A Phenomenological Exploration of the Lived Experience of Military Spouses of Veterans with Combat-related Post-traumatic Stress Disorder

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ABSTRACT

Title: A Phenomenological Exploration of the Lived Experience of Military Spouses of Veterans with Combat-related Post-traumatic Stress Disorder

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A phenomenological study was conducted to explore the essence of the experience of military spouses living with veterans with combat-related Post-traumatic Stress Disorder (PTSD). Husserlian phenomenology was chosen as the theoretical framework because it allowed a deeper understanding of the unfolding of the spouses' day-to-day experience. A purposive sample of 14 spouses living with veterans with symptoms of PTSD participated in unstructured interviews. Data were analyzed using a modification of Colaizzi's method. Four major themes were identified from data analysis: *Recognizing Life is No Longer the Same*, *Living with Unpredictability*, *Bearing the Burden*, and *Creating a New Life*. Spouses recognized that the veteran was no longer the same person, with life becoming one of living with the unpredictability of PTSD. The participants bore the burden to maintain normalcy in the family and eventually created a new life in which some remained in and others left the marriage.

PREFACE

DEDICATION

This dissertation is dedicated to my strongest supporters, my family. First, I would like to thank them for traveling this journey with me. They have made numerous sacrifices to allow me to fulfill my dream. Throughout this journey, they have not complained. Instead, they have cheered me on to be a better me.

To my husband, Ramon, I thank you for service in the U.S. Air Force and supporting our country in five separate deployments. I value your support and encouragement. Thank you supporting me to make my dream a reality.

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To our son, Kwentan, I thank you for adaptability that has allowed me to follow my dreams.

To each of my loved ones, I thank God for allowing you to walk through my life and for your patience with my ongoing exfoliating and remodeling of my life. Your belief in me and steadfast support bolstered me throughout this journey and for that I dedicate this dissertation to you.

In memoriam to my mother, Doris "Dot" James Williams, who believed in me even when I did not believe in myself, and my father, Grover "Hootie" Cleveland Williams, who demonstrated to me the value of hard work.

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Introduction

Background

Since the beginning of the overseas contingency operations in Iraq and Afghanistan (OCO) in 2001, more than 1.9 million American military members have deployed for more than 30 days. With redeployments military members have supported 3 million tours of duty (National Academies of Science, 2010). Combat-related post-traumatic stress disorder (PTSD), diagnosed in 10-18% of the veterans returning from support of OCO (U.S. Department of Veterans Affairs, 2015a), impacts intimate relationships (Lambert, Engh, Hasbun, & Holzer, 2012; Monson & Taft, 2005; Renshaw & Caska, 2012; U.S. Department of Veterans Affairs, 2015b). PTSD symptoms, which can occur after exposure to war or a traumatic experience, are described as "reliving the event (also called re-experiencing symptoms), avoiding situations that remind the person of the event, negative changes in beliefs and feelings, feeling keyed up (also called hyperarousal)" (U.S. Department of Veterans Affairs, 2013, p. 4). The disorder can affect the family (Canfield, 2014) and marital relationships during the veteran's reintegration into the family unit (Morse, 2006). How PTSD symptoms impact spouses is not traditionally captured in research or clinical practice. Moreover, many studies of the marital bond focus on the veteran's perspective (Allen, Rhoades, Stanley, & Markman, 2010; Erbes, Meis, Polusny, & Compton, 2011) or couples in therapeutic interventions (Fredman, Monson, & Adair, 2011; Monson et al., 2012; Sautter, Armelie, Glenn, & Wielt, 2011). However, there are limited investigations with a focus on the spouses' perspective (Dekel et al., 2005; Maloney, 1988; McLean, 2006; Woods, 2010). More specifically, no studies at this time reveal what it is like for a spouse to live with a veteran with PTSD from OCO. Not knowing the spouses' perception of daily life with these returning veterans limits knowledge of the impact of traumatic stress and overlooks the contribution of the military spouse in the holistic treatment of PTSD, which is integral to the married service member's total fitness (Mullen, 2013).

Research has shown that military caregivers experience physical health problems and excessive mental health and psychological distress while living with a veteran with PTSD (Price & Stephens, 2014; RAND Corporation, 2013; Yambo & Johnson, 2014). The overall health of military caregivers is a primary concern among military and civilian leaders, particularly since military caregivers often overlook their individual health needs, while caring for their veteran spouse (American Nurses Association, 2015; RAND Corporation, 2013). However, the emergence of PTSD research over the last decade does not suggest that military spouses are absent in the veterans' support. The limited quantity of studies regarding the experiences of the spouses suggests a lag in the awareness of the plight of military spouses. The few published studies revealed the perception of military spouses in phenomenological studies in terms of the meaning spouses attribute to being married to a veteran with PTSD (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005), being unrecognized by the public following the Vietnam conflict (Maloney, 1988), the inefficiency of health-related services (Mansfield, Schaper, Rosen, & Yanagida, 2014), and feelings about being a wife of a soldier with PTSD (Woods, 2010). However, each study was limited in exploring the complex and multidimensional experience of living with a veteran spouse suffering with PTSD symptoms. To this point, a phenomenological study was needed to conduct semistructured interviews that concentrate on and broaden the understanding of the spouse's unique experience. From this investigation, the experience the spouses share may become more clearly, universally recognized as to what it means to be married to a veteran with PTSD. This study has the potential to improve the care spouses receive and spark actions to design interventions for military families that may be disseminated to clinicians. Since descriptive phenomenology is designed to explain, bring to awareness, and comprehend (Yuxiang et al., 2012) "'taken for granted experiences' and to reexamine them in an intentional manner that brings to light the essence (meaning) of human experience" (Fochtman, 2008, p. 186), it was selected as the most appropriate design for this dissertation study.

Problem Statement

Military spouses are necessary to provide holistic support to married veterans that receive treatment for PTSD (Yambo & Johnson, 2014). PTSD can happen after experiencing a traumatic event during combat (Manguino-Mire, Sautter, Lyons, Myers, Perry, Sherman, Glynn, & Sullivan, 2007; Ray & Vanstone, 2009). This means that veterans are at risk for PTSD, since during their combat tours they may witness, hear, or go through a traumatic experience, such as exposure to battle, sexual or physical abuse, terrorist strike, life-threatening accident, or natural catastrophes (U.S. Department of Veterans Affairs, 2013). For the purpose of this study, a veteran is defined as an Active Duty, Guard, or Reserve service member, or retiree of the U.S. Armed Forces.

Research has shown that spouses who live with a veteran with PTSD may experience secondary traumatic stress, psychological distress, caregiver burden, relationship dissatisfaction and difficulty coping. Despite recent military operations in Iraq and Afghanistan, including multiple deployments, little is known about the spouse's experience of living day-to-day with a veteran who has symptoms of PTSD.

Purpose

The purpose of this study was to explore the essence of the experiences of military spouses living with a veteran with PTSD, which can potentially assist policy makers and clinical practitioners to understand their perspective and create appropriate treatment modalities. Describing the spouses' perspective is necessary to share their experiences and illuminate what makes their daily life difficult and what makes life simpler living with a veteran with PTSD.

Philosophical Framework

Husserl's descriptive (eidetic) phenomenology provided the philosophical framework of this study. The objective of eidetic phenomenology focuses on describing the meaning of an experience from the perspective of those who have had the experience (Munhall, 2007). Husserl's fundamental posit was that consciousness was germane to all human experience. In other words, phenomenology is the study of the lived experience in which the researcher seeks to conquer his or her personal biases, assumptions, and forethoughts to obtain pure consciousness of the participant's experience. It is a returning to the daily way of life in which the participants live to acquire a better comprehension of their experience (Munhall, 2007).

Conceptual meanings are necessary to understand the philosophical framework of phenomenology research. The following conceptual meanings provide clarity to the foundational principles of phenomenology. Existential interaction is defined as the researcher developing consciousness of the phenomena as one who does not know. For the researcher to develop consciousness as one who does not know, he or she must partake in the concept of transcendental subjectivity (Wojnar & Swanson, 2007).

Transcendental subjectivity (Husserl, 2001) refers to the researcher's efforts to forsake his or her own preconceived thoughts and describe the phenomenon in its pure, authentic consciousness. To attain transcendental subjectivity, the researcher must engage in the process of bracketing, which includes intentionally setting aside prior experiences, assumptions, and biases to avoid interference of the description of the phenomena in its pure, authentic form (Tymieniecka, 2003). The process of bracketing includes (a) setting the phenomenon aside and reviewing it; (b) exploring the phenomenon to deconstruct the structure, explain it, and analyze it; and (c) interrupt all preconceived ideas regarding the phenomena, and process the phenomena as it is (LeVasseur, 2003). This process allows the researcher to suspend preconceived thoughts as he or she listens to, observes, interacts with, or analyzes the stories of the participants (LeVasseur, 2003; Munhall, 2007). Decenter refers to the researcher exposing his or her own prejudices, dislikes, intentions, and suspicions to become the genuine and efficient 'research instrument'. It is essential for researchers to maintain a journal and document their prejudices, dislikes, intentions, and suspicions, what they assume their conclusions will be, and all barriers that might avert active listening to the meaning of the experience. Unknowing means to get to know one's self through reflection and introspection. It is crucial for the researcher to understand and accept that he or she and the participant possess two different worldviews. Intersubjectivity refers to the verbal and non-verbal interaction between the participant and the researcher (Munhall, 2007). In addition, Husserl posited that lived experiences were scientific and generalizable, if researchers maintained strict adherence to the philosophical constructs of descriptive phenomenology, and commonalities were determined among the participants (Figure 1). These conceptual meanings are central to the eidetic structure and are necessary for the researcher to accept and sustain the essence of the experience of the participants (Lopez & Willis, 2004; Munhall, 2007) (See Figure 1).

A major assumption of the phenomenological viewpoint in this study is that all experiences are comprised of a simple explanation of the spouse's experience (Dahlberg, Drew, & Nyström, 2001; Munhall, 2007). That is, the spouse's reality or what he or she feels is real and forms the foundation for the phenomenon under study. On a fundamental level, the reality of the situation is the individual's experiences with the phenomenon (Munhall, 2007). In this instance, the essence of the experience of living with a veteran spouse with PTSD symptoms is the reality of the spouse. The essence of the experience is what the researcher seeks to understand in this phenomenological inquiry. The basis for selecting this framework is to understand the essence of the experience of military spouses living with veterans with symptoms of PTSD.

Next, the meaning of the experience is created as the researcher uses the conceptual constructs of the philosophical framework to explore what makes it easier and more difficult for the spouses and provides a universal description of the phenomenon. Understanding the universal description provides a clearer picture of the essence of the lived experience of military spouses living with a veteran diagnosed with symptoms of PTSD. Findings from this study will potentially illuminate the lived experience of military spouses and the meaning behind how the spouses cope daily with the symptoms of PTSD.

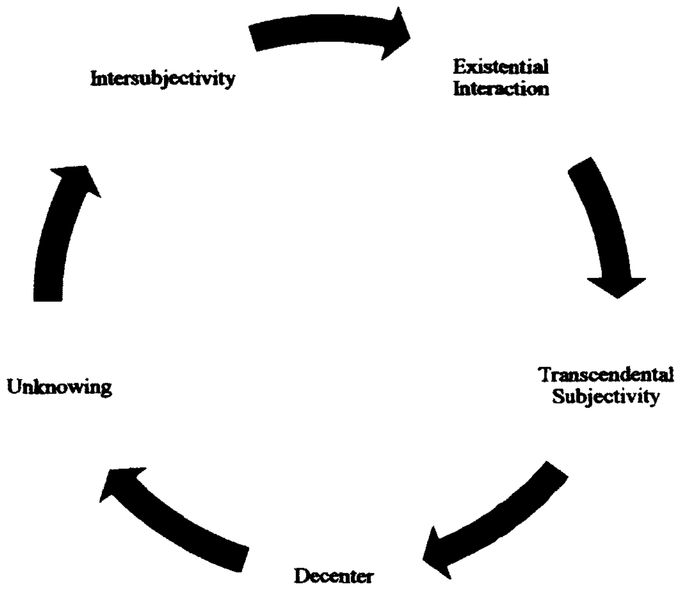

Figure I. How the Researcher Eliminates Subjective Views and Sustains Objectivity. This figure illustrates the conceptual meanings of phenomenological research.

The Colaizzi (1978) phenomenological method is a descriptive data analysis framework that was employed to ensure that the participants' words have the same meaning as the investigator understands. This method of phenomenological analysis requires that the researcher return to the participants to accomplish a final verification of the summary of the findings. Data were analyzed using a modification of the Colaizzi's seven steps of phenomenological analysis (1978). The modification included contacting three participants for validation of the findings, rather than all participants, to ensure that the research participants' words and the investigator's understanding are seamless. The analytical steps included the following;

1. Reading each participant's description of their experience from the transcript to obtain a whole feeling for the interviews

2. Returning to each transcript and extracting significant statements that directly pertain to the life experience of spouses living with veterans with PTSD
3. Formulating the meaning of each significant statement
4. Organizing the formulated meaning into clusters of themes to allow for the emergence of themes that are homogenous to all of the participants
5. Integrating the results into a description of the essence of the phenomenon.
6. Validating the findings by revisiting some participants to inquire how it compares with their experiences
7. Integrating any modifications provided by the participants into the final description of the essence of the phenomenon

Relationship among the Dissertation Manuscripts

An examination of the mental health concerns of military partners living with veterans with PTSD guided the integrative review (Appendix A, Manuscript #1; Yambo & Johnson, 2014). The mental health of partners was selected due to the paucity of studies investigating the mental health needs of military spouses. The review yielded 14 articles (10 quantitative, 4 qualitative) and was systematically guided by categorizing, critiquing, and critically integrating literature (Fink, 2005) of a specific health care concern (Whittemore & Knafl, 2005) into an inclusive body of scientific knowledge utilizing Ganong's (1987) guidelines.

Ganong's (1987) guidelines included: (a) assemble the review objective and identify the problem, (b) create the sample research inclusion and exclusion criteria, (c) search the literature review using the criteria, (d) construct a data-collection instrument, (e) determine data deduction and interpretation criteria, (f) edit the data-collection instrument when necessary to support theoretical or methodological evidence, (g) review the research and document pertinent information in the data-collection instrument, (h) evaluate data, (i) describe and explicate data, and (j) accurately sketch a comprehensive conclusion with related implications. The review was essential to explain the findings from research that acknowledged the mental health needs of the partners living with veterans with PTSD.

The integrative review revealed a lack of studies exploring the lived experience of military spouses of veterans with symptoms of PTSD as a result of a deployment to support OCO. Although three phenomenological studies explored the meaning of living with a veteran with PTSD of Israeli spouses (Dekel et al., 2005), experiences of Vietnam veteran partners due to lack of recognition from social venues (Maloney, 1988), and emotions and experiences of Army spouses related to the veterans' symptoms of PTSD (Woods, 2010), no studies explored what it was like to live with a veteran with PTSD. The majority of the investigators examined the association between symptoms of PTSD and secondary traumatic stress, caregiver burden, or general psychological distress among partners. A significant number of studies cited recruitment of partners through the veterans in a variety of settings. Notably, recruitment through the veteran overlooked the partners' ethical rights to decide to participate in the study. In some cases, it was reported that the veterans decided not to participate, thereby denying the partner the right to choose independently.

Next, a pilot study was conducted to identify and resolve methodological issues, establish recruitment protocols, expand the novice researcher experience, and revise the interview guide. The study included military spouses ($n = 3$) living with a veteran with PTSD. This preliminary work led to the refinement of the study design, interview guide, and recruitment strategies. During the integrative review, ethical issues with recruitment were identified. Spouses were recruited through the veteran, which was a violation of their confidentiality and privacy (American Psychiatric Association's Task Force on Research Ethics, 2006). Additionally, a primary concern expressed by the spouses in the pilot study was the need for privacy and confidentiality. Therefore, spouses were recruited through flyers at venues they frequented and word-of-mouth to ensure their ethical rights were preserved without involvement of their veteran spouses. To increase awareness of ethical dilemmas we encountered during recruitment of military spouses, the second manuscript highlighted ethical considerations to create awareness among researchers, clinicians, administrators, and educators (Appendix B, Manuscript #2; Yambo, Hamilton, & Johnson, 2014).

Following the pilot study, a larger study was conducted to understand the essence of the experience of military spouses living with veterans with symptoms of PTSD (Appendix C, Manuscript #3; Yambo, Johnson, Delaney, Hamilton, Miller, & York, 2015). A purposive sample of spouses ($n = 14$) were recruited through community organizations and snowball sample. The sample included spouses of veterans from active duty components of the U.S. Air Force, Army, Marines and Guard and Reserve branches. Inclusion criteria included age 21 years of age or older, male or female married to a veteran with symptoms of PTSD with a formal diagnosis or without a formal diagnosis (e.g., spouse's observation), English-speaking, and without the presence of mental or physical impairments. Mental impairments are defined as a mixture of abnormal ways of thinking, expressive behaviors, relationships, and reactions (World Health Organization, 2015a). Physical impairments are complicated health problems that interfere with body function or structure that limit activity and participation in daily life situations (World Health Organization, 2015b). Data were analyzed using the Colaizzi (1978) data analysis methodology. Four major themes were identified from data analysis: *Recognizing Life is No Longer the Same*, *Living with Unpredictability*, *Bearing the Burden*, and *Creating a New Life*. Three spouses were selected to validate the findings through a review of the summary of the findings. Each spouse expressed her positive validation of the summary of the findings.

Spouses recognized that the veteran was no longer the same person, with life becoming one of living with the unpredictability of PTSD. The participants bore the burden to maintain normalcy in the family and eventually created a new life in which some remained in and others left the marriage. These findings are consistent with the mental health concerns revealed in the integrative review. Ethical considerations tailored for the spouses facilitated the process to establish a rapport and trust of the researcher. Tailoring mental health interventions at the military, civilian, and federal level to meet the needs of the spouse is crucial for the psychological fitness of the spouse, veteran, child, and the military family.

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Discussion

Synthesis of Findings

The integrative review. An integrative review of the research (Appendix A, Manuscript #1; Yambo & Johnson, 2014) was utilized to describe the findings from studies relating to the mental health of military partners living with veterans with a diagnosis of PTSD. The review included 14 studies (see Table 1). The focus of this review was to provide a narrative description of the mental health concerns of partners living with veterans with PTSD. A thematic analyses revealed three categories of mental health concerns: secondary traumatic stress (4 of 14 studies), caregiver burden (3 of 14 studies), and general psychological distress (7 of 14 studies). This study was a critical platform for the qualitative study that later followed. First, it established what was known globally about the phenomena of how military wives deal with and adapt to the dilemma they face. Second, the study revealed the significant and complex struggles of living with a partner with a mental illness condition that was somewhat ill defined. Third, the data revealed a gap in scientific knowledge in military spouses of veterans from post-9/11 operations. Fourth, the data pointed toward the need to explore Iraq and Afghanistan War veteran spouses' perspective of their daily struggles to hoist awareness and customize clinical treatments.

Pilot study. A pilot study was conducted with participants (*n* = 3) to identify and correct flaws in the design prior to the implementation of the dissertation research. The study design was examined and questions were revised by members of the Advanced Clinical Research Practicum committee. Three major themes emerged from the significant statements and represented the essence of the lived experience of military spouses. The themes were: *His Story is Her Story*, *It Was Hard*, and *He Was a Different Person*. In the theme *His Story is Her Story,* spouses recounted their husband's traumatic experiences as if it were they were bystanders and witnessed the occurrence. With regards to the theme *It Was Hard*, all spouses felt that their husband mental condition made them feel stressed and they had difficulty coping. For the theme *He Was a Different Person,* the spouses felt that they were married to someone different and that they frequently did not recognize their husband. These themes were different than the dissertation themes because bracketing was used to avoid preconceived notions, beliefs, or assumptions about the pilot study. Furthermore, the interview guide was reconstructed to ask the spouse to share a story about what it was like to live with someone with PTSD symptoms, rather than how PTSD affected their life. With experience, I learned to ask more probing questions or statements to unravel their experiences, such as, "Can you tell me more about that?" or "Tell me how you felt when this situation occurred." In addition, the analysis of the data was inductive. Through the refinement of the interview guide, I was able to obtain a richer depiction of the essence of their experience.

The pilot study resulted in a refinement of recruitment strategies, interview guide, and a publication on ethical considerations for military spouses (Appendix B, Manuscript #2; Yambo, Hamilton, & Johnson, 2014). Initially, I planned to recruit participants on military installations, but Public Affairs offices were concerned that the privacy of the veterans would be breached. After numerous attempts to recruit on military installations, I decided to recruit spouses through community organization leaders. During the informed consent process with my first participant, she shared that she trusted me because I was a nurse. She explained that spouses in the local area were afraid to participate because other studies revealed their personal information to include the names of their children. Primarily, she was concerned about reprisal towards her husband. Her concerns were common concerns among the spouses. Listening to their concerns made me more sensitive to the recruitment needs of the spouses. Changes in recruitment were made to recruit spouses individually to preserve their autonomy, confidentiality, and privacy. Informed consent was discussed individually with each spouse. I noticed that one spouse had difficulty understanding that I was a nurse and a researcher. Therefore, I clarified the purpose of the study early in the informed consent process, so that spouses would not mistake the study for a therapeutic nursing intervention. The ethical manuscript was significant because these complex ethical concerns were presented. The key ethical concerns included recruitment through the veteran spouse, sharing spouses' confidential information without the spouses' consent, and a misconception about the therapeutic impact of the study. Furthermore, the spouses shared that they were wary of researchers because they felt their privacy would be breached. Hence, the impetus for the publication was to advocate on behalf of the spouses and to offer suggestions to improve the quality of PTSD research in military families.

Phenomenological Study. The third segment of the dissertation was to conduct a study exploring the essence of the experience of military spouses living with veterans with PTSD symptoms (Appendix C, Manuscript #3; Yambo, Johnson, Delaney, Hamilton, Miller, & York, 2015). Phenomenological inquiry was employed to guide the investigation. Colaizzi's (1978) data analysis method was used to analyze data. Four themes emerged from the data analysis: *Recognizing Life is No Longer the Same*, *Living with Unpredictability*, *Bearing the Burden*, and *Creating a New Life*. These themes represent the essence of the experience of military wives living with veterans with PTSD. In reporting on the lives of these spouses, I often drew on their words and vivid descriptions to illustrate the dilemmas they encounter. The mental condition of their husbands creates complex situations and demands complex adaptations. In interviewing them, I was struck by their determination to support their husbands, their children, and themselves. Even the spouses who chose to divorce were concerned about the mental condition of their veteran spouses and encouraged them to seek or continue PTSD treatment in their absence. All the spouses were working on ways to protect their children, while nurturing the father-child bond. It was a humbling experience to be privy to the 'behind the scenes' of the resilience that they display to the public.

This study highlights the need to acknowledge the unique contributions of military spouses to the overall family health and their knowledge of the impact of the veterans' PTSD. This study is particularly timely because there is a need to educate military and civilian practitioners on what spouses need and from these insights to develop tailored patient assessments and interventions. Additionally, implications for nurse educators and mental health professionals in interprofessional programs include the need to incorporate into their curricula the idea of military culture and the impact of trauma on the military family. Vignettes with in-depth discussion, case studies, and clinical experiences with military patients within interdisciplinary teams are also needed. More research is needed to obtain the spouses perspectives and experiences regarding mental health services and community resources. According to the U.S. Department of Veterans of Affairs (2015), approximately 60% of all separated veterans from OCO and Operation New Dawn have utilized the available services. Hence, there is a need to use the findings from this study to inform provider readiness to treat Active Duty, Guard, Reserve, and retired service members as well as military families.

Strengths and Limitations

The strengths of this study include the participation of a diverse sample of U.S. Army, Air Force, and Marines spouses. This descriptive phenomenology method was selected to explore the phenomenon of living with a veteran and clarifies the essence of the spouses' experiences with PTSD. Using descriptive phenomenology was a strength of the pilot and dissertation study because it is uniquely suited to the process of clarifying the essence of the experience of spouse's journey with PTSD. Understanding the spouses' experience brings to light the impact of traumatic stress on their wellbeing, which has the potential to impact the family's cohesion and psychological fitness.

Limitations of the pilot and dissertation study include the recruitment of spouses of veterans with PTSD symptoms transitioning into or shortly after medical retirement. Despite the spouses' decision to share their story to help other spouses, many feared reprisal towards their husbands. Finally, the inability to recruit a male spouse limits the pilot and dissertation studies' generalizability to only to female spouses.

Implications

The findings of this study describe the unique experiences and dilemmas of military spouses living with veterans with PTSD. To develop family-centered approaches to treament, military and civilian practitioners need a better understanding of the impact of traumatic stress on intimate relationships. Because they are often the venue for initial office visits, primary care clinicians should create policy and clinical practice guidelines to assist spouses with obtaining appropriate mental health treatment. Military, federal, and community organizations should continue collaborative efforts to cultivate and support spouse-specific programs.

Recommendations for future researchers include the exploration of two primary factors that put veterans at risk for suicide: relationship problems and financial concerns (Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010). With 22 suicides occurring daily (Kemp & Bossarte, 2012; U.S. Department of Veterans Affairs, 2013; Mental Health Advisory Team OEF, 2013; Mental Health Advisory Team OIF, 2008; Oppel, 2015), it is paramount that military spouses are acknowledged in the ongoing mental health of veterans with PTSD (Jakupcak et al., 2009), particulary since there is an association between suicidal ideation and PTSD in veterans who supported wars in Iraq or Afghanistan (Kang & Ballman, 2008). It is recommended that researchers work jointly with civilian, military, veteran, and other federal instiutions to create, pilot, and implement programs to address the mental health concerns among military families. Lastly, more research is needed to improve the quality of mental health services and community resources for military families.

This work has illuminated the chronicity of PTSD and the stressful environment for military families. Furthermore, it highlights the concern for transgenerational impact of living with someone with PTSD (Harkness, 1993; Yehuda et al., 2005). These concerns are well within the scope of mental health practitioners and highlights the need for greater attention to the treatment of military families.

Table 1. Studies of Military Partners Living With Veterans With PTSD.

Author	Study significance	Sample size	Design
Ahmadi, Azampoor-Afshar, Karami, and Mokhtari (2011)	To understand the prevalence of secondary trauma stress	N = 100 spouses; mean age of 43	Descriptive, correlational design
Beckham, Lytle, and Feldman (1996)	To examine caregiver burden	N = 58 partners; mean age of 44	Longitudinal design
Calhoun, Beckham, and Bosworth (2002)	To further examine the association between PTSD severity, caregiver burden, and psychological adjustment	N = 51 partners of veterans with PTSD; N = 20 partners of veterans without PTSD	Nonrandomized comparison group, cross-sectional design
Dekel, Goldblatt, Keidar, Solomon, and Polliack (2005)	To examine the significance that women ascribe to their lives as wives of veterans with PTSD	N = 9 wives	Phenomenology design
Dirkzwager, Bramsen, Adèr, and van der Ploeg (2005)	To examine whether secondary traumatization signs exist	N = 707 partners (9 males; 698 females)	Cross-sectional design
Francisković et al. (2007)	To determine the symptoms of secondary traumatic stress and possible demographic and socioeconomic factors on the occurrence of secondary traumatic stress	N = 56 wives; mean age of 42	Descriptive, correlational design
Koić et al. (2002)	To determine whether wives show traumatization, a higher rate of depression or anxiety, and higher rate of painful syndromes as a somatic equivalent of anxiety	N = 40 wives	Random comparison, descriptive, correlational
Maloney (1988)	To illuminate the experiences due to lack of recognition in media and inquiry	N = 6 female partners	Phenomenology design
Manguino-Mire et al. (2007)	To explore the relationship between psychological distress and caregiver burden in the context of specific family and treatment factors	N = 72 cohabitating	Cross-sectional design
McLean (2006)	To provide an image of the experience of living with a traumatized soldier healing from PTSD	N = 6 female spouses	Narrative inclusive design
Renshaw et al. (2011)	To determine how often scores accurately measure secondary traumatic stress/secondary traumatic stress disorder	N = 190 wives	Correlational design
Renshaw, Rodebaugh, and Rodrigues (2010)	To examine spouse's perception of combat veterans' PTSD and partners symptom severity	N = 90 female spouses	Descriptive, correlational design

Westerink and Giarratano (1999)	To assess the personal adjustment and family relationships of partners of veterans with PTSD	*N* = 37 partners (32 females, 5 males)	Descriptive, correlational design
Woods (2010)	To obtain rich descriptions of feelings and experiences of spouses due to soldier's PTSD	*N* = 10 wives	Phenomenology design

Note. PTSD = posttraumatic stress disorder. Reprinted from "An Integrative Review of the Mental Health of Partners of Veterans with Combat-Related Posttraumatic Stress Disorder," by T. Yambo and M. Johnson, 2014, *Journal of the American Psychiatric Nurses Association*, 20(1), p 41. Copyright 2014 by Sage Publications. Adapted with permission.

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Appendix A

Manuscript #1

An Integrative Review of the Mental Health of Partners of Veterans with Combat-Related Posttraumatic Stress Disorder

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This manuscript has been previously published as "An Integrative Review of the Mental Health of Partners of Veterans with Combat-Related Posttraumatic Stress Disorder".

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Teresa Yambo[1] and Mary Johnson[2]

Abstract

The aim of this article is to present an integrative review of the mental health of veteran partners living with veterans with combat-related posttraumatic stress disorder (PTSD). Living with a veteran with PTSD affects the psychological well-being and health outcomes of a veteran partner. Fourteen research articles that focused on the mental health of military partners, which directly influence the psychological well-being of veteran partners, were reviewed. Findings indicate that a range of mental health concerns exist among veteran partners living with veterans with PTSD. The mental well-being of veteran partners is affected by the emotional strain of living and caring for veterans with PTSD. For years, the partner's presence has been overlooked in the PTSD treatment. However, to promote the comprehensive health of veterans with PTSD, it is paramount to understand the mental health state of veteran partners. Understanding the mental health state of veteran partners will provide a broader perspective to the plight of veteran partners.

Keywords

posttraumatic stress disorder, military partner, spouse, integrative review

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It is estimated that combat-related posttraumatic stress disorder (PTSD) affects 11% to 20% of the two million veterans returning from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF; Spivey, 2010; U.S. Department of Veterans Affairs, 2011a). Although there has been research about the impact of PTSD on the mental health needs of veterans (Friedman, 2006; Milliken, Auchterlonie, & Hoge, 2007; Nayback, 2008), less is known about the impact of PTSD on the mental health of the partners living with a veteran with PTSD. Although a partner living with a veteran with PTSD is exposed to the proximal effects of the veteran's PTSD symptoms (Baird & Kracen, 2006), current mental health services lack guidance for the treatment of mental health needs for these partners (Substance Abuse and Mental Health Services Administration, 2011).

Recognizing the mental health issues of partners who live with veterans with combat-related PTSD is important to provide relevant, evidence-based prevention interventions (U.S. Department of Veterans Affairs, 2011b). Understanding the mental health needs of partners living with veterans with PTSD will potentially provide a cornerstone of research to establish research, policy, and clinical practice guidelines for military families.

The Review

Aim

The aim of this integrative review is to describe the findings from research pertaining to the mental health of partners living with veterans with PTSD. The following question guided this review: What is the mental health of partners living with veterans with PTSD? The World Health Organization (2012) defines mental health as "a state of complete physical, mental and social well-being, and not merely the absence of disease." Mental health is defined as the psychological state of mind that results from day-to-day living (World Health Organization, 2010) with a veteran with PTSD, which is directly connected to the veteran and veteran partner's relationship and interactions (Nelson & Wright, 1996). PTSD symptoms (e.g., recurring nightmares, flashbacks, severe reaction to triggers that represent a facet of a traumatic experience, avoidance, and hyperarousal) are behaviors that disrupt societal, work-related, or other daily functions lasting longer than 30 days (American Psychiatric Association, 2000). For this review, a veteran with PTSD is described as a member of the military service diagnosed with PTSD, regardless of rank, branch, or country. A veteran partner refers to their married or unmarried cohabitating significant other.

Design

An integrative review represents a systematic method of categorizing, critiquing, and critically integrating the existing literature (Fink, 2005) of a specific health care issue (Whittemore & Knafl, 2005) into a comprehensible body of knowledge (Ganong, 1987). In this article, an integrative review was conducted using Ganong's (1987) guidelines: (a) assemble the review objective and identify the problem, (b) create the sample research inclusion and exclusion criteria, (c) search the literature review using the criteria, (d) construct a data-collection instrument, (e) determine data deduction and interpretation criteria, (f) edit the data-collection instrument when necessary to support theoretical or methodological evidence, (g) review the research and document pertinent information in the data-collection instrument, (h) evaluate data, (i) describe and explicate data, and (j) accurately sketch a comprehensive conclusion with related implications.

Method

Selection

The following inclusion criteria were employed to select articles for the review: (a) research studies that explored the impact of PTSD on the partner's mental health and (b) publications that were in English language. Due to the paucity of research, there was no exclusion date beyond the period of coverage of the selected database: Cumulative Index to Nursing and Allied Health Literature (1981-2011), PsycINFO (1985-2011), and MEDLINE (1946-2011) and no war or country exclusions.

The initial studies were obtained for review with the assistance of two librarians, each from different universities. An independent search was also conducted using the (CINAHL), PsycINFO, and MEDLINE databases, combining and using the search terms "spouses," "partners," "wives," "female partners," "soldiers," "service member," "returnee," "military member," "veteran," "stress disorder," "combat stress," "PTSD," "war," "mental health," "psychological," "wife," "Korean," "Vietnam," "Persian Gulf," "spouse," "partner, "female partner," and "soldier." The CINAHL search produced two dissertations that were retrieved from ProQuest Dissertation and Thesis Database. In addition, research reports were selected from manual reviews of reference lists of related articles (Fink, 2005).

Sample

The initial computerized database search produced 565 articles; an additional 28 studies were retrieved from reference listings. Titles and subject headings were assessed for repeated titles, inclusion of veteran partners in the study, and inclusion of veterans who did not have combat-related PTSD, which reduced the sample to 38 articles. Each of the articles was reviewed, and those that failed to meet the inclusion criteria were eliminated. The review yielded 25 articles and two dissertations, which were reviewed extensively using the inclusion and exclusion criteria. Research reports that concentrated on the veteran with PTSD or the mental health of parents or military child of the veteran with PTSD were excluded (Al-Turkait & Ohaeri, 2008; Armstrong & Rose, 1997; Chartier-Otis, Guay, & Marchand, 2009; Evans, McHugh, Hopwood, & Watt, 2003; Frederikson, Chamberlain, & Long, 1996; Hamilton, Nelson Goff, Crow, & Reisbig, 2009; Jordan et al., 1992; Nelson & Wright, 1996; O'Toole, Outram, Catts, & Pierse, 2010; Sherman & Bowling, 2011; Sherman et al., 2005; Verbosky & Ryan, 1988). The final review yielded 14 articles (see Table 1).

Analysis

The selected studies were initially organized and analyzed according to the following: publication citation, country of research, design/sampling technique, sample characteristics, mental health concerns, mental health safeguards, and significant findings. The abstractions were reviewed and assessed for inaccuracies. Since inconsistencies in the study designs, samples, settings, country, and study variables did not allow precise statistical evaluation, a narrative analysis (Whittemore & Knafl, 2005) was conducted.

Findings

The studies included in this review were conducted in seven countries: Australia (Westerink & Giarratano, 1999), Canada (McLean, 2006), Croatia (Franciskovié et al., 2007; Koić et al., 2002), Iran (Ahmadi et al., 2011), Israel (Dekel et al., 2005), The Netherlands (Dirkzwager et al., 2005), and the United States (Beckham et al., 1996; Calhoun et al., 2002; Maloney, 1988; Manguino-Mire et al., 2007; Renshaw et al., 2010; Renshaw et al., 2011; Woods, 2010) between 1987 and 2011. Of the articles selected, two were coauthored by the same first author (Renshaw et al., 2010; Renshaw et al., 2011). Overall, the empirical studies lack homogeny in specific aims, design, and methodology.

Veteran Partner's Mental Health

The findings from the studies were organized into three main categories: secondary traumatic stress, partner burden, and general psychological stress. However, it is important to note that these categories were based on the precision of narrowly focused research aims in the studies; for example, an author specifically studied a phenomenon, such as caregiver burden.

Secondary Traumatic Stress

There is some evidence that veteran partners experience symptoms that mirror PTSD symptoms (secondary traumatic stress; Ahmadi et al., 2011; Dirkzwager et al., 2005; Franciskovié et al., 2007; Koić et al., 2002).

Secondary traumatic stress, which is sometimes referred to as secondary traumatization, is "traumatization of an individual helper or family member due to listening to painful experiences, other people's fate and exposure to suffering" (Koić et al., 2002, p. 297). The result is symptoms similar to PTSD (Francisković et al., 2007). In one study (Dirkzwager et al., 2005), partners of veterans who had one, two, or three symptoms of PTSD showed significantly more symptoms of PTSD themselves. The duration of PTSD symptoms in veterans also correlated significantly with the occurrence of secondary traumatic stress (Ahmadi et al., 2011).

Correlated with partners' symptoms of secondary traumatic stress were a negative social support network (Dirkzwager et al., 2005), high unemployment (Francisković et al., 2007), chronic pain such as headaches and backaches (Koić et al., 2007), other somatic complaints (Dirkzwager et al., 2005), sleep problems (Dirkzwager et al., 2005), and depression and anxiety (Koić et al., 2002). Although the partners of veterans with and without PTSD sought treatment for their chronic pain, treatment was less effective with partners of veterans with PTSD (Koić et al., 2007).

The duration of exposure to PTSD symptoms was not directly correlated with the length of the marriage. However, since many of the partners married before the veterans developed symptoms of PTSD, the amount of time veteran partners were exposed to veterans' PTSD symptoms appeared to be a predictive determinant of secondary traumatic stress (Ahmadi et al., 2011). Thus, longer marriages were a significant predictor of secondary traumatic stress (Francisković et al., 2007). Partners living with a veteran diagnosed with PTSD reported more dissatisfaction with the marriage than did partners of veterans without PTSD (Dirkzwager et al., 2005).

Burden

Burden has been conceptualized as the degree of difficulty managing the demands of caring for someone with a chronic illness. These demands can be objective
(e.g., financial hardship) or subjective (e.g., affective responses; Calhoun et al., 2002). Caregiver burden is related to the severity of the veteran's PTSD symptoms; as the symptoms increase, the burden increases (Beckham et al., 1996; Calhoun et al., 2002; Manguino-Mire et al., 2007). Caregiver burden is not fixed but increases over time. And, as the level burden increases, the partner experiences greater psychological distress, dysphoria, state anxiety (Beckham et al., 1996), depression, hostility, and obsessive-compulsive symptoms (Calhoun et al., 2002).

The level of interpersonal violence perpetrated by the veteran (Calhoun et al., 2002) was associated with increased burden; that is, as the level of violence increased, the degree of burden also increased. The level of threat the partner perceived from the veterans PTSD symptoms was also associated with increased burden (Manguino-Mire et al., 2007). Finally, when the veteran was less engaged in PTSD treatment, the partner experienced greater caregiver burden (Manguino-Mire et al., 2007).

General Psychological Distress

Although there is a close relationship between caregiver burden and psychological distress, some of the researchers in the studies focused only on psychological distress. Researchers using both quantitative and qualitative approaches concluded that partners of veterans living with PTSD experienced more psychological distress than partners of veterans who were not diagnosed with PTSD. In quantitative approaches, researchers deductively measured the relationship between veterans PTSD symptoms and general psychological distress. In the qualitative studies, various manifestations of psychological distress emerged as one aspect of partner's perspective of living with a veteran with PTSD.

Quantitative Approaches. In three quantitative studies, researchers measured, using different psychometric tools, the correlation between the veterans' PTSD and the psychological distress experienced by their partners. These measurement tools included a civilian version of the PTSD checklist (Renshaw et al., 2011) and the Psychological Distress Index (Renshaw et al., 2010) and the General Health Questionnaire (Westerink & Giarratano, 1999).

Psychological distress was characterized by mental health concerns, such as somatization, worry, sleeplessness, interrelationship conflict, depression. Partners living with veterans with PTSD reported more severe psychological distress when compared with partners living with veterans without PTSD (Westerink & Giarratano, 1999), with a direct association between partner general psychological distress and the veterans' PTSD symptoms (Renshaw et al., 2010) and personal circumstances (Renshaw et al., 2011). Young partners reported higher levels of general psychological distress than older partners, and male partners experienced lower levels of general psychological distress than female partners (Renshaw et al., 2010).

Partners experienced psychological distress symptoms, such as frequent nightmares, inability to focus, profuse perspiration, and moodiness, which were similar to secondary traumatic stress (Westerink & Giarratano, 1999). In fact, symptoms of general psychological distress and secondary traumatic stress often overlap. Since partners who exclusively credited their symptoms to the veteran's PTSD were more likely to experience secondary traumatic stress, some suggest that general psychological distress is a more suitable description of partners' distress symptoms (Renshaw et al., 2011).

Qualitative Approaches. Four researchers used qualitative approaches to explore the partner's perception of the experience of living with a veteran with PTSD. Their reports indicate that partners experienced a myriad of issues and concerns, which we categorized as general psychological distress.

Investigators (Dekel et al., 2005) used a phenomenological approach to explore the partner's experience of living with a veteran with PTSD. They concluded that the emotional connection between a partner and veteran affected their relationship. As such, partners perceived that their lives revolved around the veterans' PTSD symptoms, causing psychological stress at the loss of and attempt to preserve their individuality. Although the veteran was physically present, loneliness was the result of the veterans' emotional disconnection. Also, the lack of resources contributed to their loneliness and psychological distress. Despite the uncertainty the partners experienced due to the overwhelming, chronic demands of the veterans, cultural mores shaped their decisions to maintain moral and dutiful obligations to the marriage and family. Although psychological distress was common among the participants in the study, some partners perceived the experience as empowering; they were able to create balance by caring for the veteran while establishing and maintaining boundaries. In spite of their difficulties, the partners also reported that their experience made them more sensitive to veterans who struggle with PTSD symptoms on a daily basis (Dekel et al., 2005).

Feeling emotionally stable in the relationship was important to partners (Woods, 2010). For those partners of veterans returning from OEF/OIF, the experience of feeling excessive fear, loneliness, anger, and stress contributed to the emotional instability of the marital relationship. Feeling threatened by potential violence from the veterans created feelings of uncertainty because the partners did not always understand what caused the veterans' anger or what might occur when the veteran was in a state of anger. Emotional distancing in the relationship left the partners feeling alone. Although the partners felt alone, they also lacked an emotional connection with their peers because each veteran suffered from different PTSD symptoms. The partners expressed anger toward the veteran for joining the military and with the military for a lack of support. Consequently, younger partners in shorter relationships tended to separate; however, partners in longer relationships tended to remain hopeful that they would witness pieces of the veterans they knew prior to the diagnosis of PTSD (Woods, 2010).

The psychological impact of the Vietnam conflict on veterans and their partners was unacknowledged for decades (Maloney, 1988). Therefore, partners endured years of psychological distress and turmoil while living with veterans with PTSD. Due to the unsympathetic support of the community, partners' perception of the veterans' PTSD symptoms also affected the way they supported the veteran. These partners reported suffering interpersonal violence typically in conjunction with the veterans' alcohol abuse, which led to more psychological distress. However, despite the violence, the partners remained in the relationship out of a genuine concern for the veteran committing suicide in their absence. Even though violence existed at home, they reported that separating their children from the veteran was unthinkable. Like many victims of intimate partner violence, these women remained in the relationship due to reliance on the veteran. They reported feeling frightened of more violence directed at them or their children and worried that their marriage was over. Yet, they were optimistic about their relationship and felt remorseful for loving their husbands. Due to the era of the Vietnam War and the lack of support from the community, these partners suffered in silence. Surprisingly, the partners volunteered to participate in this study to determine whether they were emotionally wounded themselves (Maloney, 1988).

The story of living with a veteran with PTSD comprises the highs and lows of day to day life (McLean, 2006). Partners reported feeling uncertainty, loneliness, and emotional turmoil because of the veterans' symptoms before the diagnosis of PTSD. Their lack of understanding of PTSD symptoms created confusion, which left them perplexed about whether they were at fault for the veterans' condition. For those partners who experienced aggression, uncertainty about how to deal with the situation created more confusion about how to care for the veteran. This situation caused partners to adapt to the veterans' responses by assessing their moods and finding ways to avert hostility. Due to the uncertainty, loneliness, and emotional turmoil, partners expressed the need for emotional support from family and friends to help them deal with their psychological distress. Uncertainty and fear of the unknown about their future caused psychological distress as they struggled to make sense of their relationship and develop a better understanding of the veterans' condition. Last, along with psychological distress, partners experienced secondary traumatic stress, which left them feeling emotionally drained and unprepared to deal with the care of the veteran. The experiences these partners describe reveal the complications that contribute to the psychological distress of partners throughout the spectrum of veterans' PTSD (McLean, 2006).

Overall, partners experienced some form of psychological distress as a result of the daily struggles of living with veterans with PTSD. Specifically, the partners experienced loneliness, uncertainty (Dekel et al., 2005; McLean, 2006), emotional distancing (Dekel et al., 2005; Woods, 2010), excessive fear (Dekel et al., 2005; Maloney, 1988; Woods, 2010), secondary traumatic stress (McLean, 2006), anger (Woods, 2010), and domestic violence (Calhoun et al., 2002; Maloney, 1988; Manguino-Mire et al., 2007; McLean, 2006). These symptoms, which were caused by the stress of living with a veteran with PTSD, were perceived by the partners to have a significant impact on their identity and autonomy, thus decreasing their relationship interactions and increasing the likelihood of turmoil between the partner and the veteran (Dekel et al., 2005; Maloney, 1988).

Discussion

The aim of this integrative review was to describe the research on the postdeployment mental health of partners living with veterans with PTSD through identification and integration of empirical evidence. A review of 12 published articles and two dissertations on the mental health of veteran partners revealed that all investigators found at least one mental health concern. However, many of these studies were limited by the narrow scope of their specific aims; that is, the investigators from this review examined secondary traumatic stress (Ahmadi et al., 2011; Dirkzwager et al., 2005; Francisković et al., 2007; Koić et al., 2002), partner burden (Beckham et al., 1996; Calhoun et al., 2002; Manguino-Mire et al., 2007), and general psychological distress (Renshaw et al., 2010; Renshaw et al., 2011; Westerink & Giarratano, 1999). There were four qualitative studies (Dekel et al., 2005; Maloney, 1988; McLean, 2006; Woods, 2010) in which the authors explored the broader experience of living with a veteran with PTSD. However, in only one study the participants were partners of veterans from OEF/OIF (Woods, 2010). The others were studies of the experiences of partners of Israeli veterans (Dekel et al., 2005), female partners of Vietnam veterans with PTSD (Maloney, 1988), and partners of Canadian soldiers who had served in peace keeping missions (McLean, 2006).

Based on the studies available for this review, it is clear that partners frequently experienced mental health changes as a result of living with a veteran with PTSD. The findings from these studies indicate that veteran partners experience psychological distress with the responsibility of caring for a veteran with PTSD and, consequently, have significant mental health needs, regardless of country of origin, marital status, age, or veterans' branch of service or rank. The portrayal drawn from this review indicates that secondary traumatic stress, partner burden, and general psychological distress are mental health concerns that necessitate mental health intervention.

There are several limitations in the design of the studies reviewed. The first was the inconsistent definition of veteran partner. For example, veteran partner was described as an unmarried, married, or a combination of both types of partners living with a veteran with PTSD. Although having a sample of unmarried and married significant others in the studies leads to a more comprehensive understanding of the mental health issues of veteran partners, it limits the knowledge of issues unique to each type of relationship. Second, inconsistencies in measurement were evident in the literature. A consistent definition and standard psychometric tool to assess levels of secondary traumatic stress is necessary in order to critique or generalize the findings. Use of a consistent tool to measure psychological distress would help readers interpret the findings and would contribute to the growth of a base of knowledge on which to develop interventions for veteran partners' unique mental health needs. Because the impact of PTSD on partners' mental health varies, psychometric instruments should be developed that more precisely measure these varied mental health symptoms. Third, the narrowness of design among the studies makes it difficult to generalize the findings to all partners of veterans with PTSD. Since the mental health of partners differs based on their perceived level of burden, larger sample sizes would allow a comparison of partners with veterans with a range of symptoms. Fourth, the range in population (different countries and different wars) limits the ability to generalize to male or female partners of veterans who supported OEF/OIF. Fifth, secondary traumatic stress, also known as vicarious traumatization or compassion fatigue, is used interchangeably to describe the secondary trauma stressors experienced by health care professionals who treat veterans for combat stress (Bride & Figley, 2009). The data collection process was not specifically inclined toward this phenomenon; rather, the phenomenon was extracted from studies with distinct specific aims. All of these limitations point toward the need for more research.

Only one study (Dirkzwager et al., 2005) reported the mental health state of male veteran partners. The remaining studies in this review adopted a conventional military family paradigm, which includes a male veteran and a civilian female partner. At this time, there remains limited knowledge about the relationship and interactions of female veterans who have PTSD and their male partners. Examining the gender differences will potentially enhance mental health services and allow health care providers to make informed clinical decisions that are vital to provide quality, timely, relevant mental health interventions for traditional and nontraditional military families. Moreover, in the context of military families, as more female veterans serve in combat, the probability of more male partners reporting mental health problems is likely to rise.

Recommendations

Study findings illuminate the importance of primary, secondary, and tertiary interventions to support the mental health needs of partners of military veterans. First, primary interventions are necessary to avert mental health problems or signs of mental health problems. Primary interventions include educating partners about the symptoms of PTSD to raise awareness and provide a foundational understanding of the condition. Raising awareness through various forms (i.e., Internet media, video, brochure) will offer flexibility in learning styles. For instance, the U.S. Department of Veterans Affairs (2013) and the National Military Family Association (2012) provide complimentary pamphlets to raise awareness of the symptoms and treatment for PTSD for military partners. Since partners are treated at primary care clinics for physical as well as mental health concerns, obtaining educational information might be their first encounter with understanding PTSD. Second, screening partners for mental health problems during primary clinic visits is essential to direct medical care to appropriate referrals, particularly in the case of domestic violence (Department of Defense, 2011; Harrison, 2006). Third, a platform, like the Family Wingman Program (Westphal & Woodward, 2010) or the Family Readiness Group (Army OneSource, 2013), fosters support and detection of stress during deployment for veterans and their families. Platforms that support the military family during deployment should extend support until the family is readjusted following the long-awaited return of the veteran. Peer and clinician-led support groups during and after the veterans' deployment offer the partners a forum for their experience. The incorporation of family support programs, such as the family wingman concept, to enhance the total family fitness is crucial to the health and well-being of the partner (Westphal & Woodward, 2010). Although not explored in this review, the involvement of chaplains and spiritual leaders underscores the importance of spiritual and religious networks (Moore, Hamilton, Pierre-Louis, & Jennings, 2013).

While health care professionals construct primary interventions to prevent mental health problems from developing, secondary interventions are instrumental to cease problematic behavior. Psychotherapy and other treatment modalities are crucial factors to reclaim mental well-being. Facilitating early psychotherapy and counseling interventions to assist partners in reclaiming their mental well-being is crucial to their long-term physical and mental health. Psychotherapy and counseling interventions should be evidence-based treatments (World Health Organization, 2004) with providers who are knowledgeable about the military culture and holistic health concerns of military families with PTSD. Other treatment modalities include social support through stress management classes and community support groups. Social support is vital to keep partners connected with their community and peers. Because partners may spend little time at home while tending to the veterans' health care needs, social support must be tailored, adaptable, and patient-centered (Collins & Kennedy, 2008). In light of this review, the crux of the problem seems to be the need for more evidence-based practice strategies.

Tertiary prevention strategies refer to solutions that are aimed to restore mental health in severely, at-risk partners who struggle with long-term mental health problems. These partners struggle with a behavior pattern that limits their optimal level of functioning. For some partners, mental health problems impede their ability to function in employment outside of the home, care for small children or elderly parents, or attendance in school. Thus, tertiary prevention strategies involve a comprehensive approach composed of one or more treatment modalities. Effective interventions for these partners must include holistic, timely patient-centered care to include referrals to specialists (e.g., physicians, psychologists, psychiatrist, and lawyers), inpatient or long-term outpatient services, or medication therapy over an extended period of time. Collaboration among military and civilian health care professionals is the key to incorporate these three patient-centered prevention strategies.

Domestic violence in the military is a public health matter (Klostermann, Mignone, Kelley, Musson, & Bohall, 2012). Moreover, partners in five of the studies (Calhoun et al., 2002; Maloney, 1988; Manguino-Mire et al. 2007; McLean, 2006; Woods, 2010) reported domestic violence. Domestic violence has been connected with increased visits for medical treatment in the primary care and emergency settings (Marshall, Panuzio, & Taft, 2005). Because of the cycle of abuse (TheHotline.org, n.d.), partners' first concern is typically privacy and safety. For military partners, reporting brings a different set of privacy concerns. For example, partners might fear reprisal from the veterans' leadership, arrest and blotter report, loss of pay, and reduction in rank, especially if they live on a military installation. Fear may influence the partners' decision to report the abuse. Therefore, health care professionals must remain vigilant, while protecting the privacy and ensuring safety for the partners. Meanwhile, children are not on the sidelines; they are directly affected by domestic violence. Children witnessing domestic violence are twice more likely as adults to become victimized as women and perpetrators as men (Whitfield, Anda, Dube, & Felitti, 2003). To guide the care of victims and ensure that perpetrators are brought to justice, the Department of Defense (2011) provides policy and guidance for health care professionals of all branches of the military. Their policy includes a comprehensive, collaborative approach to the care of victims of domestic violence. State legislations varies, but some states, such as Utah (Utah Department of Health, 2008), provide a detailed reference guideline for health care professionals to assess and treat victims. Although research shows that screening for domestic violence does not increase the number of women who report the abuse (Klevens et al., 2012), health care professionals must remain watchful and advocate for both male and female victims. PTSD may increase the risk for partner violence perpetration intensely and if not treated appropriately may prevent anticipated age-related behaviors in this population. Furthermore, PTSD is a risk factor for domestic violence, but it is unknown to what degree appropriate treatment for PTSD decreases the risk of violence (Teten et al., 2010). Hence, future research and interventions should focus on the assessment of intimate partner relationship and general aggression in veterans with PTSD (Taft et al., 2009).

Focused treatment efforts are necessary to improve the assessment and treatment of the partners with more significant mental health needs (i.e., secondary traumatic stress, depression, anxiety, sleep disturbances, domestic violence). With regard to individual and couple treatment, psychotherapy interventions should be further explored for efficacy in both military and civilian mental health outpatient clinics. Finally, formal clinical studies are needed to explore treatments that can effectively reduce the symptoms of psychological distress and secondary traumatic stress in this population. These efforts should also be targeted toward alleviating partner burden. In addition, longitudinal designs are needed to understand the long-term effects of PTSD symptoms on the physical and mental well-being of partners.

Further research would also help clinicians understand the role of partners' premorbid functioning on the development of their mental health symptoms. Additional research is needed to fully understand the daily struggles of the OEF/OIF partner. Furthermore, longitudinal data with a larger sample size is needed to describe OEF/OIF partner mental health status and coping skills as they relate to living with a veteran with long-standing PTSD. Due to the lack of understanding of the pathophysiology of mental health disturbances in this population, more research is necessary to construct and pilot partner-specific clinical guidelines. More quantitative and qualitative approaches are necessary to explore the response to mental health treatment and resistance to treatment. These research and practice strategies represent a starting point that can be used to support the understanding of this population and shaping of a course of action for the transition to partner-specific mental health interventions.

Conclusion

Partners are vital to the continuity of care physically and emotionally for veterans with PTSD. They provide critical information to mental health providers about the veterans' PTSD symptoms and are central to the veteran's treatment for PTSD. As such, they are an integral part of support (e.g., emotional, spiritual, cultural, religious) for the veteran. Despite their involvement in the care of the veteran, however, their own mental health needs have been unacknowledged and overlooked. Although the diagnosis and treatment for PTSD has significantly modernized, the interest in the treatment of mental health disturbances in partners has slowly emerged. Through this review we have suggested some partner-specific strategies to improve and enhance the partner's mental health, which in essence is a call to action to ensure that the mental well being of partners becomes a priority.

Recently made public, a goal of Healthy People 2020 (U.S. Department of Health and Human Services, 2011) is to enhance mental health through preventive strategies and accessibility to relevant, cost-effective mental health services. This goal spotlights the pressing need for early assessment, diagnosis, and treatment of mental health disorders in partners living with veterans with PTSD. Experiencing the daily stress of PTSD symptoms strains marital and family bonds, depleting the emotional resources of the partner who is the nucleus of the family (Baird & Kracen, 2006). In addition, the long-term stressors associated with living with a veteran with PTSD disrupt healthy intimate relationships and cause decreased psychological functioning (Baird & Kracen, 2006). Future research about the mental health of partners living with veterans with PTSD creates the possibility for understanding the meaning and impact of the veteran's PTSD on the partners. This foundation can provide insight that will lead to the construction of partner-specific treatment interventions for PTSD.

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Author Roles

The first author conducted the literature review and wrote each draft of the article. The second author reviewed each article for relevance, revised the article, and edited each version of the article. The authors reached a consensus on purpose and development of the article.

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Table 1. Studies of Military Partners Living With Veterans With PTSD.

Author	Study significance	Sample size	Design
Ahmadi, Azampoor-Afshar, Karami, and Mokhtari (2011)	To understand the prevalence of secondary trauma stress	N = 100 spouses; mean age of 43	Descriptive, correlational design
Beckham, Lytle, and Feldman (1996)	To examine caregiver burden	N = 58 partners; mean age of 44	Longitudinal design
Calhoun, Beckham, and Bosworth (2002)	To further examine the association between PTSD severity, caregiver burden, and psychological adjustment	N = 51 partners of veterans with PTSD; N = 20 partners of veterans without PTSD	Nonrandomized comparison group, cross-sectional design
Dekel, Goldblatt, Keidar, Solomon, and Polliack (2005)	To examine the significance that women ascribe to their lives as wives of veterans with PTSD	N = 9 wives	Phenomenology design
Dirkzwager, Bramsen, Adèr, and van der Ploeg (2005)	To examine whether secondary traumatization signs exist	N = 707 partners (9 males; 698 females)	Cross-sectional design
Francisković et al. (2007)	To determine the symptoms of secondary traumatic stress and possible demographic and socioeconomic factors on the occurrence of secondary traumatic stress	N = 56 wives; mean age of 42	Descriptive, correlational design
Koić et al. (2002)	To determine whether wives show traumatization, a higher rate of depression or anxiety, and higher rate of painful syndromes as a somatic equivalent of anxiety	N = 40 wives	Random comparison, descriptive, correlational
Maloney (1988)	To illuminate the experiences due to lack of recognition in media and inquiry	N = 6 female partners	Phenomenology design
Manguino-Mire et al. (2007)	To explore the relationship between psychological distress and caregiver burden in the context of specific family and treatment factors	N = 72 cohabitating	Cross-sectional design
McLean (2006)	To provide an image of the experience of living with a traumatized soldier healing from PTSD	N = 6 female spouses	Narrative inclusive design
Renshaw et al. (2011)	To determine how often scores accurately measure secondary traumatic stress/secondary traumatic stress disorder	N = 190 wives	Correlational design
Renshaw, Rodebaugh, and Rodrigues (2010)	To examine spouse's perception of combat veterans' PTSD and partners symptom severity	N = 90 female spouses	Descriptive, correlational design

Westerink and Giarratano (1999)	To assess the personal adjustment and family relationships of partners of veterans with PTSD	*N* = 37 partners (32 females, 5 males)	Descriptive, correlational design
Woods (2010)	To obtain rich descriptions of feelings and experiences of spouses due to soldier's PTSD	*N* = 10 wives	Phenomenology design

Note. PTSD = posttraumatic stress disorder.

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Appendix B

Manuscript #2

Ethical Considerations in the Recruitment of Military Partners in Combat-Related Posttraumatic Stress Disorder Research

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This manuscript has been previously published as "Ethical Considerations in the Recruitment of Military Partners in Combat-Related Posttraumatic Stress Disorder".

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NURSING FORUM AN INDEPENDENT VOICE FOR NURSING

Ethical Considerations in the Recruitment of Military Partners in Combat-Related Posttraumatic Stress Disorder Research

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Keywords
Ethics, military health, nursing research, psychiatric/mental health

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BACKGROUND. The recruitment of military partners in combat-related posttraumatic disorder (PTSD) research necessitates nurses' awareness to their unique ethical concerns. Safeguarding the ethical rights of partners living with veterans with PTSD is crucial to the development and implementation of quality, rigorous research designs. Nurses should understand the unique ethical considerations that pertain to partners' participation in PTSD research.
OBJECTIVE. To describe the ethical considerations relating to the recruitment of partners in PTSD research.
METHOD. A succinct discussion of the recent concerns in the recruitment of military partners in PTSD research.
RESULTS. The ethical guidelines of the American Psychiatric Association are employed to describe implications for researchers, educators, and administrators. For clinical nurses, the American Nurses Association's initiative to support military families is used to guide our discussion. Nurses are in a leading position to advocate for the ethical recruitment of military partners in PTSD research.

Recruitment of military partners in combat-related posttraumatic stress disorder (PTSD) research is needed to advance our knowledge of the holistic healthcare needs and develop quality treatment modalities. Having an understanding of the experience of military partners is essential because living with a veteran with PTSD makes partners vulnerable to mental health concerns, such as secondary traumatic stress, caregiver burden, and general psychological distress (Yambo & Johnson, 2014). Their participation in research is also significant to comprehensively treat veterans with PTSD, especially since the U.S. Department of Veterans Affairs spent approximately $1.4 billion in total costs between 2004 and 2009 to treat veterans with PTSD (Congressional Budget Office, 2012). Hence, their enrollment in PTSD research is critical in identifying and developing tailored modalities to treat military partners (Yambo & Johnson, 2014), and in supporting the total force fitness of veterans (Mullen, 2010), the operational readiness of the military unit (Eaton et al., 2008), and the emotional cohesiveness of the couple (Karney, Ramchand, Osilla, Caldarone, & Burns, 2008). Yet little is known about the ethical issues surrounding the recruitment of military spouses in PTSD research. This article represents an overview of issues of importance that emerged during a qualitative pilot study that are unique to military partners living with veterans with PTSD. For this article, a veteran is an individual with symptoms of PTSD related to combat exposure or traumatic injury or experience while serving in a combat zone. A military partner lives with the veteran in an intimate or marital relationship.

Military Partners: Critical to Holistic PTSD Care

Military partners are the "hidden heroes" (FoxNews.com, 2013) in the holistic care of veterans struggling with PTSD symptoms. They live in a multicultural environment *steeped in military tradition, social* isolation, and a recurrent reformation of social networks (Padden & Posey, 2013). These partners manage geographical relocations and resettling to an unfamiliar locale, all while attempting to sustain positive family dynamics. Other cyclical experiences include military-induced separations (e.g., training, temporary duty assignments, and deployments). Although the cyclical lifestyle remains a common denominator among spouses, living with a veteran with PTSD is an individual and uniquely diverse encounter. Consistent with the RAND Corporation (2013), caring for a wounded or ill veteran causes partners to suffer from physical and mental health concerns that they are unprepared to manage with limited insight to their condition. While enduring excessive stress, these partners rarely seek medical treatment. Because of the numerous demands and stressors, participating in research may add to their stress. In other words, they must juggle childcare, scheduling and escorting the veteran to appointments, and dwindling finances while maintaining structure in their home. These many demands cause turbulence that alters their once-balanced lifestyle to an emotional chaos.

Ethical Concerns for Military Partners

Military partners have distinctive ethical concerns in PTSD research that warrant a call to action. The informed consent process, privacy, autonomy, and therapeutic misconception must be taken into consideration by researchers to ensure protection of partners' ethical rights. Their protection is also necessary to ensure the quality and validity of research. The conduct *of ethically sound PTSD research leads to the development* of tailored policy, educational objectives, practice guidelines, and scientific inquiry for military families.

Informed Consent Process

Informed consent process represents the continual ethical consideration of respecting the individual's right to decide to participate in research (Beauchamp & Childress, 2009; Ryan et al., 1979). When researchers recruit through the veteran, military partners are denied the right to refuse participation in the study. Furthermore, military values, such as rank structure and customs and courtesies, make it difficult for partners to refuse out of a sense of duty. Obedience to military authority figures is a foundational military tradition that military families embrace. Since obedience to duty is an important military custom, veterans and their families traditionally closely follow this principle. In other words, when recruiting a military partner through the veteran, he or she often participates in the study out of a sense of duty to support the mission of the military service (Smith, 2006). Although the decision to participate in a study is a personal choice, military and cultural values impact how the partner perceives the informed consent process and may mitigate the partner's right to refuse participation in the study.

Couple studies shed light on the interrelationship dynamics of the couple unit (Kuo, 2009). In couple studies, researchers gain a holistic perspective of the factors that impact the well-being of partners of veterans with PTSD (Dekel & Monson, 2010). Investigators (Ben Arzi, Solomon, & Dekel, 2000; Gallagher, Riggs, Byrne, & Weathers, 1998; Hamilton, Nelson Goff, Crow, & Reisbig, 2009; Sherman, Sautter, Jackson, Lyons, & Han, 2006) found that recruiting both members of the couple together afforded them the opportunity to provide informed consent simultaneously. In addition, recruiting a couple simultaneously eliminates the task of the partner in the role of caregiver from recruiting the veteran, thereby allowing researchers to explore the couple's interactions as they relate to the treatment of PTSD symptoms (Beckham, Lytle, & Feldman, 1996; Valentine, 1999).

Privacy

There are two ways in which a breach of a partner's privacy occurs. First, recruiting a partner through the veteran breaches the partner's privacy in that the partner's enrollment in the study is shared with another individual. Although this arrangement seems harmless, the partner's right to autonomy is also at risk. For instance, investigators (O'Toole, Outram, Catts, & Pierse, 2010; Westerink & Giarratano, 1999) found that when they attempted to recruit the participant through the veteran, the veteran's unwillingness to participate denied the partner the opportunity to make a voluntary decision to participate in the study. Second, in couple studies, ensuring distant proximity of the partner and veteran is essential to avoid divulging information and unknowingly threatening the privacy of one or both participants. In one example, *investigators (Hamilton et al., 2009; Sherman et al.,* 2006) displayed extra precautions to protect privacy in the informed consent process by separating the couple and monitoring them during the data collection. While researchers engage in diverse strategies to enroll military partners, protecting their ethical rights must be the forefront of PTSD research.

Preserving the partner's privacy also protects him or her from potential household violence. Frederikson, Chamberlain, and Long (1996) conducted a study to understand the experiences of female partners living with veterans with PTSD. However, after the investigators' initial conversation with the partners, two declined participation strictly out of fear for their safety. The safeguards for research participation also extend to the protection from domestic violence. Such precautions allow the partner to choose not to participate in research that he or she believes places him or her in harm's way. The partner's refusal to participate highlights the importance of safety. Therefore, the partner's decision to participate hinges on the protection of his or her privacy as well as his or her need to feel safe (Folkman, 2000).

Stigma represents the shame and fear associated with mental illness, which prevent the person with mental illness from seeking treatment. Stigma and the need for privacy shape the unique lifestyle of military partners living with veterans with PTSD. From a research perspective, findings indicate that stigma impacts treatment seeking in the early stage of PTSD (Hoge et al., 2004; Mittal et al., 2013). When partners lack knowledge of the pathology of PTSD, they in turn view mental illness with a limited perspective. Consequently, partners are then reluctant to participate in *research due to their fear of stigmatization. They feel* shame, which leads to family silence and social isolation (Hinshaw, 2007). Thus, the acknowledgment of partners' sacrifice and contribution is significant (RAND Corporation, 2013) and supports the establishment of trust, which is often difficult to build in the conduct of research (Brewster Smith, 2000). From a clinical perspective, healthcare information for veterans with PTSD, like other individuals with mental health concerns, should remain confidential. Therefore, safeguarding the partner's enrollment in the study is crucial to establish and build a trusting relationship. Due to the stress of caring for the veteran, participation in PTSD research during a time of vulnerability and fatigue makes it a challenge for partners to remain in a study. Therefore, researchers need to understand the gravity of the partner's personal experience, and incorporate measures to support and maintain the privacy of this unique population.

Autonomy

A third ethical concern is fostering autonomy, which means protecting the partner's independent decision to participate in the research. Researchers (Francisković et al., 2007) demonstrated the protection of the partner's autonomy in a study that measured the association between the partner's secondary *traumatic stress and the veteran's PTSD symptoms.* Although partners were initially informed of the study by the veterans, 37% refused to participate during the informed consent process with the researcher. The partners' unwillingness to participate in the study highlights the importance of autonomous decision when recruiting partners through veterans.

Another factor to consider in ensuring partners can make an autonomous decision is military customs. Since obedience to duty is an important military custom, veterans and their families traditionally closely follow this principle. Therefore, it is important to understand when recruiting a partner through a veteran that the partner's decision to participate may stem from loyalty to support the mission of the military service (Smith, 2006). Rather than counter military customs, researchers should make efforts to *comprehend overall culture and customs of military* members and their families. For in doing so, they stand to gain insight to cultivate ethical guidelines that will honor and respect the autonomy of military partners, contributing to sound PTSD research.

Therapeutic Misconception

In PTSD research, therapeutic misconception occurs when partners misunderstand enrollment in a study as a medical intervention to meet their healthcare needs. There are several factors that contribute to therapeutic misconception in PTSD research. First, the setting of recruitment and participation lead to partners' misunderstanding, particularly when they are in the same location. Next, when a nurse fills the dual role of investigator and practitioner, partners tend to mistake participation as treatment that will match their medical needs. Therefore, nurses should delineate the full scope of their dual responsibilities to foster clarity of the study's purpose and medical intervention (Steinke, 2004). Likewise, nurses, when recruiting couples in PTSD research in a clinical setting, must provide the full scope of the study to each member of the couple to avoid misconception of therapeutic treatment. When nurses provide the distinction between research and intervention, partners participate with a clear understanding of their participation and expectations (American Psychiatric Association's [APA] Task Force on Research Ethics, 2006).

Implications

In this article, we described the ethical concerns in the recruitment of military partners in PTSD research. Selected recommendations from the APA Task Force on Research Ethics (APA, 2006) and American Nurses Association's (ANA, 2014) are presented to describe implications for nursing researchers, educators, administrators, and clinicians. The proposed implications are guidelines to address the lack of knowledge about the need for PTSD research among partners and its significance. It should also be noted that, apart from this discussion, few studies explore the ethical concerns of partners in PTSD research. These implications are significant to nurses to underscore the contribution of military partners in PTSD research.

Nurse Researcher

The APA (2006) suggests that researchers strive to increase public awareness of mental illness in an ethically sound manner across organizations. To promote awareness of PTSD research, nurse researchers need to create collaborative alliances. Collaboration among nursing researchers will create opportunities to collectively explore measures to improve the quality of care for military partners (e.g., continuity of care, cost of care, effective treatment, and improved patient outcomes). Furthermore, researchers should share the compilation and dissemination of exemplary examples of ethically sound evidence-based research designs. To carry out this recommendation, civilian and military nurses should pool their energies (ANA, 2014) to highlight and share exemplary examples of ethically sound research in mental illness. Crosstalk between collaborating entities should occur in conferences, boardrooms, and research forums. Establishing a collaborative agreement among civilian and military research communities supports the dissemination of the most current research on the impact of symptoms of PTSD on military partners. In summary, expanding nurses' knowledge of the health needs of military partners living with veterans with PTSD will lead to promoting the well-being of partners, veterans, and the military family (ANA, 2014).

Nurse Educator

Despite the indication that military partners are necessary in PTSD research, few educational resources exist to prepare nurses to manage the ethical concerns surrounding their participation. Educating nurses on war-related injuries and trauma, specifically PTSD, and the impact of war-related mental illness on partners is necessary to recognize and address partner-specific healthcare needs. With regard to researchers, the task force recommends the construction of educational curricula to prepare individuals who conduct psychiatric research (APA Task Force on Research Ethics, 2006). The ANA (2014) further supports the education of nurse researchers to keep them up-to-date on ethical and regulatory standards in mental health. Likewise, Benner, Sutphen, Leonard, and Day (2010) call for a radical change in nursing education to prepare nurses for future challenges in health care. In this manner, educating nurses about ethical issues surrounding the recruitment of military partners in PTSD research means preparing them to conduct ethically sound research, and support quality patient outcomes for partners, veterans, and the military family (Daniel, 2012).

Nurse Administrator

Recruitment of military partners in PTSD research poses ethical concerns that warrant partner-specific guidelines, bylaws, or human participant standards. Administrators are crucial in the creation of mental health research policy and how policy is implemented. The task force (APA, 2006) recommends that leaders direct the promotion of mental illness research through setting precedence for research guidelines that safeguard the autonomy and well-being of participants. Thus, it is important that administrators craft a policy that directs researchers on how to conduct quality research with a military populace, specifically military partners in PTSD studies. Furthermore, mandatory ethical training regarding the distinct ethical issues that surround a military sample should be included in the organizations' Collaborative Institutional Training Initiative (2012). With the support from nursing administration, the policy will reflect organizations' partner-specific guidance in the ethical conduct of PTSD research.

Nurse Clinician

Almost one out of every eight Americans has served in the military or knows someone who has served (Collins, Wilmoth, & Schwartz, 2013). The nurse in clinical practice has a significant role in the recruitment of military partners in PTSD research. Training and educational offerings to update clinical nurses are necessary to support the ethical recruitment of military partners. For instance, training on the difference between clinical informed consent for treatment versus the informed consent process for enrollment into a study is imperative. The rationale for this training stems from the confusion that often surrounds participants who are recruited in a medical setting, such as at a doctor's visit, in a waiting room, or during a medical appointment for the veteran (Steinke, 2004). That is, participants mistakenly believe they are participating in a treatment plan that will improve their medical condition, rather than taking part in a study. Clinical nurses should have the knowledge to understand their audience (Steinke, 2004; Wjst, 2010) and be able to explain the difference to military partners. According to the ANA (2014), they should also possess the ability to lead and advocate to healthcare organizations on behalf of veterans and their families. In order to meet the criteria set forth by the ANA, perhaps additional continuing educational offerings at the state and national level are on the horizon. Keeping the clinical nurse informed of ethical considerations will, at the point of entry in health care, ensure that partners receive the informed consent process in the proper manner. Further, a clinical nurse can fully support the ethical treatment of human participants in a clinical environment, establishing ethical safeguards and trust at the point of entry. Psychologically and socially, military partners fear a breach in their confidentiality and privacy. They fear that their personal information or that of the veteran will be shared with others, particularly military leadership (Yambo & Johnson, 2014). Both military and civilian clinical nurses can be instrumental in allaying those fears by explaining the informed consent process at the point of entry. Therefore, the clinician's knowledge, skills, and attitude regarding military cultural values and the informed consent process are essential to support the ethical recruitment of military partners.

Conclusion

Safeguarding the right to autonomy and privacy is a basic ethical precept under the umbrella of respect for human participants. Further research is needed to develop a deeper understanding of the methodological issues related to the autonomy and privacy of military partners in PTSD research. Understanding ethical issues that surround the recruitment of military partners will assist researchers in establishing priorities in mental health research. Furthermore, additional research is also necessary to explore family dynamics during the recruitment process and partners' perception of the recruitment experience. Establishing research guidelines to preserve a military partner's ethical rights is integral to promote the health of veterans who, respectfully, serve and defend our country, and their families.

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Appendix C

Manuscript #3

A Phenomenological Exploration of the Lived Experience of Military Spouses of Veterans with Combat-related Post-traumatic Stress Disorder

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This manuscript has not been previously published as "A Phenomenological Exploration of the Lived Experience of Military Spouses of Veterans with Combat-related Post-traumatic Stress Disorder".

Authors: Teresa W. Yambo, Mary E. Johnson, Kathleen R. Delaney, Rebekah Hamilton, Arlene Miller, and Janet A. York.

Abstract

A phenomenological study was conducted to explore the essence of the experience of military spouses living with veterans with combat-related Post-traumatic Stress Disorder (PTSD). Husserlian phenomenology was chosen as the theoretical framework because it allowed a deeper understanding of the unfolding of the spouses' day-to-day experience. A purposive sample of 14 spouses living with veterans with symptoms of PTSD participated in unstructured interviews. Data were analyzed using a modification of the Colaizzi method. Four major themes were identified from data analysis: *Recognizing Life is No Longer the Same*, *Living with Unpredictability*, *Bearing the Burden*, and *Creating a New Life*. Spouses recognized that the veteran was no longer the same person, with life becoming one of living with the unpredictability of PTSD. The participants bore the burden to maintain normalcy in the family and eventually created a new life in which eleven remained in and three left the marriage.

A Phenomenological Exploration of the Lived Experience of Military Spouses of Veterans with Combat-related Post-traumatic Stress Disorder

Spouses are a major support to married veterans who are experiencing symptoms of combat-related posttraumatic stress disorder (PTSD) (Yambo & Johnson, 2014). PTSD may occur after exposure to a traumatic event, such as threatened death to oneself or others, the death of others, serious or threatened injury to oneself or actual or threatened physical or sexual violence. The diagnostic criteria include: one or more intrusive symptoms such as recurrent memories, nightmares, flashbacks, distress or physiological reactivity; one or more efforts to avoid the feelings related to the traumatic event(s) or avoidance of external situations that remind the veteran of the traumatic event(s); two or more changes in cognition and mood, such as the inability to recall the event(s), negative beliefs about oneself, blaming oneself for the event or its consequences, persistent negative emotions, reduced interest in activities, feelings of alienation or an inability to experience positive feelings; and two or more changes in arousal and reactivity, such as irritability, self-destructive behavior, hypervigilance, increased startle response, difficulty concentrating, or problems with sleep. These symptoms must be present for at least one month and cause significant distress or impair the individual's ability to function in day-to-day life (U.S. Department of Veterans Affairs, 2015).

Living with a veteran with PTSD has an impact on the spouse, often causing the spouse significant stress and psychological distress (Manguino-Mire, et al., 2007; Ray & Vanstone, 2009; Yambo & Johnson, 2014). Although there have been studies of the impact of PTSD on spouses of veterans from previous combat operations, a recent review of the literature revealed no published studies of spouses' experiences living with a veteran who has developed symptoms of PTSD after post-9/11 overseas contingency operations (OCO) (Yambo & Johnson, 2014). The veterans from OCO have unique experiences when compared to veterans from previous combat. For instance, OCO is the first sustained ground combat, since the Vietnam War (Hoge et al., 2004), with 75% veterans wounded by explosive devices (Helwick, 2011), more veterans married in families with more children, and availability of cutting-edge medical care (Glasser, 2011). Thus, what makes OCO different than previous operations for the spouses is that more military families are negatively impacted by PTSD, which contributes to weakened family bonds and hostility toward partners and military children (Peterson, Lester, Calohan, & Azad, 2014). To fill this gap in knowledge, the purpose of this study was to describe the experiences of military spouses living with a veteran with PTSD from OCO. Understanding the spouses' perspective will be useful to clinicians and researchers who are funding, developing and testing interventions that could potentially prevent mental health problems among military families and for mental health practitioners who care for veterans and their spouses as they manage the symptoms of PTSD.

Background

PTSD impacts approximately 11% to 20% of the two million veterans returning from OCO (U.S. Department of Veterans Affairs, 2014c) and approximately 1.1 million military caregivers provide care to post-9/11 veterans (RAND Corporation, 2013). Living with a veteran with PTSD can have a negative impact on the mental health of military spouses (Manguino-Mire, Sautter, Lyons, et al., 2007; RAND Corporation, 2013). Secondary traumatic stress, psychological distress, caregiver burden (Yambo & Johnson, 2014), marital and relationship dis-satisfaction (Galovski & Lyons, 2004; Hamilton, Nelson Goff, Crow, & Reisbig 2009), difficulty coping (Hamilton, Nelson Goff, Crow, & Reisbig, 2009), and domestic violence (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Yambo & Johnson, 2014) have been documented. Despite the evidence that military wives remain at the forefront of the veterans' family reintegration (Mullen, 2013), most researchers have limited investigations to the impact of trauma on the primary victim—the veteran with symptoms of PTSD. Veterans from OCO had unique experiences because of frequent, extended redeployments, longer exposure to ground warfare (Hoge et al., 2004) and improvised explosives (Helwick, 2011), and accessibility to advanced healthcare resources (Glasser, 2011). However, researchers found that despite the veterans' medical resources and treatments, spouses living with a veteran with symptoms of PTSD continue to struggle with mental and physical health concerns (RAND Corporation, 2013).

Method

Design

The design for this study was a modification of Colaizzi's phenomenological method (1978). Phenomenology is a research methodology that is used to understand the essence of a phenomenon (Munhall, 2007), in this case, the participant's perspective of living with a veteran with PTSD. This study was approved by the university institutional review board.

Recruitment

Participants were recruited through the assistance of community organization leaders. Recruitment efforts included flyers and word-of-mouth through community organization leaders. The flyers were written in English and provided the study's purpose, eligibility requirements, investigator's contact information, and incentives. Primary recruitment sites were community organizations.

Each participant was asked to pass along the information to other military spouses living with veterans with PTSD until the investigator retained reached saturation for the study. Further recruitment was conducted through social networking and referral by participants. Recruitment ended when via the coding and examination of the interviews it was determined that redundancy was achieved (Morse, 2007; Sandelowski, 1995).

Inclusion and Exclusion Criteria

Participants were included in this study were English-speaking spouses between the ages of 21 and 60 who were married to military Active Duty, National Guard, Reserve, or veterans who retired or were medically discharged within the past year and as reported by the spouse has a presence of PTSD symptoms as a result of combat service in OEF or OIF. Additionally, the participants had the capacity to reflect upon and discuss their personal experiences. Individuals were excluded if they were unable to participate due to mental illness, physical illness, hospitalization, inability to communicate, residing outside of the U.S., and/or were unmarried partners.

Participants

The participants ($n = 14$) included two spouses of veterans with PTSD symptoms (without formal diagnosis) and twelve spouses married to a veteran with a diagnosis of PTSD. In this study, participants ($n = 7$) reported living with a veteran with a co-diagnosis of PTSD and traumatic brain injury (TBI). The traumatic brain injury, as reported by the spouse, was the result of a traumatic event that occurred during the veteran's deployment. Some of the wives ($n = 6$) married their husbands prior to the dual-diagnosis of PTSD and TBI. One spouse married her husband after he was diagnosed with PTSD and TBI. The age range of the women was 25-56 years old (*M* = 36.21, *SD* = 8.39). All participants were women over 21 years of age married to male veterans. The participants felt that their participation in the study would potentially benefit other spouses living with veterans with PTSD.

All participants lived in the United States. The length of couples' marriages was 3-25 years (*M* = 10.4, *SD* = 5.70) and the veterans' diagnosis or symptoms of PTSD ranged from 1-9 years (*M* = 4.53, *SD* = 2.35). The participants identified as Caucasian (*n* = 10); White Hispanic (*n* = 2); and Hispanic (*n* = 2). One participant was on Active Duty. Four of the participants were caregivers through the Department of Veterans Affairs in the Family Caregiver Program. This program recognizes and offers training to a family caregiver to safely support a veteran who was seriously injured while supporting post-9/11 OCO (U.S. Department of Veterans Affairs, 2015).

Data Collection

The first author interviewed participants face-to-face in a mutually agreed upon setting. Interviews were unstructured with open-ended questions that began by asking the participants to describe an experience that exemplified what it was like to live with a veteran with PTSD symptoms. For parts of the story that needed clarification, more detail, or deeper exploration, probing questions, such as, "Can you say more about that?" were utilized. Individual questions were used to further explore what makes living with someone with PTSD symptoms either more difficult or easier. Data collection took place over one year and four months and continued until redundancy and data saturation were achieved after the 14th interview. The interviews were audio-taped and field notes were written following each interview. Recordings were transcribed verbatim by a professional transcription service. Each transcript was quality checked for accuracy by the first author.

Data Analysis

The transcripts were uploaded into the qualitative data management program, Atlas-ti (2013). Data were analyzed using a modification of the Colaizzi's seven steps of phenomenological analysis (1978). The modification included contacting three participants for validation of the findings, rather than all participants, to ensure that the research participants' words had the same meaning as the investigator understood. The Colaizzi (1978) analytical steps involved the following;

1. Reading each participant's description of their experience from the transcript to obtain a whole feeling for the interviews
2. Returning to each transcript and extracting significant statements that directly pertain to the life experience of military wives living with a veteran with PTSD.
3. Formulating the meaning of each significant statement
4. Organizing the formulated meaning into clusters of themes to allow for the emergence of themes that are homogenous to all of the participants.
5. Integrating the results into a description of the essence of the phenomenon.
6. Validating the findings by revisiting some participants to inquire how it compares with their experiences.
7. Integrating any modifications provided by the participants into the final description of the essence of the phenomenon.

Three participants compared their experience with the findings of the study. Each of the participants reviewed the findings individually and expressed agreement that the findings accurately described their experiences.

Findings

The stories the spouses told about what it is like to live with someone with symptoms of PTSD represent a snap shot of their lives. That is, their experiences reflect a story that is still unfolding and contributes to a deeper understanding of their life story. Their experience is about joining stories of their past with their present-day experience. These past and present-day stories will eventually create memories and experiences that shape their future. The participants' lives are unfolding as they experience life with a veteran with PTSD symptoms.

Analysis of the interviews revealed four major themes: *Recognizing Life is No Longer the Same*, *Living with Unpredictability*, *Bearing the Burden*, and *Creating a New Life*. A description of the themes along with supporting quotes follows to reflect the essence of the spouses' experience. Each spouse was assigned a common first name pseudonym.

Recognizing Life is No Longer the Same

When their husbands returned from deployment, the spouses noticed changes in the veterans. Outwardly their husbands looked the same, but their reactions and behaviors were different. For instance, **Alice**, a spouse of a veteran with symptoms of PTSD, shared that the subtle changes in her husband's behavior made her aware that he was no longer the same. She said,

> It started clicking to me, um, that he was having some PTSD because just like the locking of the doors. And later he told me that was because he felt like he was being followed or, you know, he got paranoid that people were after him.

Bree, whose husband had both PTSD and TBI, recounted a change in her husband's reaction when she touched him during a nightmare. She said,

> One night in the middle of my sleep, I just had turned over. I guess I accidently touched him in the middle of a nightmare, and I got thrown across the room on accident. He didn't mean to. He was asleep, but in his mind, he was having a dream when he thought I was the enemy.

Other participants' noted their husband's increasing frustration and irritation when his limit was reached. **Edna** described how she was feeling about her inability to help her husband when he reached his limits. She shared, "When he gets that way, he can fly in to fits of extreme irritability/anger, and it's better to just stay away from him. That's why I feel helpless." And **Leah**, a spouse of veteran with PTSD and TBI, recalled how her husband reacts when he reaches his limit. She said,

> We always, when he first got back, had to sit in a certain way so he could face the door and assess everything, and then just the aggression and rage. He'd go from zero to ten, like just snap without any warning. We didn't know—there's no five; it was zero to ten and all hell broke loose. Then with havin' the TBI, he doesn't remember.

The spouses struggled to understand the change in their husbands' behavior and attitudes. These changes were often observed, but sometimes they were simply hunches that something about their husband was different. For instance, **Sara**, a spouse of veteran with PTSD and TBI, recalled how she initially noticed the change in her husband's behavior but only later realized that it was a symptom of PTSD. She stated, "We had a lot of fights over him just being self-absorbed with video games all the time. Now I know that that's a common symptom of PTSD, the isolating and withdrawal. It's still a struggle."

Over a period of time, the spouses began to realize that certain conditions or events triggered a memory of a traumatic experience from their husband's deployment. **Audrey**, a spouse of a veteran with PTSD and TBI, recalled a moment that triggered the memory of a traumatic deployment experience for her husband. She commented, "We hit a certain area of the road, and it just reminded him of one area where they had issues when they were deployed. The next thing you know, he's in tears. So, triggers, it varies." **Kathy**, a spouse of a veteran with PTSD and TBI, shared her husband's reaction to a loud noise. She said,

> Since we used to live in a military town, there's a lot of artillery. Anytime you hear those booms--one time it was so close to the house. It definitely sounded like we were being attacked, and he just dropped to the ground.

When their husbands returned from being deployed, the spouses expected their husbands to resume their previous roles and responsibilities and that life would return to "normal." However, the more time the spouses spent with their husbands, the more they recognized that their husbands were no longer the same. Recognizing their husbands were no longer the same made many of them realize that they, not their husbands, needed to readjust. As **Edna**, described,

> I used to be able to talk to him and be like, "What's wrong? What's wrong?" After asking five, ten times he would tell me [what was wrong]. You don't do that anymore. You want to see him get pissed off and fly off the handle, then ask him repeated questions over and over again. I have learned recently that's a trigger for him. I don't want to do something that's going to set if off.

Living with Unpredictability

Living with their veteran spouse was turning into a life of unpredictability. The spouses often referred to the predictability of unpredictability as "walking on egg shells." In other words, they knew their husband would react, but they did not know when or where the reaction would occur. **Isabelle** reflected on this unpredictability. She explained, "Sometimes, it feels like walking on eggshells. You don't know if he's having a good day or not. Small things could trigger him." Not knowing what new experience was going to trigger a reaction coupled with the uncertainty of their husbands' reactions was stressful to the spouses. All of the spouses were trying to become more attuned to their husbands' moods and triggers. **Cassie**, a spouse of veteran with PTSD and TBI, described her struggle with the unpredictability in her husband's mood. She stated, "It's an everyday challenge. Sometimes he's happy and if he's happy, we all have a good day. A lot of times he's moody and so everybody feels like they're walking on eggshells and they have a bad day." **Sara** described how her husband's reactions impacted her mental health. She said, "It's caused me to develop anxiety problems because it was like I was walking on eggshells and all I wanted was peace in the home." Although the spouses were feeling stressed from the continual exposure to PTSD symptoms, this stress was compounded by the loss of predictability in their lives. When asked what it was like to live with someone with PTSD, **Maria**, a spouse of a veteran with PTSD symptoms, stated, “Basically, my biggest example is just it’s like a rollercoaster because it happens all the time. It’s good times and laughing, playing, tickling, then anger. You just want to get away.” **Leah** shared her viewpoint on the impact of unpredictability on her life. She explained,

> It’s very unpredictable because you don’t know. We could be shopping and be fine and then somethin’ catches his eye. Like I know crying children and women in balaclava or whatever the headdress. Certain things if he catches it, it puts him back there in whatever happened; the aggression comes out or whatever he needs to do to get out of the situation. It’s a daily stress, unpredictable.

Bearing the Burden

The spouses perceived two types of burdens, a tangible one from assuming the duties and responsibilities of their relationship, and an invisible psychological burden. With regards to the tangible burden, the spouses felt that it was their responsibility to manage the changes in their life that were sparked by their husband’s medical condition. For example, shifting roles, assuming their husbands’ chores, and/or advocating for their husbands became part of their responsibility. **Megan,** whose spouse had symptoms of PTSD, reflected on how shifting roles helped her to support her husband. She stated, “That sense of you’re dealing with—you know that this person can’t deal with the regular stuff. You step in. You take care of it for them. Cleaning, the dishes, all these little things. Even filling up the car.”

In addition, three spouses bore the psychological burden of guilt for their husbands’ traumatic deployment experience, the impact of PTSD on their life, or for starting a new life without their husband. **Cassie**, a spouse of a veteran with PTSD and traumatic injuries expressed her guilt for encouraging her husband to take the place of another military member when it was not his turn to deploy. She was feeling guilty for her husband's traumatic experience that resulted in PTSD and a traumatic injury. She shared, "I asked my husband to volunteer to go this third time to Afghanistan. I guess I feel guilty because he did go and three months later came home with 45 percent burns to his body, you know, PTSD."

Audrey described how she felt when she had to continually cancel social events because of her husband's PTSD symptoms. She said, "I feel guilty because part of being a friend is being there for your friends. If I'm gonna cancel on them and not be there for them, then how can I expect them to be there for me?" **Megan**, discussed her feelings of guilt about leaving her marriage because she is concerned about her husband's history of suicide attempts. She remarked, "In two weeks, I'm leaving and I'm still scared. I've had nightmares about him killing himself. The guilt that comes with it."

Maintaining the peace. Ten of the spouses felt responsible for maintaining peace in the family. They tried to avoid conflict, however, often felt unsuccessful in their endeavors. For example, when asked about what she felt when trying to avoid conflict in her marriage, **Megan** responded, "Frustration. Failure. Feeling 'cause I can't make all those things really happen and well. It feels like a—feels like being asked to build the Empire State building by yourself. You're like, "I just—no, can't do this." For those spouses with children, maintaining peace between their husbands and their children was emotionally exhausting because their husbands angered easily and quickly. One tactic they used to maintain the peace was to help the children understand their father's medical condition. The spouses also tried to model behavior for their children.

Yet, keeping the peace was an ongoing challenge for them. **Isabelle** described her concern regarding her children witnessing conflict in their home. She said, "Well, I just think that I wanna keep the peace in the house because I don't want my children to see their father upset, or I don't want any arguing, or yelling, or anything like to be going on." **Lily** shared how she was trying to maintain the peace in her home. She commented, "I'm whispering to the kids. 'Shh. Don't say that. Shh. Don't do that. You're dad's gonna be mad'." I'm just constantly having to play referee, peacemaker and make sure everything—I'm paving the way for him. I'm clearing everything out." **Lily** further described her concern about the emotional fragility of her family in her absence. She said,

> I feel like I'm the peacemaker in our home and it gets exhausting. Sometimes you just want to lock yourself in the room and really just want to run away, but you can't because if you do then he might hurt himself or the kids will be scared.

Dealing with spouse's emotions. The spouses experienced a myriad of emotions as they tried to navigate the journey of PTSD with their husbands. Almost half of the spouses shared that they were struggling with dealing with their husbands' coexisting mental health concerns. For example, **Leah** described her husband's mood when he came home from his most recent deployment. She said, "When he came home he shut down. He did not go to work. He didn't do nothin' for like four months. He was like in a massive depressive state." **Megan** shared how she struggled to get her husband to seek medical treatment to prevent suicide. She commented, "That's exactly the spiral that we've been in is, I leave town. He does something to try to hurt himself. I come home. I beg for him to go get help." Two additional spouses reported struggling with their husband's plan to commit suicide. To keep their husbands safe, each of these spouses described encouraging their husbands to seek mental health treatment. All three of these spouses recounted how they found themselves intervening to prevent their husband's suicide attempt. **Maria** was feeling afraid that she might not be able to keep her husband safe. She said, "I'm terrified of the snap. There's been a couple of times he's had to take himself to the [hospital] because he's suicidal. Cause he's suicidal and he snaps; things make him so angry that I can't calm him down." Many of the spouses were dealing with their husband's volatile emotions without seeking assistance from external sources. In other words, they were silently struggling with their own emotional needs, while tending to their husband's emotions.

Protecting the children. Twelve of the spouses had children and many of them expressed concern about how PTSD symptoms were impacting their children. Therefore, they were taking measures to shield their children from hostility and to prevent the children from triggering a symptom of PTSD. The mothers were also attempting to nurture the father-child bond. As **Lily** stated, "I've always gotta worry about him first. Then I've got to watch the kids and I've got to make sure the kids are good, and I gotta make sure they're not doing anything to trigger him or upset him." Six spouses noticed that their husbands were unable to relate to them or the children during a flashback. A flashback, the mothers expressed, posed a significant fear for their children's safety and their own. **Thea**, a spouse of veteran with PTSD and TBI, recalled protecting herself and their children when her husband was experienced a flashback. She stated, "You had to clear all the kids to one room, and lock yourself in the room 'cuz your husband has a knife and he's trying to kill you, but he doesn't know that he's in that mind frame." **Edna** recalled how she protected her children when her husband reacted. She said, "When he is in one of those reactive states, I have to keep the children away from him because he gets very irritable and angry. I have to keep myself away from him. I have to be very careful." **Audrey** modeled calmness to reassure her children through a difficult moment. She remarked,

> When he becomes depressed, there are a lot of tears. You have to stay strong for him and the kids because the kids look at him and they know something's going on, so they look at me as, how do you react and handle it? If I stay calm, they stay calm.

Creating a New Life

The return to life before the deployment was not happening the way the spouses anticipated it would when their husbands returned home. Therefore, all of the spouses created new ways to function around their husbands' PTSD symptoms. **Bree** described how she altered how she tends to errands. She said, "We have to change our shopping schedule around a lot. He doesn't like to be where there's a lot of people. When we do, he just—he has anxiety." **Kathy** reflected on the changes in their social life. She recalled, "We could never go out, ever. We couldn't go out to crowded places. We couldn't go to restaurants or couldn't go even grocery shopping. Couldn't go anywhere where there were crying kids and babies because that set him off, too."

***Not seeing old friends; creating new friends*.** Despite having a network of friends, six of the spouses described feeling alone in dealing with their husband's symptoms of PTSD. **Lily** described why she sought support from like-minded spouses. She remarked,

> I enjoyed being around other spouses that were experiencing similar situations because they understood. They didn't judge and they didn't look down on you. They understood exactly what you were going through, and sometimes you'd hear their stories and you're like, "Oh, my day wasn't that bad today then." As silly as it sounds, it helps you get through.

All of the spouses were gravitating towards individuals who accepted their experience. **Thea** discussed ending her participation in a support group because she could not identify with the individuals who did not understand her experience. She remarked, "That's why me and my friend get along so well. Our husbands were in the same place. I couldn't go to those groups and listen to those women talk when their husbands are just complaining about folding the laundry." The spouses cultivated relationships with individuals who provided them with ongoing emotional encouragement. Receiving emotional encouragement became a lifeline, linking them to those individuals who understood their plight.

***Making sense of the relationship*.** Restructuring ways of thinking and reacting was important to the spouses. Two of the spouses talked about this structuring as the "new normal." However, their new normal was not a destination, but rather an ongoing journey. **Michelle**, a spouse of veteran with PTSD and TBI, recalled how she was able to accept her new way of living. She remarked, "Seeing that MRI made me realize there's no way he's ever coming back. We started our new normal that day that I was in [treatment facility]. He cannot multitask anymore. He can only do one thing at a time." **Lily** shared how she was learning to understand her husband's angry outbursts. She mentioned, "Not taking it personal, 'cuz I did that for a while. I took everything personal.

I thought it was always me or something, but I realized it was his PTSD. Over time it helped me react differently, respond differently." Because of the impact of PTSD symptoms on their marriage and family, the spouses altered their lifestyle to cultivate a way of living that fit their relationships.

Three spouses shared that they were contemplating divorce as their way of creating a new life. **Megan** described how her struggles with her husband's medical condition impacted her decision. She commented, "I've actually filed for divorce just this month because it's something I've had to do. 'Cause I'm at the point with after many struggles with his PTSD and all the problems that have come with it." **Alice** explained how the stigma of PTSD impacted her husband's decision to resist medical treatment. She said, "Before the divorce I was begging him, "Go talk to someone, please. Like maybe we can work on it if—I'll go talk to someone individually; you go talk to someone individually." But he won't because of the stigma." Both spouses perceived that their new normal was to be without their husbands. In spite of filing for divorce, both spouses believed that they would reconsider the divorce if their husbands were willing to engage in treatment and made progress towards reducing self-destructive behaviors.

Adjusting the environment. As their lives unfolded, the spouses were learning to adapt their surroundings to their husband's condition. For instance, **Isabelle**, a spouse of a veteran with PTSD discussed how she created structure for her husband. She said,

> I have a dry erase board to write everything down. If I'm gonna be working, I make sure to write it on there. I even text him reminders. I always have to keep reminding him about certain things, so he doesn't forget.

Audrey shared how she is restructuring her life to support her husband. She stated,

> I schedule all the doctor's appointments. I make sure he has his medications. I use my iPhone. It connects to his iPhone and his iPad, so I have reminders set up, and I can send him reminders to take the medications. I communicate with the doctors, if there's a question. I've developed a good rapport with his doctors.

Understanding PTSD and TBI. These spouses described feeling unprepared to deal with their husbands' PTSD symptoms and neurological problems associated with TBI. **Michelle** shared her difficulty with understanding her husband's dual diagnosis. She said, "I wish, [my husband], I could have tattooed on your forehead "PTSD" and "TBI" because you look the same, but you do not act the same." **Sara** reflected on the complexity of PTSD and TBI symptoms. She remarked, "PTSD by itself is hard enough. The TBI on top of it, it completely changes. I mean it affects their hormones. It's affected the way he thinks, the way he talks. The way he processes things." Because the spouses were limited in their knowledge of how to deal with the veteran's dual diagnosis, they were experiencing difficulty with communicating with their husbands.

Discussion

This phenomenological study adds to earlier descriptions of the experiences of military spouses living with veterans with PTSD (Dekel et al., 2005; Lyons, 2001; Maloney, 1988; McLean, 2006; Ray & Vanstone, 2009; Woods, 2010), supports marital adjustment findings revealed in PTSD research conducted with Vietnam veterans' partners (Evans, McHugh, Hopwood, & Watt, 2003; Jordan et al., 1992; Koenen, Stellman, Sommer, & Stellman, 2009; Riggs, Byrne, Weathers, & Litz, 1998) and Ex-World War II Prisoners of War (POWs) (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004) and former Israeli POWs (Dekel & Solomon, 2006), and provides a deeper understanding of the impact of combat-related traumatic stress on family relationships (Canfield, 2014; Henry, 2001; Ray & Vanstone, 2009; Maguen, Stalnaker, McCaslin, & Litz, 2009). The findings of this study support the evidence that spouses struggle to balance their day-to-day life due to the symptoms of PTSD (Mansfield, Schaper, Yanagida, & Rosen, 2014).

Often, the military spouses struggle alone in silence. It is little surprise that many of the participants expressed loneliness amid the mental health resources that are available to them. Additionally, these findings are consistent with findings from research with Vietnam veteran spouses (Lyons, 2001) and Canadian peacekeepers spouses (McClean, 2006) that revealed spouses readjust their lives around the veteran's symptoms without regard to their own personal physical and emotional wellbeing and little is known about the cost of such resiliency.

This study is one of the few qualitative studies conducted to explore the essence of the experience of U.S. military spouses living with a veteran with PTSD symptoms from OCO. In this investigation, the themes and significant statements described were comparable to the themes of previous research; i.e, feelings of anger, confusion, fear, and loneliness, thoughts of confusion to understanding PTSD symptoms, and descriptions of the complexity of their relationship with their husband (Woods, 2010). Furthermore, they were consistent with themes identified by Dekel and associates (2005) in wives of Israeli veterans: the illness as navigating living, between merging and individuation, partners as present-absent, separation and divorce, and partners as empowers. These themes revealed that spouses perceived that navigating their husband's illness made it difficult to maintain their individuality, which created emotional dissonance in their relationship that led to thoughts of separation and divorce. However, despite the emotional dissonance, partners remained in the relationships, feeling a sense of empowerment to make household decisions on their husband's behalf. This research, which focused on these women's lived experiences, detailed the myriad adjustments they make on many fronts to keep themselves and their children safe, to regulate their husband's emotions and affect and to preserve the threads of their relationships.

This research also provided insight to the spouses' perception of PTSD as ever-changing, unpredictable, and stressful to their family dynamics and relationships. Although, each spouse felt that living with a veteran with PTSD was an individual experience, their lives were interwoven in commonalities that cut across all the spouses, regardless of veteran's PTSD symptom severity. The findings indicate that living with a veteran with PTSD is stressful for the spouses due to the complexity of the condition. On a positive note, five spouses reported gaining insight on how other spouses coped with a difficult situation and working to 'normalize' their experience through the experiences of others. In other words, when the spouses connected with other individuals, they were able to make sense of their situation. When spouses made sense of their situation, they were able to identify common stressors and utilized their awareness of others' ways of coping to cultivate their individual coping strategies. Unfortunately, two spouses, who were unable to connect with others, were feeling exceedingly stressed and lonely in their efforts to cope.

Limitations of the study include the absence of a male spouse in the sample. Although community organizations included male spouses, we were unsuccessful with the recruitment of a male spouse. One male spouse intended to participate; however, his veteran wife had a co-occurring, incurable illness that prevented his participation. Therefore, findings cannot be generalizable beyond female spouses. In addition, it is not possible to control for the interaction of PTSD and the impact of multiple deployments.

Conclusion

The experiences of these military spouses draw attention to the tremendous stress of spouses of veterans who suffer with PTSD and traumatic injuries. Community organizations were crucial to offering resources and connecting spouses to appropriate referral services. Yet, there remains a deep need to nudge collaborative efforts among civilian, military, and federal components to support the health and well-being of military spouses. Although programs, such as Families Overcoming Under Stress (FOCUS project) are underway to address family resilience enhancement, most of the emphasis has been on deployment and has not targeted PTSD and spouse resilience (Saltzman, Bartoletti, Lester, & Beardslee, 2014). However, even when there are collaborative efforts like the FOCUS project, military spouses lack the tools to effectively cope with the stress of PTSD symptoms. Thus, it is paramount for community and private organizations to link the spouses with resilience services early in the military separation process. Respect and understanding of the spouses unique position in the treatment of PTSD warrants the unveiling of obscure systematic processes to provide continual support for the military families.

Reintegrating is a challenge for the military family. According to Substance Abuse and Mental Health Services Administration (SAMSHA, 2014) enhanced behavioral health clinical guidelines are necessary for veterans and military families can receive tailored care to help them cope with the complexities of PTSD. Future studies are needed to understand the impact of traumatic stress on the spouse and the military family. Clearly, we are on the cusp of transforming health care to acknowledge and care for the unsung heroes of military families—military spouses. It is our hope to keep military families together through educational programs to increase awareness of their plight.

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