Chamberlin, 2012).

Group therapy has been proven to be beneficial to partners of veterans with PTSD. Harris and Fisher (1985) conducted a qualitative study with partners of Vietnam veterans (*N* = 162) to explore their perceptions of group therapy. Group therapy was conducted via open and closed meetings. The open group meetings were not scheduled, open to new and current participants, and repetitive in the information provided due to new participants. Closed meetings were scheduled and open to only current participants. Closed group meetings were found to be more beneficial than open group meetings due to the stability of group members, unbiased support from the group members, non-repetitious information, and the implementation of problem solving techniques (Harris & Fisher, 1985).

Critical Interaction therapy is one of various therapies used for treating veterans with PTSD and their partners. Johnson, Feldman, and Lubin (1995) explored the benefits of Critical Interaction therapy with veterans and their

partners (*N* = unknown); three transcripts illustrated the use of the therapy. Critical Interaction therapy uses a series of interventions that bring the veterans' traumatic memories to the forefront while allowing the partners to witness the memories. One of the intervention goals is to help alleviate the veteran's fear of exposing traumatic events to the partner; it also allows for intervention, diffusion, and bypassing of highly emotional reactions by the therapist. Other goals are to provide an environment for open communication, problem-solving techniques, comfort, support, and education to the participants (Johnson et al., 1995).

A technique similar to Critical Interaction therapy is Integrative Behavioral Couple Therapy for PTSD. Integrative Behavioral Couple Therapy (IBCT), developed by Jacobson and Christensen (1996), sought to improve relapse rates seen with traditional couple therapy through the implementation of an emotional acceptance intervention that specifically targets the PTSD symptom of avoidance. IBCT focuses on the following areas: (a) level of distress; (b) level of commitment to the relationship; (c) conflict areas; (d) what makes the conflict a problem; (e) the individual and relationship strengths that keep the couple together; (f) deployment-related issues; and (g) PTSD-related issues. The use of IBCT was explored for 12 weeks by Erbes, Polusny, MacDermid, and Compton (2008) on an Iraqi War veteran recently released from active duty and his spouse. Shortly after the veteran returned home, the veteran exhibited moodiness, a loss of interest in work, increased alcohol intake, isolation, and

insecurities relating to the spouse's friends and outings. The IBCT sessions focused on PTSD education, sharing and validation of their experiences, and acceptance of these experiences and each other. The therapy proved useful in reducing arguments, social isolation, and self-abusive behaviors (Erbes et al., 2008).

Another couple-based therapy used by mental health providers is Structured Approach Therapy (SAT). Sautter, Armelie, Glynn, and Wielt (2011) described the use of Structured Approach Therapy (SAT) to reduce relationship problems stemming from PTSD. SAT treatment occurs over twelve to fifteen sessions and it targets the veteran's avoidance and numbing symptoms with the goal of improving the couple's relationship. SAT focuses on stress inoculation training and consists of the following three phases: (a) an educational phase that provides information on PTSD, its psychosocial effects, and the role of avoidance and numbing in perpetuating relationship problems; (b) a skills training phase for emotional communication and emotion regulation; and (c) an application phase that focuses on the application of skills that the couple learned. The implementation of SAT proved successful at the Family Mental Health Program in the Southeast Louisiana Veterans Healthcare System among veterans who served in the Operation Enduring Freedom (OEF) / Operation Iraqi Freedom War (OIF). Spousal support was a contributing factor to the SAT sessions (Sautter et al., 2011).

The use of couple-based therapy is ongoing among military, mental health providers but its success rate is dependent on participation. Some noted barriers to treatment for the partners of veterans with PTSD are fear of stigma, social isolation, lack of transportation, feeling of worthlessness and scheduling (Outram et al., 2009; Sherman, Sautter, Lyons, Manguro-Mire, Han, Perry, & Sullivan, 2005).

Buchanan, Kemppainen, Smith, MacKain, and Cox (2011) conducted a qualitative study that explored the perspectives of partners of veterans (*N* = 34) from the OEF/OIF War regarding PTSD. The study utilized Flanagan's Critical Incident technique questionnaire and the findings identified barriers to PTSD treatment and interventions that could lessen these barriers. The most prominent barrier to PTSD treatment was the partners' lack of PTSD knowledge. Informal sources, such as the media, Internet and other partners of veterans with PTSD were sources of education. The findings indicated that there is a critical need for formal training on PTSD that includes awareness of the barriers to PTSD treatment inclusive of denial of symptoms, stigma of the diagnosis, and fear of jeopardizing a military career (Buchanan et al., 2011).

Summary

The literature review revealed several limiting factors in the design of the studies. One was the inconsistency in the definition of a partner. Depending on the culture and the country, the definition of partner ranged from that of a spouse to that of a cohabitating individual. Most studies included only female partners. There were also inconsistencies in the instruments used to evaluate PTSD, secondary traumatic stress, general distress, and caregiver burden. Lastly, the demographics (different countries and different wars) limit the ability to generalize the partners of the veterans with PTSD. However there are also strengths. The demographic diversity allows the reader to conclude that the symptoms of PTSD and its effect on partners and spouses is not isolated to one country or a specific war; it has affected veterans and their intimate partners internationally. Some of these effects persisted for years after the wars have ended and negatively impacted the family unit.

The findings from this literature review highlight the relevance of providing support to spouses and partners of veterans with PTSD. The findings establish the reality of the problem both for spouses and the couple. Spouses and partners of these veterans are high risk, indirect victims of the veterans' PTSD. Successful PTSD treatment of the veteran is dependent upon good social support and stable family functioning. To sustain stable family functioning, the

spouses and partners of these veterans need support services that not only provide treatments/therapies but also teach them coping mechanisms.

According to Remer and Ferguson (1998), the spouses and partners need to obtain optimum support for themselves leading to individual satisfaction which will then enable them to be supportive to the veterans. This goal can be obtained by providing education about traumatic stress, acquiring skills for dealing with traumatic stress, and increasing the spouses'/partners' awareness and personal development (Remer & Ferguson, 1998). The findings also make clear the lack of studies and therefore knowledge about the experiences of the partners of veterans with PTSD. We know they may be in trouble; we do not know the details of their experiences which will support developing effective interventions. Gaining an understanding of the lived experiences of partners of veterans with PTSD will assist nursing, healthcare professionals, and the government to better understand the global effects of PTSD on the family and to develop and implement effective interventions to lessen and possibly alleviate the negative effects of PTSD on the individual, couple, and family.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This mixed-method, phenomenological study explored the lived experiences of intimate partners of veterans with PTSD and to assess the impact of the veterans' PTSD on their intimate partners. A mixed-method design is the use of a primary qualitative or quantitative component with a corresponding qualitative or quantitative component that enhances the primary component (Munhall, 2007). Almost every trauma-related study should include some measure of PTSD symptoms. Furthermore, research has shown that the use of self-report instruments may increase response accuracy (Solomon, Keane, Newman, & Kaloupek, 1996). For this study, the qualitative method of phenomenology is the primary component and the quantitative component is in the form of instruments to collect data that enhances the description of the participants' experiences. According to Tymieniecka (2003), phenomenology sheds light on previously ignored phenomena of the human experience. Very few studies have been dedicated to this population. Therefore, a phenomenological approach is appropriate for this study to obtain an understanding of life with PTSD from the intimate partner's perspective.

Setting

Participants were recruited from three sites, namely the Texas Alliance of Military Women, the 4005th U.S. Army Hospital, and the HHC 75th Training Command. The Texas Alliance of Military Women Institute, a non-profit organization located in Houston, TX, assists military veterans and their families with reintegration into civilian workplaces and communities using supportive services inclusive of counseling, coaching, legal, education, and financial services (Texas Alliance of Military Woman, 2015). The 4005th U.S. Army Hospital, a reserve hospital unit located on Ellington Field in Houston, TX, provides support and backfill medical help to Fort Hood in Killeen, Texas. The HHC 75th Training Division, an army reserve unit headquartered in Houston, TX on Ellington Field, conducts Mission Command and Staff Training for army component forces and foreign militaries. These sites provided approved letters of support from staff responsible for flier postings for this study (Appendix A).

Participants

Thirty participants were recruited from the Texas Alliance of Military Women, the 4005th U.S. Army Hospital, and the HHC 75th Training Division Army Reserve unit at Ellington Field Military Installation. A few methodologists have provided sample size guidelines for several of the most common qualitative research designs and techniques. With respect to phenomenological studies, Creswell (1998) recommended a sample size of 10. In general, as noted by Sandelowski

(1995), sample sizes in qualitative research should not be too small, which would make it difficult to achieve data saturation, theoretical saturation, or informational redundancy. At the same time, the sample should not be too large which would make it difficult to undertake a deep, case-oriented analysis. Therefore, the pre-determined sample size for the study was thirty participants or until data saturation was achieved. Data saturation is achieved when no new themes or essences are emerging from the interviews and the data does not include new information (Spezaile & Carpenter, 2007).

Selection criteria were women and men, over the age of 18, who identified themselves as intimate partners of military veterans with PTSD. Given the focus of the study, it was appropriate that all participants were adults who were currently, or have been, significant others of military veterans with PTSD. Male and female intimate partners were included in the study since PTSD affects both male and female veterans. For the purposes of the study, the term “intimate partner” was inclusive of spouses, ex-spouses, widowers, girl/boyfriends, domestic partners, and common law partnerships. Study participants were chosen regardless of race, age, or any other demographic characteristic. Completion of the questionnaire required the participants read, write, and speak English.

A snowball technique was used to recruit participants from the PTSD support group and the military installation. In attempting to study “hidden populations” for whom adequate lists and consequently sampling frames are not

readily available, snowball sampling methodologies may be the only feasible methods available (Faugier & Sargeant, 1997, p. 792; Goodman, 1961). Snowball sampling technique begins with the researcher finding an individual, referred to as the "source" or the "seed," who has the desired characteristics (e.g. inclusion criteria). Through that person's social networks, similar participants are recruited in a multistage process. After the researcher recruits the initial participants, the participants then recruit others starting a process analogous to a snowball rolling down a hill (Wasserman, Pattison, & Steinley, 2005). The CEO of the Texas Alliance of Military Women and the army commanders of the two army reserve units were contacted and given fliers to distribute to potential study participants. Study fliers were also posted at each of these sites and they contained the purpose of the study, the inclusion criteria, the principal investigator's contact number, and the words "Take One and Pass On."

Protection of Human Subjects

Texas Woman's University Institutional Review Board approval was obtained prior to the proposed study. All relevant guidelines according to the rules and regulations of the Institutional Review Board of Texas Woman's University were followed to protect the rights of the study participants. Potential participants were provided a recruitment brochure and/or an invitation letter that will contain an email link to the online questionnaire. Prior to beginning the online study, the participants were presented with an explanation of the purpose

of the study, the risks and benefits, and a statement indicating that participation is completely voluntary and the participants can discontinue the study at any time. Every effort was made to minimize the risks to the study participants.

Potential Risks

A PsychData online format was used by the study participants to submit responses without identifying themselves. Although precautions were taken, there was a potential risk of loss of confidentiality with any email, downloading, and internet transactions. The participants were assigned code numbers on PsychData. The information on PsychData was only accessed by the researcher and it was stored on the researcher's laptop. The information will be stored for a period of three years after data collection is complete. The researcher's laptop, a highly protected computer, required the use of the researcher's right index finger for log-on. When not in use, the researcher's laptop was kept in a locked file cabinet in the researcher's library at home. Only the researcher had access to the key to the file cabinet. The PsychData account will be deleted three years after analysis on or before September 2019.

The identifiable data (participants' email addresses) were stored on a password-protected email account specifically set up for the first step of the gift card distribution. The identifiable data were deleted from the email account within 1-2 days after the participants' email addresses were sent the ICARD customer service. The email account was password protected and it was deleted

immediately after the last gift card was emailed. The participants' email addresses were deleted from the inbox and the trash folders immediately following the emailing of the participants' email addresses to ICARD customer service within 1-2 days.

The participants were reminded that they could stop or discontinue the online study at any time. In the event of emotional distress, an emergency contact list of numbers was available at the beginning and at the end of the online questionnaire as a resource for any emotional distress that the participants might experience. PTSD brochures were also available at the beginning and at the end of the online questionnaire in PDF format with phone numbers for family support. To address the loss of time, the participants were informed that they could stop or discontinue the online study at any time.

Potential Benefits

The participants were informed that the purpose of the research was to contribute to the body of knowledge in the field of nursing on the secondary effects of PTSD on intimate partners. Sharing their stories can help them make sense of their experiences, cope with the loss of normalcy, find solace with others with similar experiences, and aid in emotional and physical healing (Cox, 2001; Dyer & Thompson, 2000). Upon completion of the online questionnaire, the study participants were directed to a separate website to leave their email addresses. The PI used the services of ICARD Gift Card located online at

www.icardgiftcard.com. After receiving the participants' email addresses, the PI emailed the participants an ICARD gift card. The participants received the ICARD gift card with a redemption code. The participants entered their redemption code and chose from among 250 merchants to redeem their gift card. After redemption, the ICARD Gift Card customer service sent a $50 gift card to the participants via email or regular mail depending on the participants' preferences.

Data Collection

Interview Guide

The interview guide consisted of open-ended questions. It was designed to elicit rich responses regarding the discovery that the partner was diagnosed with PTSD, life changes post PTSD, support system, and current worries (Appendix B).

Demographic Data

A demographic questionnaire was designed to gather information about age, gender, ethnicity, marital status, education level, employment status, household income, size of city, name of residence state, name of war(s) where veteran performed his or her tour of duty, and the length of the veteran's exposure to combat (Appendix C).

Instruments

The Brief Cope Scale (BCS; Carver, 1997). This is a 28-item self-report instrument that consists of 14 subscales, of two items each that assesses general

adaptive and maladaptive coping mechanisms. The 14 subscales consist of active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame. Responses range from "I haven't been doing this a lot" (1 point) to "I have been doing this a lot" (4 points); scores are computed from a minimum of 2 points to a maximum of 8 points. Higher scores indicate increased utilization of that coping behavior. This instrument is the abbreviated version of the COPE Inventory scale. Scales are computed with no reversal of coding. The scale's internal consistency, test-retest reliability, and concurrent validity have been established (Tuncay, Musabak, Gok, & Kutlu, 2008). In Tuna's (2003) study on cross-cultural differences in coping strategies as predictors of university adjustment of Turkish and U.S. students, Cronbach's alpha was .82 which exceeded the minimally accepted value of .50 (Tuna, 2003).

The Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). Secondary traumatic stress refers to the observation that people, such as family and friends, may become direct victims of a trauma due to their close contact with trauma survivors (Figley, 1995). The STSS is a 17-item instrument with Likert-type choices created to measure intrusion, avoidance, and arousal symptoms associated with indirect exposure to traumatic events via one's professional relationships with traumatized clients (Bride et al., 2004). Respondents are instructed to read each item and indicate how frequently

the item was true for them in the past 7 days using a 5-choice, Likert-type response format ranging from 1 (*never*) to 5 (*very often*) (Shah, Garland, & Katz, 2007, p. 62). The items reflect specific responses to the respondents work with trauma victims. A higher total score of 38 and above indicates secondary trauma. The instrument's construct validity and internal reliability has been established with a Cronbach's alpha of .93 (Bride et al., 2004).

The General Well-Being Schedule (GWBS; Dupuy, 1977). This is an 18-item scale designed to assess selected aspects of subjective well-being and distress. The first 14 items are scored on a 6-point scale and the last 4 items are scored on a 10-point scale. The potential score range is from 0 to 110 (Baron & Matsuyama, 1988). A high score above 70 represents positive well-being while a low score below 70 represents distress. Initial internal consistency coefficient scores ranged from .91 to .95. Test-retest reliability .68 to .85. The instrument's validity and average correlation between the individual subscales and criterion ratings were .65 to .90 (Fazio, 1977) (Appendix D).

Data Collection Procedures

As part of ensuring rigor, prior to data collection, the researcher attempted to write down all preconceptions and assumptions regarding the experiences of intimate partners of veterans with PTSD with the goal of putting them aside. Husserl (1913/1982) termed this process bracketing which allows the researcher to put aside previous assumptions so that the data collection is free from bias.

Bracketing strengthens validity of the data collection and analysis while maintaining objectivity of the phenomenon under study (Ahern, 1999; Speziale & Carpenter, 2007). Further discussion of how bracketing was achieved in this study is included in the section below on rigor.

Data collection commenced after the study fliers were distributed. Study flyers were posted at the Texas Alliance of Military Women site, the 4005th US Army Hospital, and the 75th HHC Training Division. Those who participated in the study logged on to the PsychData website provided in the flyer and accessed the online questionnaire. Participants were assigned a code number prior to beginning the online questionnaire to maintain anonymity. The online questionnaire was designed to elicit quantitative and qualitative data to answer the three research questions. At the completion of the online questionnaire, participants were directed to a password-protected email address to request their $50 gift card. After the request was submitted, a $50 gift card was emailed to them from the PI for redemption on the ICARD Gift Card Services, Inc. website. Data collection continued with the intent of achieving data saturation (Speziale & Carpenter, 2007). The principal investigator and the research committee members who have experience in qualitative research studies determined when data saturation was reached. Data saturation occurs when the researcher believes that no new themes or essences are emerging from the interviews and the data does not include new information (Spezaile & Carpenter, 2007).

Data Analysis

Qualitative and quantitative data analysis was used in this mixed-method, phenomenological study. Colaizzi's (1978) method was used as a methodological guide answering the research question, "What is the lived experience of the intimate partner of a veteran with PTSD?" Colaizzi's method consists of seven steps. The procedural steps for applying Colaizzi's method included: (a) Describing the phenomenon of interest; (b) Collecting participants' descriptions of the phenomenon; (c) Reading all the participants' descriptions of the phenomenon; (d) Extracting significant statements; (e) Spelling out the meaning of each significant statement; (f) Organizing the aggregate formalized meanings into clusters of themes; and (g) Writing an exhaustive description.

The seven steps in the data analysis were implemented as follows. Following the collection of each participant's online transcript, each transcript was read and reread to gain perspective on the phenomenon and make sense of the participants' accounts. From the 27 transcripts, 163 significant statements were extracted. Significant statements from each transcript were extracted and recorded on a separate document noting the page and line numbers. Meanings were formulated from these significant statements. Key words and phrases identified and organized according to formulated meanings. The formulated meanings were categorized according to reoccurring, broad categories common to all of the participants. Relevant data in these categories were color-coded and

clustered into significant themes and subthemes. An exhaustive description on the lived experiences of intimate partners of veterans with PTSD was created from the findings of the study. This exhaustive description was formulated by comparing topics for consistent themes and bridging themes for their conceptual meanings. Lastly, validation of the findings was sought by returning to the transcripts, key participants (i.e. support group leaders) and subject matter experts on posttraumatic stress disorder (Colaizzi, 1978). The bracketing journal was referenced to ensure objectivity in the exhaustive description.

Quantitative data analysis was used to answer the quantitative research questions: Are intimate partners of veterans with PTSD at risk for the development of secondary traumatic stress? What coping mechanisms do the intimate partners of veterans with PTSD develop? The Secondary Traumatic Stress Scale was administered online and scored by the principal investigator at the completion of the online questionnaire. A score of 38 or above was indicative of secondary traumatic stress (Bride et al., 2004). The Brief Cope Scale and the General Well-Being Scale were administered online and scored by the principal investigator. A score of above 70 on the General Well-Being was indicative of positive well-being while a score below 70 was indicative of distress. The Brief Cope Scale was scored to assess the participants' adaptive and maladaptive coping behaviors. The results of the scales contributed to a thick description of

the participants and were discussed as they supported or did not support the results of the qualitative analysis.

Scientific Rigor

Rigor and trustworthiness was established by utilizing criteria of Lincoln and Guba's framework which includes credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Trustworthiness and rigor were enhanced by dedicating sufficient time with the data, following up on participant feedback, engaging in peer/expert feedback, using the participants' verbatim accounts of the lived experience, and providing an audit trail (Ashworth, 1997; Johnson, 1997; Koch, 1994; Lincoln & Guba, 1985; Robson, 1993). Credibility refers to the "truth, value, or believability" of the findings that have been established by the researcher through prolonged observations, engagements, or participation with informants or the situation is which cumulative knowing is the "believable" or lived-through experiences of those studied (Morse, 1994, p.105). Credibility was demonstrated when participants recognized the reported research findings as their own experiences (Speziale & Carpenter, 2007).

Credibility was established by prolonged engagement with the data, triangulation of information from the qualitative and quantitative data, and member checking (Stringer, 1999). An audit trail of the data collection and data analysis was kept. Any changes made in the data analysis by the researcher were dated and kept in a binder to provide a step-by-step record of the data

analysis. A diary was kept that contained field research gathered from attending several support group meetings. The contents of the diary are descriptions and interpretations of the researcher's experiences to enhance the researcher's self-awareness. According to Guba and Lincoln (1989), self-awareness is essential for reflection of experiences. Self-Awareness allows for the reflection on personal biases and preconceived ideas about the phenomena under study. Acknowledging subjective bias was done through continuous bracketing whereby the researcher attempted to achieve neutrality by putting aside prior understandings or preconceptions about the phenomenon (Wall, Glenn, Mitchinson, & Poole, 2004).

Continuous bracketing was achieved by the researcher using a reflective diary. With the reflective diary, the researcher followed Fischer (2009) bracketing practice to ensure that authentic bracketing was performed. According to Fischer (2009), authentic bracketing is accomplished by identifying and recording assumptions about the topic and reexamining the previous and current assumptions against emerging insights about the phenomenon. The researcher used self-disclosure to share her background and interests relating to the phenomena in the reflective diary. This reflection was inclusive of preconceptions, thoughts, and feelings. The researcher continued this bracketing process throughout the data collection and analysis by revisiting previous and emerging assumptions ensuring that the data were free from the

researcher's subjectivity. Credibility was further enhanced through member checking whereby the researcher returned to the support groups and PTSD experts to verify the accuracy of the findings.

Dependability shows that findings are consistent and can be repeated by another researcher (Lincoln & Guba, 1985). Dependability is met through securing credibility of the findings (Speziale & Carpenter, 2007). The researcher established dependability along with credibility through an inquiry audit whereby data, supporting documents, research plan, and data collection was reviewed and scrutinized by committee members. Dependability was improved by using methods triangulation. The analysis of qualitative and quantitative data helped ensure that the findings were comprehensive. One method may not adequately explain a phenomenon but Speziale and Carpenter (2007) indicate that combining methods can provide a more complete understanding and description of the phenomena.

Confirmability refers to the repeated direct participatory and documented evidence observed or obtained from primary informant sources. It involves obtaining direct and often repeated affirmations of what the researcher has heard, seen, or experienced with respect to the phenomena under study (Morse, 1994, p.105). Confirmability was established by the identification of repeated themes and ideas during the data analysis. Morse (1994, p. 106) refers to repeated themes as recurrent patterning whereby repeated instances, sequence

of events, experiences, or life ways recur over time in designated ways and in different or similar contexts. Confirmability was further established using a decision trail. Koch (1994) noted that a decision trail provides a means for the researcher to establish audit trail linkages. Leaving a decision trail entails discussing explicitly decisions taken about the theoretical, methodological and analytical choices throughout the study. The researcher left an audit trail, engaged in member checking, and used a subject matter expert which added to confirmability.

Transferability refers to whether findings from a qualitative study can be transferred to another similar context or situation and still preserves the particularized meanings, interpretations, and inferences from the completed study (Morse, 1994, p. 106). Transferability was established through an in-depth understanding of the phenomenon through reading and rereading the online transcript and through reading literature reviews. A detailed, written account regarding the participants, methodology, analysis, and findings was provided to allow readers to form generalizations that are applicable to other demographics experiencing a similar lived experience. Data analysis was carefully documented so that it can be replicated by another researcher.

CHAPTER IV

ANALYSIS OF DATA

This mixed-method, phenomenological study was designed to explore the lived experiences of intimate partners of veterans with PTSD. Guided by the philosophy of Edmund Husserl and the method described by Colaizzi (1978) data were collected and analyzed to increase understanding of intimate partners' experiences of living with veterans with PTSD. Additionally, three instruments were used to collect quantitative data about coping, secondary traumatic stress, and general well-being. The quantitative findings are informed by the qualitative themes. In this chapter a description of the sample is followed by a discussion of the findings supported by key statements from the participants and the participants' scoring on the instruments. Specific patterns, themes, and subthemes emerged from the data and the three instruments were scored and summarized to answer the research questions: (a) What is the lived experience of the intimate partner of a veteran with PTSD? (b) Are intimate partners of veterans with PTSD at risk for the development of secondary traumatic stress? and (c) What coping mechanisms do the intimate partners of veterans with PTSD develop? The discussion is organized by the patterns, essential essences (themes), and subthemes followed by descriptive statistics of the data from the

instruments, the Brief Cope Scale, the Secondary Traumatic Stress Scale, and the General Well-Being Scale. A summary of the findings is also provided.

Description of the Participants

The participants were members of PTSD support groups for spouses and family members. The sample was primarily recruited from local PTSD support groups in the greater Houston metropolitan area. Some participants were recruited out of state by participants attending the local Houston PTSD support groups. Thirty-three participants were recruited and 27 (*N* = 27) of them (82%) completed the online study in its entirety. The online study was completely voluntary and anonymous. The responses from the six participants who began the study but did not complete it were not used in the data analysis.

All of the participants were English-speaking; a majority of the participants (88.9%) were female, predominantly Caucasian, married, and employed for wages. The predominant age range was 36 to 45 years. The intimate partners were veterans who were predominantly male (88.9%). The participants were predominantly in heterosexual relationships with the exception of two participants, one in a female-female and one in a male-male relationship. The predominant length of time of the intimate partners in relationships with the veterans were 5 years or less (18.5%) to 10 years (18.5%). An overwhelming majority (74%) of the intimate partners' veterans had participated in the

Iraq/Afghanistan War with the length of exposure to combat ranging from 1 to 5 years (Appendix E).

Qualitative Findings

To arrive at the findings that describe the lived experience of intimate partners of veterans with PTSD, Colaizzi's (1978) method was followed. The findings obtained from the participants' transcripts resulted in an in-depth, exhaustive description of being an intimate partner of a veteran with PTSD. The findings are discussed in four sections: the overarching theme, the themes (essences) and subthemes, the return to the experts, and scores of the three instruments. The findings from the quantitative instruments were used for thematic validation and enhancement of the qualitative findings.

Overarching Theme: It Has Affected Every Aspect of Our Lives

The overarching theme yielded the understanding that PTSD is an *all-encompassing* disorder that places the intimate partner of the veteran on a life-changing trajectory. PTSD affects all aspects of the intimate partner's life including daily living, psychological functioning, intimate relationships, family life, social life, and finances. Consistently, participants identified PTSD as the central focus in their lives. One participant, a 70-year-old woman, stated, "It has affected every aspect of our lives…from financial to child-rearing, sexual to outside activities, and friendships. It has been the elephant in the room."

A 45-year-old woman expressed a similar sentiment regarding the life-changing effects of PTSD in the following statements:

> Everything has changed because of PTSD. From not going out to dinner to not seeing friends. We normally don't socialize. I am more cautious around him now because I don't know how he is from one moment to the next. I feel more like his mother instead of his wife at times because I'm taking care of him so much. There is little to no involvement with the kids' activities. Right now my husband is unable to function to go to work so we have no income coming in. So now I have to go out and earn money while taking care of him too.

A 72-year-old woman described her partner's PTSD as all-consuming:

> PTSD produces a self-centered world. Life becomes very much about them. How they feel, what they want, what is occurring or has already momentarily occurred…often we go from crisis to crisis. And everything in all our lives waits upon their needs and their feelings for that moment.

Data analysis resulted in six themes that support the overarching theme: (a) My partner's PTSD takes a mental and physical toll on me; (b) My partner with PTSD has a tendency to be highly aggressive and violent; (c) Financial life is a struggle; (d) Family life is hard; (e) I am more cautious; and (f) I seek out help and resources. The six themes and a brief description of the formulated meaning for each theme are presented in Table 1.

Table 1

Themes and Meanings Supporting the Overarching Theme

Themes	Meanings
My partner's PTSD takes a mental and physical toll on me.	Living with a veteran with PTSD can be traumatic for the intimate partner, resulting in adverse mental and physical manifestations.
My partner has a tendency to be highly aggressive and violent	Describes the uncontrollable and nondiscriminatory acts of violence and aggression perpetuated by the veteran with PTSD.
Financial life is a struggle	Refers to the ongoing crisis of financial stability attributed to the veteran's PTSD.
Family life is hard	Highlights different aspects of dysfunction within the family unit resulting from the veteran's PTSD symptoms and sequelae.
I am more cautious	The intimate partner constantly struggles to maintain a peaceful environment by trying to prevent PTSD triggers.
I seek out help and resources	The intimate partner's plight in seeking out resources to help in understanding and coping with the veteran's PTSD.

The Themes (Essences)

The participants described their experience of living with a veteran with PTSD and PTSD's impact on their lives including its symptomatology and sequelae. The themes were categorized according PTSD's effect on the intimate partners' (a) psychological and physical functioning, (b) incidences of violence

and hostility, (c) financial instability, (d) family unit impact, (e) apprehension, and (d) help-seeking behaviors. Six themes and 17 subthemes emerged from the data and they are presented in Table 2. Each of the themes and subthemes is presented next with accurate, written accounts from the participants.

Table 2

Themes and Subthemes

It has affected every aspect of our lives	**Categories**	**Themes**	**Subthemes**
	Psychological/ Physiological Functioning	My partner's PTSD takes a mental and physical toll on me	I am worried about my mental well-being. I have high anxiety. I felt alone.
	Violence and Hostility	My partner has a tendency to be highly aggressive and violent	I tried to hide the domestic violence. The veteran with PTSD has trouble controlling his or her temper. We have physical altercations.
	Financial Instability	Financial life is a struggle	Primary bread winner. I am unable to work. He has been fired from several jobs.
	Family Unit Impact	Family life is hard	I feel more like his mother instead of his wife. We have become more distant. How will our children turn out?
	Apprehension	I am more cautious	He gets easily upset. Walking on eggshells.
	Help-Seeking Behaviors	I seek out help and resources	Get an official diagnosis of PTSD. Seek a support group. Get counseling.

Theme One: My partner's PTSD takes a mental and physical toll on me. This theme embodies the intimate partners' burdens of living with and taking care of veterans with PTSD. Dealing with PTSD is onerous. Living with a veteran with PTSD can be traumatic for the intimate partner, resulting in adverse clinical mental and physical manifestations. Participants shared the demands that PTSD places on their lives, mentally and physically. Several participants expressed concern over their own deteriorating health and the health of the veterans. A 45-year-old White woman wrote, "I worry about the future. As we age, will I be able to assist him in the same capacity that I do now?" Another participant, a 70-year-old Hispanic woman, expressed similar concern regarding her own physical health, "Getting older has produced more ailments and physical difficulties for us both. I worry about my husband's mental capacity as he ages." The veterans' PTSD affected the intimate partners' mental functioning in various ways. Theme One was broken down into three subthemes of psychological distress that include (a) I am worried about my mental well-being, (b) I have high anxiety, and (c) I felt alone.

I am worried about my mental well-being. Concern of the participants regarding their own mental health was evident throughout the data sets. Some participants maintained their mental stability with the help of family members, clergy, support groups, and professional help while some engaged in self-

destructive behaviors to cope. A 43-year-old Hispanic woman shared the unhealthy coping mechanisms that she employed to help her mental distress.

> I often self-medicated so that I could deal with the negative feelings I had. The habits that I developed in order to cope with my ex-husband's PTSD have not gone away. I am worried that I have grown dependent on the things that I used to make me feel better then.

A man in his late 30s shared a similar self-destructive way of dealing with his mental struggles, "I often wish that I did not have feelings for her so that I could just break up with her and go on with my life. I usually deal with my feelings by going out and drinking with friends."

I have high anxiety. Despite some participants' knowledge and understanding about the symptoms and sequelae of PTSD, some still functioned under a continual, acute stress and anxiety. Some participants developed psychological symptoms similar to veterans with PTSD. A 42-year-old White woman explained the development of her psychological distress.

> Increased my anxiety because of his high anxiety, paranoia, and fear of public… It has begun to wear me down after all this time and I have high anxiety as well. Constant stress that everything has to be right to his liking…the children are starting to show signs of anxiety from living in the pressure of his high stress level.

A 43-year-old Hispanic woman commented on her stress level that she attributed to PTSD, “My ex-husband’s PTSD, and the problems it caused, made me feel extremely stressed out and embarrassed.”

I felt alone. In this subtheme, participants focused on the distress of being lonely while in a committed relationship. The participants attributed loneliness to the veterans’ desires for solitude which resulted in the isolation of family and friends. A 61-year-old White woman shared her experiences of isolation from her husband in the following statement, “If I was not with the children, or with some other family member, I was alone. My husband preferred to be alone most of the time…My husband and I did not spend much time together.”

A 39-year-old Mixed-race male explained the reasoning for his loneliness and mental distress. “I do not discuss my girlfriend’s condition with anyone…I am afraid that my girlfriend will be very upset if I discuss her situation with anyone; this has made me feel alone and extremely frustrated.”

Theme Two: My partner has a tendency to be highly aggressive and violent. Acts of aggression and violence perpetrated by the veterans were identified as common behaviors by the participants. Aggression and violence from the veterans was described as their prevailing reality by one-third of the participants. The participants shared that nobody was safe from the veterans’ violence and aggression when it occurred. The participants further noted that the

veterans' aggression and violence could be brought on by trivial incidences. This was clearly reflected in the following response, "People often complained that he was extremely angry and aggressive at times when there was no reason to be." The theme, my partner has a tendency to be highly aggressive, was broken down into three subthemes: (a) I tried to hide the domestic violence, (b) The veteran with PTSD has trouble controlling his or her temper, and (c) We have physical altercations.

I tried to hide the domestic violence. In this subtheme, participants shared their bouts with domestic violence and their attempts to hide it from their children, family, and friends. Participants expressed embarrassment and they isolated themselves to hide the violence and to prevent others from knowing about the veterans' PTSD problems. Additionally, participants reflected on the incidences of domestic violence, its victims, and its long-lasting effects. The lingering effects of domestic violence were eloquently explained by a 72-year-old White woman in the following statement, "Our grown children to this day still deal with issues that all too often surface from their childhood memories and the long ago domestic violence. Because of it, they too, have low self-esteem struggles of their own." A 38-year-old White woman shared her child's attempts to shield her from domestic violence. "My 14-year-old tries to intervene and take up for me when my husband is verbally abusive."

A veteran with PTSD has trouble controlling his or her temper. The veterans' uncontrollable tempers consumed some of the participants' lives; they expressed frustration at the unpredictable nature of their tempers. A 40-year-old African-American woman noted, "My husband has been having trouble controlling his temper. He has had several occasions where he ended up in a physical altercation with someone that ended with him being taken to jail." A 25-year-old White woman described similar experiences with her partner's temper. "His temper is unpredictable and recently he seems to be having a hard time remembering things." Some of the veterans' uncontrollable tempers prevented them from being able to financially contribute to the family. A 32-year-old White woman described her partner's unpredictable temper in the following statement, "He gets easily upset at the smallest things and he can't hold down full-time employment for long. He is worried that his temper will explode on his boss and he will get fired."

We have physical altercations. Participants shared that violence exhibited by the veterans extended beyond the nuclear family. A 43-year-old Hispanic woman expressed problems that developed between her family and her spouse due to his violence. "My ex-husband's PTSD did cause a divide between him and my family. There would often be extreme altercations between my family and my ex-husband because my family would not accept the way he treated me." A 38-year-old White woman shared that her partner's violence was

directed at the pets. “My husband never hit me but he threw objects and lashed the pets when he had outbursts.”

Theme Three: Financial life is a struggle. This theme captured the ongoing financial crisis due to the veteran’s inability to work and/or maintain employment. The majority of the participants (92%) suffered from financial instability. Some of the noted consequences from their financial instability were bank account closings, repossessions, bankruptcies, and foreclosures. The financial struggle was described by a 45-year-old Asian woman:

> Right now my husband is unable to function to go back to work so we have no income coming in. I have always been a homemaker. So now I have to go out and earn money while taking care of him too. We are a family used to $50,000+ a year and down to $10,000. Trying to get financial help has been one circle after another. Everyone has given me the run around of why they can’t or won’t help us. I get nowhere with every agency.

Primary breadwinner. PTSD symptoms made it difficult for some of the veterans to maintain employment. Participants expressed frustration and stress from being the sole providers in their households. Participants described their willingness to meet financial obligations but sometimes their efforts were insufficient. A 39-year-old Mixed-Race man shared, “Being that my girlfriend cannot keep a job, I usually have to pay my bills and her bills. Though I have a

pretty good income, I do not make enough to pay for two separate households. I have a lot of financial stress." A 27-year-old African-American man explained, "My partner's PTSD has affected us financially because I am the only one that is getting a steady and sufficient paycheck. Though my partner receives government assistance, it is not enough to sustain us both."

I am unable to work. The veterans' avoidance and maladaptive coping behaviors made it difficult for some participants to maintain employment. A 40-year-old White woman noted, "He doesn't like being alone and has high anxiety when we are away from him. I had to quit my job. Financial life is a struggle. We are paycheck to paycheck every month but we have food, water, shelter, and each other." A 36-year-old woman described her partner's drug addiction and its effect on their finances. "My partner's PTSD has made financial situations stressful. There have been times when my partner has spent most of our money on drugs in order to make herself feel normal."

He has been fired from several jobs. Getting fired from their jobs was a common reason that veterans could not contribute financially to the household. A 40-year-old African-American woman shared her experiences of her partner's bouts of unemployment, "My husband's PTSD has caused a difference in our financial status because he sometimes gets in trouble at work for his behavior. He has been fired from several jobs since we have been together, and he often finds it hard to find new jobs due to the fact that he would prefer staying home in

his controlled environment." A 43-year-old Hispanic female noted, "My ex-husband's PTSD eventually led us to a point where we had to file for bankruptcy. Being that he often got fired for verbally/physically attacking someone or for disappearing for hours."

Theme Four: Family life is hard. In this theme, participants identified PTSD as a major cause of dysfunction within the family unit. Avoidance behaviors by the veterans resulted in their self-isolation from the family. A 61-year-old White woman shared her dilemma in explaining her partner's behavior to family members.

> Prior to the diagnosis, my husband would often refuse to participate in family outings, and he would often spend days off to himself. I often struggled to try and explain my husband's behavior to our children and the rest of our family. It was hard for them to understand why it seemed like he just did not want to be a part of the family.

I feel more like his mother instead of his wife. Participants expressed exhaustion and frustration regarding their role changes in the relationship. Participants found themselves functioning primarily as caregivers to their partners instead of as intimate partners. A 44-year-old White woman commented on the extent of her caregiving, "A majority of my time is spent caring for my husband since his mental status started deteriorating." A 45-year-old Asian woman expressed her feelings regarding her caregiver status, "I feel more

like his mother instead of his wife at times because I'm taking care of him so much. From a strong man to a child."

We have become more distant. Participants conveyed their difficulty in maintaining a close relationship with the veterans. A 33-year-old White woman described the growing distance between the veteran and the family in the following statement.

> It is difficult to be intimate sometimes. It is also difficult to maintain a stable family life; his relationships with his children seem very strained. We all withdraw from him when he is having a hard time with his temper.

A 27-year-old African-American man explained the stagnation in the relationship, "My partner's PTSD has made it hard for our relationship to grow. The issues my partner has made me want to spend less time with him. I am often gone for long periods of time; this makes my partner worry about the security of our relationship. My partner and I often argue, and we do not see each other often even though we live in the same house."

How will our children turn out? Participants worried about the effects that PTSD will have on their children. Concerns ranged from regret for staying in the relationship thereby preventing the children from having a normal childhood to supporting the veteran by teaching the children the symptoms of PTSD and precautions to take around the veteran. A quandary concerned the smaller children with limited comprehension and understanding of PTSD. A 68-year-old

White woman shared, “The children did not understand his PTSD and they did not understand why they could not play in the house when he was home. All noises made by the children upset him and we all tiptoed around the house when he was home.” A 33-year-old White woman shared, “I worry about how our children will interpret the behavior caused by his PTSD.”

Theme Five: I am more cautious. This theme captures the heightened sense of awareness that the participants have regarding their partner’s PTSD. Because of their hyper-vigilance, some participants were able to detect triggers for the PTSD symptoms as well as preventing an onset of PTSD symptoms. A 39-year-old Mixed-Race man described awareness of his body language which could trigger his partner’s PTSD symptoms.

> I have to be very careful when I am around my girlfriend, especially when we are having a disagreement about something. If I get loud, or my body language shows that I am upset, my girlfriend gets really scared and she does everything she can to get away from me. It is hard to relax around her because I am afraid that I will do or say something that will cause her to have a panic attack.

A 40-year-old African-American woman conveys her hyperawareness to the triggers of her intimate partner’s PTSD:

> My husband’s PTSD has made our social life a little difficult. I have to watch him and look for signs of his PTSD being triggered. I have had a

few occasions where I had to try my best to keep my husband from hurting someone or getting hurt by someone. Sometimes it is just easier to socialize at home by inviting very close, and trusted friends and family to come over.

Walking on eggshells. The expression "walking on eggshells" was a common phrase used by the participants to describe the tense environment at the homes. Participants noted that they consciously avoiding talking about significant event, days, and places that were painful memories for the veteran. In addition, the participants tried to maintain a peaceful home free from noise to avoid triggering the veterans' PTSD symptoms. A 37-year-old White woman stated, "Sometimes we have to tiptoe around topics and events to ensure we do not cause an onset."

A 70-year-old Hispanic woman noted the tension the children endured, "Our children grew up in a household that consisted of *walking on eggshells* to coexist with their father." A 38-year-old White woman longed for normalcy in the home for the children's sake. "Now that he is home, there is the consistent feeling of *walking on eggshells.* The children cannot be children because they need to be quiet at all times."

Participants further described their experiences of living in an uneasy and unsafe environment in their homes. A 30-year-old African-American woman sadly noted the following about her partner, "His symptoms make me feel as if I

was there in the war with him and it can make me feel like I'm a threat or in danger." A 43-year-old Hispanic woman described her fearful marriage to her partner. "My husband's PTSD made our marriage extremely difficult and scary. I was never really able to relax and enjoy myself when I was around him. There was always a sense of pending danger in our home."

He gets easily upset. Participants acknowledged their feelings of powerlessness in dealing with the veterans' unpredictable temperaments. The veterans' mood swings and emotional outbursts set off trepidation in the participants. A 32-year-old White woman described her current mental state with her partner, "Basically functioning trying not to upset him…I feel helpless and hopeless with our situation." A 36-year-old White woman described the volatile environment around the veteran, "My partner's PTSD makes it hard to be around her sometimes. She has major mood swings that make me nervous. We argue a lot over things that are not real problems." A 43-year-old Hispanic woman expanded on the veterans' volatility in the following statement. "…Also, there were many occasions where my ex-husband would explode with emotion over minor stressors; this made it hard for people to be around him."

Theme Six: I seek out help and resources. The final theme captures the importance of support and counseling; a common perception among the participants was that they had a critical need to join a support group and seek help in dealing with the veterans' PTSD. At the onset of PTSD symptoms and

prior to seeking support, participants conveyed the thought that they were alone in their experiences with the veterans. A 45-year-old White woman shared the importance of obtaining support.

> Know that you're not alone. There are hundreds of spouses caring for veterans that can support you. Don't be afraid to reach out and ask for help. Asking for help doesn't make you weak, it shows strength. Take care of yourself so you don't get compassion fatigue.

Get an official diagnosis of PTSD. Participants expressed feelings of denial, uncertainty, and certainty with the veterans' PTSD symptoms. Participants expressed relief when the veterans were officially diagnosed because it confirmed their abnormal behavior. A 70-year-old Hispanic woman whose partner was in the Vietnam War shared her difficulty in obtaining a diagnosis. "What made it difficult at the beginning, many decades ago, was not knowing what the elephant was-unacknowledged, undiagnosed, untreated." A 72-year-old White woman expressed relief with obtaining a diagnosis:

> Once there was a diagnosis, a name given to this condition, it was a Hallelujah moment! The elephant in the room finally had a name. This made it real to the world and the doubters who dwelled there and now there was counseling and psychiatry available, group support therapy, and medications.

Seek a support group. Participants experienced understanding and a sense of comradery when they received support from support groups, family, clergy, and friends. A 72-year-old White woman expressed the importance of attending a support group for intimate partners of veterans with PTSD. "Group support made all the difference…I realized I wasn't the only one in this world going through something so bizarre. What I was sensing, feeling, and experiencing all existed in others' lives as well. I learned there were LOTS of us." A 70-year-old Hispanic woman expressed similar sentiment about support groups:

> Finding and getting support from others who also know what I'm talking about and dealing with has been my salvation. Seeking like hearted people has been my answer to this trauma and what it brings to the American family's doorstep.

Participants who did not have a support system expressed feelings of loneliness and despair in their relationships with their partners. A 45-year-old White woman commented on the difference that support made in her life:

> I didn't become aware of support until five years post injury. If I had support earlier, I would have handled our situation better. I tried to keep our life like it was before and that wasn't possible. I didn't know that I was grieving for the loss of our future dreams and what we had before injury, which was detrimental.

Get counseling. Participants' perceptions varied regarding the benefits of counseling. The majority of the participants and their partners that received counseling expressed gratitude and relief with the counseling sessions. Some participants expressed dissatisfaction with counseling that was provided by civilian mental health providers. Their perception was that the civilian providers did not fully understand military families and the PTSD problems of the veterans. A 40-year-old White woman expressed the benefits of counseling in the following statement, "It saved us! I felt alone and confused and angry and he felt all the same things and more. The Vet Center helped us with counseling. We go as a couple, individually, and as a family." A 40-year-old White woman explained the difference that counseling made in her life:

> Once I became aware of other women in my situation, then I reached out and received counseling, which made all the difference in my coping skills. After receiving counseling through a private counselor, I learned to deal with my emotions and coping skills, which in turn allowed me to help him function. I don't get wound up about little things anymore.

Returning to the Experts

To validate the findings of the qualitative data, the final step in Colaizzi's methodology, member check, was performed. Member check consisted of validation of the findings by subject matter experts and support group members. Initially, a thematic table and the online interview guide were emailed to the

leader of the local PTSD support group and a mental health provider at the local Army Reserve hospital unit for review. The people were subject matter experts due to their extensive work in counseling and treatment of veterans diagnosed with PTSD and their family members. The table (Table 2) depicted the overarching theme, the themes, and the subthemes that emerged from the data. The online, interview guide of open-ended questions (Appendix B) provided review of the questions that were used to elicit data for the emergent themes. After reviewing the table and interview questions, follow-up phone calls were conducted to discuss the six themes and seventeen subthemes. During the phone calls, written accounts from the participants were read to the experts when they requested supporting information for specific themes or subthemes. The responses from the experts indicated agreement with the thematic table. One of the PTSD experts expressed excitement, relief, and identification with the themes from the data.

> I can relate to all of the themes. It is as if someone reviewed my life's journey and struggle with my partner's PTSD! Even after 30 plus years of living through and surviving the turmoil that PTSD brought into my life, I still get excited and relieved when I receive confirmation that my struggle was real and not a figment of my imagination. Living with PTSD has reconfirmed my calling from God which is to help spouses of veterans of PTSD. We are the silent victims whom society tends to overlook.

The second part of member check was presentation of the findings to members of a support group. The thematic table was presented to eight members in attendance at one of the local PTSD support group meetings. The group members reviewed the themes and subthemes in detail. Discussion ensued which included reading the written accounts that corresponded to each theme and subtheme. Responses from the eight support group members indicated agreement with the themes and subthemes. One support group member stated, "I agree. I have experienced all of themes except domestic violence." The group member then asked if verbal abuse was a form of domestic violence. Another group member in agreement stated, "These themes are surreal. Reading this themes is like looking at a mirror of my life." Although there was total agreement with the thematic table, one support group member felt that something was missing. The group member felt that specific PTSD symptoms of the veterans, such as flashbacks, nightmares, and suicidal thoughts that intimate partners deal with should have been included in the themes.

> When I participated in the study, I specifically talked about flashbacks and nightmares that my husband was having. He thought about suicide two times and he has been hospitalized for these thoughts. The public should know about his flashbacks, nightmares, and suicidal thoughts. I need more help. I am at my wits end.

This participant's final quote adds to the already overwhelming evidence

for the overarching theme, PTSD Has Affected Every Aspect of Our Lives. She is in desperate need of help for her husband's symptoms and the effect they have on both their lives.

Quantitative Findings

The results from the three screening scales, the Secondary Traumatic Stress (STS) Scale, the Brief Cope Scale (BCS), and the General Well-Being (GWB) Scale, support the qualitative findings. The responses on the scales by the majority of the participants indicate they experienced secondary traumatic stress, difficulty coping, and an impaired sense of well-being.

Secondary Traumatic Stress

The Secondary Traumatic Stress Scale (STS) score, comprised of three subscales - intrusion, avoidance, and arousal, was calculated for the total scale score and the subscale scores. Participants with a total STS scale score of 38 and higher were considered to have secondary traumatic stress and those with a total STS scale score below 38 were considered to not have secondary traumatic stress disorder (Bride et al., 2004).

Eighteen participants (66.7%) met the diagnostic criteria for secondary traumatic stress; nine participants (33.33%) did not meet the diagnostic criteria. All of the participants reported at least one symptom of secondary traumatic stress as a result of living with a veteran with PTSD. The range for the total STS

scale scores was 21 to 74. The total secondary traumatic stress mean was 45.37 with a *SD* of 14.63 (Table 3).

Table 3

Descriptive Statistics Secondary Traumatic Stress Scale

Participants (%)	**Subscales**	**Mean**	***SD***	**Range**
Scored < 38 9 (33.33%)	Intrusion Subscale	13.37	5.02	5.00 – 24.00
Scored > 38 18 (66.67%)	Avoidance Subscale	17.11	6.00	8.00 – 28.00
	Arousal Subscale	14.88	4.79	7.00 – 25.00
	Total STS Scale	45.36	14.63	21.00 – 53.00

Note: Scores 38 or < indicative of STS, Scores > 38 indicative of no STS. (N = 27)

Symptoms indicative of secondary traumatic distress were endorsed for participants' responses of *occasionally, often,* and *very often* for the past year. Participants endorsed avoidance symptoms more frequently than other symptoms with 62.9% experiencing discouragement about the future and 22.2% experiencing gaps in memory about significant other. Arousal symptoms received the second most frequent endorsements, with 70.3% of participants endorsing being easily annoyed and 48.1% feeling jumpy. Intrusion symptoms received the fewest participant endorsements, with 66.6% experiencing heart palpitations when reflecting on the work with the veterans and 29.6% having disturbing dreams about their veterans (Table 4).

Table 4

Percentage of Participants with Specific STS Symptoms

STS Symptoms	***n* (%)**
I felt emotionally numb	**15(55.5)**
My heart started pounding when I thought about my work with my significant other	**18(66.6)**
It seemed as if I was reliving the trauma(s) experienced by my significant other	12(44.4)
I had trouble sleeping	**18(66.6)**
I felt discouraged about the future	**17(62.9)**
Reminders of my work with my significant other upset me	**14(51.8)**
I had little interest in being around others	10(37.0)
I felt jumpy	13(48.1)
I was less active than usual	**15(55.5)**
I thought about my work with my significant other when I didn't intend to	**18(66.6)**
I had trouble concentrating	**16(59.2)**
I avoided people, places, or things that reminded me of my work with my significant other	9(33.3)
I had disturbing dreams about my work with my significant other	8(29.6)
I wanted to avoid working with my significant other	**14(51.8)**
I was easily annoyed	**19(70.3)**
I expected something bad to happen	**17(62.9)**
I noticed gaps in my memory about my significant other	6(22.2)

Note: STS symptoms reported <50% of participants as occasionally, often, or very often are in bold. (N = 27).

Brief Cope Scale

Coping strategies are used to help individuals overcome stressful events (Folkman & Lazarus, 1980). Active coping is the process of taking active steps to try to circumvent the stressor or to ameliorate its effects (Carver, Scheier, & Weintraub, 1989). To learn what coping mechanisms intimate partners of veterans with PTSD use, the participants completed the Brief Cope Scale. There is no overall score on the Brief Cope Scale; the score for the dominant coping behavior is set by the individual researcher using the scale (Carver, 1997). A score of five and above was set by the principal investigator to be representative of the dominant coping behavior. A minimum score of 5 was set to indicate coping behavior prevalence because 5 is the median of scores attainable on the Brief Cope Scale.

The most prevalent adaptive coping behaviors used by the participants were active coping (mean 5.77), use of emotional support (mean 5.14), positive reframing (mean 5.44), planning (mean 6.11), acceptance (mean 6.55), and religion (mean 6.22) followed by the use of instrumental support (mean 4.81). The most prevalent maladaptive coping behavior used by the participants was self-distraction (mean 5.33) followed closely by venting (mean 4.77) (Table 5). The participants overwhelming displayed adaptive coping behaviors for stressors associated with living with a veteran with PTSD.

Table 5

Brief Cope Scale Descriptive Statistics

Categories	**Coping Behaviors**	**Sum**	**Mean**	***SD***
Adaptive Coping Behaviors	Active coping	156	5.77	1.62
	Use of emotional support	139	5.14	2.36
	Use of instrumental support	130	4.81	2.14
	Positive reframing	146	5.40	2.17
	Planning	165	6.11	1.76
	Acceptance	177	6.55	1.55
	Religion	169	6.25	1.99
Maladaptive Coping Behaviors	Self-distraction	144	5.33	2.13
	Denial	69	2.65	1.64
	Substance use	92	3.40	2.13
	Behavioral disengagement	95	3.51	2.19
	Venting	129	4.77	2.00
	Humor	78	2.88	1.25
	Self-blame	99	3.66	1.98

14-scales comprised of 2 items. Scores range from 2 to 8. Higher scores indicate increased utilization of that coping behavior. (N = 27).

General Well-Being Scale

Quality of life encompasses the physical, mental, and social well-being of an individual. The GWB Scale was administered to validate the findings from the qualitative data on the intimate partners' overall quality of life measured by their general well-being. Possible range for the total scores on the GWB is 0-110. Scores of 70 and above indicated positive well-being; scores below 70 indicated distress. The means and standard deviations from the GWB scale were calculated to answer to assess the overall well-being of the participants. The total well-being mean was 64.85 (*SD* 2.83). The range for the total scores was 60 to 71. Only one participant (3.7%) scored above 70 indicating positive well-being; 96.3% (*n* = 26) of the participants scored below 70.

Summary of Findings

The purpose of this mixed-method study was the explore the lived experiences of intimate partners of veterans with PTSD. Intimate partners described living with veterans with PTSD as a stressful, emotional, and consuming experience. Colaizzi's (1978) methodology for qualitative data analysis was followed step-by-step and revealed an overarching theme, six main themes, and eighteen subthemes that convey the essences of the experiences of intimate partners living with veterans with PTSD. PTSD experts and PTSD support group attendees reviewed and supported the findings. The quantitative data analysis validated the findings from the qualitative data analysis. Intimate

partners living with veterans with PTSD employ more adaptive coping behaviors than maladaptive coping behaviors. Despite the reported use of positive coping behaviors, intimate partners of veterans with PTSD reported that their quality of life was negative, with scores below the cut-off score for positive well-being, and two-thirds of the participants had results indicating secondary traumatic stress. The quantitative results support the qualitative findings that PTSD affected every aspect of the participants' and their families' lives.

CHAPTER V

SUMMARY OF THE STUDY

This mixed-method, phenomenological study explored the lived experience of intimate partners of veterans with PTSD. Twenty-seven participants described their experiences of life with veterans with PTSD. The study aimed to gain an understanding of the impact of PTSD on the lives of intimate partners of veterans with PTSD, their risk for developing secondary traumatic stress, and their coping mechanisms for dealing with the PTSD. The impact of PTSD on the intimate partners' lives is multifaceted; it effects their psychological and physical well-beings, financial status, and family functioning. PTSD and its effect on veterans is widely researched yet little is known about the effect of the veterans' PTSD on the intimate partners who are often the primary caregivers for the veterans and who often have first-hand experience with the PTSD symptomatology. The nursing literature provides a small body of evidence about the lived experiences and harmful/negative effects of PTSD on the intimate partners but there still exists a lack of understanding of the phenomenon and not enough evidence to garner greater support, and resources for the intimate partners of veterans with PTSD, and stimulate more research.

To better understand a phenomenon that is not well understood, Husserl suggested viewing the human experience of the phenomenon. He proposed that

human experience of a phenomenon was the basic building block of science (Husserl, 1913/1982). To explore the lived experiences of intimate partners of veterans with PTSD, a mixed-method, phenomenological design was implemented. The design allowed the researcher to gather and analyze written transcripts of the phenomenon. Then the qualitative findings were validated with findings from the analysis of data from the same sample acquired using three quantitative instruments. Through purposive sampling, 27 participants were recruited from local PTSD support groups in the Houston metropolitan area. The resulting 27 transcripts were evaluated using Colaizzi's (1978) methodology resulting in an in-depth, exhaustive description of the lived experiences of intimate partners of veterans with PTSD.

This chapter provides a summary of the findings. A discussion of the findings is discussed in the context of findings from related studies. That discussion is followed by implications for nursing practice and recommendations for future studies.

Summary of Findings

Although each participant's experience was unique, there were multiple commonalities in their descriptions of their experiences as an intimate partner of a veteran with PTSD. Data analysis led to the identification of an overarching theme, 6 themes (essences), and 17 subthemes. The overall perspective of the participants was that living with a veteran with PTSD was unpredictable and life-

changing. The six themes (essences) that were identified are: (a) *My partner's PTSD takes a mental and physical toll on me*, (b) *My partner has a tendency to be highly aggressive and violent*, (c) *Financial life is a struggle*, (d) *Family life is hard*, (e) *I am more cautious*, and (f) *I seek out help and resources*.

There were some unexpected findings in the data that came from the three instruments. The scores from the Brief Cope Scale indicated that the participants overwhelmingly used adaptive coping mechanisms when dealing with the veterans' PTSD however approximately 67% of the participants met the criteria for secondary traumatic stress on the Secondary Traumatic Stress Scale and 93% of the participants' General Well-Being scores indicated that they were distressed. The themes from the interviews and the results from the instruments provide a deeper understanding into the lives of intimate partners living with veterans with PTSD.

Discussion of the Findings

The findings of this study are the essences of intimate partners living with veterans with PTSD. These findings are consistent with and expand on what is known about the lives of intimate partners living with veterans with PTSD. The following discussion of the findings is organized according to the major themes and what is known about intimate partners' experiences.

My Partner's PTSD Takes a Mental and Physical Toll on Me

The lives of the participants in this study were so intertwined with the veterans' PTSD symptoms that some of them developed symptoms similar to their partners' PTSD. The participants' symptoms, termed secondary traumatic stress, may develop in individuals who are in close proximity to the traumatic experiences of others (Figley, 1995). In this study, 67% of the participants (*n* = 18), met the criteria for secondary traumatic stress from the Secondary Traumatic Stress Scale. The findings that participants have secondary traumatic stress symptoms is consistent with Greene, Lahav, Bronstein, and Solomon's (2014) findings that wives of ex-POWs with PTSD reported more secondary traumatic stress symptoms and were high risk for psychiatric problems compared to the wives of veterans without PTSD. One participant whose spouse fought in the Vietnam War described her long-term struggle with secondary traumatic stress. This finding validates the Ahmadi et al. (2011) study that showed a positive correlation between the intimate partners' secondary traumatic stress and the veterans duration of PTSD symptoms.

The general well-being of the participants was negatively affected by the veterans' PTSD symptomology with 96% (*n* = 26) meeting the criteria for distress according to the General Well-Being Scale. Participants expressed concern about their mental and physical health including problems with anxiety, anger, caregiver burden, fatigue, paranoia, loneliness, mental distress and instability,

feelings of worthlessness, and feelings of helplessness. This finding supported the findings by Westerink and Giarratano (1999) and Koic et al., (2002) who found that partners living with veterans with PTSD developed physiological problems and reported psychological distress characterized by mental health concerns. A unique finding about the psychological and physiological distress of the intimate partners in this study is that 100% of the participants (*N* = 27) experienced some form of psychological and/ or physiological distress regardless of age of the participants, length of time in the relationships, gender, marital status, and wars that the veterans participated.

My Partner has a Tendency to be Highly Aggressive and Violent

The participants experienced aggression and hostility from the veterans including emotional outbursts, physical altercations, throwing of objects, verbal abuse, pet abuse, and domestic violence. Acts of violence perpetuated by veterans with PTSD were consistent with findings reported in the literature across various disciplines. Previous findings show that veterans with PTSD exhibited more hostility evidenced by increased acts of aggression and violence, violence-related job problems, and increased family dysfunction (Beckham, Moore, & Reynolds, 2000; Caroll et al., 1985; Chemtob, Hamada, Roitblat, & Muraoka, 1994).

Participants in this study acknowledged their struggles with the veterans' anger and domestic violence that had long-lasting psychological effects on the

family. This finding was supported by several studies that found positive associations between veterans' PTSD and their perpetration of domestic violence (Byrne & Riggs, 1996; Jordan et al., 1992). One particular study by Taft, Street, Marshall, Dowdall, and Riggs (2007), showed a link between anger, PTSD symptoms, and violence. Veterans' anger, measured on the State-Trait Anger Expression Inventory (STAXI), revealed that trait anger mediated the effects of PTSD symptoms on physical assault and psychological aggression perpetration. Anger was identified as a potential pathway through which PTSD symptoms lead to abusive behavior. The findings provide a rationale for the increased likelihood of domestic violence among intimate partners of veterans with PTSD (Taft et al., 2007).

A unique finding in this study was the participants' attempts to shield the children from the domestic violence. Even after these attempts, one participant described the lingering effects from the domestic violence on her adult daughter. Multiple studies have explored the long-term effects of domestic violence experienced in childhood that extends into adulthood. Previous findings have shown that witnessing or being a victim of domestic violence in childhood increases the likelihood of drug abuse, psychological dysfunction, low-self esteem, and the inability to maintain intimate relationships in adulthood (Colman & Widom, 2004; Hill, Kaplan, French, & Johnson, 2010; Shen, 2009; White & Widom, 2008). There are also immediate effects of domestic violence that

present during childhood. A study by Harkness (1991) found that children who experience violence in the families of veterans with PTSD have higher rates of depression, anxiety, hyperactivity, poor academic performance, and poor socialization. The findings from the present study show the calamitous effects that domestic violence has on children.

Financial Life is a Struggle

The participants in this study expressed their unremitting financial short-comings resulting from their decrease in family income due to the veterans' inability to maintain full-time employment. Frustration was expressed by one participant regarding the veteran's paranoia which hindered the participant from working to help support the family. Consistent with previous findings, participants accepted the veterans' inability to financially support the family and they took on roles of primary financial providers. Klaric et al. (2010) found that the spouses of veterans with PTSD often bore the financial burden due to the veterans' inability to function at work; it further showed that spouses of veterans with PTSD experienced lower economic status more frequently than spouses of veterans without PTSD. A unique finding in this theme was the intimate partners' resilience in their new roles as primary breadwinners; they put the needs of the family first in spite of the veterans' inability to be a productive financial contributor. The intimate partners' roles of sole providers were similar to previous findings of Dekel, Goldblatt et al. (2005) who found that the wives of the

veterans with PTSD became empowered through their caregiver role; they remained vigilant in their savior role and they became the foundation of their homes.

Family Life is Hard

Participants in this study identified PTSD symptomatology as the culprit for family dysfunction affecting the relationships between the intimate partners, the veterans, and the children. PTSD has been shown to interfere with the veterans' ability to engage in supportive relationships and the intimate partners are often left responsible for stabilizing fractured family relations in the household (Solomon et el., 1992). The participants in this study expressed disdain with the veterans' avoidance behaviors (i.e. desire to be alone, refusal to socialize) which caused physical and emotional distancing within the families and extended to outside relationships. Previous studies found manifestations from avoidance behaviors included: (a) sexual dysfunction in both the veteran and the intimate partner, (2) isolation of the veteran from family members, (c) withdrawal of family members from the veterans, (d) lack of marital intimacy in the relationship, and (e) regret/ guilt from the intimate partners for remaining in the relationships with the veterans (Jordan et al., 1992; Solomon et al., 1992).

An important aspect of this theme was the effect of the veteran's PTSD on the children. The participants in this study vigilantly worked to maintain a quiet, trigger-free environment in their homes. The stressors of maintaining a

continuous, noise-free environment kept the children from experiencing normal childhoods which indirectly created an atmosphere of fear and distancing. One participant reflected on her children tiptoeing around the house and withdrawing when the veteran could not control his temper. Consistent with previous findings by Emdad and Sondergaard (2005), withdrawal was found to follow episodes of angry outbursts from the veterans leading to disconnection from family members and impaired communication. Psychological problems exhibited by the children were reported by the participants. One participant highlighted the psychological problems of anxiety and paranoia that her children developed from growing up in such a stressful environment. Jacobsen, Sweeney, and Racusin (1993) found that children of veterans with PTSD were aggressive, socially inept, and experienced difficulty when dealing with psychosocial stressors. Symes, McFarlane, Fredland, Maddoux, and Zhou (2015) examined the mediating effects of maternal PTSD symptoms on the relationship of parenting behaviors (positive parenting, inconsistent, poor supervision) and found a relationship with child internalizing and externalizing behaviors in households of domestic violence.

I Am More Cautious

This theme highlights the heightened state of anxiety that intimate partners of veterans with PTSD endure continually. The participants in this study described their daily lives as a continuum of walking on eggshells and living in a home with a sense of pending danger. This is consistent with previous findings

that have shown that intimate partners living with a veteran with PTSD function in a constant state of uncertainty and fear (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Galovski & Lyons, 2004; McLean, 2006). The participants described the veterans as being oversensitive to noise, body gestures, comments, specific dates, and events. The participants conveyed their inability to relax in their homes due to their need to remain hyper-vigilant to prevent the triggering of the veterans' PTSD. This finding supports those of McLean (2006) who found that intimate partners living with veterans with PTSD adapted to the PTSD by assessing the veterans' moods and by finding ways to prevent the veterans' emotional explosions.

I Seek Out Help and Resources

The participants' desires for support and resources is the last theme in this study. The findings from this study show that support and help from family, friends, professionals, clergy, and group support members improve the participants' understanding of PTSD, improved their coping skills in dealing with PTSD symptoms, improve their mental health, reaffirmed that they were not alone in their situations, and helped alleviate some of their burdens of dealing with PTSD alone. These findings are similar to those of Outram et al. (2009) who found that support from informal (i.e. family, friends) and formal sources (i.e. healthcare providers, counselors) have a positive impact on spouses of veterans with PTSD.

Sherman et al. (2005) conducted a study on the mental health needs of intimate partners living with Vietnam veterans with PTSD and they found that the partners overwhelmingly supported having access to therapy to help them effectively cope with the veterans' PTSD. Furthermore, Bland et al. (1997) found that individuals that receive support have better mental health outcomes. The participants overwhelmingly agree that support, in the form of PTSD support groups, changed their lives for the better and helped educate them about PTSD and its sequelae. PTSD support groups provided the participants with a "voice", a sense of connection, non-judgmental understanding, empathy, and a safe harbor that promoted adaptive coping mechanisms.

Although the benefits of support are evident in the findings and literature, some participants did not seek out help and support for the following reasons: (a) denial of PTSD symptoms, (b) lack of education and knowledge, (c) lack of available resources, (d) lack of time due to family responsibilities, and (e) the desire for privacy and secrecy regarding the PTSD diagnosis. The findings were consistent with those of Buchanan et al. (2011). They found that partners of veterans with PTSD had very little knowledge about the symptoms of PTSD; they also discovered that one of the barriers to seeking support was the fear of nondisclosure due to the stigma associated with PTSD. Another barrier to seeking support was caregiver burden where the spouses of veterans with PTSD become so engulfed with the veterans' care to the point of neglecting their own

needs (Williams & Williams, 1987). In addition to caring for the veterans, the intimate partners' available time is limited due to them over-functioning in the parenting and financial roles (Lyons, 1999).

An interesting finding in this theme is substance use as a coping mechanism. Two participants disclosed that they self-medicated to help them cope with the veterans' PTSD. Those same participants also expressed frustration regarding their lack of a support system. This finding conveys the criticality of support systems to intimate partners of veterans with PTSD and they support the findings from the Brief Cope Scale.

Using emotional support involves getting moral support, sympathy, or understanding. Positive reframing involves viewing a stressful situation in positive terms. Planning is the process of thinking about how to cope with a stressor which involves coming up with action strategies and thinking about the steps to take to best handle the situation. Acceptance is accepting the reality of the stressful situation. Turning to religion might serve as a source of emotional support. Using instrumental support involves seeking advice, assistance, or information (Carver et al., 1989). Self-distraction is the process of diverting attention away from the stressor. Venting involves focusing on the stressor and venting those feelings (Scheff, 1979). Support systems, particularly formal systems, have been shown to decrease distress, improve family problem solving, increase positive coping, and increase knowledge (Lucksted et al., 2013).

Framework

The use of Husserl's descriptive phenomenology provided the theoretical framework for this study. Through descriptive phenomenology, the researcher explored and obtained an in-depth understanding of the lived experiences of intimate partners of veterans with PTSD. Husserl's systematic method provided the venue for enlightening the commonalities in the lives of intimate partners of veterans with PTSD.

Assumptions

The assumptions are re-examined below:

1. Intimate partners of veterans with PTSD are at risk for the development of psychological, physical, and social problems. This study fully supported this assumption. The participants described psychological, physical, and social problems that they experienced in detail. Some of the findings from the qualitative data were validated on the three instruments.
2. Intimate partners of veterans with PTSD can benefit from knowledge gained about the lived experiences of other intimate partners of veterans with PTSD. This assumption was fully supported in the participants' responses regarding the invaluable importance of attending support groups.
3. Subjective experiences can inform researchers about the lived experience phenomenon that is not well understood or documented. This assumption

was fully supported by this study. The responses from the online interview were rich and they helped the researcher understand the far-reaching effects on PTSD on the intimate partners' lives.

4. Descriptive, phenomenological research methodology can provide knowledge about the lived experiences of intimate partners of veterans with PTSD that will improve the care of these individuals. This study fully supported this assumption. The six themes identified common areas of concern for the intimate partners where research and care can be directed to improve their lives.

Conclusions

This mixed-method, phenomenological study provides insight into the experiences of 27 intimate partners living with veterans with PTSD. The overarching theme and the six themes of this study were fully supported by findings from other studies. Unquestionably, veterans' PTSD symptomatology affects all aspects of their intimate partners' lives. The following conclusions are drawn from this study:

1. Intimate partners of veterans with PTSD experience psychological and physiological distress which affect their general well-being. Being in close proximity to veterans with PTSD is stressful, sometimes resulting in the development of secondary traumatic stress in the intimate partners.

2. Intimate partners of veterans with PTSD endure unpredictable, aggressive, and violent acts from the veterans which can have long-term effects on their psychological health. The children, unseen victims of the violence, have impaired psychological functioning and social skills.
3. Intimate partners of veterans with PTSD experience financial uncertainty as a result of the veterans inability to contribute financially on a consistent basis. As a result, the intimate partners assume the role of primary financial provider.
4. Veterans with PTSD frequently isolate themselves from the family resulting in impaired relationships with the intimate partners and the children. To maintain a stable, functioning family unit, the intimate partners assume the primary role of parent and caregiver.
5. Intimate partners of veterans with PTSD live in a state of hyperawareness and fear where they function to avoid triggering the veterans' anger, emotional outbursts, and PTSD symptoms. Their hyper-vigilance and maintenance of a noise-free, stress-free environment helps to alleviate the triggers.
6. Establishing a support system and seeking treatment was important to the intimate partners of veterans with PTSD. Attendance in support groups was highly rated as the most beneficial source of support. Support groups

helped intimate partners understand that they were not alone in their experiences.

Implications

The findings in this study indicated that the veterans' PTSD affects all aspects of the intimate partners' lives. The intimate partners are typically the primary caregivers for the veterans with PTSD and with this caregiver role come the stresses and burdens of dealing with a tremendous life-changing mental illness. With so much attention directed towards the veterans, the intimate partners are the "unacknowledged patients" whose mental and physical needs often go unnoticed by healthcare providers. Through our nursing practice, it is imperative that nurses and nurse practitioners be educated about the effects of PTSD on the intimate partner. Nurses need to aware that intimate partners can present with psychological problems, physiological problems and a combination of the two that stem from the veteran's PTSD. Nurses should also be knowledgeable about secondary traumatic stress and its non-discriminating affects on intimate partners regardless of gender, sexual orientation, and socioeconomic status.

Being that violence and aggression are manifestations of the veterans' PTSD, nurses should be vigilant about recognizing signs of abuse experienced by the intimate partners and the children. Although the majority of the participants easily identified signs of violence and abuse, a small minority did not.

One participant did not identify violent actions towards pets and verbal outbursts as abusive behaviors since the veteran did not make physical contact. Nurses should also be cognizant of the intimate partners' fear to disclose violent behavior for valid reasons. Some participants may choose nondisclosure due to the stigma associated with PTSD and others may simply fear the veterans' retaliation and anger regarding disclosure of such information. When signs of PTSD and violence at present in the intimate partners' lives, nurses should implement interventions that consist of thorough assessments, active listening, validation of the intimate partners' experiences, appropriate referrals, and adaptive coping mechanisms.

An unforeseen, vulnerable population from the findings is the children. Children are seen as "silent victims" due to their inability to understand and/ or change their living environment. The affects of the veterans' PTSD on children has been shown to be destructive to their psychological development. Research has shown that children who grow up in traumatized families experience more psychological problems, behavioral problems, academic dysfunction, socialization problems, and opiate use (Beckham et al., 1997; Galovski & Lyons, 2004). Nurses must intervene for the children of veterans with PTSD to ensure that their needs are met and to protect them from harm. Interventions for children affected by PTSD needs to occur early and be age-appropriate. Some interventions that might be beneficial to the children of veterans with PTSD are

play or art therapy (Azar & Wolfe, 1989), yearly assessments and follow-ups, group therapy with emphasis on socialization skills, family therapy, and adaptive coping mechanisms.

Education is an important part of nursing. Not only should nurses be aware of the detrimental effects of PTSD on the intimate partners, they should educate and help the intimate partners understand PTSD and its effect on their families. With the widespread use of the Internet and its accessibility, nurses should provide educational information on PTSD that is readily accessible with contact information for referrals and other resources. Nurses can also provide information in print to distribute to veterans and their families when they visit healthcare facilities. One of the concerns expressed by the participants was their lack of information and education regarding PTSD. Providing educational materials in print and on the Internet can help alleviate this problem. It is important that both nurses and nurse practitioners be knowledgeable about PTSD and its effect on intimate partners and their children. Nurses are often the first and sometimes the only contact that patients have in the healthcare system; they play significant roles in early detection of mental and physical illnesses. Nurses' significance in treating veterans and intimate partners of veterans will continue to increase as the military seeks civilian healthcare providers to assist in the growing need for mental health providers. Evidence shows how the effects of PTSD significantly impact the health of intimate partners and children of veterans

with PTSD. Nurses, the largest group of gatekeepers in healthcare who work together to improve the status of vulnerable populations and communities, will be important in the identification and early intervention PTSD sequelae in intimate partners and children of veterans with PTSD.

Limitations

This study has several limitations. The study is a mixed-method, phenomenological study with primary emphasis on the qualitative methodology. The qualitative nature of this study might not be representative of all partners of veterans with PTSD. Secondly, the majority of the participants were of female gender which further limits the representativeness of intimate partners of veterans with PTSD. The gender inequality prevented the researcher from drawing inferences according to gender from the findings. Lastly, the study was a Web-based, self-report questionnaire that carries the risk of response bias.

Strengths

This study has several strengths. The mixed-method design allowed for rich responses and validation of the responses with the instruments which strengthened the findings. Secondly, the sample size was appropriate to allow for data saturation to occur; data saturation occurred when the 22nd participant completed the study but the researcher continued to the 27th participant in search of new findings. Thirdly, the sample consisted of both heterosexual and same-sex participants (one lesbian couple and one gay couple). To date, there is no

known research on the impact of veterans' PTSD on same-sex partners, only heterosexual partners. The study allowed for data collection from same-sex intimate partners; the findings from the same-sex intimate partners were consistent with those from heterosexual intimate partners which further strengthened the findings.

Recommendations for Further Studies

There is a need for further research on the effects of veterans' PTSD on their intimate partners and children. The findings from this study clearly indicated the devastating effects of PTSD on the lives of intimate partners of veterans and their children. The intimate partners are the "silent victims" of PTSD who bare the burden of caring for veteran with limited understanding and empathy from society contributing to a state of isolation. Widespread evidence-based nursing research should be conducted with special emphasis on interventions, treatments, education, and social support. Interventions should be implemented by civilian and military nurses that include treatments that restore healthy mental functioning. Future research should also focus on early assessment, intervention, and treatment for domestic violence.

The children are also affected by the veterans' PTSD and by domestic violence. Future studies, both qualitative and quantitative, should be conducted to assess the effects of PTSD symptomatology on children of American war veterans; the majority of the research has been conducted in other countries. A

good body of research has been conducted on the effects of domestic violence on children and it has shown that children in violent households tend to mirror the violence in their adults relationships or become victims of domestic violence (Whitfield, Anda, Dube, & Felitti, 2003). Research has further shown that children in homes with veterans with PTSD are high risk for exposure to domestic violence thus placing them at high risk for developing secondary traumatic stress termed trans-generational trauma transfer (Margolin & Vickerman, 2007; Taft et al., 2005). The key to effectively treating children of veterans with PTSD is through early diagnosis and interventions. Evidence-based nursing research is needed to explore effective education, interventions, treatments, and therapies that decrease PTSD sequelae on the children.

Lastly, public awareness and education is the key to gaining support for the intimate partners and children of veterans with PTSD. Nursing and the healthcare community need to place emphasis on strategies to improve the well-being of intimate partners and children of veterans with PTSD. Public awareness is needed to bring attention to this vulnerable population. Campaigns are continuously conducted to bring awareness and garner support for the brave veterans that fought for our country. Campaign propaganda can be seen at sporting events, Veteran's Day celebrations, and discounts from restaurants and retail stores among other things. Similar campaign propaganda should be

implemented to bring help bring more support to the intimate partners and the children of veterans with PTSD.

Summary

Little is known about the behind-the-scene heroes (intimate partners) and their struggles when the veterans return home mentally impaired. The intimate partners are left to pay for the costs of war, their veterans' PTSD, which tremendously affects their personal finances, family relationships, intimate relationships, and mental and physical health. Public awareness is the first step to education, treatment, funding, and the implementation of government policies that will help alleviate the intimate partners' burdens of caring for the veteran.

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Appendix A

Site Approval Letters

DEPARTMENT OF THE ARMY
4005TH UNITED STATES ARMY HOSPITAL
JOINT FORCES RESERVE CENTER ELLINGTON FIELD
10949 AEROSPACE AVENUE SUITE 2215
HOUSTON TEXAS 77034

REPLY TO
ATTENTION OF:

AFRC-RMC-CCB

21Sep 2014

ATTN: The Internal Review Board, Texas Woman's University, Houston, TX

I grant permission for MAJOR Sabrenda T. Littles to post flyers at the 4005th United States Army Hospital Expansion located at 10949 Aerospace Ave, Suite 2215, Houston, TX 77034 for her research titled Living with PTSD and its Impact on Life, An Intimate Partner's Perspective, for one year beginning September 30, 2014.

JAIRO HENAO
CPT, AN, USAR
HHC Commander
4005th US Army Hospital (E)
Work (832) 380-7133

DEPARTMENT OF THE ARMY
ARMED FORCES RESERVE CENTER
10949 AEROSPACE AVENUE
HOUSTON, TEXAS 77034

REPLY TO
ATTENTION OF:

ARRC-TTX-LG (190)

11 January 2015

ATTN: The Internal Review Board, Texas Womans University, Houston, TX

I grant permission for the MAJ Littles, Sabrenda T. to post flyers at the Joint Forces Reserve Center, located at 10949 Aerospace Avenue, Houston, TX 77034-5563, for her research titled, Living with PTSD and its Impact on Life, An Intimate Partner's Perspective, for one year beginning January 11, 2015.

DUSTIN J. JAEGER
SSG, ENG, USAR
Construction Engineer

Worklife Institute

1900 St. James Place • Suite 880 • Houston, Texas 77056 • (713) 266-2456 • Fax (713) 266-0845

January 22, 2015

ATTN: The Internal Review Board, Texas Woman's University, Houston, TX

I grant permission for Ms. Sabrenda T. Littles to use the Texas Alliance of Military Women at 1900 Saint James Place, Suite 800, Houston, TX 77056 for her research titled, Living with PTSD and its Impact on Life, An Intimate Partner's Perspective, beginning February 1, 2015.

Sincerely,

Dr. Diana C. Dale, PhD, LMFT
Program Director
713-963-9456
www.worklifeinstitute.com

Appendix B

Interview Guide

Interview Guide

1. What events helped you to understand that your partner had PTSD?
2. How has your life changed because of your partner's PTSD?
    a. How has your partner's PTSD affected your relationship with your partner?
    b. How has your partner's PTSD affected your family life?
    c. How has your partner's PTSD affected your social life?
    d. How has your partner's PTSD affected your work and financial life?
3. How has getting support in dealing with your partner's PTSD worked out for you? What helped you get support? What made it difficult for you to get support?
4. What feelings have you had about your partner's PTSD? (For example, relief that the condition was diagnosed, embarrassment about the diagnosis, and others). How do you deal with your feelings?
5. What worries or concerns do you have now?
6. What advice would you give to others who are dealing with partners with PTSD?
7. Is there anything else that you would like to say about your experiences as a partner of a veteran with PTSD?

Appendix C

Demographic Questionnaire

Demographic Questionnaire

1. What is your age in years?_____

2. What is your gender?

_____Female

_____Male

3. What is your partner's gender?

_____Female

_____Male

4. How long have you and your partner been in a relationship? _____ If no longer together, how long was the relationship? _____

5. Which war did your partner participate in? (**Select all that apply**)

_____Iraq/Afghanistan War (October 2001 to present)

_____Gulf War (August 1990 to February 1991)

_____Vietnam War (1959 to April 1975

_____Korean War (June 1950 to July 1953)

_____World War II (December 1941 to August 1945)

_____World War I (August 1914 to November 1918)

_____ Other

6. What was the length of your partner's exposure to combat?

_____ < 1 year

_____ 1-5 years

_____ > 5 years

7. Which ethnic or racial group describes you accurately?

_____White, Caucasian, or of European background

_____Black or African background

_____Hispanic or Latino

_____Asian

_____American Indian or Alaskan Native

_____Native Hawaiian or Other Pacific Islander

_____Mixed ethnicity

_____Other

8. What is your marital status?

_____Married

_____Widowed-not remarried

_____Divorced-not remarried

_____Separated

_____Never married

_____Common-law

_____Girlfriend/boyfriend

_____Domestic partner

9. What is the highest level of education completed?

_____No formal education

_____Completed grade school (1^{st}-8^{th} grade)

_____Some high school

_____Completed high school-Diploma or Equivalent (GED)

_____Vocational, technical, trade, or business school beyond the high school level

_____Some college, but no degree

_____Associate's degree

_____Bachelor's degree

_____Some graduate school

_____Master's degree

_____ Doctorate degree

10. Which state do you live? Indicate by placing the 2-digit abbreviation.___

11. What is your employment status?

_____Employed for wages

_____Self-Employed

_____Homemaker

_____Out of work

_____Unable to work (EX. Disabled)

_____Student

_____Retired

12. What is your total household income?

_____Less than $10,000

_____$10,000 to $29,999

_____$30,000 to $49,999

_____$50,000 to $69,999

_____$70,000 to $89,999

_____$90,000 to $109,999

_____$110,000 to $129,999

_____$130,000 to $149,999

_____$150,000 or more

13. What is the size of the city that you live in?

_____Less than 1,000 people

_____1,001 to 10,000 people

_____10,001 to 50,000 people

_____50,001 to 100,000 people

_____100,001 to 500,000 people

_____500,001 to 1,000,000 people

_____More than 1 million people

Appendix D

Instruments

Brief COPE Scale

These items deal with ways you've been coping with the stress in your life since your significant other's post-traumatic stress disorder symptoms began. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently? Do not answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true **FOR YOU** as you can.

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.

2. I've been concentrating my efforts on doing something about the situation I'm

in.

3. I've been saying to myself "this isn't real.".

4. I've been using alcohol or other drugs to make myself feel better.

5. I've been getting emotional support from others.

6. I've been giving up trying to deal with it.

7. I've been taking action to try to make the situation better.

8. I've been refusing to believe that it has happened.

9. I've been saying things to let my unpleasant feelings escape.

10. I've been getting help and advice from other people.

11. I've been using alcohol or other drugs to help me get through it.

12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

General Well-Being Scale

For each question, choose the answer that best describes how you have felt and how things have been going for you *during the past year*.

1. How have you been feeling in general?

5 _____ In excellent spirits

4 _____ In very good spirits

3 _____ In good spirits mostly

2 _____ I've been up and down in spirits a lot

1 _____ In low spirits mostly

0 _____ In very low spirits

2. Have you been bothered by nervousness or your "nerves"?

0 _____ Extremely so—to the point where I could not work or take care of things

1 _____ Very much so

2 _____ Quite a bit

3 _____ Some—enough to bother me

4 _____ A little

5 _____ Not at all

3. Have you been in firm control of your behavior, thoughts, emotions, or feelings?

5 _____ Yes, definitely so

4 _____ Yes, for the most part

3 _____ Generally so

2 _____ Not too well

1 _____ No, and I am somewhat disturbed

0 _____ No, and I am very disturbed

4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile?

0 _____ Extremely so—to the point I have just about given up

1 _____ Very much so

2 _____ Quite a bit

3 _____ Some—enough to bother me

4 _____ A little bit

5 _____ Not at all

5. Have you been under or felt you were under any strain, stress, or pressure?

0 _____ Yes—almost more than I could bear

1 _____ Yes—quite a bit of pressure

2 _____ Yes—some, more than usual

3 _____ Yes—some, but about usual

4 _____ Yes—a little

5 _____ Not at all

6. How happy, satisfied, or pleased have you been with your personal life?

5 _____ Extremely happy—couldn't have been more satisfied or pleased

4 _____ Very happy

3 _____ Fairly happy

2 _____ Satisfied—pleased

1 _____ Somewhat dissatisfied

0 _____ Very dissatisfied

7. Have you had reason to wonder if you were losing your mind or losing control over the way you act, talk, think, feel, or of your memory?

5 _____ Not at all

4 _____ Only a little

3 _____ Some, but not enough to be concerned

2 _____ Some, and I've been a little concerned

1 _____ Some, and I am quite concerned

0 _____ Much, and I'm very concerned

8. Have you been anxious, worried, or upset?

0 _____ Extremely so—to the point of being sick, or almost sick

1 _____ Very much so

2 _____ Quite a bit

3 _____ Some—enough to bother me

4 _____ A little bit

5 _____ Not at all

9. Have you been waking up fresh and rested?

5 _____ Every day

4 _____ Most every day

3 _____ Fairly often

2 _____ Less than half the time

1 _____ Rarely

0 _____ None of the time

10. Have you been bothered by any illness, bodily disorder, pain, or fears about your health?

0 _____ All the time

1 _____ Most of the time

2 _____ A good bit of the time

3 _____ Some of the time

4 _____ A little of the time

5 _____ None of the time

11. Has your daily life been full of things that are interesting to you?

5 _____ All the time

4 _____ Most of the time

3 _____ A good bit of the time

2 _____ Some of the time

1 _____ A little of the time

0 _____ None of the time

12. Have you felt downhearted and blue?

0 _____ All the time

1 _____ Most of the time

2 _____ A good bit of the time

3 _____ Some of the time

4 _____ A little of the time

5 _____ None of the time

13. Have you been feeling emotionally stable and sure of yourself?

5 _____ All the time

4 _____ Most of the time

3 _____ A good bit of the time

2 _____ Some of the time

1 _____ A little of the time

0 _____ None of the time

14. Have you felt tired, worn out, used-up, or exhausted?

0 _____ All the time

1 _____ Most of the time

2 _____ A good bit of the time

3 _____ Some of the time

4 _____ A little of the time

5 _____ None of the time

Circle the number that seems closest to how you have felt generally *during the past month*.

15. How concerned or worried about your health have you been?

Not Concerned at all	10	8	6	4	2	0	**Very concerned**

16. How relaxed or tense have you been?

Very relaxed	10	8	6	4	2	0	**Very tense**

17. How much energy, pep, and vitality have you felt?

No energy at all, listless	0	2	4	6	8	10	**Very energetic, dynamic**

18. How depressed or cheerful have you been?

Very depressed	0	2	4	6	8	10	**Very cheerful**

Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **year** by circling the corresponding number next to the statement.

NOTE: *"Significant other" is used to indicate persons with whom you have been engaged in a helping relationship. Significant other represents the veteran that you are/were involved (i.e. spouse, ex-spouse, deceased spouse, boyfriend/girlfriend, etc.).*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb……..1		2	3	4	5
2. My heart started pounding when I thought about my work with my significant other ……...1		2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my significant other ……..1		2	3	4	5
4. I had trouble sleeping……1		2	3	4	5
5. I felt discouraged about the future……..1		2	3	4	5
6. Reminders of my work with my significant other upset me……1		2	3	4	5
7. I had little interest in being around others……..1		2	3	4	5
8. I felt jumpy……1		2	3	4	5
9. I was less active than usual……1		2	3	4	5
10. I thought about my work with my significant other when I didn't intend to……1		2	3	4	5
11. I had trouble concentrating……1		2	3	4	5
12. I avoided people, places, or things that reminded me of my work with my significant other ……1		2	3	4	5
13. I had disturbing dreams about my work with my significant other ……..1		2	3	4	5
14. I wanted to avoid working with my significant other ...1		2	3	4	5

15. I was easily annoyed.……1	2	3	4	5
16. I expected something bad to happen.……1	2	3	4	5
17. I noticed gaps in my memory about my significant other ……..1	2	3	4	5

Appendix E

Sample Demographic Characteristics (*N* = 27)

Sample Demographic Characteristics (*N* = 27)

Characteristics	*n* (%)	Characteristics	*n* (%)
Gender (Intimate Partner)		**Highest level of education**	
Female	24(88.9)	Completed high school	4(14.8)
Male	3(11.1)	Vocational, technical, or trade school	3(11.1)
		Some college but no degree	8(29.6)
Gender (Veteran)		Associate's degree	3(11.1)
Female	3(11.1)	Bachelor's degree	5(18.5)
Male	24(88.9)	Some graduate school	1(3.7)
		Master's degree	3(11.1)
Age range (Intimate Partners)			
18-25	1(3.7)	**Employment status of partner**	
26-35	8(29.6)	Employed for wages	15(55.6)
36-45	14(51.8)	Self-employed	1(3.7)
46-65	2(7.4)	Homemaker	6(22.2)
>65	3(11.1)	Unable to work	1(3.7)
		Student	1(3.7)
Veteran war participation		Retired	3(11.1)
Iraq/Afghanistan War (Oct 2001-present)	20(74.0)		
Gulf War (Aug 1990-Feb1991)	4(14.8)	**Total household income**	
Vietnam War (1959-Apr 1975)	6(22.2)	Less than $10,000	1(3.7)
		$10,000 to $29,999	2(7.4)
Length of veteran's exposure to combat		$30,000 to $49,999	8(29.6)
		$50,000 to $69,999	13(48.1)
<1 year	4(14.8)	$70,000+	2(7.4)
1-5 years	21(77.8)	Rather not say	1(3.7)
>5 years	2(7.4)		
		Size of city that partner resides	
Ethnic or racial group (Intimate Partner)		< 1,000 to 10,000 people	3(1.1)
White, Caucasian, or European	15(55.6)	10,001 to 50,000 people	5(18.5)
Black or African	6(22.2)	50,001 to 100,000 people	7(25.9)
Hispanic or Latino	2(7.4)	100,001 to 500,000 people	5(18.5)
Asian	2(7.4)	500,001 to 1,000,000 people	2(7.4)
Mixed ethnicity	2(7.4)	More than 1 million people	5(18.5)
Marital/relationship status		**Length of time in relationship with vet**	
Married	17(63.0)		
Widowed-not remarried	1(3.7)	< 5 years	5(18.5)
Divorced-not remarried	4(14.8)	5-10 years	5(18.5)
Common-law	1(3.7)	11-20 years	2(7.4)
Girlfriend/boyfriend	2(7.4)	21-30 years	2(7.4)
Domestic partner	2(7.4)	31-40 years	2(7.4)
		41+ years	2(7.4