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Army Reservists Spouses' Perceptions of Secondary Traumatic Stress: A Phenomenological Study

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Capella University, 2012

B Mus, State University of New York at Potsdam, 1987

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

While it is commonly known that combat-related posttraumatic stress disorder (PTSD) has profound, long-term effects on soldiers, its effects on spouses of affected soldiers are less understood. Some spouses who provide care for soldiers with PTSD develop symptoms that are similar in nature. These symptoms include but are not limited to depression, anxiety, isolation, hypervigilance, and a strong startle effect. This study explored the lived experiences of 8 spouses of Army Reservists who returned from deployment in either Iraq or Afghanistan with combat-related PTSD. This study used the couple adaptation to traumatic stress model to explore the couple's response to traumatic stress. The study also includes a discussion of the history of PTSD, including changes in criteria with the revisions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), including the most recent change in the latest version (DSM 5). Although secondary traumatic stress is not recognized in the DSM 5, an increase in awareness may result in a better understanding of mental health needs within the military culture. The study consisted of 8 semi-structured interviews among 8 female spouses of Army Reserve soldiers, using Colaizzi's method of data analysis. The results of this study identified psychological distress in all participants in connection with relationship changes, psychological distress, and lack of available mental health services. The results of this study may assist mental health professionals understand that the mental health needs of spouses of Reservists often differ from those of active duty spouses. This study may support social change by promoting the need for additional training for counselors who work with this population.

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Dedication

For my husband, Bill: None of this would have ever been possible without your continuous love and encouragement. You kept me motivated at times when I wanted to quit and gave me strength when I had none. I love you endlessly.

For my children, Jaime and Erica: You allowed me to be selfish while I pursued my dreams. You are two of the finest women I have ever known. I am so proud of you, and I love you both so very much.

For my best friend, Kim: You are the best friend one could ever have! You were instrumental in my career development. Your patience, guidance, and friendship gave me the courage to pursue my education. You are the wind beneath my wings!

For my soldiers and their families: You are the reason that I pursued a career in counseling. My 7 years as a member and coordinator of the Family Readiness Group encouraged me to enter this profession. I dedicate this study to you with love and gratitude. Thank you for your service to our country.

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I want to sincerely thank my chair, Dr. Wynn Dupkoski, for her encouragement and feedback. You did not allow me to give up, even when I honestly believed that I had nothing left to give. Somehow, you inspired me to work harder, and reach further. I am forever grateful!

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Chapter 1: Introduction to the Study

Spouses of combat veterans often experience dramatic impact and secondhand trauma because of their loved ones' experiences. Posttraumatic stress disorder (PTSD) in soldiers returning from combat has been a common occurrence since the onset of the War on Terror in 2001 (Lewis & Reese, 2009). Xue et al. (2015) reported that PTSD among soldiers and veterans has been studied for more than 30 years. Xue et al. noted that the effects of combat-related PTSD, which interfere with personal and social functioning, include symptoms such as withdrawal, anger, and aggression. Since the War on Terror began in 2011, PTSD has been reported at elevated rates that have not been seen since Vietnam. According to Zhou et al. (2014), soldiers returning from combat in Iraq and Afghanistan reported rates of PTSD at 8% and 35%, respectively. Among those returning from combat in Iraq or Afghanistan, 9% developed PTSD shortly after returning from combat, and an alarming 35% developed symptoms within 1 year after the combat experience (Zhou et al., 2014)—a rate significantly higher than for individuals exposed to natural disasters or other traumatic experiences.

Interestingly, risk factors differ between men and women who develop PTSD symptoms (Nickles et al., 2017; Sippel et al., 2017; Vogt, 2017). Women are more likely to develop symptoms of depression, are more likely to experience interpersonal relationship difficulties, and are more likely to be exposed to ongoing trauma. Women are more likely to blame themselves for becoming victims but are more likely to pursue mental health treatment than their male counterparts (Nickles et al., 2017; Sippel et al., 2017; Vogt, 2017). On the other hand, men tend to exhibit *fight or flight* tendencies and

respond more aggressively to traumatic events (Nickles et al., 2017; Sippel et al.,2017; Vogt, 2017).

Although Klaric et al. (2010) noted that Criterion A in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association [APA], 1980) and the DSM-IV (APA, 1994) indicated that people can be both directly and indirectly traumatized, secondary traumatic stress (STS) remains excluded from the DSM-5 (APA, 2013). Hamid, Ebadi, and Zarea (2015) considered the spouses of soldiers affected by PTSD as indirect victims of war. When combat-affected soldiers suffer psychological distress, spouses report similar symptoms, which they attribute to the deployment. Bjornestad, Schweinle, and Elhai (2014) postulated that, due to the prevalence of PTSD reported among combat veterans, their spouses have an increased risk of developing STS. Mordeno et al. (2017) reported that with the changes incorporated in the DSM-5, indirect exposure as defined in Criterion A leads to questions concerning the necessity for the consideration of STS, as indirect exposure to the traumatic event is now considered primary. As researchers continue to connect the effects of PTSD in combat veterans with psychiatric distress in their spouses, the aim of this study was to explore the experiences reported by spouses, as well as the available mental health resources for affected spouses. The purpose of this study was to explore the experiences of spouses of Reservists as they coped with combat-related PTSD and to understand the meaning of these experiences. This study helped to facilitate social change by identifying the need for additional mental health services for spouses of Reservists with symptoms of STS. In Chapter 1, I introduced the background of the study as I

discussed PTSD and STS in relation to soldiers and their spouses. I discussed the gaps in the literature, noting that few studies have focused on spouses of Army reserve soldiers or on same-sex couples. Chapter 1 contains the problem statement and a description of the purpose of the study. I included the research question for the study, as well as the interview questions that I used. I discussed the conceptual framework of the study and introduced the couple adaptation to stress model (CATS). I also included a discussion of my decision to use hermeneutic phenomenology as the approach to my study. Chapter 1 contains a discussion of the assumptions, scope and delimitations, and limitations in my study. I provided a definition of the terms used and a discussion of how this research contributes to social change.

Background

Mental health issues following deployment to combat zones are not exclusive to those who served there. Renshaw et al. (2011) asserted that combat-related PTSD is connected to psychological distress in spouses of service members or veterans. The authors noted that there are specific criteria for symptoms of STS (or secondary traumatic stress disorder), yet researchers often use this term to describe general distress when referring to spouses of service members with PTSD. To measure reported symptoms in spouses, Renshaw et al. conducted a study using 190 wives of male soldiers who displayed higher levels of symptoms of PTSD. As Renshaw et al. noted, although many researchers use the term STS liberally, spouses with STS are likely to require different mental health treatment from those with other mental health diagnoses. Renshaw et al. asserted that treatment for spouses with STS should be similar in nature to treatment for

soldiers with PTSD. Treatment recommendations include some form of exposure therapy and cognitive behavioral therapy.

Ein-Dor, Doron, Solomon, Mikulincer, and Shaver (2010) defined *attachment anxiet*y as concern regarding the availability of the partner during a time of need, which may result in maladaptive attachment behaviors and anxiety for military spouses of soldiers with elevated levels of PTSD. Ein-Dor et al. noted that attachment levels for spouses of soldiers with elevated levels of PTSD were higher than for spouses of soldiers with no reported symptoms. They further suggested that elevated levels of attachment anxiety were directly related to the soldiers' PTSD and might result in higher levels of STS. Although Ein-Dor et al. noted that the experiences of the soldiers in their study are directly related to the onset of PTSD, they are not parallel with those reported by U.S. soldiers in relation to the War on Terror.

Dirkzwager, Bramsen, Ader, and van der Ploeg (2005) examined whether STS reactions exist among family members of former soldiers. The authors studied the differences between family members of former combat soldiers who had various levels of PTSD. Spouses of one subgroup were compared to parents in the remaining subgroup. The authors postulated that the "spouses of soldiers with higher levels of PTSD would view the relationship less favorably, experiencing more problems in social contacts than spouses of soldiers with lower levels of PTSD symptoms" (para. 8). The study had 1,476 participants, with an average age of 32 years. Twelve percent of participants possessed a degree from a college or university. Ninety-nine percent of the partners in the study were female. There was no mention of ethnicity in the study. Dirkzwager et al. used the Self-

Rating Inventory for PTSD (SRIP) to measure PTSD symptoms of both peacekeepers and their family members. The authors concluded that the spouses of soldiers with elevated levels of PTSD also experienced higher levels of PTSD, sleeplessness, somatic complaints, diminished social support, and a decline in overall satisfaction in the relationship. Higher levels of PTSD and other symptoms occurred for partners of peacekeepers in comparison with peacekeepers' parents as a result of the intimate relationships within couples and the fact that the peacekeeper was often the partner's primary source of support. Dirkzwager et al. contended that their research was consistent with the results of other studies conducted regarding military veterans but could not rule out the possibility that the PTSD symptoms of the partners in the study predated the peacekeepers' PTSD symptoms and hence influenced the soldiers' likelihood of developing PTSD symptoms. They presupposed that soldiers with higher levels of PTSD were likely to develop marital difficulties. On the other hand, peacekeepers with marital difficulties prior to deployment were more likely to develop PTSD.

Couples often have trouble with relationship functioning when soldiers deploy to combat zones. Erbes et al. (2012) examined the association between PTSD symptoms and relationship functioning following deployments to Iraq. The authors interviewed 49 National Guardsmen and their significant others. The age range for soldiers in the study was 21 to 53 years, with a mean age of 34.71 years (SD = 7.39); the mean age for partners was 33.61 years (SD = 8.43). All of the soldiers were male, and their partners were female. Ninety-two percent of soldiers (n = 41) and 96% of partners (n = 47) were Caucasian. The first of these interviews was conducted in person, with soldiers

interviewed in one room and their significant others interviewed in another. This took place within the first year of the soldiers' return from Iraq. The second evaluation was conducted between 6 and 9 months later through a questionnaire sent through the mail. The data collection for this report involved self-report questionnaires administered after soldiers had been released from active duty and prior to any redeployments (Erbes et al., 2012, p. 188). Erbes et al. studied couple readjustment using the Dyadic Adjustment Scale and PTSD using the PTSD Checklist—Military Version. The first evaluation (Time 1) reported a significant decline in partner relationship adjustment, but not in soldier relationship adjustment (Erbes et al., 2012). Erbes et al. reported that while some studies suggested that the association between PTSD and the functioning of the family is bidirectional, the results of their study did not indicate that couple adjustment affects the development of PTSD. Erbes et al. acknowledged the limitations of their study, indicating that their sample consisted of only a single brigade with little variation in ethnicity. Erbes et al.encouraged additional research that reflects differences in gender as well as the military status of partners in the association between PTSD symptoms and the overall functioning of the couple.

Both Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have resulted in elevated levels of PTSD and mental health symptoms among spouses of those who have served in these conflicts. Nelson-Goff, Crow, Reisbig, and Hamilton, (2009) explored the experiences of 45 male soldiers from OIF and OEF and their spouses or partners. They determined that trauma symptoms such as sleep disorders, dissociation, and sexual issues on the part of the soldier resulted in decreased levels of satisfaction

within the relationship. The study included 45 married couples. All participants were over the age of 18, had been in their relationship for a minimum of 1 year, and indicated that they were not experiencing any substance abuse or domestic violence. Among the soldiers who participated in the study, 95.6% (n = 43) served in OIF, and 4.4% (n = 2) served in OEF. Additionally, 91.1% (n = 41) were recruited from the Ft. Riley area while 9.9% (n = 4) came from the Ft. Leavenworth area. Nelson-Goff et al. reported that the average length of deployment was 10.3 months (SD = 3.98) and the average time between the deployment and participation in the study was 5.10 months (SD = 3.39). Nelson-Goff et al. used the Traumatic Effects Questionnaire (Vrana & Lauterbach, 1994) to determine any history of trauma and the types of trauma experienced. Among those reporting traumatic events, 82% indicated that their deployment to a combat zone was their most traumatic event, and 24% of their partners reported the same. Nelson-Goff et al. also used the Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R) in their study. They concluded that that the soldiers' emotional status played a profound role in their relationship dissatisfaction. They concluded that they could no longer consider trauma as merely an individual event.

Couples with children experience unique challenges when soldiers deploy to combat zones. Palmer (2008) studied the risk and resilience factors that affect military families whose members are coping with a soldier affected by PTSD. The authors suggested that psychosocial and academic stress in children is directly correlated to the mental health symptoms of their parents. Current research suggests that the effect of PTSD on family members appears mostly negative. In a similar fashion, Samper, Taft,

King, and King (2004) asserted that in Vietnam veterans, PTSD and decreased levels of parental satisfaction were connected and that decreased levels of attachment in children were present.

Combat experiences affect not only active duty soldiers and their spouses; Reservists and National Guardsmen are also affected. Herzog, Everson, and Whitworth (2011) studied the effects of combat exposure in deployed National Guardsmen on their children and spouses. Symptoms of trauma, substance abuse, and domestic violence experienced by the family members were identified (Herzog et al., 2011). The authors postulated that immediate family members of soldiers undergoing symptoms of PTSD have an elevated risk of developing STS. The study consisted of a one-time survey issued to qualifying National Guardsmen and their spouses. Qualified participants were required to have a spouse or significant other residing with them, and at least one child between the ages of 2 and 18. The following items were contained in the survey: demographic questions, the PTSD Checklist (PCL-M), the Secondary Trauma Scale, the hurt-insult-threaten-scream (HITS) screening tool, the relax-alone-friends-family-trouble (RAFFT) screening tool (Bastiaens et al. 2002), and the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). The results were from a sample of 108 participants representing 54 couples, with ages ranging from 28 to 53 years (Herzog et al., 2011). Based upon the results of their study, the authors concluded that family members of soldiers with elevated symptoms of PTSD were at risk of developing their own symptoms of distress. Additionally, Herzog et al. recommended additional studies

regarding this topic and highlighted preventive treatment, which supports the purpose of the current doctoral study.

The United States remains engaged in the War on Terror, which began on October 7, 2001 in Afghanistan with OEF (Congressional Research Service, 2015). President Barack Obama announced the end of OEF on December 28, 2014. OIF began on March 19, 2003 and officially ended on August 31, 2010. Operation Freedom's Sentinel (OFS) began on January 1, 2015, as a means of providing continued training and assistance to the Afghan military (Congressional Research Service, 2015). To date, the War on Terror is the longest foreign war in the history of the nation. As the military continues to deploy troops to multiple areas around the world, Reservists will likely remain part of that rotation. Although the military attempts to provide the necessary services to help families of Reservists, it is not surprising that spouses of Reservists do not receive equal preparation or services that are readily available to active duty spouses. I sought to explore the experiences of spouses of Army Reservists who returned from Iraq or Afghanistan with combat-related PTSD. I sought to increase awareness within the military community that a problem exists among this population. Once a better understanding of the problem exists, mental health professionals may be able to provide more appropriate treatment for those in need.

Gaps in the Literature

There appeared to be distinct gaps in the current literature. There was evidence to support the existence of STS in female spouses of soldiers (Buchanan, Kemppainen, Smith, MacKain, & Cox, 2011; Renshaw et al., 2011), yet few studies had explored the

effects of PTSD on male spouses of female soldiers or among same-sex couples. Furthermore, while there were multiple recent studies of PTSD in soldiers and STS in spouses of soldiers, few studies had examined the effects of PTSD among spouses of Reservists and members of the National Guard (Girwirtz et al., 2010). I explored the effects of STS solely among spouses of Reservists, excluding active duty soldiers and spouses. Additionally, there was no current literature less than 5 years old that addressed these effects among the spouses of Reservists and members of the National Guard. Most of the current literature pertained to the impact of deployment in terms of the couple's functioning and marital satisfaction, with some prior studies examining the experiences of soldiers returning from combat in Vietnam (Gerwirtz et al., 2010). Rather than exploring marital satisfaction, I sought to explore the effects of STS in the couple using the CATS model. Another gap was that literature had addressed STS in female spouses of male soldiers with PTSD but had not addressed the reverse. I explored the lived experiences of spouses, with a recommendation for additional studies for same-sex couples. I used a hermeneutic perspective to conduct a qualitative study with a phenomenological design to explore the personal experiences of spouses of Army Reserve soldiers who were formally diagnosed with PTSD and how they interpreted these experiences.

There appeared to be an additional gap in current literature, due to recent changes incorporated in Criterion A for PTSD in the DSM-5 (APA, 2013). Morendo, Go, and Yangson-Sorondo (2017) reported that the criteria for PTSD in the DSM-5 now encompass indirect exposure to the traumatic event, which casts doubt on the distinction

between PTSD and STS. Horesh (2015) asserted that because secondary exposure to trauma is now deemed a primary source, separating the two disorders may be unnecessary.

Problem Statement

According to the U.S. Department of Veterans Affairs (2014), approximately 10-18% of soldiers who served in combat in Iraq and Afghanistan have been diagnosed with PTSD. Soldiers have reported relationship difficulties and/or marital problems (Erbes et al.,2012). Additionally, the spouses of these soldiers have reported higher rates of psychological symptoms such as anxiety, sadness, anger, displacement, and dissatisfaction in the marriage. De Burgh, White, Fear, and Iversen (2011) attributed these symptoms to what they referred to as STS.

Ahmadi, Azampoor-Afshar, Karami, and Mokhtari (2011) noted that caregivers of individuals with PTSD are at elevated risk of developing STS. Ahmadi et al. noted that the symptoms of STS are similar in nature to those of PTSD, even though the secondary person (in this case, the military spouse) did not actually encounter the traumatic circumstances but developed similar symptoms due to a relationship with the traumatized individual. Ahmadi et al. conducted a quantitative study with veterans of the war between Iraq and Iran from 1980-1988 and their spouses. For this study, Ahamadi et al. used the diagnostic criteria from the DSM-IV-TR (APA, 2000). The average age of the veterans in this study was 41.5 years (Ahamadi et al., 2011). Among the veterans in the study, 31% were not high school graduates, 28% had graduated from high school, and 41% held postgraduate degrees. Among spouses, the figures were 35%, 47%, and 18%,

respectively (Ahamadi et al., 2011). The inclusion criteria for this study required 5 years of marriage and cohabitation for the couples; any participants with a history of substance abuse were excluded. Nothing in the study indicated whether any of the soldiers were Reservists or which branches of the military participants represented. I sought to explore the experiences of the spouses of Army Reservists who returned from deployment in Iraq or Afghanistan with combat-related PTSD. I did not include active duty soldiers in my study, as my purpose was to explore and understand the lived experiences of spouses of Army Reservists. A gap in the literature was evident, in that although qualitative studies of this topic existed, the predominant approach of studies that identified this problem was quantitative. The purpose of this study was not to quantify the number of spouses of Reservists and National Guardsmen affected by combat-related PTSD. A qualitative study allowed the richness of the lived experiences to become more evident and made it possible to pinpoint common themes. Few studies have addressed issues of PTSD and related STS from the perspective of spouses of Reservists and National Guardsmen (Gwirtz et al., 2014). According to Beks (2016), it has only been within the past 25 years that there has been any diligent study of the effect of soldiers' PTSD on their spouses. Because less is known about how spouses with STS understand their experiences, counselors may be prevented from providing appropriate interventions to them. Renshaw et al. (2011) reported difficulty in determining the nature of STS symptoms in spouses, in that previous psychological symptoms and general distress may exacerbate STS symptoms. The recommendation for appropriate treatment is contingent upon these symptoms. For example, Renshaw et al., recommended exposure therapy for spouses

who displayed genuine PTSD-like symptoms but recommended individual or group therapy for those displaying general distress symptoms. Franciskovic et al. (2009) stressed the importance of treatment for the traumatized soldier and the spouse, as treatment is contingent upon healing the family system. Brown-Bowers et al. (2012) recommended cognitive behavioral conjoint therapy for treating affected couples, while Renshaw et al. cautioned that this treatment approach could result in additional traumatization for the affected spouse. There appeared to be a discrepancy in treatment recommendations that required further study. None of the authors addressed STS symptoms in spouses of Reservists, which may differ depending upon the amount of support and mental health treatment received. I sought to explore the meaning of the experiences of spouses of Reservists and National Guardsmen with combat-related PTSD.

Purpose

The purpose of this qualitative, hermeneutic, phenomenological study was to explore the lived experiences of spouses of Army Reserve soldiers who had been formally diagnosed with PTSD and how they interpreted the meaning of these experiences. I used the CATS model (Nelson Goff & Smith, 2005) to explore the ways that military couples cope with both PTSD and STS. Other qualitative studies in this arena have been conducted using a narrative approach in chronological order (Nelson Goff & Smith, 2005). In contrast, I explored the meaning of the experiences of a group of military spouses so that I could identify similar themes that constituted the similarities in these lived experiences. Unlike in a quantitative study, in which the purpose is to

determine a specific number of affected individuals, in this study, I gathered information regarding military spouses' lived experiences from a controlled environment. I sought to develop an understanding of the similarities among these reported experiences in a natural setting. The similarities in these experiences may be overlooked by military officials because literature shows that mental health services are either not offered or are not sought (Verdeli et al., 2011). Results from this study provide insight concerning how to improve service provision to military spouses.

Research Question

The research question for this study was as follows: What is the meaning of the lived experiences of spouses of soldiers who have developed combat-related PTSD symptoms after serving in Iraq or Afghanistan?

In this study, spouses of soldiers with combat-related PTSD were asked to share their life experiences after their soldiers returned home from Iraq or Afghanistan. The research question captured these experiences, including difficulty with reintegration, marital dissatisfaction, and mental health issues.

Conceptual Framework

The purpose of this qualitative study was to explore the lived experiences of spouses of Army Reservists who returned from Iraq or Afghanistan with combat-related PTSD. I used the CATS model to explore the couple's response to traumatic circumstances (Nelson-Goff & Smith, 2005). CATS incorporates a circular approach to describe the way that trauma affects the primary victim as well as the significant other, addressing the effects upon the couple and relationship. In other words, the model

provides a systemic description of the nature of the traumatic event for the primary victim, how the response from this trauma affects the significant other (secondary victim), and how the reactions from the secondary victim exacerbate the symptoms of the primary victim (Nelson-Goff & Smith, 2005). Dekel and Monson (2010) noted that there is solid evidence to support the assertion that PTSD has a significant effect upon the overall functioning of significant others. Gathering data through semistructured interviews, I used the CATS model to understand the spouse's response to the soldier's trauma. Nelson-Goff and Smith (2005) asserted that the response to traumatic stress occurs in the form of a circle, as the response of the traumatized individual affects the response of the significant other, which, in turn, affects the primary individual once again. The response may occur in the form of emotional, behavioral, cognitive, or biological responses (Nelson-Goff & Smith, 2005). Additionally, Nelson-Goff and Smith noted that individual responses may vary from mild to severe. In this study, I used the CATS model to concentrate on the individual response of the spouse, as opposed to the overall functioning of the couple. Most of the available literature emphasizes the overall functioning of the couple, per the model. Additionally, I used this model to structure the interview questions with spouses, which I discuss in Chapter 3.

I selected hermeneutic phenomenology for this study, as this approach allows a researcher to understand and interpret the lived experiences of others using dialogue. This approach permits a researcher to gain understanding through listening while openly discussing his or her assumptions (Gadamer, 1998). Koch (1998) presupposed that exploring experiences with storytelling was sufficient when conducting research. Koch

also noted that hermeneutics guide the researcher to interpret what is happening, rather than directing the researcher regarding what to do. Considering my personal experience as the spouse of a soldier with combat-related PTSD, hermeneutic phenomenology provided me with an opportunity to discuss my preconceptions of personal experiences during the interviews with the participants. Sloan (2014) asserted that the hermeneutic phenomenologist focuses upon the description of the meaning of individuals' experiences and how the meaning of these experiences influences their life choices. As the spouse of a retired soldier with combat-related PTSD, I had personal experience with the subject matter. My intent during these interviews was to focus on the description of participants' experiences to understand the meaning of their stories. I discuss my conceptual framework in more detail in Chapter 2.

Interview Questions

1. What were your experiences when your spouse first came home from combat?
2. Tell me about your relationship with your spouse after he or she returned from combat.
3. Tell me about your soldier's experience with PTSD.
4. If his or her behavior changed since returning home, how has this behavior affected you?
5. Tell me about your experiences as you coped with his or her changing behaviors.
6. Describe your symptoms and tell me what steps you took after you started noticing changes in yourself.

7. How did your spouse respond to these changes, and how did it affect you?
8. What kind of mental health treatment did you receive, if any?

Nature of the Study

I used a qualitative, phenomenological hermeneutic approach for the completion of this study. This approach allowed me to explore and interpret the lived experiences and perceptions of spouses of soldiers with combat-related PTSD.

A phenomenological study was most appropriate due to the anticipated themes (similarities) in the experiences of the participants. I used face-to-face and telephone interviews to gather data. To participate in the study, participants must have been married at the time of the deployment. Soldiers must have served in either Iraq or Afghanistan in response to OIF, OEF, or OFS. Soldiers must have returned from combat at least 1 year ago, but no longer than 14 years ago. They must have been diagnosed with PTSD by a qualified mental health professional. I did not diagnose any soldiers or participants involved in this study.

Definition of Terms

Couple adaptation to traumatic stress model (CATS): Provides a systemic description of the ways that the individual and couple systems are affected by a traumatic event. The model indicates that the level of functioning within the primary survivor or traumatic symptoms will produce a systemic response, which may result in STS symptoms in the partner. The CATS model is circular, and as a result, the symptoms in the secondary trauma survivor may exacerbate the symptoms in the primary survivor (Nelson-Goff & Smith, 2005). In this study, the CATS model was used to explore the

ways in which spouses of Reservists responded to the traumatic symptoms displayed by the soldiers.

Diagnostic and Statistical Manual of Mental Disorders (DSM): Developed by the American Psychiatric Association (APA), the DSM is for mental health professionals and researchers for diagnosis and classification of mental disorders (APA, 2013).

Family Readiness Group (FRG): An organization sponsored by the U.S. Army supporting military families during deployment (de Burgh et al., 2011). The FRG is comprised of family members, soldiers, and other volunteers, and its purpose is to disseminate information and providing support and outreach for military families as they contend with deployments and separations. The FRG serves as a network linking family members and the chain of command.

Operation Enduring Freedom (OEF): Deployment of U.S troops to Afghanistan on October 7, 2001, in response to the attacks that occurred on September 11, 2001 (Congressional Research Service, 2015).

Operation Freedom's Sentinel (OFS): A follow-up mission conducted as a means of proving continued support and training to Afghan security forces (Congressional Research Service, 2015).

Operation Iraqi Freedom (OIF): Deployment of U.S troops (with the assistance of Great Britain) to Iraq on March 20, 2003, due to the belief that Saddam Hussein harbored weapons of mass destruction (Congressional Research Service, 2015).

Posttraumatic stress disorder (PTSD): Categorized in the DSM-5 (APA, 2013) as a traumatic and stress-related disorder, PTSD is a psychiatric disorder that may develop

because of experiencing or witnessing a life-threatening event. The criteria for the diagnosis of PTSD include the occurrence of a stressor (exposure to a traumatic event); intrusive symptoms (recurrent, involuntary memories); avoidance; negative alterations in cognition and mood (inability to recall specific events, negative and distorted thoughts); alterations in arousal and reactivity (irritability, reckless or risky behaviors, hypervigilance, strong startle response, difficulty concentrating, and difficulty sleeping); duration of the aforementioned criteria for more than 1 month; and functional impairment (social impairment). The aforementioned symptoms must not be related to substance abuse or medication (APA, 2013).

Secondary traumatic stress (STS): PTSD that develops as a response to a traumatic event experienced by another individual. According to the National Child Trauma Stress Network (2017), individuals affected by secondary stress may re-experience their trauma or develop increased symptoms of arousal or avoidance and may display decreased safety and trust as a response to exposure to the indirect trauma.

Assumptions

In this study, the first assumption was that STS exists among spouses of soldiers returning from deployment with combat-related PTSD and that participants have STS symptoms. I assumed that spouses of Reservists have similar symptoms to those of active duty spouses. I assumed that participants were forthright concerning their mental health symptoms and portrayed their experiences accurately and honestly.

I assumed that I would continue to acquire participants until I achieved saturation. Mason (2010) hypothesized that when one is determining the appropriate sample size for

a study, the guiding factor should be saturation, as the purpose of qualitative research is to develop an understanding of the meaning behind the phenomenon. I selected 8 spouses of Army reserve soldiers who had been formally diagnosed with combat-related PTSD for the study. I selected two additional participants to serve as alternates in the event of dropout or if saturation did not occur with the original participants.

Scope and Delimitations

I confined this study to spouses of Army Reservists because multiple studies had explore the experiences of spouses of active duty soldiers. I selected participants based on the specific criteria that were necessary for the study. I did not select participants based upon their gender, race, or religious beliefs, nor were participants selected based upon their husband's rank. The study was exclusive to spouses of Army Reservists who met the following criteria: (a) spouses must have been at least 18 years of age at the beginning of the study, (b) spouses must have been married at the time of the deployment, (c) soldiers must have served in Iraq or Afghanistan as Army reservists, and (d) soldiers must have returned from combat at least 1 year but less than 14 years prior to the beginning of the study. I used a snowball sampling of eight spouses who met the criteria, as these participants' experiences were fundamental to the phenomenon that I planned to explore. I screened participants for symptoms but did not formulate any diagnosis. The spouse must not have reported any prior military experience. I selected eight participants to support rich, thick descriptions of data. If I had not reached saturation with eight participants, I had agreed to continue interviewing additional spouses until this occurred. Developing rich, thick descriptions and using snowball sampling were necessary aspects

of determining transferability (Creswell, 2013; Patton, 2002). Patton (2002) noted that the credibility of a study is not based upon the sample size used but is contingent upon the richness of the data collected and the ability of the researcher to analyze the data accordingly. Patton further asserted that the triangulation of data may enhance the credibility of a study. Lincoln and Guba (1985) asserted that credibility in a qualitative study may also be enhanced by making available a certain portion of the raw data for other researchers to analyze. Lincoln and Guba further posited that another method to increase credibility in a qualitative study is using "member checks" (i.e., asking the participants in the study to substantiate the findings). Patton referred to triangulation as the use of multiple means or sources within qualitative research to develop an understanding of the phenomena. There are several types of triangulation, including method, investigator, theory, and data source (Carter et al., 2014). In this study, I used data source triangulation, which involves the collection of data from different types of people (e.g., individuals, groups, families, and communities) to obtain numerous perceptions as a means of collecting and validating data (Carter et al., 2014).

I chose to conduct a qualitative study of the lived experiences of spouses of Army Reservists with combat-related PTSD, as few studies had focused solely on Army Reservists. While some of the literature that I located included Reservists and active duty soldiers, I did not locate any studies whose focus was Reservists and their spouses. I traveled to the chosen convenient location, as this allowed me to have easier access to participants without inconveniencing them with their travel. I chose to conduct a qualitative study using semi-structured personal interviews to explore and understand the

meaning of the experiences of spouses of Army Reservists who had returned from combat in Iraq or Afghanistan with combat-related PTSD. This allowed me to interview spouses from deployments to both countries, if applicable.

Limitations

The primary concern regarding the limitations of this study was researcher bias, as I am the spouse of a retired reservist who returned from Iraq with combat-related PTSD. Although I did not develop STS, I certainly understood and empathized with the spouses who experienced day-to-day challenges with their soldiers. I took great care to explore my personal bias, as I understood that the stories of the participants affected me. I took many field notes after each interview to express my feelings and experiences. I also kept a journal of these experiences and discussed them with my dissertation chair regularly. I did not develop any symptoms of distress but was prepared to seek supervision immediately. I planned to seek my own services if deemed necessary. To increase trustworthiness, I used the following interventions to support credibility, transferability, dependability, and confirmability: triangulation of data sources (a method to achieve data saturation); member check (the process of ensuring accuracy of what is recorded during the interview process); rich, thick description (a detailed descriptive account of the researcher's field experiences); an audit trail (a detailed record of all of the steps taken throughout the research project); and reflexive art journaling (a process in which the researcher writes a detailed free-form description of his or her experiences shortly after they occur as a means of reflecting upon, summarizing, and contemplating ideas.

Morrow (2005) asserted that "many factors may interfere with a fair collection and interpretation of data, including the researcher's emotional involvement with the topic of interest, presuppositions formed from reading the literature, and various aspects of interaction with research participants" (p. 254). It was important for me to self-assess many times throughout this project and seek supervision as needed. Morse et al. (2008) asserted that one method that is used to ensure reliability and validity in a qualitative study is the use of the verification process. Data are thoroughly checked, and analysis and interpretation are constantly monitored and substantiated. After each interview, the transcript was created as soon as possible. I initially had a transcriptionist, but she was unable to continue with the project due to her own issues as a military spouse. After completing the transcriptions, I coded them accordingly to extract themes from the codes. I created basic themes from the codes extracted from the interviews to create organizing themes.

Of course, it was important to consider potential stigma for soldiers and the possibility that they would be hesitant to encourage their spouses to participate. Kim, Thomas, Wilk, Castro, and Hoge (2010) stated that in the military, soldiers with PTSD are often scrutinized and not considered worthy or capable of serving. In order to ensure the confidentiality of the participants, all data that were collected were stored on a computer with a password known only to me. Audio recorders were stored in a locked desk, including all written data, including field notes and informed consent forms signed by the participants. Participants were assigned a pseudonym so that their names were known only by me.

The military is rich in cultural diversity. It was important that I understood the military culture itself, as well as the culture of my participants (Redmond et al., 2015). Participants were selected based on the specific criteria indicated for the study. Participants were not selected based upon their gender, race, or religious beliefs, nor were participants selected based upon their spouse's rank.

Significance

Per the Index of Military Strength (2016), the Army Reserve and National Guard provide approximately 38% of the military. Since the attack on the United States on September 11, 2001, the reserve component of the military has been highly utilized at the highest rate since the Korean War. According to the Index of Military Strength, a reported 280,000 Reservists were deployed in support of Army global operations from 2001-2016. In 2015 alone, the Army Reserve reported 16,058 Army Reserve soldiers serving on active duty, with nearly 2,600 serving in Afghanistan (U.S. Army Reserve Posture Statement, 2015).

Because of the increased use of the military in global operations, military spouses are reporting mental health symptoms following soldiers' return from combat in Iraq or Afghanistan (Goff, Crow, Reisbig, & Hamilton, 2009). I hoped to increase the awareness that Army Reserve military spouses report symptoms that are comparable to those of soldiers who are diagnosed with PTSD. Specifically, I explored STS symptoms as reported by spouses of Army Reservists. This study may serve as a means of increasing awareness of the mental health needs of this population, anticipating an understanding of the need for mental health services for spouses of Reservists. The results of this study

may help secure much-needed mental health services for affected spouses and may promote social change by including potential mental health provisions for spouses of Reservists during and after soldiers' return from combat. Additionally, the results of this study may add to strategies that may lead to more successful integration of soldiers back into their primary relationships as well as aid in the development of coping skills for spouses. This may help Reserve components prepare more effectively for future deployments.

Summary

While several researchers have discussed the impact of deployment on military spouses, most studies have emphasized marital dissatisfaction (Beks, 2016). I used a phenomenological approach to explore the lived experiences of spouses of soldiers returning from OIF, OEF, or OFS with combat-related PTSD. While other studies have discussed many of these experiences, I explored these experiences regarding the response of the spouses based upon the soldier's' PTSD symptoms. This study could benefit the counseling field by providing a framework for understanding and treating symptoms of STS in spouses. This study may benefit the military, as additional mental health services could be incorporated for spouses with such symptoms. The central research question for this study was the following: What are the lived experiences of spouses of soldiers who have developed combat-related PTSD symptoms after serving in Iraq or Afghanistan?

In Chapter 2, I provide an exploration of current literature on military deployments and their effects upon spouses, as applied using the CATS model. In Chapter 3, I provide a detailed explanation of the research design method used in the

study. In Chapter 4, I report the results of the research, and in Chapter 5, I discuss the implications of the research and include recommendations for future research.

Chapter 2: Literature Review

Introduction

De Burgh et al., (2011) noted that spouses of soldiers affected by combat-related PTSD display symptoms of anxiety, sadness, anger, displacement, and dissatisfaction in the marriage. De Burgh et al. referred to these symptoms as STS. Bjornestad, Schweinle, and Elhai (2014) reported that while PTSD and its effects upon those who have experienced trauma have been extensively studied, studies exploring STS and general psychological stress among military spouses have been limited, particularly in the United States (Bjornestad et al., 2014). Additionally, the authors noted that the lack of specific assessment tools to measure STS remains problematic.

Nelson-Goff et al. (2009) reported that there have been limited studies examining the effects of STS in American spouses of soldiers returning from combat in Iraq or Afghanistan. Additionally, Bjornestad et al. (2014) reported that there has been limited research on stress among spouses of National Guardsmen. The authors asserted that less preparation, not residing near military installations, and lack of support and resources result in different experiences for spouses of National Guardsmen compared to their active duty counterparts. The purpose of this study was to explore the experiences of spouses of Army Reservists and the way they coped with STS. The CATS model was used to explore these experiences as the couple coped with both combat-related PTSD and STS.

According to Adams (2013), more than 2.5 million soldiers from the Army, Navy, Marines, Air Force, Cost Guard, and other Reserve and National Guard units have served

in Iraq and Afghanistan, with many serving multiple tours. Baiocchi (2013) asserted that since 2008, the typical length of deployment for soldiers has increased by 28%. Baiocchi also noted that since 2011, approximately 73% of all active-duty soldiers have served in these combat zones—an increase from 67% in December 2008. A reported 45% of the soldiers deployed to Iraq or Afghanistan were Reservists and national guardsmen (Military.com, 2018).

Traumatic experiences have been an integral part of the human experience (Friedman, 2015). Friedman (2015) noted that traumatic experiences have been described in literature for centuries, with accounts offered by authors including Homer in *The Iliad*, Shakespeare in *Henry IV*, and Dickens in *A Tale of Two Cities*. Although PTSD is not exclusive to war, its presence in war has been well documented (Solomon, Dekel, & Mikulincer, 2008). According to Summerall (2010), during the Civil War era, PTSD was known as *soldier's heart*. During World War I, the name changed from *soldier's heart* to *shell shock* or *combat fatigue*. During World War II, this term was changed once again to *battle fatigue*, with the accepted terminology settling on *gross stress reaction* in the first edition of the DSM. This name changed once again to PTSD in the DSM-III (Summerall, 2010). The U.S Department of Veteran Affairs (2015) reported that approximately 11-20% of veterans who served during OIF and OEF developed PTSD because of their combat experience. This rate was elevated in comparison to the reported 12 % with combat-related PTSD from the Gulf War and was second only to the 30% of soldiers diagnosed with combat-related PTSD after service in Vietnam. In 2009, the National Institute of Health asserted that soldiers who served in Afghanistan reported

lower rates of PTSD (11%) as compared to those who served in Iraq, where higher rates of combat-related PTSD were reported (20%).

Throughout this chapter, I discuss the history of PTSD among soldiers and how it has been diagnosed. Changes in the criteria for PTSD from the DSM-III to the DSM-5 are examined. This chapter also contains a description of STS as it relates to military spouses and the challenges they face. Additionally, this chapter contains a discussion of caregiver burden and its effect upon spouses of Army Reservists. Finally, I introduce the CATS model as it relates to the dyad of the couple.

Search Strategies

I used multiple databases to locate relevant sources for this study. The databases used for this study included ResearchGate, Educational Resource Information Center (ERIC), PsycARTICLES, and SocINDEX with Full Text. Google and Google Scholar were also used to locate articles. Google Scholar was connected to the Walden University library. I also obtained articles from the U. S. Department of Veteran Affairs, the National Center for PTSD, and the National Center for Biotechnology Information.

Key Words

I used the following keywords in the study: *secondary traumatic stress*, *caregiver burden, compassion fatigue*, *vicarious trauma*, *military spouses*, *posttraumatic stress disorder,* and *CATS model*. I combined search terms, such as *military spouses* and *caregiver burden*, *military spouses* and *secondary traumatic stress*, and *Army spouses and posttraumatic stress disorder*. These keyword searches provided access to studies through the databases. Articles that were applicable to the study were included in the

literature review. Most of the articles that were included in the literature review were published between 2012 and 2018 and thus reflected the most recent sources of information. A few articles that I reference were dated before 2008; these were primarily included to support the history of PTSD and changes in the diagnostic criteria.

Conceptual Framework

The conceptual framework for this study was the CATS model (Nelson-Goff & Smith, 2005). This model is used to describe the way in which the primary trauma survivor's level of functioning systematically affects the secondary trauma survivor, resulting in symptoms of STS, as described by Figley (1998). The symptoms of posttraumatic stress in the secondary partner may exacerbate the symptoms in the primary survivor (Nelson Goff et al., 2016). As a result, the overall functioning of the couple may be negatively affected (Oseland et al., 2016).

Oseland et al., (2016) reported that when developing the CATS model, Nelson-Goff and Smith (2005) understood that the symptoms of hyperarousal, re-experiencing the event, maladaptive thoughts, and avoidance negatively affect the significant other, referred to as the *secondary trauma survivor* (Nelson-Goff & Smith, 2005). As the secondary trauma survivor reacts to the symptoms of the primary survivor, his or her behavior may, in turn, affect the primary trauma survivor. Nelson-Goff and Smith identified specific characteristics and unresolved distress as *predisposing factors* (see Appendix A). These factors include previous or childhood trauma, mental illness, the coping skills of individuals, and trauma-specific characteristics. It is presumed that these factors affect couple functioning by disrupting roles and causing interpersonal conflict.

Oseland et al. (2016) reported that Nelson-Goff and Smith considered *couple functioning* to include issues of attachment, overall relationship satisfaction, support, issues with roles within the couple, stability, adaptability, intimacy, communication, and conflict. Nelson Goff and Smith asserted that a principle underlying the CATS model is that "adaptation to traumatic stress in the couple dyad is dependent on the systemic interaction of the three primary concepts: individual level of functioning, predisposing factors and resources, and couple functioning" (p. 151). Although Oseland et al. noted that the primary function of the CATS model is relationship functioning, I used this model to explore the experiences of spouses of Reservists as they reacted and attempted to cope with soldiers' PTSD symptoms.

As related to military couples, Nelson-Goff et al. (2016) acknowledged that sharing information related to trauma could negatively affect both parties. Nelson-Goff et al. reported that there are no current studies that address the effects that disclosure of trauma has upon military couples, particularly related to the couple's overall functioning. Nelson-Goff et al. encouraged additional research to explore the effect that the disclosure of war-related trauma (and other traumatic experiences) has upon soldiers and their spouses. In this study, I used the CATS model to explore this level of functioning. There have been other studies among military couples in which researchers have used the CATS model (Wick, 2010; Wick & Nelson-Goff, 2014). This was not the aim of my study, as I intended to explore the effects of combat-related PTSD upon the spouse only. Based on the results of my study, future researchers may use the CATS model to explore issues other than overall couple functioning following a traumatic event. This may prove

to be helpful for other researchers exploring the effects of combat-related PTSD among spouses of soldiers.

According to Nelson-Goff et al. (2007, 2009), the CATS model was originally developed for marital and family therapy and has been moderately tested with female spouses of soldiers. In their study, Melvin et al. (2011) included additional *predisposing factors*, which included age, gender, the rank of the soldier, history of previous mental or physical trauma**,** and any current violence or coercion in the couple (p. 3). The aim of their study was to investigate the association between the functioning of the individual with PTSD symptoms (soldier) and how these symptoms affected the couple (Melvin et al., 2011). Melvin et al. presupposed that the couple's functioning, as perceived by both parties, would be negatively affected by PTSD in one or both members and that this relationship would intensify with lower levels of resilience, younger individuals, females, soldiers of lower rank, marital discord, and higher levels of exposure to trauma.

There are concerns among some researchers about the use of the CATS model because it was designed for couples with one traumatized individual. There is no mention within this model if there is any variance among traumatized males and traumatized females (Shamai et al., 2016). In my study, exclusion criteria prevented spouses with previous military experience from participating.

Posttraumatic Stress Disorder Diagnostic Criteria

To understand STS, it was essential to understand PTSD and its history. While STS has yet to be determined as a formal diagnosis and is not included in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, APA, 2013), it is

notably present in the literature and should be understood as such. PTSD in some form has been present since the incorporation of the DSM-I (APA,1952). Andreasen (2011) posited that the term *PTSD* evolved after World War II from the term *gross stress reaction*, under the influence of the Veterans Administration. The term *gross stress reaction* was based upon the idea of stress reactions in combat soldiers. The concept of gross stress reaction was created by psychiatrists, who may have had diverse backgrounds and training, to create a standard language for diagnosis and to determine disability levels (Andreasen, 2011). The description provided in the DSM-I (APA, 1952) indicated that the disorder was a reaction to a great or remarkable stressor that resulted in immense fear. The initial diagnosis was provisional, indicating that if persistent symptoms existed, a new diagnosis was warranted. This diagnosis was firmly attributed to psychodynamic traditions and was attributed solely to combat experience (Andreason, 2011).

Koren, Norma, Cohen, Berman, and Klein (2005) contended that soldiers injured in combat present with an increased likelihood of developing psychological distress if they sustained a combat-related injury during the time of deployment. The authors asserted that more traditional views, such as that of psychoanalysis, indicated that physical injury serves as a protective barrier against the onset of PTSD. Physical injury was once considered to serve as a means of minimizing the psychological effects of a traumatic event (Koren et al., 2005). With attention placed upon the actual wound, mental health professionals believed that there was a decreased chance of an individual developing anxiety or other psychological responses to the trauma. Koren et al. noted that

in the past, mental health professionals held that physical wounds receive more sympathy from those in the outside environment, as opposed to psychological wounds, which are not evident to others. These conclusions have evolved in the last few decades as more researchers have conducted studies to test such theories. Koren et al. noted that studies conducted with Vietnam veterans did not support previous theories, as veterans who returned home absent of physical injuries displayed higher rates of PTSD than those returning home after sustaining injuries. Koren et al. further noted that literature now indicates that injury is more likely to increase the likelihood of developing PTSD, contrary to what was believed in the past. Andreasen (2011) further reported that because the diagnosis related to injuries because of combat experience, the gross stress reaction was eliminated from the DSM-II published in 1968.

In 1980, the APA incorporated the term PTSD into the DSM-III (U.S. Department of Veterans, 2015). Initially, the APA chose the term *gross stress reaction* as the term to be reinstated (Andreasen, 2011). Although considered to be arguable at the time, the implementation of the PTSD diagnosis into the DSM-III provided the psychiatric world with the means with which to fill the gap that was evident until that time. The significant change was with the understanding that the distress was attributed to an event that occurred outside the affected individual and was not deemed as a weakness on the part of the individual (U.S. Department of Veteran Affairs, 2015). Additionally, this diagnosis allowed mental health professionals to examine the environmental stressors (trauma) that led to the problem, in contrast to the prior belief of individual weakness (neurosis; U.S. Department of Veterans, 2015).

Initially, with the DSM-III, the diagnosis of PTSD required a traumatic event. Such events included but were not to traumas occurring during war, such as physical assaults; rapes; bombings such as the events at Pearl Harbor, Hiroshima, and Nagasaki; natural disasters such as earthquakes and hurricanes; and manmade disasters such as nuclear explosions, forest fires, and civil unrest (National Center for PTSD, 2016). The events were required to be significantly different from other life-altering changes such as divorce, bankruptcy, illness, and job loss. Patients must have personally experienced the trauma to receive the diagnosis of PTSD.

With subsequent revisions of the DSM (i.e., DSM-III-R [1987], DSM-IV [1994], DSM-IV-TR [2000]), the criteria for the diagnosis of PTSD evolved (APA, 2000). Elhai, Grubah, Kashdan, and Frueh (2008) noted that these changes were incorporated to refine the diagnosis due to a concern with construct validity. As the diagnostic criteria changed, the definition of the word *trauma* was tightened to specify the onset of the trauma with symptoms, which might overlap other potential diagnoses, including anxiety and mood disorders (Elhai et al., 2008).

Breslau (2002) postulated that the definition of PTSD in the DSM-IV-TR (APA, 2000) was little changed from earlier editions. While there were changes in the definition of PTSD, Breslau noted that the s*tressor criterion* distinctly changed from earlier editions. Per previous editions of the DSM, the traumatic experience was described as an overwhelming event that occurred outside of one's normal range. The DSM-IV-TR definition of a traumatic event was more subjective and expanded upon many possibilities. The DSM-IV-TR included examples, which provided an expansion of

previous stressors, which included war, natural disasters, and criminal violence. The DSM-IV-TR definition of the criterion was divided into two parts, which contained the range of qualifying stressors (Criterion A1). Criterion A2 required that the stressor involve immense fear, horror, or a sense of helplessness. Included as an approved stressor for the first time was the sudden or unexpected death of a loved one, including death from natural causes.

Current Diagnostic Criteria for Posttraumatic Stress Disorder

In 2013, the American Psychiatric Association (APA) reviewed the criteria for PTSD. More emphasis was placed upon the behavioral aspects of PTSD, and the APA proposed four specific diagnostic clusters, compared to three clusters per the DSM IV-TR (APA, 2000). They were defined as re-experiencing, avoidance, negative cognitions and mood, and arousal (APA, 2013).

- *Re-experiencing* describes the spontaneous memories of the traumatic event, persistent dreams of the event, flashbacks, or other extreme or sustained emotional distress.
- *Avoidance* describes disturbing memories, thoughts, feelings, and reminders of the occurrence.
- *Negative cognitions and mood* describe numerous feelings, which include maladaptive blame of self or others, separation from others, or a significant reduction in any interest in activities, or the inability to recall important aspects of the occurrence.

- *Arousal* is described as aggressive, risky or self-destructive behavior, disturbances with sleep, and hypervigilance. (APA, 2013)

Additional changes per the DSM V included a reclassification of PTSD and Acute Stress Disorder from the class of Anxiety Disorders to a new class known as Trauma and Stress-Related Disorders (US Department of Veteran's Affairs, 2015). Per Houston, Webb-Murphy, and Delaney (n.d.), the change in classification of PTSD into the new category was based on the actual exposure to the traumatic event. Additionally, the criteria for PTSD per the DSM-5 also changed. Houston et al. noted a change in criterion A , indicating that this section is more clearly defined than in past editions of the DSM. The authors asserted that the change in this section includes a more detailed description which includes specific examples of the trauma. Such examples address how the event was experienced and whether the event was experienced directly or indirectly. The authors further indicated that to provide more streamlined definitions of trauma, the newest version of the DSM excludes the sudden, but unexpected death of a friend or family member, due to natural causes. However, the death of a friend or family member due to suicide, accident, or assault would qualify for criterion A. The requirement that the person must react with immense fear, helplessness, or horror was eliminated. It is now accepted that a substantial emotional reaction to the event does not always occur, as it is understood that individuals trained for potentially harmful events (firefighters, law enforcement, and soldiers) may not display an emotional reaction immediately following the event (Houston et al., n.d.).

Some clusters of the benchmarks remain as part of the criterion but have been renamed. For example, re-experiencing has been changed to intrusion symptoms, and arousal has been changed to alterations in arousal and reactivity (Elhai & Palmieri, 2011). Elhai and Palmieri further posited that avoidance and numbing were divided into two clusters, avoidance (Criterion C) and negative alterations in cognitions and mood (Criterion D). Additional changes to the subtypes and specifiers are also included as part of the changes in the DSM-5. Per the DSM-IV-TR, a diagnosis of Acute PTSD was given if the symptoms were present between one and three months, while a diagnosis of Chronic PTSD was rendered for symptoms lasting longer than three months. These specifiers have since been removed from the DSM-5. If symptoms have occurred for a period of at least one month, the diagnosis of PTSD is given. If the symptoms have lasted for a period of three days to one month, the client is given a diagnosis of Acute Stress Disorder. Houston et al. (n.d.) indicated that the full diagnosis of Delayed Expression (known in the DSM-IV-TR as Delayed Onset PTSD), does not occur until at least six months following the traumatic event. This remains unchanged. Other changes to the DSM-5 regarding PTSD include the addition of two new subtypes: Preschool (in children under the age of 6) and Dissociative PTSD, which is the diagnosis of PTSD with conspicuous dissociative symptoms (DSM-5, 2013). Although the DSM-5 includes secondary trauma experiences in the PTSD criteria, because of the established literature using STS and the lack of body of research based on the DSM-5, I focused on STS in my review of the literature and my study's construct.

Secondary Traumatic Stress

When one attempts to provide emotional support, he or she is often affected by feelings of sympathy when attempting to process the aversive emotions while providing comfort for the individual (Beehr, Bowling, & Bennett, 2010). Such attempts may also lead to Secondary Traumatic Stress (STS) in the caregiver. Figley first introduced the term Secondary Traumatic Stress in 1983 (Figley, 1998). Figley described Secondary Traumatic Stress as "the natural consequent behaviors and emotions resulting from the knowledge about a stressful event experienced by a significant other (family members); it is the stress that results from helping or wanting to help a traumatized person" (p. 7). Baum, Sharon, and Rahav (2014) reported that STS results solely from the knowledge of or the exposure to an individual who was traumatized. Baum et al. (2014) noted that only STS is measured by symptoms that are identical to symptoms of PTSD, which occurred because of direct experience of a traumatic event.

Lahav, Kanat-Maymon, and Solomon (2016) noted that per the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, the knowledge of a loved one's traumatic event qualifies as first-hand trauma. Lahav et al. asserted that secondary trauma typically includes the symptoms displayed by the primary trauma survivor, including symptoms of PTSD and emotional distress. The authors conducted a longitudinal study to examine the directional association between posttraumatic stress and attachment issues among indirect trauma survivors (wives). Lahav et al. collected data from wives of combat veterans during two different time periods. For T1 (2003-2004), 82 wives of ex-POWs participated in the study (74%), whereas 116 wives (79%) participated in T2

(2010-2011). The control group consisted of 72 wives (71%) at T1 and 56 wives (54%) at the second level. There were no significant differences between the wives of ex-POWs and control wives (n = 116) and wives of control veterans (n = 56). Regarding age, Lahav et al. (2016) reported the following demographics (M =58.28, SD = 5.79). A higher number of wives of ex-POWs considered themselves to be religious (44%), compared to the control group at 28.6%. Spouses of ex-POWs were less educated (M =14.16, SD = 3.20) than control wives (M =15.50, SD = 2.92). Lahav et al. examined the differences in posttraumatic stress and attachment insecurities between wives of ex-POWs and control wives at both the T1 and T2 levels. Lahav et al. reported several sets of results. In the first group (Wives' PTG as a Function of Study) the MANOVA showed a significant difference between the two groups (ex-POWs and control wives), in respect to wives' PTG, Pillai's trace F (6, 138) = 2.69, p < .05, partial eta squared =.11 (p. 191). Lahav et al. reported that MANOVA showed significant differences when the groups were divided (wives of ex-POWs with PTSD, ex-POWs without PTSD, wives of controls. Lahav et al. noted that in respect to wives' PTG, Pillai's trace F (12, 268) = 4.24, p < .001, partial eta squared = .16 (p. 191). In terms of Wives' PTG and Husband's PTSD Trajectories, ANOVA and MANOVA indicated significant differences between four groups (wives of ex-POWs with chronic PTSD, wives of ex-POWs with delayed onset of PTSD, wives of resilient ex-POWs, as well as the wives of the control group). The wives' PTG score was F (3,72) = 6.34, p < .01, as well as all PTG subscales, Pillai's trace F (15, 207) = 2.55, p <.01, partial eta squared = .16 (p. 191). To examine the longitudinal changes in PTS, Lahav et al. conducted two-way ANOVAs; first with two

study groups (wives of ex-POWs and control wives) at T1 and T2. An additional two-wave ANOVA consisted of three groups of wives of ex-POWs with PTSD, wives of ex-POWs without PTSD, wives of controls) at T1 and T2. The ANOVA for the two study groups (wives of ex-POWS and control wives) revealed only a significant main effect for group, F (1, 75) = 5.86, $p < .05$, partial eta squared = .07 (p. 192). For the group of three, the ANOVA revealed only a significant main effect for group, F (2,72) = 10.52, $p < .001$, partial eta squared =.23. There was no significant effect for time, F (1, 72) = .92, n.s., partial eta squared = .01. Additionally, Lahav et al. noted no significant effect for time × group interaction, F (2, 72) = 1.37, n.s., partial eta squared = .04 (p. 192). Lahav et al. reported that wives of ex-POWs revealed higher levels of PTSD than that of the control wives. There were no differences between the groups regarding attachment insecurities. Wives of ex-POWs displayed significantly higher levels of posttraumatic stress compared to wives whose husbands without PTSD and control wives. Additionally, Lahav et al. noted significant associations of attachment insecurities and posttraumatic stress symptoms among wives of ex-POWs and control wives. Lahav et al. noted that higher levels of posttraumatic stress symptoms were associated with higher levels of attachment insecurities. Lahav et al. concluded that anxious military spouses of veterans with PTSD might be more vulnerable to their symptoms and suggested the possibility that these spouses do not provide sufficient support for soldiers, which negatively affects the soldier's coping skills, thus leading to the development of PTSD. In this study, there was no mention of Reservists. While this study provides valuable information that links higher levels of PTSD and higher levels of attachment insecurities, it remains to be seen

if the results from this study would be different if it included spouses of Reservists or members of the National Guard. Lahav et al. suggested that the lack of spousal support may lead to the development of PTSD. Considering the lack of available resources for families of Reservists and National Guardsmen, it is possible that the results from this study may have otherwise indicated higher levels of distress among spouses.

Diehle, Brooks, and Greenberg (2017) reported that while mental health and other care providers often develop STS from treating affected clients, the opinions of whether families pose the risk of developing STS in response varies. Deckel et al. (2016) expressed concerns that the effects of combat-related PTSD upon spouses require additional understanding and exploration. Dekel et al. noted that some recent studies suggest that PTSD in spouses of veterans is not in conjunction with the veteran's symptoms but attributed to spouses' preexisting distress. Dekel et al. conducted a study of a sample of 300 Israeli male veterans and their wives. The sample included all male soldiers who contacted the Israeli Defense Force's mental health. Dekel et al. reported doubling the overall sample, including soldiers who did not seek mental health services. The authors utilized the Traumatic Life Events Questionnaire, the PTSD inventory, The Life Functioning Scale, The Mental Health Inventory, and The Boundary Ambiguity Scale. Although there were no differences between the groups regarding age, education, ranks or role in the military (combat vs. non-combat), Dekel et al. reported that the levels of PTSD were pointedly higher (*M*- 2.23, *SD* = .82) in the study group than the control group. As expected, Dekel et al. reported higher levels of mental health issues among wives of soldiers with elevated levels of PTSD. Dekel et al. also noted an association

between females' ambiguous loss due to males' PTSD, as well as an association with secondary traumatic stress among females with a history of trauma. Again, this study did not contain a discussion of soldiers serving in the reserves.

Diehle et al. (2017) asserted that while some scholars believe that the traumatic symptoms displayed by combat veterans may affect significant others, insufficient literature exists to determine if significant others experience PTSD or STS. Diehle et al. reviewed several current articles and concluded that the strongest symptoms of STS among spouses appeared from help-seeking veterans with PTSD. It should be noted that studies suggest that gender plays a part in the degree of symptomology reported by the affected individual (Baum et al., 2014). It is reported that women are more likely to experience symptoms than men, and experience stronger reactions (Baum et al., 2014). The authors acknowledged that limitations of these studies, reporting that while gender differences exist, Baum et al. (2014) advised against generalizations. Despite this caveat, Baum et al. believed that it was important to consider the possibility that females are more susceptible to STS, as women are more sensitive to the traumatization of others.

To support their presuppositions, Baum et al. (2014) conducted a meta-analysis to examine the current literature of both males and females involved in close, personal relationships with traumatized individuals, such as spouses, parents, children, and therapists. Baum et al. examined literature from 1990-2012, reporting 17 results of 1623 identified subjects. Per their analysis, Baum et al. determined that all studies indicated a higher probability of secondary traumatization in females, with a mean size effect of 0.48. Additionally, the moderator analysis indicated that while females were at an

increased risk of developing secondary traumatization, studies conducted in the United States showed fewer gender discrepancies than studies conducted in other countries (Baum et al., 2014). Overall, Baum et al. concluded that females displayed greater symptoms of PTSD, including intrusion and avoidance symptomology than males. Baum et al. expressed the importance of informing professionals who provide care to the families of traumatized individuals of the increased vulnerability in women.

Secondary Traumatic Stress With Military Spouses

Intimate partners of soldiers with combat-related PTSD not only report relationship dissatisfaction but also report increased psychological distress (Davidson, Berah & Moss, 2006; Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005; Manguno-Mire et al., 2007). In a meta-analytic review, Lambert, Engh, Hasbun, and Holzer (2012) noted that while some studies report robust findings of the association between PTSD and STS in partners, others report less significant correlations (Chartier-Otis, Guay, & Marchand, 2009; Gold, Taft, Keehn, King, King, & Samper, 2007). A possible reason for the discrepancy is associated with sampling and power issues, and the nature of the trauma that was experienced (Lambert et al., 2012). Other studies display significant connections between the soldier's PTSD symptoms and the psychological distress in the spouse, with exacerbated symptoms in one partner correlating with greater psychological difficulties of the other partner (Lambert et al., 2012). Traumatic events involving human endangerment prove to be greater in intensity and duration than other types of traumatic events and increase the likelihood of developing PTSD (Charuvastra & Cloitre, 2008). Ein-Dor, Doron, and Solomon, (2010) noted that significant others often respond to the

PTSD symptoms in their loved ones by displaying symptoms that are similar to the traumatized individual. Ein-Dor et al. hypothesized that attachment insecurities and related symptoms could be projected to a didactic level, as the attachment insecurities in one partner affect the significant other and can contribute to psychological distress. Because of the secondary partner over-identifying with the PTSD symptoms in the primary traumatized individual, the secondary partner may develop Secondary Traumatic Stress (Ein-Dor, Doron, & Solomon, 2010; Nelson Goff & Smith, 2005). Few studies to date explore the perspective of PTSD and STS from the perspective of spouses of Reservists. I explored the experiences of spouses of Reservists with increased psychological distress, attributed to the combat experience from the soldier to better understand their perceptions of PTSD and the way they are affected.

Renshaw et al. (2011) conducted a study consisting of 190 wives of soldiers displaying elevated levels of PTSD symptoms. Renshaw et al. conducted their study to analyze the percentage of wives who related their symptoms to their husbands' military experiences versus events from their own lives. Of the 136 service members who reported deployments either all or part of the following year, the average length of deployment was 11.31 months (*SD* = 4.04 months). Of the servicemen, 71.1% were White, 11.1% were Hispanic, 10.5% were African-American, and 7.4% reported *other*. Of the wives who participated, 70.0% were White, 11.6 were Hispanic, 10.0% were African-American, and 8.3% reported as *other*. The average age of the servicemen was 27.83 (*SD* = 5.64), while the average age for wives was 27.09 years (*SD* = 5.90). Most wives reported having a high school diploma (27.4%) or GED (27.9%). Only 5.8% did

not complete high school. Of the wives, 22.1% reported earning a technical or associate degree, 12.1% having a bachelor's degree, and 4.7% reported having earned an advanced degree. After rating their PTSD symptoms, the wives answered questions attributing the symptoms that they endorsed (Renshaw et al., 2011). Of those interviewed, only 20% attributed their symptoms completely based upon their husbands' deployment. Those wives who did attribute their symptoms to their husbands' deployment displayed a greater overlap between some of their responses on the PTSD measure and their responses to a measure of general psychological distress (p. 461). The mean score for service members who completed the PCL was 50.06 (*SD* = 11.45), whereas the wives' mean score was 34.87 (*SD* = 15.36). Of the sample, 20 wives (10.5%) denied any symptoms per the PCL. Of the sample, 79 wives (41.6%) scored higher than 34 on the PCL-C, with 58 (30.5%) scoring higher than the originally recommended cutoff of 44. Forty-five wives (23.7%) scored within the moderate level of severity (scoring 3 or higher) to warrant a diagnosis of PTSD. Of these 45, 41 (21.6% of the entire sample) also showed higher scores than the cutoff of 44. Renshaw et al. indicated that depending on the metric used, 21.6% to 41.6% of spouses scored high enough on the PCL-C to render a diagnosis of PTSD. Of the 170 wives who reported two or more symptoms, 106 (62.4%) denied that their symptoms were related in any way to their husbands' deployment. Of this sample, 42 (24.7%) attributed their symptoms of their husbands' deployment and their own experiences, while 22 (12.9%) considered their current symptoms to be directly related to their husbands' military experience. Renshaw et al. acknowledged the limitations of the study, as all the measures were self-reported, which poses the

possibility of bias. Renshaw et al. further reported that the soldiers were not formally diagnosed with PTSD per a diagnostic interview. Renshaw et al. noted an additional concern that the wives were all civilian and encouraged additional research. Renshaw et al. noted a final limitation in their study was that each participating soldier was still on active duty. The results may have varied if the soldiers were no longer serving on active duty.

It is understood that communication during and following deployments poses challenges for soldiers and spouses (Summers et al., 2016.) In both instances, soldiers must determine a comfortable level of disclosure to their spouses. The post-deployment transition is often difficult, not only in reestablishing household roles, but in terms of the communication between the soldier and the spouse (Summers et al., 2016). Summers et al. (2016) reported that several studies indicated that soldiers who disclose the nature of their trauma to their spouses may benefit, both physiologically and psychologically. Summers et al. conducted a study to explore qualitative and quantitative data from individuals who disclosed lower levels of trauma (n = 15) and their intimate partners, for understanding the experiences of disclosure of low trauma among Army couples. The study consisted of 13 couples, comprised of one low disclosure individual. Two couples were classified as low disclosure. Seven couples were deemed low-mixed, (where one partner has low disclosure, but the other reports mixed). Four couples were deemed low-high, as such (where one partner reports low disclosure, and the other reports high levels). Summers et al. reported the following hypothesis for the study: Low trauma disclosure participants will report higher individual symptoms and numbers of traumatic

events and more impaired relationship functioning compared with their spouses coded as mixed or high trauma disclosure (p. 560). The average age of the participants was 32.42 years (*SD* = 8.458), with an age range of 19-51 years. Most participants identified as White (69.2%; *n* =18). All male participants were in the United States Army, whether active duty or reserve, and had only deployed to Iraq or Afghanistan once. Participants engaged in qualitative interviews, and completed several assessments, including the Traumatic Events Questionnaire (TEQ). Summers et al. (2016) used the Traumatic Events Questionnaire to measure all participants' experiences with trauma that indicated the potential to develop symptoms of PTSD. The scale also included six items related to war events. Summers et al. reported that there were 17 questions used to develop a total score of 0-17, with higher scores reflecting higher levels of traumatic events. In the study, the Cronbach's alpha estimate for the Traumatic Events Questionnaire was $x = .73$. Summers et al. measured trauma symptoms with two separate assessments: The Purdue Posttraumatic Stress Disorder Scale-Revised (PPTSD-R) and the Trauma Symptom Checklist-40 (TSC-40). Summers et al. assessed relationship adjustment using the Dyadic Adjustment Scale (DAS). Per the results of their study, in contrast with their hypothesis, Summers et al. concluded that low trauma disclosure participants did not report higher symptoms of trauma, nor did higher numbers of traumatic events contribute to increased relationship distress. Summers et al. reported that the mixed group of participants reported the lowest levels of relationship distress but reported the highest levels of PTSD symptoms. Notably, the group reporting higher levels of disclosure reported the greatest number of traumatic events.

In the qualitative aspect of their study, Summers et al. (2016) identified several themes that were based on the codes from the CATS model (Nelson Goff & Smith, 2005). These themes identified the impact that the trauma can have upon everyone, as well as the impact of their relationship functioning. Per the results of their study, Summers et al. determined that soldiers who disclose the nature of their trauma experienced decreased levels of interpersonal stress, decreased depression, personal growth, and an increased self-concept. Summers et al. also noted that studies indicate that soldiers who did not disclose the nature of their trauma were more likely to report lower psychological health, as well as a decrease in overall life and relationship satisfaction. Statistics for the study are as follows: Low Trauma Disclosure Group (*n = 15*), DAS: mean = 103.1 (*SD* = 19.89); TEQ: mean = 5.87 (*SD* = 2.53); TSC: mean = 31.23, (*SD* = 15.05); PPTSD-R: mean = 40.8, (*SD* = 17.9). In the mixed trauma disclosure group (*n* = 7), DAS: mean = 96.2, (*SD* = 15.35); TEQ: mean = 4.7 (*SD* = 3.77); TSC: mean = 29.2 (*SD* = 20.91); PPTSD-R: mean = 46.2 (*SD* = 25.53). In the high trauma disclosure group (*n= 4*), DAS: mean = 114.25 (*SD* = 20.12); TEQ: mean = 7.0 (*SD* = 4.97); TES: mean = 31.5 (*SD* = 27.90); PPTSD-R: mean = 40.5 (*SD* = 22.17). This article provides valuable information for my study, as there is an inclusion of Reservists. Additionally, Summers et al. identified themes other than couple functioning when using the CATS model. This is the first article located with such themes.

Although some researchers suggest that increased communication leads to decreased psychological distress, this is not always the case for spouses of traumatized veterans. Campbell and Renshaw (2013) reported increased psychological stress among

partners when soldiers with increased symptoms of PTSD conveyed their traumatic experiences. Additionally, higher levels of traumatic stress and more disclosure of the trauma may affect the relationship quality among both the individual and the secondary traumatized survivor (Monk & Goff, 2014).

Whether it is the primary or secondary trauma survivor, the way he or she copes with the traumatic event often determines the overall adjustment to life changes and ongoing stressors (Weinberg, 2011). Weinberg conducted a study to examine spousal perceptions of terror victims' coping, and the association with secondary trauma. Weinberg evaluated 72 spouses of civilian trauma survivors (ages 21-69) using the Posttraumatic Stress Symptom Scale-Self-Report (PSS-SR), and the COPE Inventory In the study, two-thirds of the sample (65.35%) of the spouses were female, with the mean age of the sample at 43.71 (*SD* = 10.81). Fifteen spouses (20.83%) experienced previous trauma, of which 33 (45.8%) deemed the injury to the victim as *difficult*. Half of the sample (47.2%) considered the injury to be *mild*, while 8.3% considered the nature of the injury as *slight*. The mean of the elapsed time between experiencing the event and participating in the study was 43 months (*SD* = 19.62). Weinberg noted that coping strategies are considered either problem or emotion-focused. Weinberg asserted that for survivors of traumatic circumstances, problem-focused coping results in decreased psychological distress, while increased psychological stress is related to emotion-focused coping. Weinberg noted that the partner's perceptions of the way the primary trauma survivor copes is directly related to the secondary trauma survivor's experiences. In hypothesis 1, Weinberg found a significant difference in the spouses' emotion-focused

coping and those belonging to the victim. Spousal perception of the victim's coping strategies as emotion-focused ($M = 3.04$, $SD = 1.09$) was suggestively higher than those of the spouse ($M = 2.67$, $SD = 1.06$, $t = 3.12$, $p < .05$). Per these results, Weinberg concluded that spouses considered the emotion-focused coping of the partner as more than their own. However, Weinberg determined that hypothesis 1 was partially supported, as there was no significant difference between the victim's perception of problem-focused coping strategies ($M = 3.62$, $SD = 1.52$) and the problem-focused coping strategies of the spouse ($M = 3.72$, $SD = 1.00$, $t = .61$, $p > .05$).Weinberg reported that for hypothesis 2, Pearson correlations indicated a negative correlation ($r = -0.35$, $p < .01$) with the spouses' perception of the problem-focused coping strategies of the victim and secondary trauma, and a positive correlation ($r = 0.41$, $p < .01$)between the spouses' perceptions of the victim's emotion-focused coping strategies and the onset of secondary trauma. Weinberg noted that per the results of the study, in partial support of hypothesis 2, when spouses who considered the victim's coping strategy to be highly problem-focused and low in emotion focus, the, in turn, displayed fewer symptoms of secondary trauma. Weinberg reflected upon two studies conducted by Renshaw, Rodebaugh, and Rodrigues (2010), and Renshaw, Rodrigues, and Jones (2008) and indicated that with military spouses, increased psychological distress was directly related to their perceptions of the soldier's PTSD symptoms. Additionally, per the study conducted by Renshaw et al. (2008), Weinberg reported that spousal perceptions of the severity of the PTSD symptoms in soldiers led to the development of the psychological distress in spouses. Despite these findings, Weinberg cautioned that to date, no studies specifically explored

the perceptions of the coping strategies of couples who experienced exacerbated stressful situations. Weinberg encouraged additional research to explore this phenomenon.

Challenges for Military Spouses

While military life can be challenging for soldiers, families also face many hardships as they adapt to the military lifestyle. Green, Nurius, and Lester (2013) reported that deployment to combat zones resulted in elevated stress factors and greater emotional stress for military spouses. Sharing concerns in a military marriage can prove to be challenging, as each partner strives to balance the need to discuss their desire to share their concerns with their desire to protect one another from becoming affected by the knowledge of these concerns (Joseph & Afifi, 2010). Rather than taking the risk of imposing potential distress, soldiers and their spouses often engage in *protective buffering* (Joseph & Afifi, 2010). Winterheld (2017) defined protective buffering as a coping strategy utilized by those in a close relationship where one withholds imperiling information from the other partner, defers to the other partner in an altercation, or puts forth a strong front in the presence of the other Winterheld reported that while protective buffering may help diminish relationship distress in partners, protective buffering also allows one a means of self-protection during challenging circumstances. For example, one may use protective buffering as an opportunity for one to avoid disagreements with the other partner and as a means of reducing one's negative feelings regarding the issue. Protective buffering may result in diminished personal and relationship well-being (Winterheld, 2017). Protective buffering becomes particularly challenging, as the distress on both parties is considerably more than with the non-military couple. For example,

military couples face the possibility of long-term separations, serious injury, or death. Upon reviewing the study by Joseph and Afifi (2010), Carter and Renshaw (2016) noted that in military spouses, despite positive intentions, protective buffering resulted in increased psychological distress and decreased marital satisfaction. Reviewing a study conducted by Rosetto (2013), Carter and Renshaw reported that while partners preferred open communication, most military spouses in the study made efforts to maintain positive communications with their soldier, out of concern for the safety and emotional well-being of the soldier. Carter and Renshaw reported that while both qualitative and quantitative studies depicted benefits of open communication during deployments, qualitative studies conducted among soldiers suggests that open communication may negatively impact their work functioning. To understand these behaviors, Carter and Renshaw recommended additional research to assess relationship outcomes, the psychological health of each partner, and the occupational functioning of the soldier, as he or she relates to levels of disclosure and withholding.

Caregiver Burden

Tanielian et al. (2013) reported that the unseen costs of war are becoming more apparent. The lives of injured veterans are forever changed, many of whom will require indefinite care. Family members are providing this necessary care, which is often an unfamiliar role (Conrad et al., 2017). Many of these newfound duties include feeding, bathing, dressing, caring for wounds, and ensuring that the loved remains compliant with his or her medication regimen (Hunt & Reinhard, 2015). In addition to the duties, household chores and general maintenance, caregivers also assume the roles of financial

management, providing transportation and preparing meals (Tanielian et al., 2013). Conrad et al. (2017) reported that the overall wellbeing of the loved one is contingent upon the effort of caregivers. Meffert et al. (2014) reported that while the symptoms of secondary traumatic stress are not as disabling, symptoms such as avoidance, arousal, and intrusiveness are similar. Meffert et al. noted that secondary traumatic stress should not be confused with vicarious trauma, burnout, or compassion fatigue. Meffert et al. noted that vicarious trauma and secondary traumatic stress are often used interchangeably, but vicarious trauma is used to describe PTSD symptoms among healthcare workers who provide care to traumatized individuals. Meffert et al. noted that while there are similarities between secondary traumatic stress and compassion fatigue, the latter describes the level of burnout among care providers.

Since the onset of the War on Terror in 2011, traditional roles and duties among caregivers changed dramatically (Tanielian et al., 2013). Before September 11, 2001, approximately 60% of caregivers were women, with an average age of 49 years (Weber-Raley & Smith, 2015). These caregivers tended ill children, aging parents, or loved ones who were recently discharged from a care facility. RAND Corporation researchers (Ramchand et al., 2014) noted that among the caregivers, four million caregivers of veterans of the World War ll, the Korean Conflict, the Vietnam Conflict, and Operation Desert Storm were also included. Hunt and Reinhard (2015) reported that this group of 42.1 million caregivers provided an excess of 37 billion at-home care hours each year, valued at approximately $450 billion.

After the onset of the War on Terror in 2001, caregivers were forced to adapt to a new manner of providing care due to serious physical injuries and emotional distress (Baker, 2014). Tanielian et al. (2013) reported that most wounded veterans were in good overall health before any combat-related injury and were relatively young. These veterans may now require more intensive care (often requiring 24 care) over the course of several decades. This level of care is often met with frustration and exhaustion, particularly among first-time caregivers, such as spouses and friends (Tanielian et al., 2013). Currently, the focus of the current literature is the overall wellbeing of the patient, rather than concern for the caregiver (Tanielian et al., 2013). Tanielian et al. noted that the Elizabeth Dole Foundation sponsored a four-month Rand Corporation study that explored the experiences of caregivers to outline the support provided for veterans in their homes. The study consisted of 28,000 spouses, parents, children and friends. Most of the caregivers in the study were younger female spouses, with an average age of 38 (Tanielian et al., 2013). Approximately 20% of the caregivers provide unpaid care for veterans for more than forty hours per week (Ramchand et al., 2014). Tanielian et al. reported that the out-of-pocket expenses were an estimated 2.5 times greater than those not providing care for veterans. The demands for care often prompt caregivers to reduce their hours of work, resign or enter early retirement. Ramchand et al. (2014) asserted that the loss of work hours results in an annual loss of $5.9 billion.

Conrad et al. (2017) reported that members of the military Reserve and National Guard experienced multiple deployments to combat zones, such as Iraq or Afghanistan. According to IOM (2013), members of the military Reserve and National Guard are more

likely to experience mental health issues, which is likely attributed to the lack of strong relationships among members of their deployed units and decreased familiarity with the active-duty environment. Additionally, members of the military Reserve or National Guard may not receive the same amount of post-deployment support and guidance, decreasing the likelihood of identifying any issues (IOM, 2013). Caregivers of Reservists and members of the National Guard reported difficulty navigating veteran healthcare services and often seek assistance from civilian providers (Tanielian et al., 2013). It is important to report these findings, as there appears to be a lack of resources for spouses of Reservists and members of the National Guard. The findings in this study may help to promote social change for such military families.

It should be stated that the effects of traumatic circumstances are not exclusive to the persons who witnessed the event (Deckel & Monson, 2010). Link and Palinkas (2013) reported that 34% of National Guardsmen and Reservists are married and have children. The effects of PTSD also affect significant others, family, friends, and caregivers. Among the effects that are reported by these individuals are headaches, difficulty breathing, vivid recollections, increased vulnerability, mistrust of others, and the desensitization of emotions (Deckel & Monson, 2010). Spouses reported feeling isolated and misunderstood by others, as socialization was limited due to the soldier's hesitation to go out in public. Thus, spouses reported difficulty maintaining friendships, as well as strained relationships with family (Hayes et al., 2010).

Military life poses unique challenges, due to the reported amount of self-sacrifice on the part of the non-deployed spouse. In addition to their parenting requirements, roles

that are often assumed by caregivers include assisting the soldier with everyday life activities, performing as mental health therapists, advocating on behalf of the soldier's medical care, and, in some cases, serving as the legal representative for the family (Tanielian et al., 2013). Caregivers of soldiers' experience unique challenges regarding responsibility. The amount of time that may be required to care for the wounded soldier may result in job loss for the caregiver (Tanielian et al., 2013). Additionally, the amount and nature of the necessary care may result in substantial emotional turmoil for the caregiver. Caregivers report devoting endless hours assisting their soldier, as caregivers attempt to cope with anxiety, fear, rage, and irritability. Furthermore, many spouses report spending a great deal of their time encouraging their soldiers to eat, shower, and take their medication (Hayes et al., 2010). Unlike professional caregivers, loved ones who provide care often experience both psychological, behavioral, and physiological stress, which affects their overall wellbeing (Bevans & Sternberg, 2012). Link and Palinkas (2013) postulated that deployments to war zones are associated with long-term health challenges for spouses or partners of veterans and were likely to be associated with combat exposure and combat-related PTSD from the soldier.

Rajabi-Mashhadi et al. (2015) defined caregiver burden based upon physical, emotional, financial, and social duties. They noted that the nature of the illness or injury not only affects the patient but also affects those who provide their care (Rajabi-Mashhadi et al., 2015). Additionally, Rajabi-Mashhadi et al. reported that the behavior of the person receiving care also serves as a determining factor regarding stress for the caregiver. Rajabi-Mashhadi et al. noted that several instruments were used to measure the

levels of burden in caregivers, including the Zarit Caregiver Burden Interview (ZBI), Caregiver Strain Index (CSI), Screen for Caregiver Burden (SCB), and Burden Index of Caregivers (BIC). Rajabi-Mashhadi et al. conducted a study with 100 caregiver spouses of soldiers from the Iran-Iraq war (1980-88) with chronic spinal cord injuries using the Persian version of ZBI-12, along with the Persian SF-36 to measure the reliability and validity of the ZBI-12. Rajabi-Mashhadi et al. reported that the original English version of the questionnaire contained 29 items, followed by a shorter version, developed in 1985, consisting of 22 items. Rajabi-Mashhadi et al. reported that of the original sample, twenty-eight wives were not included, as they did not meet the inclusion criteria or did not wish to participate. As a result, 72% of the participants remained eligible for the study. Rajabi-Mashhadi et al. reported administering the ZBI-12 to all participants, followed by 48 random participants three days later, to ensure validity. Rajabi-Mashhadi et al. reported a strong internal consistency of the questionnaire (Cronbach's alpha 0.77). In addition to the ZBI-12, participants also completed the Persian version of the Short Form Health Survey (SF-36). The authors reported that the SF-36 is well known and is used to measure people's general health. The SF-36 consists of 36 items and eight subscales, including Physical Functioning (PF), Social Functioning (SF), Vitality (VI), Role Emotional (RE), Bodily Pain (BP), Role Physical (RP), Mental Health (MH), and General Health (GH). The 72 participants varied in age from 31 to 66 years with a mean age of 44.7. Of the sample, 51.3% reported primary school educations, 45.8 % earned a high school diploma, and 2.8% reported having a master's degree or higher. Eighty-nine percent of participants were unemployed.

Rajabi-Mashhadi et al. (2015) used 11 interview questions for their study. In question one (You don't have enough time for yourself?) the mean (SD) was 1.618(1.618). The ceiling effect percentage was 48.6%§, while the floor effect percentage was 20.8%§. The ICC reported at 0.752. The results for question two (Stressed between caring and meeting other responsibilities?) were as follows: The mean (*SD*) was 2.72(1.638). The ceiling effect percentage was 22.2%§, with a floor effect percentage at 54.2%§. The ICC was 0.741. The results for question 3 (Angry when around your relative?) were as follows: The mean (*SD*) was 0.82(1.282). The ceiling effect percentage was 63.9%§, with a floor effect percentage at 8.3%. The ICC was 0.831. The results for question 4 (Your relatives affect your relationship with others negatively?) were as follows: The mean (*SD*) was 0.61(1.306) with a ceiling effect percentage at 79.2%§ and a floor effect percentage at 9.7%. The ICC was 0.793. In question five (Strained when you are around your relative?) the results were as follows: The mean (*SD*) was 0.15(0.664) along with a ceiling effect percentage at 94.4%§ and a floor effect percentage of 1.4%. The ICC was 0.889. For question six (Your health has suffered because of your involvement with your relative?) Rajabi-Mashhadi et al. reported the following results: The mean (*SD*) was 2.22(1.746) with a ceiling effect percentage of 31.9%§ and a floor effect percentage of 41.7%§. The ICC was 0.883. For question seven (You don't have as much privacy as you would like, because of your relative?) Rajabi-Mashhadi et al. reported the results as follows: The mean (*SD*) was 0.74 (1.434). The ceiling effect percentage was 75%§, the floor effect percentage was 13.9%, and the ICC was 0.779. In question number eight, (Your social life has suffered because you are caring for your

relative?) the results were as follows: The mean (*SD*) was 0.61(1.327). The ceiling effect percentage was 79.2%§, the floor effect percentage was 11.1% and the ICC was 0.727. For question nine (You have lost control of your life since your relative's illness?) Rajabi-Mashhadi et al. reported the following results: The mean (*SD*) was 0.47(1.021), with a ceiling effect percentage of 77.8%§, a floor effect percentage of 4.2% and an ICC of 0.750. For question ten (Uncertain about what to do about a relative?) the results were as follows: The mean (*SD*) was 0.44(1.047). The ceiling effect percentage was 80.6%§, with a floor effect percentage of 5.6% and an ICC of 0.966. The results for question eleven (You should be doing more for your relative?) were as follows: The mean (*SD*) was 2.25(1.659) with a ceiling effect percentage of 27.8%§, a floor effect percentage of 38.9%§ and an ICC of 0.797. The results for the final question (You could do a better job in caring for your relative?) were as follows: The mean (*SD*) was 1.53(1.678), with a ceiling effect percentage of 47.2%§, a floor effect percentage of 23.6%§ and an ICC of 0.768.

Rajabi-Mashhadi et al. (2015) reported that their findings, compared to other caregiver groups revealed a significant difference. Rajabi-Mashhadi et al. stated that the scores among caregivers of cancer patients were higher but reported that caregivers of patients with acquired brain injury (ABI) were poorer. Rajabi-Mashhadi et al. reported that the mental health of the person proving care is a determining factor in his or her quality of life. Specifically, if the caregiver dedicates most of his or her time providing care for the loved one, he or she will experience decreased mental and physical health and will report increased burdens. This article provides valuable information for my

study, as it includes research questions that are similar to those in my study. The primary concern here is the education demographics, as more than fifty percent of the participants were not high school graduates. It is unknown if one's educational achievements have any effect upon resilience to traumatic stress.

The involvement of the United States military in combat zones, such as Iraq and Afghanistan, in support of Operation Iraqi Freedom and Operation Enduring Freedom has increased the awareness of PTSD and the effects upon soldiers and their families (Monson, Taft, & Fredman, 2009; US Department of Veteran Affairs, 2015). Substance abuse, domestic violence, and other marital difficulties are present among veterans with combat-related PTSD as a response to these symptoms (Herzog, Everson, & Whitworth, 2011). Herzog et al. (2011) conducted a study to examine the effects of exposure to combat upon soldiers in a mid-west Army National Guard unit. The study also examines the secondary effects of combat exposure upon the spouse and children. Herzog et al. reported that of the surveys sent to potential participants, they received 87 responses from participants, of which 54 couples were deemed eligible for the study. The study contained the following assessments: PTSD checklist, Military Version (PCL-M), the secondary trauma scale, (STS) the hurt-insult-threaten-scream (HITS), the relax-alone-friends-family-trouble (RAFFT), and the child behavior checklist (CBCL). In the study, only soldiers completed the PCL-M, while spouses completed the STS. Herzog et al. reported that in the study, all soldiers were male, with an age range of 28-53 years. All spouses in the study were female, with an age range of 25-52 years. Children in the study had an age range of 2-17 years. Herzog et al. reported the results of the PCL-M ranged from 17 to 78

(*M* = 31.57*; SD* = 14.10). Five of these soldiers (10.8%) scored within the diagnostic range in the assessment. In the STS assessment, spouses ranged from 18 to 78 (*M* = 32.30; *SD* = 11.89). Herzog et al. reported that the combined total mean on the CBCL was 45.98 with a standard deviation of 38.63. Children of male soldiers who scored higher on the PCL displayed averages in the 76.7 percentile on the total problems scale of the CBCL, as compared to normal range, 72.9% on the internalizing problems scale, and 68% on the existing problem scale in the CBCL. Of the children who participated in the study, two scored in the clinical range, while one scored in the borderline range for total problems on the CBCL. Three participating children scored in the clinical range for internalizing problems, with one scoring in the clinical range for externalizing problems.

Herzog et al. (2011) concluded that per their study, their findings agree with previous literature that suggests that spouses of soldiers with elevated levels of PTSD are at an increased risk of developing secondary traumatic stress. Herzog et al. noted that secondary traumatic stress might affect people in a manner similar to the effects of PTSD upon soldiers returning from combat. Herzog et al. acknowledged the limitations of their study, noting that the primary sample of the study consisted of well-educated, higher-ranking soldiers and spouses. Herzog et al. noted that the National Guard unit that participated in the study had an active family program, with an emphasis upon integration. Herzog et al. acknowledged the absence of junior enlisted families. In this study, the information provided in the article is valuable, as there is an acknowledgement that spouses of soldiers with elevated levels of combat-related PTSD pose a higher risk of developing STS. To avoid the limitations listed in this article, I ensured that spouse of

soldiers of all ranks could participate, as the possibility existed that spouses of higher ranked soldiers have a greater understanding of military life and may have resources that are unknown to spouses of junior enlisted soldiers.

Renshaw and Campbell (2011) distinguished that the symptoms of numbing and withdrawal contributed the most the spousal distress. In support of this theory, Caska and Renshaw, (2011) replicated other studies, which concluded that the PTSD symptoms in soldiers and caregiver burden among spouses are directly related to the psychological symptoms that are reported by spouses. Their study supported a previous study, conducted by Dekel et al. (2005), who asserted that spouses were psychologically affected by the symptoms of anxiety and depression in soldiers and affected relationship satisfaction. Similarly, Renshaw, Allen, Rhoades, Blais, Markman, and Stanley (2011) reported that 20% of the 190 soldiers and spouses who participated in their study reported that anxiety and depression were directly attributed to the deployment. It remains to be seen if there is any difference in the number of affected spouses of Reservists. My study sought to bridge the gap between distress in active duty spouses versus that reported in spouses of Reservists.

Due to the nature of care that is often required by injured veterans, one must question the quality of life reported by those who provide care. Saban (2016) reported that to date, little is known about the perceived health and the way caregiver burden contributes to their overall quality of life. Saban conducted a qualitative study to describe caregivers' *perceptions of health, somatic symptoms, caregiver burden* and their *perceived quality of life* as a means of identifying the way the variables affect their

quality of life. Participants in the study completed the following assessments: Patient Health Questionnaire-15, Caregiver Reaction Assessment, and Quality of Life Index (Saban, 2016).

To measure somatic symptoms, Saban (2016) used the Patient Health Questionnaire-15, consisting of 15 somatic symptoms. Per the assessment, symptoms are scored from 0 ("not bothered at all") to 2 ("bothered a lot"). The total score of the Patient Health Questionnaire-15 ranges from 0-30, with higher scores reflecting more severe symptoms. Saban noted that cutoff scores of 5, 10, and 15 are indicative of low, medium, and high levels of somatic symptoms.

To measure caregiver burden, Saban (2016) used the Caregiver Reaction Assessment (CRA), which consists of 24 items, using a Likert-type scale, ranging from 1-5 (strongly disagree to strongly agree, respectively.) Saban reported that the CRA measured five aspects of caregiver burden, including the effect upon self-esteem, the effect on schedule, the effect of finances, the lack of family support, and effect on health, (p. 683). Per the CRA, the effect of self-esteem reflects the caregivers' perspective upon caregiving, and whether the caregiver finds this job rewarding. The effect upon schedule reflects the extent that caregiving has regarding interrupting daily activities and the extent to which caregiving affects any time for relaxation. The effect of finances measures the extent that caregiving has upon one's financial comfortability. The lack of family support measures the extent to which caregivers feel abandoned by other family members. The fifth scale, effect on health is used to determine the caregiver's physical abilities to provide care and measures energy levels (Saban, 2016).

The final assessment in the study conducted by Saban (2016) was the Perceived Quality of Life Index (QLI), which measured the degree of satisfaction with purviews that are important to oneself and is a worldwide measure of QOL. The QLI consists of 33 items used to measure overall satisfaction (1 = very dissatisfied to 6 = very satisfied) and importance (1 = very unimportant to 6 = very important). The domains measured with this tool are *health and functioning*, *psychosocial/spiritual*, *social and economic,* and *family*.

The average age of the participants in the study was 43.1 (*SD* = 15.3). Of the sample 90% were married (*n* = 36). Twenty-nine participants (72.5%) were White, and 11 participants (27.5%) were Black, Hispanic, or Other. Fifty-five percent of the sample reported employment, with the remaining 45% reporting no current employment. The mean for the duration of care provided was 49.4 months (*SD* = 29.7) with the average number of hours per week was 35.5 (*SD* = 40.4).

The results of the study were as follows: For general health, the average rating was 2.40 ± 0.74 with 40.0 percent of participants reporting fair or poor general health. Saban (2016) reported that the mean score for the PhQ-15 was 11.38 ± 4.92 (range: 1.00–23.00), which specified moderate to higher levels of somatic symptoms deemed as bothersome. Saban reported that per the study, the most bothersome somatic complaint was feeling fatigued or having lower energy levels (57.5%). Forty percent reported difficulty sleeping, and 30% reported symptoms of frequent headaches. Saban reported that additional somatic complaints included changes in bowel functioning (32.5%), nausea (27.5%), back pain (27.5%), and joint pain (27.7%) (p. 685).

Using the CRA, the mean score for caregivers on the self-esteem subscale (mean = 4.08 ± 0.65) was close to the maximum score of 5.00, indicating that participants were content with their role as caregivers. The CRA subscales of disrupted schedule (mean = 3.60 ± 0.90) and finances (mean = 3.13 ±0.95) were the highest ratings among the four negative CRA subscales, which suggested that these issues were more of a burden than the effect on health (mean = 2.75 ± 0.75) and lack of family support (mean = 2.70 ± 0.98).

Saban (2016) reported that marital status, level of education, race, income, employment status, the relationship to the patient, and the number of hours per week providing care were not associated with the QOL. Saban also included perceived health, somatic symptom score, five aspects of caregiver burden (effect on caregiver's self-esteem, schedule, finances, health, and lack of family support), and caregiver age. The model accounted for 64 percent of the variance in the QOL score, F (8, 31) = 9.59, $p <$ 0.001. In this model, the caregiver burden subscale scores of self-esteems ($\beta = 0.28$, $p =$ 0.02) and effect on finances ($\beta = –0.27$, $p = 0.05$) and the somatic symptoms score ($\beta =$ –0.28, $p = 0.04$) had significant partial effects in the model (p. 685).

Saban (2016) reported that participants in the study were younger when compared to those in other studies but indicated that the participants displayed similar demographics to other caregivers of veterans with traumatic brain injuries. Saban reported that overall, participants conveyed lower levels of QOL (mean = 18.08 ± 5.50) compared with informal caregivers of patients awaiting lung transplant (mean = 22.81 ±

4.50), caregivers of patients with breast cancer (mean = 22.32 ± 3.40), and caregivers of patients with life-threatening dysrhythmias (mean = 24.20 ± 3.60).

Saban (2016) asserted that 40% of participants reported fair to poor general health, which they attributed to the lack of support from family members. The most common somatic complaints were lower back pain (27.5%), difficulty sleeping (25%) and hypertension (20.0%). Saban acknowledged the limitations of the study, noting a cross-sectional design, a small sample size, and convenience sampling. For this reason, Saban stated that the results of the study were not generalizable. Saban acknowledged the possibility that individuals who did not participate in the study may have reported different results. Saban encouraged additional researchers to develop appropriate interventions to provide support for caregivers. While this study provided useful information to reflect a significant problem among caregivers of wounded veterans, Sabin does not indicate if the study was exclusive to active duty soldiers or if it included members of the Reserve or National Guard.

Couple Adaptation to Stress

Trauma, as defined in the DSM-5 (APA, 2013) is as follows: "directly experiencing, witnessing, or learning of an instance that involves the actual or threatened death, serious injury, or sexual violence to oneself or others" (p. 271). Because of a traumatic experience, some people develop symptoms of PTSD, which is considered an acute response (PTSD; APA, 2013). According to Oseland, Schwerdtfeger, Gallus, and Nelson-Goff, (2016) many trauma survivors make efforts of self-preservation by avoiding events which may serve as triggers. Additionally, trauma survivors often detach

themselves from others, display a limited affect, and engage in maladaptive behaviors as a means of coping with their anguish (Oseland et al., 2016).

Sippel et al. (2015) reported that within the military, social support plays a profound role in one's psychological resilience and mental health. Strong attachment and interpersonal relationships can also influence the interval and intensity of the traumatic response, as well as the emotional and cognitive thought processes (Johnson & Williams-Keeler, 1998; Oseland et al., 2016). Zerach et al. (2015) asserted that although attachment dimensions are known to affect PTSD symptoms among trauma survivors, there is little research that explores the association between secondary traumatic stress and spouses' marital relationships. Zerach et al. reported that spousal symptoms of STS may hinder the necessary support or may result in irritability in times when patience is critical. Additionally, spouses attempting to care for injured veterans without outside support may lead to a decreased marital adjustment. Zerach et al. also noted that it is reasonable to conclude that spouse with high levels of attachment anxiety (with a traumatized spouse) are likely to be more affected by the spouse's distress and may over-identify with the spouse's distress. Thus, this occurrence may hinder the survivor's recovery, or cause it to become stagnant. The question remains whether the soldier's recovery is additionally hindered, and if so, does a lack of available mental health services for the spouse affect this issue?

Oseland et al. (2016) reported that Nelson-Goff and Smith (2005) developed the couple adaptation to stress model (CATS) as a means of recognizing the interpersonal effects upon the couple, emphasizing the couple dyad. According to Nelson-Goff and

Smith (2005), the CATS model is used to explore the individual response to the trauma and the effects upon the couple. Nelson-Goff and Smith asserted that symptoms, including hyperarousal, re-experiencing, cognitive alterations, and avoidance could negatively affect the partner, referred to as the secondary trauma survivor. The symptoms displayed by the secondary trauma survivor may also negatively influence the symptoms of the primary trauma survivor, as he or she is affected by the symptoms of the secondary trauma survivor. Nelson- Goff and Smith considered that unresolved stressors and interpersonal issues served as predisposing circumstances, including trauma which occurred during childhood, mental illness, and individual coping skills, which could potentially affect the exchange of symptoms within the couple. This is particularly important for spouses of Reservists, due to their inexperience with multiple deployments, the lack of a close-knit military community, and a shortage of available mental health services.

Nelson-Goff and Smith (2005) reported that the couple functioning element of the model included issues with attachment, satisfaction within the relationship, support and nurturance within the relationship, the disruption of relationship power, stability, the ability to adapt, intimacy, the couple's ability to communicate, and conflict within the relationship. The CATS model addresses the functioning of the couple regarding the impact of the trauma. Oseland et al. (2016), noted that the primary focus of the model is the relationship functioning of the couple, as influenced by their responses to trauma. I did not explore relationship satisfaction or dysfunction but explored the personal experiences of spouses of Army Reservists, using the CATS model as the secondary

trauma survivor. As soldiers returning from combat in Iraq and Afghanistan continue to report symptoms, the current study will benefit from this framework, as most studies address combat-related PTSD according to the functioning of the couple, rather than as individuals and how they affect one another.

Supportive Services for Military Spouses

Mental health services for spouses of Reservists or National Guardsmen are not always readily available, nor are spouses always receptive to pursue such services. Unlike active duty families, whose insurance coverage remains the same, Tri-Care coverage reservists and their families terminates soon after the soldier returns to civilian life. Additionally, spouses face certain barriers to obtaining mental health services. For example, Westphal and Convoy (2015) asserted that there is a concern within the military that civilian mental health professionals do not understand military life and the experiences of deployment. Additional barriers include the need to travel greater distances to receive services, scheduling conflicts, and the cost associated with the treatment.

To treat symptoms, Westphal and Convoy (2015) asserted that the first step is to develop an awareness of the symptoms and how they affect the overall daily functioning of the affected person. For affected spouses, Westphal and Convoy recommended incorporating self-monitoring, exercise, meditation, engaging in leisure activities, enjoying time with loved ones, and engaging in individual psychotherapy when necessary. Individual therapy may help the client learn and incorporate effective coping skills.

Couple's therapy may also prove to be helpful to the soldier and spouse as such therapy allows both parties to address the issues that are related to the PTSD and how they are individually affected (National Center for PTSD, 2017). Cognitive-behavioral conjoint therapy was designed to assist couples in alleviating the symptoms of PTSD while strengthening their relationship (Brown-Bowers at al., 2012). Cognitive-behavioral conjoint therapy consists of 15 sessions. The primary goal of this therapeutic approach is to teach couples the necessary skills to solve their current problems and to teach them strategies to address future issues.

Couples counseling may also include retreats that are offered by the military. A recommended therapeutic intervention for couples affected by combat-related PTSD is The Veteran Couples Integrative Intensive Retreat. This week-long therapeutic approach utilizes traditional couples therapy while incorporating psychoeducation, yoga, exercise, and activities to promote wellness. During this time, couples are encouraged to interact with other participants, as peer support is a crucial element in the success of this approach.

Summary of Literature Review

Posttraumatic stress disorder in soldiers returning from combat is a common occurrence since the onset of the war on terror in 2001 (Lewis & Reese, 2009). The emotional strain resulting from symptoms of distress in the soldier (the primary trauma survivor) is often assumed by the spouse (the secondary trauma survivor). When such emotional strain occurs, spouses often develop symptoms of secondary traumatic stress (Nelson-Goff & Smith 2005). Symptoms of Secondary Traumatic Stress develop when

the secondary trauma survivor over-identifies with the symptoms reported by the primary survivor. The CATS model (Nelson-Goff & Smith, 2005) was used to describe how soldiers and spouses are affected by the traumatic experience. The model suggests that the impact of the trauma upon the primary survivor sets in motion the response of the secondary survivor, with the potential of developing symptoms of Secondary Traumatic Stress. The CATS model is circular, which indicates that the symptoms of secondary traumatic stress revert to the primary trauma survivor and affects him or her once again.

As indicated in the CATS model, the effects of traumatic symptoms are not exclusive to the person who experienced the traumatic event. When spouses of combat-affected soldiers experience distress related to the trauma, they often report symptoms that are similar in response to those reported by soldiers. In addition to their symptoms, spouses often struggle with the additional responsibilities of caring for the soldier, as well as other family and work-related responsibilities. Bevans and Sternberg (2012) asserted that the term caregiver burden was initially coined for those caring for adults with chronic illness, such as dementia. Bevans and Sternberg noted that authors have since compared the duties of caring for a trauma-affected soldier to those who care for loved ones with dementia and chronic schizophrenia. For military spouses, the term partner burden is also used. Spouses face challenges caring for the affected soldiers and often develop their psychological distress. Many spouses fail to obtain mental health treatment for themselves.

In Chapter 2, I outlined the criteria for PTSD and the most recent changes incorporated into the DSM-5, including the reclassification of the disorder from the

category of Anxiety Disorders, to Other Trauma and Stress-Related Disorders. I discuss the history of PTSD, which began as the term Gross Stress Reaction (created for psychiatrists) and how the term evolved in the DSM throughout the years. I introduce secondary traumatic stress in Chapter 2, described by Figley as the emotional reaction to a traumatic experience of a significant other resulting from the knowledge about the stressful event experienced by a significant other. Additionally, STS is known as distress resulting from the desire to assist one who has been traumatized (Baum et al., 2014). In military spouses, STS is becoming more evident, as it is reported that between 11-20% of combat veterans are affected by symptoms of PTSD. As the emotional cost of caring for affected soldiers becomes overwhelming, spouses often develop symptoms that are nearly identical to those of the affected soldier (Baum et al.,2014). Current literature indicates that it is reasonable to assume that an association between PTSD in soldiers and the development of STS in spouses is evident (Kianpoor et al., 2017). The literature suggests that female spouses appear more susceptible to STS, as females are typically more empathic. Numerous studies suggest that the mimicking of symptoms is due not only because of the primary survivors' narrative but also related to the empathic relationship between caregivers and those who directly experienced the traumatic event (Arnedo and Casellas-Grau, 2016; Avieli et al., 2015; Choi, 2016; Gil and Weinberg, 2015; Mehus and Becher, 2015; Rzeszutek et al., 2015). A gap in the literature between PTSD and STS appears evident due to the changes incorporated in the DSM-5 (APA, 2013), as criterion A added the inclusion of indirect exposure (Mordeno, Go, & Yangson-Serondo, 2017). While STS is considered as a conceivable cause in the development of

PTSD, there appears to be a discrepancy between the definition of secondary trauma defined in the current DSM and the use of STS in the current body of literature. As previously stated, most of the literature explores the experiences of spouses of active duty soldiers. There were few identified studies which reflected the experiences of spouses of Army Reservists or members of the National Guard.

In Chapter 2, I also discussed Caregiver Burden (a term originally coined for those caring for older adults with significant chronic illnesses and dementia) and how spouses are affected as they provide direct care for the affected soldier. Many spouses report feelings of depression, isolation, and mistrust of others. They often report feeling misunderstood. In some cases, spouses must spend a significant amount of time devoted to the soldier, ensuring that his or her basic needs are met, including eating, sleeping, hygiene issues, and medication compliance. In addition to the psychological symptoms, those spouses who were employed often experience job loss and financial concerns.

In Chapter 2, I introduced the CATS model, as the couple adaption to traumatic stress (Nelson Goff & Smith, 2005). This model describes the effects of the traumatic stress upon the couple, rather than each. According to the CATS model, the secondary person reacts to the symptoms of distress presented by the primary traumatized individual and develops a stress reaction. In a circular fashion, the primary traumatized individual then reacts to the distress symptoms relayed by his or her significant other and develops additional stress reactions. I have concluded with a discussion of recommended therapeutic interventions, including cognitive behavioral conjoint therapy. In Chapter 2, I addressed potential barriers for spouses of Reservists, due to lack of available services in

their area and termination of health insurance coverage, as the soldier transitions back to civilian life.

This study identified a gap in the literature, as there were limited studies that explored the effects of PTSD in Reservists upon their spouses. While the literature connected PTSD and STS in soldiers and spouse, respectively, a gap remained, possibly due to the lack of available services for families of Reservists (Westphal & Covoy, 2015). In this study, I explored the lived experiences of spouses of soldiers who returned from combat with symptoms of PTSD. Additionally, I explored secondary traumatic stress directly related to the soldier's combat experience. I specifically addressed issues of secondary traumatic stress, as reported by spouses of Reservists. I described and discussed the research methodology in Chapter 3.

Chapter 3: Research Method

I conducted a qualitative study to explore and understand the lived experiences of spouses of soldiers who returned from combat in Iraq and Afghanistan and developed symptoms of PTSD because of this deployment. I gathered data for the study using semistructured interviews, conducted either face-to-face or by phone. The analysis was guided by the following research question: What is the meaning of the lived experiences of spouses of soldiers who have developed combat-related PTSD symptoms after serving in Iraq or Afghanistan?

The central phenomenon of the study was the lived experiences of spouses who developed psychopathological symptoms in response to their soldier's combat-related experience in Iraq or Afghanistan. Renshaw et al. (2014) found that combat-related PTSD and psychological distress among spouses are related. Psychological distress among spouses is related to additional responsibilities and burden, as well as their concern for the psychological symptoms of the soldiers (Nash & Litz, 2013; Renshaw et al., 2014). In contrast, other researchers, particularly those who work with trauma survivors, consider the distress described by spouses as indicative of symptoms of STS (Renshaw et al., 2011). A phenomenological approach allows researchers to explore individual subjective experiences and perceptions in order to identify commonalities among participants.

The purpose of this phenomenological study was to explore the lived experiences of spouses of Reservists who returned from a deployment to Iraq or Afghanistan with combat-related PTSD. In this chapter, I provide a detailed discussion of the methodology

that I used to conduct this study. I used semistructured personal interviews and participant-selected artifacts to explore spouses' experiences after soldiers returned from combat, including their mental health symptoms and experiences locating suitable counseling services. I provide a detailed description of the research method that I used for the study, including the research design and rationale, my role as the researcher, the methodology, and issues of trustworthiness. I provide a summary of key elements, including the research design, setting, sampling, and analysis of the data. Finally, I offer a discussion of validity, ethical concerns, and procedures to protect the participants in the study.

Research Design and Rationale

My research question for this study was the following: What is the meaning of the lived experiences of spouses of soldiers who have developed combat-related PTSD symptoms after serving in Iraq or Afghanistan? The research design best suited to this study was qualitative, as I sought to explore the personal experiences reported by the participants, rather than quantifying the number of spouses reporting STS symptoms. A qualitative study allows a researcher to explore a phenomenon using more than one lens, making it possible to explore and understand the multiple facets of the phenomenon (Baxter & Jack, 2008). A qualitative study was beneficial for the development of future studies, as the results may not be generalized and may benefit a future study (Silverman, 2013).

I chose a hermeneutic phenomenological approach for this study, which allows researchers to probe, uncover, and interpret the meaning of participants' stories

(Greenfield & Jensen, 2010). These experiences may be used to increase awareness of a specific issue with the aim of promoting social change. Sloan and Bowe (2014) reported that the focus in this approach is on understanding the meaning of experience by identifying experiences, engaging with the data interpretively, and placing less emphasis upon the essences that are important to descriptive phenomenology. Additionally, Sloan and Bowe noted that the researcher's reflection of the experience is helpful in interpreting the meanings discovered or to provide additional value to those reflections.

A phenomenological approach emphasizes the relationship between the individual or group and the circumstances, both external or internal, that are included in the study (Embree,1997). Groenewold, (2004) noted that authors are well known for rebutting one another, recommending that researchers develop a firm understanding of all methodologies before making a final decision. In this study, a phenomenological approach was the most appropriate to explore the personal experiences of spouses of soldiers with combat-related PTSD to assess the meaning of their circumstances. Ray and Vanstone, (2009) noted that interpretive phenomenology allows researchers to ask questions in order to interpret the meaning of the phenomenon and understand the human experience.

Mapp, (2008) explained that Heidegger developed the phenomenological approach known as *hermeneutics*, which translates to *interpretation*. Hermeneutic phenomenology differs from Husserlian phenomenology, as the former approach encourages researchers to include their knowledge and experiences in a study, whereas Husserlian phenomenology promotes bracketing, which requires the researcher to

suspend his or her own personal beliefs and experiences (Mapp, 2008). As a result, hermeneutic phenomenology uses the personal experiences and knowledge of the researcher as a means of interpretation. Holloway, (1997) noted that researchers who endorse phenomenology are hesitant to impose techniques, which frequently results in criticism from other scholars. Phenomenology is defined by Langdridge, (2007) as a discipline that "aims to focus on people's perceptions of the world in which they live and what it means to them; a focus on people's lived experience" (p. 4). The focus in phenomenology is the human experience and the meaning of experiences (Langdridge, 2007). For this study, my intention was to interview military spouses of soldiers with combat-related PTSD to understand and interpret their life-changes consequent to the soldiers' return from combat. A phenomenological approach was best suited for this study, given that the way in which STS manifests in the military population remained unclear. Additionally, an improved understanding of the effects of soldiers' PTSD symptoms on spouses may be instrumental in supporting additional research and treatment for STS.

Hermeneutic Lens

Kafle, (2013) stated that researchers using hermeneutic phenomenology attempt to reveal a phenomenon through the personal experiences of subjects, as told by their stories. Kafle noted that with this school of thought, interpretations are the only source of information, and he considered descriptions to be an interpretative process. Sloan and Bowe (2014) reported that in hermeneutic phenomenology, the focus is placed upon understanding the meaning of the reported experiences by identifying specific themes

that emerge from the stories of the participants. Dilthey (1987) reported that nature is interpreted, but life experiences must be understood. I used a hermeneutic lens for this study. Kafle described hermeneutics as the idea that interpretations are the only tools that people have, and descriptions are an interpretative unconscious process. Flood (2013) noted that a hermeneutic approach surpasses the description of a central phenomenon and explores the embedded meaning behind concepts. As stated in Chapter 1, Flood asserted that the hermeneutic phenomenologist focuses upon the description of the meaning of individuals' experiences and how the meaning of these experiences influences their life choices. Van Manen (2007) contended that an important aspect of investigating lived experience is reflecting upon the nature of the phenomenon. Van Manen (1997) noted that reflection illustrates what in a prereflective sense already presents itself as a primal understanding. Langdridge (2007) described phenomenology as a practice that emphasizes people's perceptions of their world and their understanding of these perceptions. Langdridge also considered phenomenology to be a qualitative method with a concentration upon the human experience as the topic. In this study, I conducted semistructured personal interviews to explore the lived experiences of spouses of Army Reservists and interpreted their experiences as they were embedded in different linguistic contexts. The purpose was to understand the meaning of participants' experiences through collaboration, according to their recollections.

As a military spouse, there was concern that I would filter or distort the gathered information, which is a common occurrence (Xue et al., 2015). A hermeneutic phenomenological approach was ideal for this study, as the researcher using this

approach incorporates personal experiences and understanding into the research (Mapp, 2008). This approach allowed me to interpret the data according to my own experiences and knowledge. Mapp (2008) asserted that phenomenology stresses that only one who experienced the phenomena can convey these experiences to others. It was assumed that my experiences as a military spouse of a soldier with combat-related PTSD were similar in nature to those of the participations. Due to this background, I could interpret similar experiences more effectively than a researcher with no military experiences.

Role of the Researcher

In this study, my role as the researcher was to understand the experiences of Army Reserve spouses through my interpretation of those experiences. Using the hermeneutic lens, I used the stories provided by the participants to understand their experiences. Gadamer (1976) noted that description is an interpretative process and requires a bond to the subject matter that is formed using oral communication, as language facilitates understanding. Reiners (2012) contended that in hermeneutic phenomenology, researchers should not nullify their prior understanding of or engagement in the subject matter. As a military spouse and a researcher, I had prior personal understanding of military culture and the effects of deployment. Here, a bias was actually advantageous, as hermeneutic researchers are embedded in their world (Reiners, 2012). As previously stated, Mapp (2008) explained that a hermeneutic approach invites the researcher to use his or her personal experiences and knowledge of the subject matter and to interpret these experiences accordingly. Heidegger did not believe that researchers could explore phenomena in a neutral or detached manner (Sloan

& Bowe, 2014). My experience with the military as the spouse of an affected soldier and my experience as a licensed mental health counselor proved beneficial as I interpreted the interviews and experiences of the participants. Smith et al., (2009) asserted that when used as a methodology and means of analysis, phenomenology is often difficult to unfold.

I am a 54-year-old female with 7 years of experience as a mental health counselor. I am a licensed counselor in the State of New York, a Nationally Certified Counselor, a Certified Clinical Mental Health Counselor, a Certified Clinical Trauma Professional, and a Credentialed Alcohol and Substance Abuse Counselor Trainee. I am a doctoral candidate in counselor education with a specialization in trauma and crisis. I am also a military spouse of a soldier with combat-related PTSD. For this reason, I was invested in exploring the experiences of other spouses, for finding commonality, recommending treatment, and contributing to additional research on this topic.

My role in this study was to delineate the personal experiences of spouses of Reservists who returned from Iraq or Afghanistan with combat-related PTSD. I served as an observer-participant in this study and engaged in some self-disclosure of my own experiences as a military spouse of a soldier with combat-related PTSD. I deciphered the data that were collected in detail to capture participants' lived experiences as accurately as possible. I collected data by conducting semistructured interviews with spouses of soldiers. Participants had been married at the time of the soldier's deployment, and the soldier had returned from combat at least 1 year but less than 14 years prior to the time of the interview. Similarly, all participants had a qualified soldier who served in the

selected combat zones, who had been formally diagnosed with PTSD by a qualified mental health professional.

Given the sensitive subject matter, it was important for me to understand that my relationship with participants could result in some ethical dilemmas. I am the spouse of a Reservist with combat-related PTSD, which could have affected my judgment. It was possible that I would over relate to the participants, causing them discomfort. Here, it was important for me to remain self-aware and take the necessary steps to ensure that my efforts were genuine. This was not the time for me to project my feelings onto the participants. Although slight, the possibility remained that exploring the experiences of the participants would affect my mental health. For this reason, I frequently practiced reflexive journaling to express my feelings and experiences (Anney, 2014). I also sought supervision to address these issues as they arose.

Due to my perceptions, it was important to exercise active listening to ensure my understanding of participants' accounts (Rogers, 1980). It was also important to respect the dignity of the participants and act only in their best interests (APA, 2013). Sanjari et al. (2014) outlined the importance of respect for the privacy of participants, ensuring genuine interactions, and ensuring that the stories of participants are not misrepresented. As previously stated, I regularly engaged in reflexive journaling and sought supervision as needed.

Methodology

Participants

I recruited spouses of Army Reserve soldiers who had served in Iraq or Afghanistan and experienced combat-related PTSD for the study by posting my recruitment letter on Facebook sites pertaining to military families and soldiers with PTSD. I received permission from moderators to post my recruitment letter (see Appendix B). I encouraged spouses to contact me for a confidential screening and discuss informed consent regarding their participation. This allowed spouses to participate confidentially, without concern for retribution for the soldier. I conducted eight spousal interviews and achieved saturation. The expectation was that 10 participants would be sufficient to achieve saturation and would provide sufficient data to explore and understand participants' personal experiences, based upon the initial screenings for participation for the study. It should be noted that in a qualitative study, there are no definitive rules for sample size due to changes in identified themes or the characteristics of the participants (Archibald & Munce, 2015). The achievement of saturation determined the final number of participants. Malterud, Siersma, and Guassora (2015) described saturation as occurring "when the researcher no longer receives information that adds to the theory that has been developed" (p. 6). I chose snowball sampling for the study, due to some difficulty obtaining permission from the military to conduct my study on post. Archibald and Munce (2015) suggested strategies for recruiting participants for a qualitative study. First, the individual should conduct his or her own screening process for identifying eligible participants and advising them of the purpose of the study. I

confirmed with Walden University's Institutional Review Board that I was able to recruit participants using Facebook, emails, and word of mouth. No participant was expected to commute more than five miles from his or her home, as I assumed for any travel. If travel was required, I conducted interviews in public places, but I maintained privacy at all times. I conducted most interviews by phone, as the majority of participants did not reside in New York State.

I received permission from two moderators from Facebook sites to post my letter of recruitment. Archibald and Munce (2015) reported that having a liaison within organizations assists researchers, as liaisons may encourage and refer only those who meet the criteria for the study. The moderators were supportive of my efforts and encouraged members to consider participating.

Although I had no prior personal relationship with my participants before they entered my study, Archibald and Munce (2015) recommended continued engagement with participants before recruitment. The authors noted that long-term relationships are meaningful and promote trust among participants, which may assist with recruitment. As a means of taking this step, I requested permission to join both Facebook sites and participated in their discussions. It was important to understand and acknowledge the possibility of gender differences in the participants, as this study was not limited to wives of soldiers. Here, it was important that I pay close attention to the terminology used to describe the research project, as this could have affected recruitment (Archibald & Munce, 2015). These terms were clearly defined in the inclusion and exclusion criteria.

Additionally, Archibald and Munce (2015) advised researchers to have sensitivity toward aspects of the data collection process such as the duration of interviews.

I asked participants to sign an informed consent document, which outlined the purpose of the study, how the data was used, and also included a detailed description of the risks and benefits of participating in the study. The document also included a description of the way the researcher protected participant identities and explained that they had the option to end their participation at any time without concern for retribution.

Inclusion Criteria

The soldier and spouse must have been married at the time of the deployment to be eligible for participation. The soldier must have served in Iraq or Afghanistan in response to Operation Iraqi Freedom, Operation Enduring Freedom or Operation Freedom's Sentinel. The soldier must have returned from combat at least 1 year before participating in the study, but not more than 14 years after the combat experience.

Exclusion Criteria

The spouse must report that the soldier was formally diagnosed with combat-related PTSD by a qualified mental health professional. I screened participants for symptoms, but I did not evaluate or diagnose anyone. The soldier must not have received a previous diagnosis of PTSD for any other deployment. The spouse must not report any prior military experience.

Instrumentation

I served as the primary instrument for this study (Pezalla, Pettigrew, & Miller-Day, 2012). From a hermeneutic perspective, I focused upon the subjective experiences

of the spouses. I used face-to-face semi-structured interviews as the primary means of collecting data. The interviews consisted of eight open-ended questions intended to explore the lived experiences of spouses of Reservists who returned from Iraq or Afghanistan with combat-related PTSD (see Appendix D). The anticipated duration of each interview was approximately 60-90 minutes. I audio recorded each interview and took field notes following each interview. I transcribed each interview into MS Word documents, which I used to code the themes.

Interview Questions

1. What were your experiences when your spouse first came home from combat?
2. Tell me about your relationship with your spouse after he or she returned from combat.
3. Tell me about your soldier's experience with PTSD.
4. If his or her behavior changed since returning home, how has this behavior affected you?
5. Tell me about your experiences as you coped with his or her changing behaviors.
6. Describe your symptoms and tell me what steps you took after you started noticing these symptoms?
7. What resources were available to you as a military spouse?
8. What kind of mental health treatment did you receive, if any?

Procedures for Recruitment, Participation, and Data Collection

I conducted personal interviews with spouses who met the criteria. The interviews lasted approximately 60 minutes per participant. Before conducting any interviews, I waited for the Walden University Institutional Review Board (IRB) to provide permission. I conducted some interviews face-to-face, but most were conducted by phone. I audio recorded each interview and took notes during the interview. I decided to hand code my notes, to limit expenses and to avoid difficulty navigating qualitative software. The audio recorder remained in a locked box and was only accessible to me. I interviewed spouses of soldiers who were diagnosed with combat-related PTSD. I used eight prepared questions in a semi-structured interview, which I recorded, using an audio recorder. I did my best to conduct the interviews in a setting that was comfortable for the participant. As previously stated, the anticipated time to conduct each interview was 60-90 minutes. I completed most interviews in 60 minutes. I used the interview questions to explore the lived experiences of spouses of soldiers who returned from combat in Iraq or Afghanistan with PTSD.

Participants had the option to end their participation in the study without concern for consequences. If the participant had already engaged in an audiotaped interview, I was prepared to ensure that all content was deleted and would not use their information in the study. I met with each participant individually at the end of the study to conduct an exit interview. I did so either in person or by phone, depending upon their location. I discussed the results of the study and how their participation contributed to the study. Although I did not provide counseling or treatment, I briefly assessed each participant to

ensure their emotional well-being. I provided each participant with a list of counseling resources and mobile crisis organizations in their area, in the event of any participation-related distress. I was prepared to assist them in scheduling an appointment if needed. No participant reported any distress, nor did any request assistance.

Data Analysis Plan

According to Ketokivi and Choi (2014), the motivation in conventional theory testing is deduction. I used a deductive approach to analyze the data in this study. I conducted semi-structured interviews with pre-prepared questions with spouses of soldiers who are formally diagnosed with combat-related PTSD by a qualified mental health professional. I audio recorded and analyzed the interviews as soon as possible after I conducted them. I coded each interview to identify themes. To assist me with my analysis of the collected data, I incorporated Colaizzi's data analysis, using the specific steps ascribed to this method. Morrow, Rodrigues, and King (2015) described the seven steps to Colaizzi's method as follows: *Step 1- Familiarization*: In this step, the researcher becomes familiar with the data collected from the participants by reading the participant accounts multiple times. *Step 2- Identifying significant statements:* This step requires the researcher to identify all the participant statements that are directly related to the phenomenon of the research. *Step 3- Formulating meanings:* After carefully reviewing the statements of the participants, the researcher identifies the meanings of these statements that specifically pertain to the research phenomenon. Here, it is important for the researcher to reflexively bracket his or her presuppositions to truly experience the phenomenon. Morrow et al. (2015) noted that Colaizzi understood that complete

bracketing is impossible. *Step 4- Clustering themes:* After fully identifying the meanings of the phenomenon, the researcher then clusters these meanings into specific themes. Here again, it is essential that the researcher takes steps to bracket any presuppositions to avoid any influences from existing theory. *Step 5- Developing an exhaustive description*: Here, the researcher composes a complete description of the themes, while incorporating the themes identified in the previous step. *Step 6- Producing the fundamental structure*: In this step, the researcher condenses the previous description into a short statement that describes only the essential aspects of the specific phenomenon. *Step 7- Seeking verification of the fundamental structure*: In this final step, the researcher returns the central structure statement to all participants to determine if it provides an accurate description of their experience. The researcher may modify earlier steps related to his or her analysis if deemed necessary.

Polit and Beck (2010) found that Colaizzi's means of data analysis encourages the researcher to revisit the participants and share the results of the data to ensure that it reflects their experiences (Shosha, 2012). Shosha (2012) reported that Colaizzi used a seven-step process, which encourages the researcher to self-reflect when analyzing the data collected. I used Colaizzi's method to assist me to identify the common themes that emerged, such as specific words, phrases, and perceptions reported by spouses. The data was structured to explore the phenomenon of the symptoms of STS. The identified themes from the interviews were expected to answer the research questions.

Reflexive bracketing is not typically used in hermeneutic phenomenology but given the nature of the subject matter and my personal experiences, it was necessary to

protect myself from the potentially negative effects that could have occurred from exploring this challenging material. Chan et al. (2013) reported that presuppositions often limit our understanding of the participants' experiences due to an extensive knowledge of the phenomenon. Chan et al. recommended that researchers maintain the concept of bracketing throughout the process, to identify and minimize potential influence.

The possibility always exists that a participant will report experiences that differ from the other participants. Before conducting any interviews, I screened participants to ensure that they met the criteria. If the experiences of any participant greatly differed from the purpose of the study, I was prepared to complete the interview and thank him or her for participating. This did not occur. I completed field notes immediately after the interview.

Hermeneutic Circle

Rapport and Wainwright (2006) considered the hermeneutic circle as a process of interpretation which is achieved through a continuous process of reexamining propositions and asking pertinent questions to confirm the meaning of the phenomenon. Tuohy et al. (2013) reported that the purpose is to ask pertinent questions to discover and understand the meaning of the lived experiences. This reciprocal process involves back-and-forth questioning, allowing researchers the opportunity to expand upon the ideas, leading to the hermeneutic circle. According to Wilson (2014), the hermeneutic circle serves as an interpretive device and is achieved through reflection or articulation of an experience that starts with real-world understanding. Wilson reported that interpretation and understanding form a circular relationship, as researchers interpret his or her

understanding, yet understanding ascends from interpretation. In this study, in addition to the prepared questions that I used with each participant, based upon their responses, I continued a dialogue with them, asking additional questions, to obtain additional information to understand and interpret more about their personal experiences.

Issues of Trustworthiness

A key concern in qualitative research is that the researcher can never be completely objective, as the researcher gathers and interprets the information (Farelly, 2013). Lincoln and Guba (1985) considered credibility, dependability, confirmability, and transferability as the necessary criteria for determining rigor in the research (Houghton et al.,2013). Hammarberg, Kirkman, and de Lacey (2016) asserted that in order to ensure trustworthiness in qualitative research, one must state the purpose of the study, how it was conducted, decisions related to procedures, and must be transparent and explicit about the details of data generation and its management. One who reviews the research should be able to follow and understand the study according to the sequence of events and the decisions based upon the progression of events. Hammarberg et al. (2016) noted that this only occurs when the original researcher provides rich descriptions, explanations, and justification of the chosen methods.

To minimize bias, I continued to review sources and verify information that was shared by the participants. I communicated regularly with the dissertation chairperson and sought clinical supervision to ensure that the interpretation of the data that I collected supported the interviews, rather than the researcher's personal experiences as a military spouse. To ensure that the research accurately reflected the information gathered from

each interview, I provided the participants with the option to review the transcripts from their interviews, reflecting the initial findings before proceeding to the next phase of the study (Morse et al., 2002).

Credibility

According to Noble and Smith, (2015), qualitative research often receives criticism for the lack of rigor and transparency, as well as criticism of the methods and analytical procedures used in the study. Some scholars also criticize qualitative research methods, due to concerns about researcher bias, and the lack of specific standards in which to evaluate the quality of the research (Noble & Smith, 2015). Lincoln and Guba (1985) outlined specific criteria to demonstrate rigor in qualitative research. Lincoln and Guba created comparable terminology to compare credibility for qualitative and quantitative research. The terms included the following: Validity (quantitative) and Truth-Value (qualitative); Reliability (quantitative) and Consistency, Neutrality, or Confirmability (qualitative); Generalizability (quantitative) and Applicability (qualitative). In order to ensure credibility of a qualitative study, Noble and Smith recommend the following strategies: Accountability for personal bias, which could influence the researcher's conclusions; Recognizing sampling biases and continuous observation of methods to reflect data collection and analysis; Accurate, detailed record-keeping and reflective field notes; Maintaining a record of similarities and differences to indicate different perspectives; Strong, detailed descriptions of accounts from participants; Displaying clear, concise terms in regard to thought process in field notes; Consultation with other scholars (analysist triangulation), to decrease researcher bias and

to illuminate blind spots; and inviting and encouraging feedback from participants to ensure an accurate interpretation of the phenomena explored (member-checking). I spent a great deal of time in the field interacting with participants to establish trust and rapport, blend in, and learning more about the experiences of the participants (prolonged engagement). To ensure the rigor of my study, I regularly discussed my concerns with my committee chair, to recognize and address my biases. I took frequent field notes, to help me recognize and recall these biases. I also wrote self-reflection journal notes after each field experience. Korstjens and Moser (2018) also recommended persistent observation, encouraging researchers to read and reread the data, analyzing and revising concepts accordingly.

Transferability

According to Petty et al. (2012), one assumes that the findings of the study are specific and not generalized. Due to my history with the military, I chose snowball sampling as a means of ensuring that I had no prior relationship with participants. Robson (2011) recommended that the researcher utilizes detailed, thick and descriptive data collection of the phenomena for others to ascertain the extent to which they may apply the data to their circumstances. According to Robson, this process is known as theoretical or analytical generalization. Here, it was critical to provide as much descriptive detail as possible, to ensure that the perspective of each participant was well represented.

Dependability

In a qualitative study, it is understood that there are many variables included in each study, including differences in people, contexts, and time, which prevents a study

from being replicated (Petty, Thompson, & Stew, 2012). As data analysis continues, researcher insight and creativity changes. According to Guba (1981), an audit of these processes allows others to track these variances appropriately. To facilitate this audit, I ensured that I took many field notes after meeting with participants, and as I analyzed the data that I collected. It was my position that if there was a specific trail of my procedures, others would likely understand my reasoning.

A qualitative study explores the entire phenomenon in all its complexity (Petty et al., 2012). Interpretation of the complex phenomenon is often challenging for researchers. Guba (1981) recommended prolonged engagement, persistent observation, and peer debriefing as a means of establishing a deep understanding of the phenomenon. To ensure the credibility of my study, I worked closely with my committee and followed their recommendations, as I was aware that they not only serve as guides, but also, as gatekeepers. I also collaborated with my peers who were also pursuing doctoral degrees in counselor education and supervision. Many of my peers had already completed their dissertation and provided valuable insight during this process.

Confirmability

In a qualitative study, confirmability is essential to ensure that the results of the study can be confirmed by other researchers (Anney, 2014). Anney noted that studies suggest that audit trails and reflexive journaling are effective means to achieve confirmability. According to Anney, an *audit trail* is a progression in which the researcher examines the inquiry process to validate the data. In this process, the researcher must substantiate all decisions, including the way the data were collected, how

the data was recorded, and how the researcher analyzed the data. For an audit trail to be effective, the researcher must ensure that he or she retains all raw data, including field notes, interview questions, and any documented observations during this process (Anney, 2014).

Reflexive journaling requires the researcher to accurately document all activity that occurred in the field, particularly the researcher's personal account of the experiences (Anney, 2014). This process also requires the researcher to assess the influences of his or her own perceptions, interests and experiences related to the qualitative research process (Anney, 2014). Engward and Davis (2015) noted that reflexivity is an acknowledgment of the limitations of the research. Engward and Davis identified the difference between reflection and reflexivity, stating that *reflection* encourages the researcher to look back or more deeply as a means of gaining insight of the phenomena. Engward and Davis noted that r*eflexivity* involves a self-awareness of the decisions made throughout the research and the impact of that relationship.

Ethical Procedures

Upon approval from the Walden University IRB, I began my recruitment process. I joined two Facebook sites that were exclusive to military spouses. I identified myself as a doctoral candidate from Walden University and requested permission from the moderators to post my recruitment letter. Both moderators were receptive and supportive. I provided moderators with a copy of the letter, as well as copies of the informed consent document.

Before proceeding with the study, each participant signed a consent form, which thoroughly outlined the purpose of the study, how the research would be used, and the risks and benefits of participation. I advised participants that their participation was voluntary, and they could discontinue their participation in the study without reason or concern for consequences. In addition to fully complying with the direction of the Walden University Institutional Review Board (IRB), I ensured that I complied with the rules and expectations of each Facebook group.

I issued all participants a pseudonym to strictly maintain their confidentiality and created a file for each participant. I stored all information in this file and password protected the files to ensure confidentiality. Transcripts of each interview will remain in these files for at least five years.

In the event of any significant psychological stress, either during the interview or any other aspect of the process, I was prepared to end the meeting immediately. I was prepared to provide the participant with the contact information for the mental health crisis agency in his or her area and to encourage the participant to contact the agency in my presence. Although I was unable to provide mental health treatment for distressed participants, I was fully prepared to provide mental health first aid such as support; de-escalation and referrals if needed. I was willing to assist the participant in securing free mental health services through Military One Source and stressing an immediate need for services. Additionally, I encouraged the participant to reach out to a family member or close friend, to ensure their safety, particularly as they returned home. I prepared to address all medical emergencies accordingly, using 911, if necessary. If an adverse event

occurred, I was aware of my obligation to contact my chairperson and the Walden University IRB immediately. Fortunately, there were no medical emergencies, nor did I have to refer anyone for services. All participants were aware that they could withdraw from the study at any time without concern. Although it was not required by the Walden University IRB, I included a sample withdrawal letter for participants, if desired. Participants were also advised that they were welcome to inform me by phone or email that they wished to exit the study. As previously stated, if a participant had already engaged in a recorded interview, I was prepared to delete all materials and shred any related transcriptions. This did not occur with any participant.

Summary

I explored the lived experiences of spouses of soldiers who returned from combat in Iraq or Afghanistan and developed posttraumatic stress disorder directly related to the combat experience. I limited my study to spouses of Army Reservists; as multiple studies have been conducted on this topic. This population represents a minority population of the military. There were distinct gaps in the literature, as few studies explored the effects of PTSD upon male spouses of female soldiers or among same-sex couples. Additionally, there was no current literature less than five years old that addresses these effects among the spouses of Reservists and members of the National Guard. Finally, few studies addressed these issues among spouses of members of the reserve or National Guard. In this study, I selected ten participants for the study or until I achieved saturation. I conducted semistructured personal interviews, either face-to-face or by phone. I explored

the experiences of secondary traumatic stress in spouses of soldiers, as related to the soldier's symptoms of PTSD. I discuss data collection and analysis in Chapter 4.

Chapter 4: Results

In this qualitative phenomenological study, I used a hermeneutic approach to explore the lived experiences of spouses of Reservists who returned from Iraq or Afghanistan with combat-related PTSD. I used the CATS model to explore the experiences of spouses of Army Reservists as they reacted to and attempted to cope with the PTSD symptoms exhibited by the soldiers. The participants consisted of eight female spouses of male Army Reserve soldiers with combat-related PTSD from service in Iraq or Afghanistan. I derived the data from individual personal interviews, which I conducted either face-to-face or by phone. All participants provided informed consent, which included information about the protocols indicated by the Walden University IRB. Participants answered eight open-ended semistructured interview questions to explore spouses' lived experiences after soldiers returned home from combat in Iraq or Afghanistan. The research question for this study was the following: What is the meaning of the lived experiences of spouses of soldiers who have developed combat-related PTSD symptoms after serving in Iraq or Afghanistan?

Although there were no issues that affected client participation at the time of the interviews, there were personnel issues that occurred after conducting the first two interviews. Prior to conducting the initial interviews, I recruited a former colleague to serve as my transcriptionist. I provided her with the audio recorder for the first interview, but she was unable to conduct the transcription. My transcriptionist did not disclose to me that she was a former military spouse of a soldier with combat-related PTSD. Upon listening to the first few minutes of the interview, she reported experiencing emotional

distress that prevented her from proceeding. My former colleague notified me of the dilemma immediately and returned the audio recorder to me at that time.

In Chapter 4, I provide introductions for my participants, including brief descriptions of marital status, demographics, and the combat zone where their spouses served. I discuss my procedures for data collection and analysis, including the challenges that I experienced during the process. I provide a description of how I ensured trustworthiness in my study. Finally, I discuss the results of my study.

Setting

I conducted my qualitative interviews in locations that were most comfortable for the contributors. I did not conduct any interviews on a military installation. Six participants requested phone interviews due to their location. Participants voluntarily met or spoke with me for these interviews and expressed no concern about confidentiality. All participants informed their spouses of their decision to join the study. None expressed any concern about repercussions for their spouses. As previously stated, all participants signed informed consent documents and were informed of the risks and benefits of taking part in the study.

Demographics

The demographics for this study included participants' age, race, and gender, as well as the country where the soldier served (see Table 1). I attempted to recruit participants within 100 miles of my home in New York State because I was familiar with the area and the protocol of the military installations in this area. Although I preferred to conduct face-to-face personal interviews, I located very few local participants. As a

result, I conducted most of my interviews by phone. I had difficulty obtaining permission to conduct my study on a military installation and eventually decided to change my recruitment method to snowball sampling. I obtained permission for the change from Walden University's IRB. Additionally, I received permission from two different Facebook sites related to military spouses to post my letter of recruitment. I obtained several participants using this method.

Table 1

Participant Demographics

Participant	Age	Race	Gender	Country of combat
P 1 Ann	48	Caucasian	Female	Afghanistan
P 2 Mae	32	Caucasian	Female	Afghanistan
P 3 Karen	45	Caucasian	Female	Iraq
P 4 Maria	35	Hispanic	Female	Iraq
P 5 Carmen	53	Hispanic	Female	Iraq
P 6 Jennifer	48	Caucasian	Female	Both
P 7 Jean	53	Caucasian	Female	Iraq
P 8 Jules	48	Black	Female	Iraq

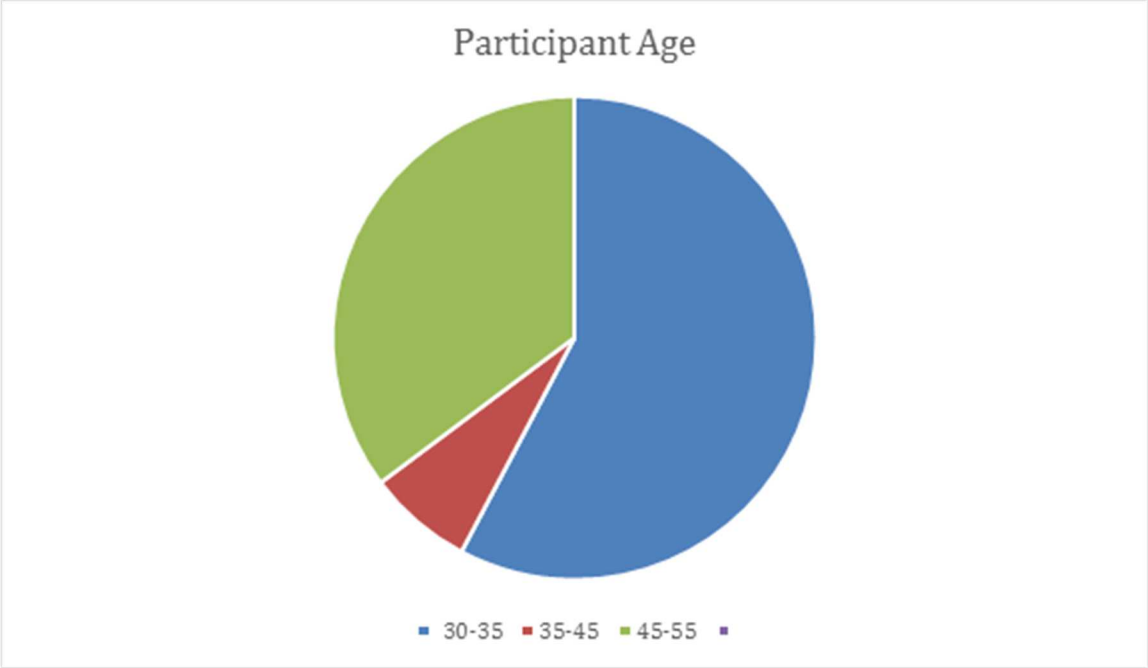

Figure 1. Age of participants.

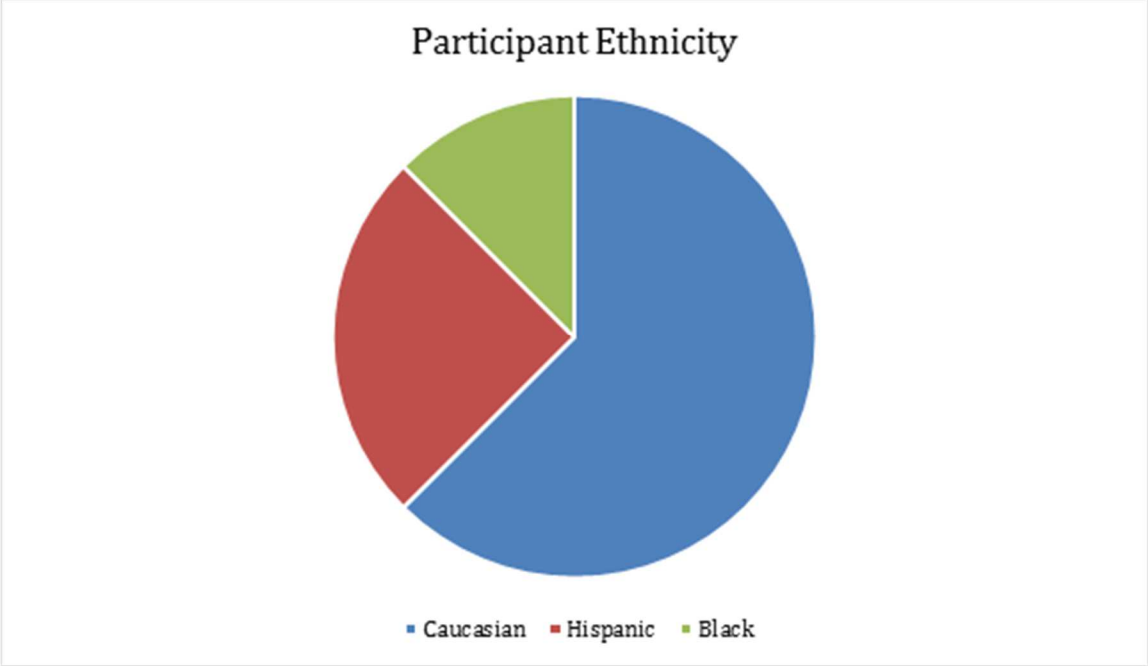

Figure 2. Ethnicity of participants.

P1, Ann

Ann was a 48-year-old Caucasian female who was married with four children. Her husband was a staff sergeant who served in Afghanistan. Ann's husband was wounded in combat and received a traumatic brain injury. Ann and her husband were still married and resided in Illinois.

P2, Mae

Mae was a 32-year-old Caucasian female who was married with two children. Her husband was a private first class and served in Afghanistan. Mae's husband was not injured during his combat experience. They remained married and resided in California.

P3, Karen

Karen was a 45-year-old Caucasian female who was married with two children. Her husband was a sergeant who served in Iraq. Karen's husband was not injured during combat. Karen and her husband were still married and resided in New York.

P4, Maria

Maria was a 35-year-old Hispanic female who was married with one child. Her husband was a specialist who served in Iraq. Maria's husband received non-life-threatening injuries in combat. Maria and her husband remained married and resided in Georgia.

P5, Carmen: Carmen was a 53-year-old Hispanic female who was married with five children. Her husband was a sergeant first class who served in Iraq. Carmen's husband was not injured during combat. Carmen and her husband remained married and resided in Colorado.

P6, Jennifer

Jennifer was a 48-year-old Caucasian female who was married with two children. Jennifer's husband was a sergeant and served in both Iraq and Afghanistan. Jennifer's husband was not injured in combat. Jennifer and her husband were divorced and resided in Arizona.

P7, Jean

Jean was a 53-year-old Caucasian female who was married with two children. Her husband was a sergeant first class and served in Iraq. Jean's husband was not injured in combat. They remained married and resided in New York.

P8, Jules

Jules was a 48-year-old African American female who was married with three children. Jules's husband was a sergeant who served in Iraq. Jules's husband was seriously injured in combat and was now disabled. Jules and her husband had separated but had recently reunited. Jules and her husband resided in New York.

Data Collection

I collected data for this study between August 3, 2018, and September 28, 2018. I conducted three face-to-face interviews in rural upstate New York. I conducted four other interviews by phone, due to participants' location. I interviewed one participant from Arizona, one from Tennessee, one from Georgia, and one from Virginia. Due to the transient nature of military families, I did not have any information regarding their geographical region of origin. I did not request their exact location as a means of maintaining their confidentiality. I recruited participants using snowball sampling with

Facebook, emails, personal recommendations, and word of mouth. I screened participants for eligibility either by phone, by email, or in person.

As a former Battalion Family Readiness Group Coordinator, I was well aware of the military protocol to interact with potential participants and was sensitive to their needs. Of the volunteers screened, 14 female spouses met the criteria for the study. One male spouse of a female soldier and three female spouses also met the standards but decided not to participate. One female participant appeared to meet the criteria but disclosed that she and her husband had not met until after his deployment. The remaining potential participants did not respond to my emails.

I conducted face-to-face personal interviews in locations determined by the participants, which included public libraries, cafes, and restaurants. Some participants chose to conduct their interviews by phone either due to their own convenience or location. Most participants preferred the option of a phone interview, due to family and work obligations. All participants allowed me to audio record their interviews. After each conversation, I wrote field notes, including any concerns that I had. I did not believe that this would be necessary as I began conducting interviews, but soon after, I discovered the benefit of doing so, as one spouse reported experiences similar to my own. I found that field notes helped me to manage my subjectivity, due to the personal sensitivity of the subject matter. I conducted one interview per day and transcribed the interviews as soon as possible afterwards. As previously stated, I originally arranged for a transcriptionist to transcribe the interviews, but she was unable to do so, as she did not originally disclose to me that she was a former military spouse herself. She was only able to listen to a few

minutes of the first interview before experiencing tertiary traumatic response. My former transcriptionist and I discussed the situation and agreed that it was best that she not continue with the project. She returned the audio recorder to me without completing any transcription. Due to her reported symptoms, I provided her with a list of mental health resources. I notified my chairperson of the change and decided to personally transcribe the remaining interviews. After completing the transcription of each interview, I hand-coded each document, searching for identifiable themes. While I originally planned to use a software program such as NVivo, I decided to hand code my interviews instead. After completing the coding process, I scheduled another appointment with each participant to review the information to ensure accuracy. I also invited participants' feedback. I met twice with all participants, either by phone or in person. I stored the transcriptions and field notes in a Dropbox that was accessible only to me. I was able to access these documents on my personal computer, which allowed me to have a seamless transition between my home and work offices.

Data Analysis

I used Colaizzi's method of data analysis to ensure the credibility and reliability of my results. Wirhanna et al. (2018) noted that Colaizzi's method may be used to reliably understand the experiences reported by participants. Per Colaizzi's method, I took the following steps to analyze my collected data: First, I listened to my recorded interviews to ensure that each interview was audible. After transcribing each interview in MS Word, I read the interview at least twice, to understand the content of the information provided by the participant. I highlighted specific identified statements in each interview,

which accurately described the phenomenon. I took these extracted themes and placed them in a separate document that I used to organize my themes. Using a template created for this purpose, I formulated meanings from specific participant statements and organized them into categories and subcategories. The stories and accounts of the participants appeared similar in nature and provided an exhaustive description of the phenomenon. With these identified themes and subthemes, I was able to describe the fundamental structure of the phenomenon (Shosha, 2012). Finally, after transcribing each interview, extracting themes, and providing an interpretation of the findings, I scheduled another appointment with each participant, either by phone or in person, to ensure that I accurately interpreted the participant's personal experiences. Per the information extracted from each qualitative interview, I identified three major themes and several subthemes, which I discuss later in this chapter. My original intent was to interview 10 spouses, but I was able to achieve saturation with 8 participants. I found no discrepancies in any of their reported experiences.

Evidence of Trustworthiness

In order to establish trustworthiness in this study, I provided a rich description of the methodology that I used, to assist future researchers who choose to conduct additional research of this topic or expand upon my findings (Gunawan, 2015). To strengthen credibility in my study, I used a reputable qualitative method to explore the lived experiences of spouses of soldiers who returned from combat in Iraq or Afghanistan with combat-related PTSD. My chosen method encourages researchers to free themselves from biases, assumptions, and feelings about human experiences. Qualitative

phenomenology allows the researcher to explore to understand how people experience a particular situation or phenomenon, with no regard to social or cultural norms, traditions, or preconceived notions about the experience.

I maintained contact with my participants throughout the study to discuss the transcriptions of their individual interviews, and I used member checking to ensure that I accurately described and understood their individual experiences. In terms of transferability, I hoped to interact with a more diverse population, but I experienced difficulty recruiting diverse participants. Despite this limitation, I recruited participants from different areas of the United States, and I was able to achieve saturation with eight participants. I used snowball sampling as a means of recruiting my participants. As previously stated, my primary method of recruitment was through social media (Facebook). I joined two different Facebook groups related to military deployment. I requested permission from the moderators to post recruitment letters. Each participant contacted me by email or Facebook Messenger to arrange a time to conduct a personal interview.

In the event that future scholars wish to replicate my study, I took steps to ensure that there was a clear, concise record of my methods, including a rationale for my decisions. I conducted an audit trail throughout the process, to ensure that I maintained an accurate account of the steps taken. I maintained close contact with my dissertation chair and often sought advice from other scholars. I also maintained close contact with my participants, providing them with a copy of their transcribed interviews, to ensure that I accurately reflected their experiences. Finally, I engaged in reflexive journaling, as I

discovered that one participant had similar experiences to my own. I discussed this in detail with my dissertation chair to ensure that I was free of any bias when I accounted for the participants' experiences.

Dependability in qualitative research is often challenged, due to changes in researcher insight and creativity, as well as interpretation among researchers (Guba, 1981; Petty et al., 2012). To strengthen dependability in my study, I sought frequent feedback from my committee chair, to decrease the chance of any bias. I wrote field notes after conducting each interview and used reflexive journaling as a means of processing the received data. I also used member checking and peer review, maintaining close contact with my participants and other doctoral scholars. I found it helpful to consult with other doctoral students and used their feedback from my field notes as a dependability trail.

In order to strengthen confirmability, as previously stated, I conducted an audit trail, outlining each step of the process, including field notes, interview questions, and observations during the interviews (Anney, 2014). Due to the sensitive nature of the content and my own personal experiences with the military, I also engaged in reflexive journaling, to provide a detailed description of my field activity. I found reflexive journaling to be helpful, as I was able to identify my personal experiences and perceptions during the interview process. Additionally, reflexive journaling was helpful for me to acknowledge and become more self-aware that there were limitations to my study (Engward & Davis, 2015).

Results

The research question for this study was as follows: What is the meaning of the lived experiences of spouses of soldiers who have developed combat-related PTSD symptoms after serving in Iraq or Afghanistan? After conducting an analysis of the data collected from the personal interviews, I discovered four distinct themes that suggest a direct connection between the PTSD symptoms in soldiers, and secondary traumatic symptoms reported by the participants. Based upon the transcribed interviews, I was able to ascertain three primary themes, with several subthemes: *Shifts in Relationships, Psychological Distress, Secondary Traumatic Stress, and Available Mental Health Resources*.

Shifts in Relationships

Through my semi-structured qualitative interviews, I identified several subcategories under the category of Shifts in Relationships, including a brief honeymoon period, lack of intimacy/ problems reconnecting, caregiver burden, sexual problems, and role difficulties. All participants reported similar issues within this category.

Honeymoon period. In the subcategory of honeymoon period, participants (Ann, Jean, Jennifer, and Jules) reported that their husbands "tried to act like the deployment never happened." Ann reported that the honeymoon phase for them lasted for approximately two weeks before she noticed any change in her husband's behavior. Ann admits that at first, she wanted to believe that her husband was exactly the same as before he left for deployment. Jean reported that her husband appeared the same, noticing only that he lost a significant amount of weight. "He was so happy to be home and to be with

us again." She reported feeling startled when she first noticed the change in her husband, as it

> came out of nowhere and I didn't know what to do to help him. I thought I was prepared for the changes, but I definitely wasn't. Other than the change in his weight, I thought he was the same person, but clearly, this was not the case.

Jennifer reported that she expected to see a change in her husband, but she did not notice anything right away. They did not have any children at the time of his deployment, and they were "inseparable" after he returned.

Lack of intimacy. Most participants reported a lack of intimacy with the soldier. Ann noted that she and her husband no longer possessed the closeness that they had prior to his deployment. She noted that they no longer held hands, cuddled, engaged in long conversations, and no longer had a strong connection. "It's like that part of our marriage was just gone." Ann reported taking this change personally. "I internalized this, thinking that there was something wrong with me." Mae reported a series of difficulties once her husband returned from Afghanistan. "I was pregnant with our first child when he left, and I had our son while he was deployed. So, it was definitely a big change to have him come home from Afghanistan, but also now to be parents and have a nine-month-old that he didn't really know." Mae admitted that it was a difficult adjustment for her, as she was accustomed to being by herself with her son. She admitted that she felt uncomfortable and did not know what to do at first. Jules reported "walking on eggshells all the time. I never knew what was going to set him off, or what he needed to be happy. I felt like everything I did was wrong. It made me a nervous wreck!"

Sexual problems. In addition to the lack of intimacy, some participants reported sexual problems. Ann reported that she and her husband had a healthy sex life prior to the deployment but noted that her husband had very little interest in sex after his return. "… after all, how can you have healthy sex when he was constantly 'sleepless in Seattle', checking everything all the time." Ann admitted that she internalized her husband's lack of sexual interest, believing that there was something wrong with her. She denied any concern with infidelity during the deployment, but noted that she worried that she was "not attractive enough, not smart enough, not tall enough, etc." Jules noted that her husband became hypersexual, "to the point that he wanted sex all the time. The problem was, he started getting it from other women, too. I just couldn't handle that. It made me feel so inadequate. I was so damned angry for so long!" Maria reported sexual problems immediately. "I didn't feel any love from him, it was just sex. There was no closeness. I just felt like he was satisfying an itch. It was so hurtful to me!" Jennifer reported similar circumstances, stating that her husband rarely showed any affection towards her. "I worried that I wasn't attractive to him anymore, and even had suspicions that he was unfaithful during his deployment. I heard that a bunch of guys were unfaithful…"

Role difficulties. A few participants reported difficulties with roles following the deployment. Jean reported that she had become used to assuming all household chores and had some difficulty relinquishing some of these responsibilities upon her husband's return from Iraq. Although Jean's husband returned from deployment ten years ago, she admitted that she still struggles with roles. "I guess I never went back to asking anyone for help. I was so used to it and still am." Mae reported difficulty parenting, as her son

was born during her husband's deployment. She noted that she was a single parent for nine months, then had to share that role with her husband. She admitted struggling with this concept for quite some time. Although she wanted her husband to get to know his son, she admitted becoming accustomed to a certain way of doing things. Ann reported her frustration with the change in roles, as she reported "feeling more like his mother than his wife. I had to constantly pick up after him! I resented that so much!"

Caregiver burden. All participants reported issues with caregiver burden. Every participant reported difficulty coping with their spouses' isolation, noting that it also affected them. Everyone noted that their soldier did not want to be around extended family or friends immediately upon returning home. Most participants reported difficulty coping with this behavior. Carmen noted that she was anxious to take her husband back to church, as she wanted to "show everyone that he was safely home again and give thanks to God." Karen reported that her husband did not want anything to do with his friends, nor did he want to see anyone, which caused her great concern. She admits that she felt isolated, herself, as she felt compelled to avoid family and friends, as well. Carmen reported that her husband "isolated himself in the bedroom for hours at a time. I didn't know what to do! Do I spend time with him up there, or do I leave him alone? It was so confusing!" Jean reported that she lost several friends after her husband returned from combat, as he did not want to spend time with other people. She admitted that it was a very lonely time for her, and she started developing symptoms of depression. Maria reported her frustration, as she felt that she had to be the buffer between her husband and everyone else. "I had to watch over him constantly to make sure he didn't argue with

people. It took such a toll on me!"

Psychological Distress

The second theme that I identified from my interviews was psychological distress. All participants reported some aspect of psychological distress, which they attributed to the deployment and as related to the shifts in their relationship. Participants reported symptoms of anger, anxiety, and depression. Dekel, Siegel, Fridkin, and Svetlitsky (2018) noted that current literature suggests that female spouses of soldiers with PTSD are at an increased risk of developing mental health symptoms due to their empathic nature. After I conducted qualitative semi-structured interviews with eight female participants, I determined similar results in support of the current literature.

Anger. Ann reported her anger and frustration regarding her husband's inability to remember basic household tasks. "I got so mad at him! I couldn't understand why he didn't remember and started thinking that he had early Alzheimer's." In addition to his diagnosis of PTSD, this participant's husband also received a traumatic brain injury from a combat mission. She acknowledged that she did not understand the nature of a traumatic brain injury at first, but now believes that caring for her wounded warrior is more complicated than some.

Ann was most forthcoming about her feelings of anger. Ann reported feeling shocked and angry when her husband hit their dog out of frustration, "then went back to eating his dinner like nothing ever happened." She was angry with him for his lack of intimacy and affection, as well as his inability to perform typical household tasks. Ann stated that her husband tried to attribute her symptoms to the early onset of menopause,

which she reported infuriated her. She admitted that she internalized many of her husband's behaviors, thus affecting her self-esteem and self-efficacy. Jules admitted having extreme anger towards her husband, as he resumed heavy drinking upon his return from Iraq. She acknowledged having a different expectation of him, as he had no access to alcohol for nearly one year. She admits hoping for a different outcome.

All participants reported similar experiences where they were affected by their spouses' anger. Jean reported feeling helpless and scared after her husband lost his job, due to his anger. Karen reported feeling on edge "all the time" when her husband became much more aggressive, which affected his job performance in law enforcement. Jules and Carmen both reported feeling anxious and hypervigilant, because their husbands yelled more often, "even over the smallest thing!" Jennifer reported one incident of domestic violence from her husband. "He pushed me up against a wall when we had an argument. He never, ever did this before!"

Anxiety. Four spouses (Jean, Karen, Jennifer, and Ann) reported anxiety in response to risky behaviors from their soldier. Most notably, participants expressed concern related to high levels of spending and worried about financial hardship. Jean reported that within the first two weeks after her husband returned, they purchased new furniture, a new grill, a new PlayStation 4, and several other household items. Karen reported that while her husband was deployed, she proudly saved six thousand dollars, which was a lot of money to them. She noted that her husband became paranoid and started spending massive amounts of money to ensure that they could become autonomous, as he feared the end of the world. She reported feeling upset and

disappointed that her husband "blew through the money so quickly. No one in our house likes tuna, but we had lots of it!" Ann reported feeling "keyed up all the time," as she never knew what to expect next from her husband. She acknowledged worrying about him all the time, and had difficulty concentrating at work.

Depression. Several participants reported symptoms of depression. Jules reported feelings of helplessness that her husband stopped showering all together and struggled every day to get out of bed. She admitted to being slightly less attracted to her husband, due to his lack of hygiene and his lack of physical exercise. Jules admitted feeling guilty for her decreased attraction to her husband. Mae also reported feeling anxious and depressed in response to her husband's depressive symptoms. Jean reported her anger that her husband had very little ambition and sat in front of the television most of the time or played his PlayStation. She also indicated feeling less attracted to her husband due to his lack of hygiene and had feelings of guilt. Jennifer admitted that in response to her husband's depression, she became very depressed, herself. She admitted feeling as though things were hopeless at times. "I just wanted my life back!" She and her husband eventually separated and are now divorced.

Karen appeared to cope most effectively, as she disclosed the least amount of distress and did not feel the need to seek mental health treatment. The other spouses admitted feeling isolated, sad, displaced, and wondered if any aspect of their lives would ever return to normal. Most spouses attended briefings prior to the soldiers' return from combat, yet all admitted that they were not fully prepared in terms of what to expect. Mae reported that she felt robbed after her husband came home, as he had no interest in

engaging in most activities, and still had to do things on her own. Ann reported feeling depressed as she blamed herself for her husband's lack of intimacy. She noted that she questioned whether she was pretty enough, smart enough, etc. She also admitted feeling depressed, as she "tried so hard to fix everything." Ann admitted to having nightmares that her husband was seeing a woman who looked completely different from her.

Secondary traumatic stress. In addition to the symptoms of psychological distress reported by participants, I also discovered the frequent presence of *Secondary Traumatic Stress,* which I considered the third theme. Per the results of my qualitative interviews, I identified notable symptoms of hypervigilance and isolation. While it is understood that Secondary Traumatic Stress is not listed in the DSM-5 (APA, 2013), all participants reported symptoms similar in nature to the PTSD symptoms from their spouses. Although I screened all participants for eligibility for the study, I did not provide them with a mental health evaluation, nor did I render any diagnosis. Two spouses indicated that they had past symptoms of depression.

Hypervigilance. All participants reported hypervigilance, in direct response to the behaviors exhibited by their spouses. Per their report, this reported symptom appeared to be most similar in comparison to the symptoms shared by their spouses. Ann reported difficulty sleeping most nights, as her husband "constantly got up in the night to check the doors and windows." As previously stated, Karen reported feeling anxious that her husband was unable to function unless he was armed at all times and felt that she had to "keep an eye on him most of the time." Jean reported feeling confused that her husband still takes caution where he parks in a parking lot, ensuring that he "always has

an easy way out." All participants reported difficulty with fireworks and noted that they take all steps to avoid them. Carmen expressed her frustration, stating that "no one understands what it is like for soldiers when they hear the sounds of fireworks. For my husband, it takes him back to Iraq every time."

All spouses reported that they feared the unknown in multiple situations. Jean reported that simply going shopping with her husband was difficult, particularly when he first came home, as he was often confrontational with diverse populations. She noted that her husband often made loud remarks about the hygiene of Middle Eastern individuals, which deeply embarrassed her. Karen reported increased concern when her husband was working, due to the increase in his aggressive behaviors. As a member of law enforcement, she worried if her husband "would go too far." Ann admitted feeling anxious long after her husband's return, not only due to his behaviors, but due to a mix-up when her husband was injured. Ann stated that her husband was in fact injured during his deployment. She was about to receive a visit from a casualty affairs officer, as one of his fellow soldiers was killed. She reported that her husband called her and advised her of the "mix-up," which helped forewarn her, but she felt anxious, even after hearing from him. Ann reported reliving that conversation for a very long time afterward.

Isolation. All spouses reported feeling alone. Although approximately half of the participants engaged with the Family Readiness Group (FRG), the others indicated that they did not have a strong group in place. Several spouses believed that they did not have the same type of support that active duty spouses received. Mae noted that 50% of the people in her town were military, but most were active duty soldiers, but reported that

there was a difference for those who lived on base. She could not recall anyone from her husband's reserve unit reaching out to her. She did not believe that most people understood what she was experiencing, particularly because she and her husband did not have other military friends. Jules admitted her hesitation to reach out to anyone else, as she was embarrassed by her husband's substance use and infidelity. She did not believe that anyone "could possibly understand" and reported that she felt like she was the only one with such experiences. Carmen reported that her husband was active guard reserve (AGR) and felt particularly isolated from others. She did not have the comradery afforded to active duty spouses and had no friends in the military. All spouses reported feeling misunderstood by members of their community and received minimal, if any support.

Available Mental Health Resources

The final identified theme was *Available Mental Health Resources*. As previously stated, only half of the participants reported any involvement with the FRG, while others reported no military support during their spouse's deployment. Only one participant (Mae) reported living in a community consisting of other military families. The remaining participants reported residing a considerable distance from the Army Reserve Unit. Five participants (Ann, Jean, Karen, Jules, and Carmen) reported residing within 70 miles of an active duty military installation but indicated that this duty station had nothing to do with their spouse's reserve unit. All participants felt isolated from other military families and had little understanding of military life. Most participants indicated that that they only used the military health insurance (Tri-Care) during the deployment and were unaware of any other services available to them upon the soldiers' return.

Jean shared that she began seeing a therapist prior to her husband's deployment and engaged in ongoing services while her husband was in Iraq. She reported that she continued with therapy for a few months after her husband's return, which helped her to process her "ever changing feelings." Ann stated that she sought therapy, but did not do so for two years, stating "I wanted to fix things by myself." Ann indicated that she had a friend who was a mental health counselor, and often talked to her about her feelings. She noted that her friend helped her to understand the nature of PTSD and traumatic brain injuries. Ann admitted that she had many issues to address in therapy, as she internalized so many of her husband's behaviors. Ann reported that therapy was helpful, but she still has issues with her husband that require strong coping skills. Mae reported that she and her husband went to counseling for nearly three years following his return from deployment. She noted that their therapist required them to read several books related to PTSD, one from the perspective of the spouse, and the other from the soldier. Although she states that the therapy was helpful, she admitted having difficulty reading some of the books, as she considered them "depressing." Ann also reported reading "everything I could get my hands on that was related to PTSD." Karen noted that her husband received therapy from a therapist in private practice, and still sees him occasionally, when necessary. She did not receive any therapy on her own. She stated that she coped fairly well and did not feel the need to pursue services. None of the participants reported any awareness of available resources, including Military One Source. Ann reported thinking that this service was available for "people who used drugs." None of the participants reported any resources offered by their spouse's reserve unit following the deployment.

Carmen reflected her frustration, stating “once they were back home, the army cut them lose and acted like they didn’t exist. They could pursue services at the VA clinics, but there was absolutely nothing for us.” Jules reported similar experiences, stating that her husband attended “a couple of counseling sessions,” but did not continue. “We didn’t have any health insurance after he came home, but it didn’t even matter. It’s not like there was anyone in this area qualified to work with military issues.” Maria reported a similar experience. “I went to see a therapist for two or three sessions, but I didn’t continue after that. I felt like the therapist was taking my husband’s side and had no idea what I was feeling.” Jennifer reported that she tried to persuade her husband to attend couple’s therapy, but he refused. “He didn’t want to admit that anything was wrong.” Jennifer began attending counseling after she and her husband separated. Although they did not reunite, Jennifer believes that therapy was helpful for her to understand her experiences. She does not blame her husband as she did in the past. “Sometimes, even good marriages don’t survive deployments.”

Of the 8 participants, each shared similar stories regarding their personal experiences following their husbands’ return from combat. I was able to identify three primary themes from my analysis of their individual personal interviews. As previously stated, only Karen reported minimal coping difficulties, although she reported many difficulties in response to her husband’s behavior. Although there was a slight variance in her ability to cope with her husband’s behaviors, her experiences were otherwise similar in nature to those of the other participants.

Couple Adaptation to Traumatic Stress Model

The couple adaptation to traumatic stress model is used to describe how couples respond to trauma. The model is used to describe the nature of the traumatic event upon the primary survivor, the effects of the trauma upon the significant other (known as the secondary trauma survivor), and the effects from the secondary trauma survivor upon the primary trauma survivor. According to Nelson-Goff and Smith, (2005), the CATS model is dependent upon three specific factors: the individual level of functioning of both partners, predisposing factors and resources, and the functioning of the couple. Nelson-Goff and Smith identified predisposing factors such as childhood trauma, mental illness, individual's coping skills, and trauma-specific characteristics. Regarding the functioning of the couple, Nelson-Goff and Smith considered attachment issues, relationship satisfaction, support, stability, adaptability, intimacy, communication, and conflict as primary factors in the CATS Model.

In order to be eligible for participation in this study, all soldiers must have received a diagnosis of PTSD by a qualified mental health professional. All participants reported feeling the effects of their husband's PTSD. I applied the use of the CATS Model for each participant as follows:

P1, Ann. Ann reported that her husband had strong symptoms of PTSD, as well as affects from his traumatic brain injury. Ann reported that her husband experienced frequent nightmares, flashbacks, exacerbated hypervigilance, anger, memory loss, and anxiety. Ann reported some personal history of depression, which she attributed to multiple miscarriages. Ann denied any history of childhood trauma and believed the she

coped reasonably well with the loss of her pregnancies. In her interview, Ann reported extreme difficulty coping with her husband's behavior. She reported feeling disconnected with him, due to his changing behavior and her frustration for her inability to help him. Ann acknowledged developing symptoms of her own, including anger, anxiety, depression, frequent nightmares, and hypervigilance. Ann reported relationship dissatisfaction due to multiple stressors, including her husband's behavior and lack of intimacy. She reported that her husband was affected by her symptoms, often becoming frustrated with her. Ann stated that her husband did not understand the nature of her symptoms and believed that she was developing symptoms of menopause. Ann does not believe that her husband understood that her symptoms developed in direct response to his PTSD symptoms.

P2, Mae. Mae reported that her husband exhibited strong symptoms of anger, frustration, and hypervigilance. She noted that her husband was always looking at his surroundings, wondering what other people were doing. She stated that her husband always had to be aware of the exits. Mae noted that driving with her husband was stressful, as he constantly looked around him, wondering who was trying to harm him. Mae denies any personal mental health history, but reported that she developed symptoms of depression, as she continued to feel isolated. She reported feeling robbed, as she continued having to do things on her own and acknowledged becoming resentful. Mae noted feeling afraid at times, particularly when her husband was asleep, worrying that he might impose harm upon her. Mae reported that her husband was angry when she began exhibiting her own mental health symptoms, as he did not understand how the

deployment and his symptoms affected her. Mae and her husband engaged in couple's counseling.

P3, Karen. Karen reported that her husband exhibited strong symptoms of aggression and hypervigilance. She stated that her husband was more physically aggressive in his job capacity in law enforcement. She also reported that her husband spent a great deal of money stockpiling items, as he feared for the end of the world. She stated that he never went anywhere without his side arm, even when mowing the lawn. Karen was distraught by her husband's changing spending habits upon his return and reported symptoms of anxiety that was related to his behavior. She denied any previous history of mental health symptoms, including any past trauma. Of all the participants, Karen appeared to cope the best with her husband's developing symptoms and did her best not to show any anxiety in the presence of her husband. Since doing so, her husband was not affected by her own symptoms.

P4, Maria. Maria reported that her husband exhibited symptoms of anger, increased aggression, flashbacks, and hypervigilance. She reported her own history of anxiety and depression, as her parents divorced when she was very young, and she did not see her father for several years. She reported developing symptoms of anxiety in response to her husband's behavior, particularly after he became confrontational with others. As previously stated, Maria often strived to deescalate situations when her husband became argumentative with others, as she stated that she never knew what to expect when she was in public places. Maria reports that her husband became enraged

several times when she displayed symptoms of anxiety following verbal altercations with others. She reported that he accused her of not supporting him when he needed her most.

P5, Carmen. Carmen reported that her husband displayed strong symptoms of depression following his return from combat. She noted that he isolated himself in their bedroom and did not want to interact with other people. Carmen reported that her husband was easily agitated and frequently yelled at her and the children. She admitted that when her husband yelled, it triggered past trauma experiences for her, as she was the victim of domestic violence from a previous relationship, where she was badly beaten. Carmen reported that she became more anxious and hypervigilant in response to her husband's changing behaviors. She stated that her husband often became angry with her when she displayed any type of anxiety. He became angry when she expressed feelings of disappointment when he was unwilling to leave the house, even to attend church services.

P6, Jennifer. Jennifer reported that her husband became depressed after returning from combat. He often isolated himself and was anxious and irritable. Jennifer reported that prior to the combat experience, her husband was not an angry or violent person, but began exhibiting aggressive behaviors upon his return. She indicated that during an argument, he shoved her against a wall, which was out of character for him. Jennifer began developing symptoms of depression, anxiety, and hypervigilance. She had some nightmares following their domestic incident but indicated that they did not last long. Her primary concern was hypervigilance, as she "walked on eggshells all the time." Jennifer acknowledges that she had a past history of trauma, as her father drank heavily and was violent towards her mother when she was present. Jennifer was removed from her

parents' home at age 12 and was placed with her aunt and uncle. She reported that her husband was remorseful after their domestic incident but became angry with her when she displayed any of her own symptoms, frequently reminding her that she had "no right to be traumatized."

P7, Jean. Jean reported that her husband isolated himself and did not want to interact with others. He was depressed and cried easily. He was angry and confrontational with others and easily lost his temper. Jean reported that while her husband never experienced any nightmares, he was extremely hypervigilant and always had to be aware of his surroundings. In response to her husband's behaviors (particularly in public) Jean became particularly anxious and hypervigilant. Jean acknowledges that she experienced some anger but noted that her anger was directed at the poor quality of mental health services that her husband received when he did decide to engage in treatment. Jean reported a history of depression and anxiety, reporting that she was involved in a serious automobile accident at age 16, where her passenger was seriously injured. Jean reported that her husband was loving and supportive but stated that he became angry with her if she became anxious when they were in public. He accused her of "throwing him under the bus" with her therapist when she reported how she felt when he made comments about Middle Eastern people in public.

P8, Jules. Jules's husband was seriously injured in combat, as his vehicle was hit by an improvised explosive device (IED). Upon his return, Jules reported that her husband was angry, depressed, and hypervigilant. He experienced nightmares and flashbacks and had difficulty interacting with others. Jules reported that although her

husband drank before the deployment, his drinking significantly increased, and he began having sexual relationships with other women. Jules reported that she developed symptoms of depression, feeling particularly guilty for her decreased attraction towards her husband due to his poor hygiene. She reported feeling anxious, as her husband yelled a great deal of time, particularly when he was intoxicated. Jules reported feeling angry due to her husband's frequent indiscretions. Jules reported a history of depression. She stated that her husband became enraged if she exhibited any symptoms in his presence and blamed her for the reason that he stepped outside of their marriage. Jules reported that her husband accused her of not supporting him and blamed her for his increased drinking.

Summary

When exploring the lived experiences of spouses of Army Reservists who returned from deployment with combat-related PTSD, it appears that most spouses developed some mental health symptoms of their own, in response to the soldiers' symptoms. These symptoms include, but are not limited to depression, anxiety, hypervigilance, anger, and frustration. Using semistructured qualitative interviews, I was able to identify 4 specific themes with several subthemes. Of the 8 participants, only one exhibited minimal mental health symptoms and appeared to cope well, despite ongoing stressors. Of the 8 participants, 2 reported that their marriages ended and attributed the divorce to the deployment experience. Of the 2 participants reporting divorce, one participant (Jules) recently reported that she and her husband reunited and did not complete their divorce proceeding. Using the CATS model, I was able to identify the

connection between the PTSD symptoms and behaviors exhibited by the soldiers, and the mental health symptoms that developed among the spouses. Most participants reported negative responses by the soldiers, as spouses displayed their own symptoms. In the final chapter of this study, I discussed the findings, addressed the limitations, provided recommendations for future research and offered implications of the findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

As the War on Terror enters its 18th year, it has become the longest military conflict in the United States in recent history (Byman & McCants, 2017). Due to the multiple deployments to these combat zones, the need for Reservists and National Guardsmen remains high (Polusny et al., 2016). Soldiers continue to report symptoms of PTSD at alarming rates, which deeply affects military families regardless of their active duty status (Polusny et al., 2016). Although STS is not included in the DSM-5 (APA, 2013), military spouses continue to express mental health symptoms that they attribute as a response to the PTSD symptoms reported by soldiers. The purpose of this qualitative hermeneutic phenomenological study was to explore the lived experiences of spouses of Army Reservists who returned from Iraq or Afghanistan with combat-related PTSD. My description of the spouses' experiences depicts a significant need for accessible mental health services for spouses, which do not appear to be available at this time.

In this study, I discovered four primary themes, consisting of *shifts in relationships, psychological distress*, *secondary traumatic stress*, and *available mental health resources.* In the first theme (shifts in relationships), I discovered issues with intimacy, sexual problems, role difficulties, and caregiver burden. In the second theme (psychological distress), I discovered issues with anger, anxiety, and depression. In the third theme (secondary traumatic stress), I uncovered issues of hypervigilance and isolation. In the final theme (available mental health resources), there was a notable lack of services for spouses, and participants were not aware of any resources available to

them. In this chapter, I provide a discussion of the findings, limitations, and implications from the study and offer recommendations for mental health resources, as well as recommendations for additional research.

Interpretations of the Findings

In this qualitative phenomenological hermeneutic study, I conducted semistructured personal interviews with eight spouses of Army reservists who returned from Iraq or Afghanistan with combat-related PTSD. All eight participants reported distress on some level, which they attributed as a direct response to their soldier's behaviors and symptoms; this result was similar to those of other studies (Bjornstad et al., 2014; Dirkzwager et al., 2005; Renshaw et al., 2011). Of the eight participants, one spouse appeared to experience the most distress, as her husband had a significant injury during his deployment and suffered from a traumatic brain injury. Of the eight participants, this spouse (Ann) reported the most residual effects from the deployment, both for herself and for her spouse. Studies conducted by Renshaw, Rhodebaugh, and Rodrigues, (2010) and Reshaw, Rodriques, and Jones, (2008) support the findings in this study, indicating that the severity of PTSD symptoms leads to spousal distress. Additionally, Rajabi-Mashhadi, (2015) determined that the behavior of the trauma survivor determines the level of caregiver distress. One participant (Karen) reported the least symptoms, despite problematic behaviors from her husband. Karen appeared to cope and adjust well to her changing circumstances. Karen's interview supports the findings reported by Nelson-Goff and Smith, (2005), which indicated that the level of trauma experienced by the primary trauma survivor affects the perceptions of the secondary

trauma survivor. The findings noted in my study with all participants support the study conducted by Weinberg, (2011), who asserted that the coping skills of the caregiver affect the adjustment of the trauma survivor.

Monson, Taft, and Fredman (2009) and the U.S. Department of Veterans Affairs (2015) reported that substance abuse, domestic violence, and marital issues were related to PTSD symptoms in soldiers. All spouses reported that their soldier's PTSD symptoms and behaviors negatively affected their marriage to some extent. One couple subsequently divorced. Most couples continued to struggle with marital issues. Nearly all spouses reported strong relationships prior to the deployment to Iraq or Afghanistan. One participant (Jules) reported a significant increase in alcohol consumption, as well as infidelity in her marriage. Seven of the eight participants reported a significant decrease in marital intimacy.

Ahmadi et al. (2011) asserted that caregivers of individuals with PTSD have an increased likelihood of developing STS. The findings of my study supported this, as nearly all participants developed symptoms of distress in direct response to their spouse's PTSD. Nelson-Goff (2016) reported that both parties may be affected when one shares information regarding a traumatic event. This was certainly reflected in my study, as one participant (Ann) developed additional distress when she was mistakenly notified that her husband had died. Although this was not the case, she continued to develop symptoms when her husband shared information about the event. Ann acknowledged that her husband became angry in response to her symptoms, noting that she was not there and did not have a right to her feelings. Ann's experiences also support the study conducted

by Baum et al. (2014), who asserted that individuals often develop symptoms of STS based upon knowledge of or direct exposure to a traumatized individual. Additionally, Greene et al. (2015) asserted that the knowledge that a loved one experienced a traumatic event constitutes firsthand trauma.

In contrast, Summers et al. (2016) reported that there are several studies that support soldiers disclosing the nature of trauma to their spouses, as they benefit both physiologically and psychologically. My study did not support this assertion, as most spouses developed psychological distress in response to the disclosure from the soldier. Additionally, nearly all participants reported that their soldier became angry in response to their reactions as the spouse. Summers et al. reported that the soldiers who disclosed the least amount to their spouse developed the most psychological health issues and decreased relationship satisfaction. Although I did not explore the overall psychological health of the soldiers, the aforementioned study does not support the findings in my study. In support of my study, Campbell and Renshaw, (2012) reported increased psychological stress in spouses when soldiers shared their traumatic experiences. In my study, all but one participant reported increased distress in response to the soldier's behavior and reported symptoms. Additionally, Weinberg, (2011) asserted that the coping skills of the primary traumatized individual are connected to the spouse's response to the primary individual's ability to cope.

One participant (Karen) reported the least psychological distress in response to her husband's deployment. This appeared to be related to the concept described by Joseph and Afifi, (2010) as *protective buffering.* Karen reported that her husband did not

disclose many details related to the deployment, nor did she push the issue. Upon her husband's return from combat, Karen noted that she did her best not to respond negatively to her husband's changing behavior, although she acknowledged that she felt distressed. Winterheld, (2017) asserted that protective buffering may decrease the likelihood of relationship distress while serving as a means of self-protection for the person experiencing challenging circumstances. Of all participants, Karen reported the least amount of relationship discord following the deployment, which is in support of Carter and Renshaw's (2016) statement that open communication may negatively affect functioning. Ann displayed the highest level of psychological stress, which partially supports Carter and Renshaw's study. As previously stated, Ann reported receiving distressful news from her husband, as he was able to reach her by phone prior to receiving a visit from a casualty affairs officer. She did not disclose any additional information regarding their communication during her husband's deployment.

As stated in Chapter 4, all participants reported caregiver burden on some level. Rajabi-Mashhadi et al., (2015) noted that caregiver burden includes physical, emotional, financial, and social obligations. Per the results of my qualitative interviews, Ann reported more physical and psychological distress from her spouse, while Karen reported that her primary concern was finances. The results of my study support those of Rajabi-Mashhadi et al., as Ann's husband received a traumatic brain injury, likely contributing to her higher level of caregiver burden. Although Saban, (2016) conducted a study indicating that 40% of participants reported fair to poor general health, this was not indicated in my study, as none of the participants shared any concerns with their general

health. Saban indicated that participants attributed their health challenges to lack of support from family members. None of the participants in my study reported any concerns regarding lack of support from family members.

The results of the study support the CATS model, in that all of the participants were directly affected by the traumatic response of the soldiers. When applying the CATS model to the symptoms reported by the participants, there appeared to be a circular motion of response involving the primary trauma survivor (soldier), the effects of the primary survivor's symptoms upon the secondary trauma survivor (spouse), and the subsequent effects upon the primary trauma survivor (Nelson-Goff & Smith, 2005). In the current study, seven out of eight participants reported negative reactions from their spouses in response to their own symptoms. All seven reported that their spouses became angry when participants developed their own mental health symptoms. All seven of these participants reported that their spouses did not understand the nature of these symptoms, as the spouses did not experience any combat. Six of the eight participants reported prior mental health symptoms, including depression and anxiety. Two participants (Jennifer and Carmen) reported a history of trauma. Of the two, Jennifer struggled with her spouse's response to her mental health symptoms.

As stated in the literature review, Oseland et al., (2016) noted that trauma survivors often avoid certain events that may trigger memories of past trauma. All participants in my study reported that their soldier often avoided interactions with family and friends. Most participants reported frustration resulting from this behavior and indicated often feeling isolated and alone. One participant (Mae) indicated that she often

felt as though she were still a single parent, although her husband was present. Zearach et al., (2015) reported that when spouses display symptoms of STS, they are often unable to provide the necessary support for the traumatized individual and may become irritable at times when patience is most important. Nearly all participants reported negative reactions from their spouses in response to symptoms of anxiety, depression, irritability, and so forth, which exacerbated symptoms in all couples. As previously reported, Karen appeared to manage her own symptoms, resulting in the least amount of couple distress.

Limitations

For this phenomenological hermeneutic study, I explored the lived experiences of eight military spouses of Army reservists with combat-related PTSD and achieved saturation with this sample size. I recruited participants from several different states throughout the continental United States. All of the military spouses were female, as no male spouses chose to participate in the study. There were no same-sex couples, which could have affected the results of the study. There was little diversity in the sample, as five of the eight spouses were Caucasian, with two Hispanic and one African American spouse participating. Additionally, there were no participants under the age of 30, nor were any of the soldiers officers. Although I conducted interviews with spouses from different areas within the continental United States, I was only acclimated with the area in which I conducted the interviews personally. For example, I had no knowledge of the population, culture, or diversity of the location of participants located outside New York.

I experienced some difficulty with sampling, as I intended to conduct all of the interviews face-to-face at a military installation. I attempted to obtain permission from

the Battalion Commander to conduct my interviews at a specific battalion on post, but despite my efforts, I was unable to obtain permission. In order to conduct interviews on a military installation, I was required to have sponsorship from an officer with the minimum rank of Brigadier General. I was able to obtain this sponsorship easily, but without permission from the current Battalion Commander, I was unable to proceed. I made the decision to change my sampling from purposeful to snowball sampling, using Facebook groups that were specific to military spouses. I contacted Walden University's IRB to request permission for the change. After obtaining approval, I contacted the moderators of the specific groups, advising them of my study and requesting permission to recruit participants.

I originally planned to have a former colleague transcribe my interviews, but she was unable to complete the task due to emotional distress. She did not disclose to me that she was a former military spouse of a soldier with combat-related PTSD. She was only able to listen to the first few minutes of the first interview before she notified me that she was unable to proceed. I decided to transcribe the interviews personally and notified my participants of my decision. I originally expressed concern about bias, due to my own experiences as military spouse of a soldier with combat-related PTSD. I found that I related with the experiences of one participant, but I remained self-aware of the circumstances and sought supervision to address the issue. I remained in contact with my participants after transcribing the interviews to ensure that my transcriptions accurately represented their stories.

As the spouse of a retired soldier with combat-related PTSD, I shared many of the participants' experiences and feelings and shared much of the same background as several participants. I worked for 7 years as a Family Readiness Group Leader, either on the company or Battalion level. My involvement with the military provided me with a personal lens on military spouses and their experiences. I used reflexive journaling as a means of monitoring any potential personal bias. On the other hand, my understanding of the military culture and these shared experiences only underscored the importance of studying this particular population.

Recommendations

The findings for this study show that spouses of soldiers returning from Iraq or Afghanistan with combat-related PTSD display symptoms that are similar in nature to those of the soldiers. Although this is not evident in every military spouse, every participant in my study displayed some type of mental health symptom, including depression, anxiety, hypervigilance, anger, and isolation. As noted in Chapter 2, the literature suggests that females are more susceptible than males to developing symptoms of STS, due to their empathic nature. It remains unclear if spouses of higher ranked soldiers (officers) experience less symptoms or if there are additional resources available to them. Future research may answer this question.

For future research, it is important to explore the experiences of both female and male spouses, as well as same-sex couples and transgender individuals. I recruited all participants through Facebook pages. It is possible that fewer male spouses of soldiers participate on such sites. Future researchers should consider posting fliers in locations

close to military installations, including coffee shops and retail stores, as a means of recruiting male participants.

Another recommendation is for future researchers to consider conducting a longitudinal study to explore the experiences of spouses of soldiers returning from combat with PTSD over a longer period of time. A longitudinal study may determine a change in spouses' ability to cope with PTSD symptoms in soldiers, as well as develop more effective coping skills themselves. Although my study required soldiers to have returned from combat at least 1 year but no more than 14 years prior, I did not explore the experiences of the spouses over a specific period of time. Although all participants expressed some psychological symptoms during their qualitative interviews, it would be interesting to explore their experiences at a later time, to determine if symptoms were exacerbated, decreased, or remained the same. It would be interesting to contact these participants after 1 year to explore their experiences.

A final recommendation is to provide more training for FRG Leaders, as they often serve as the point of contact for all spouses and are often expected to assist spouses in resolving their problems. Prior to deployments, Regional Readiness Commands should conduct several training sessions for FRG Leaders, spouses, and family members to educate them on the topics of PTSD and STS. These trainings should be conducted by licensed mental health professionals. Additionally, FRG Leaders should be well aware of mental health services in the surrounding area, as well as other helpful organizations, such as Military One Source, and should be ready to make referrals as necessary.

Implications

Redmond et al. (2015) identified the military as a culture of its own. As stated earlier, soldiers often hesitate to seek treatment due to the stigma associated with PTSD symptoms (Kim et al., 2010). Similarly, spouses of soldiers also express concern regarding treatment, as their behavior reflects upon the soldier. As stated in chapter 4, spouses of reservists may face even more challenges, partly due to the potential lack of available services and the absence of support from the military community. Additionally, spouses of reservists are only covered by tri-care during the deployments and for a limited time following their return. Although Brown-Bowers (2012) recommended cognitive-behavioral conjoint therapy, Reservists and their spouses may find it challenging to participate in couple's counseling due to the time constraints associated with Tri-Care. It should also be stated that the military only recognizes evidence-based interventions such as cognitive behavioral therapy and acceptance and commitment therapy, which may limit treatment options (Carrola & Corbin-Burdick, 2015).

Mental Health Professionals

This study explored the lived experiences of spouses of soldiers who returned from Iraq or Afghanistan with combat-related PTSD. The results of this study identified a connection between the symptoms of PTSD and secondary traumatic stress. Understanding the connection between PTSD and STS provides an opportunity for counselors to consider the most appropriate interventions for this population. There is always the possibility that less experienced counselors may not have sufficient training to treat clients with trauma related to the military and risk causing more harm to the client.

While counselors may have the best of intentions, ill-prepared counselors commit ethical fallacies. An additional concern is the medical model (used for the last four decades) when combined with managed health care may significantly limit treatment options (Carrola & Corbin-Burdick, 2015).

In order to effectively work with military spouses, it is essential for mental health professionals to understand the military culture. This study identified a lack of services for spouses of Reservists, as well as minimal participation in the FRG among the participants. Mental Health professionals must understand the services that are available in order to make the appropriate referrals (Hall & Moore, 2016). For example, mental health counselors must understand the purpose of the FRG in order to encourage spouses to utilize their services (Hall & Moore, 2016). This study may promote social change by identifying the specific mental health needs of spouses of Reservists, as well as the lack of available services. As noted in Chapter 4, one participant in the study did not pursue mental health treatment, stating that no one in the area was qualified.

Counselor Educators and Supervisors

It is important for counselor educators and supervisors to understand that therapists who work with traumatized clients are at risk of developing vicarious trauma (Taylor, 2018). Although counselors may have some training related to trauma, the experiences of soldiers and spouses may extend beyond this training. Padaman, Shafranske, and Faldender (2015) reported that a strong relationship between supervisors and their supervisees increases the likelihood of an honest discussion of vicarious trauma. Counselor educators and supervisors must provide a safe environment in order to ensure

that less experienced therapists understand the potential symptoms for developing vicarious trauma.

As previously stated, Redmond et al. (2015) noted that the military is a culture in and of itself. Reservists may prove to be more of a challenge, due to the combination of both military and civilian life. It is important for counselor educators and supervisors to promote the development of cultural competence as related to the military, in order to understand spouses' specific needs and to provide appropriate services. This study identifies the perceptions and experiences of Army Reserve spouses of soldiers with combat-related PTSD, which appears to be less understood than with their active duty counterparts. When working with members of the military and their families, it is imperative that counselor educators and supervisors ensure that counselors understand military culture, including knowledge of the Army Reserves. Here, counselor educators have the opportunity to include military life and its stressors when teaching cultural competence to counselors-in-training. This study may serve to identify the importance of cultural competency, as related to the military and may promote the need for counselor educators and supervisors to include this understanding when teaching and supervising counselors-in-training. This study also serves to increase awareness of the effects of PTSD upon spouses of soldiers returning from combat and promote a better understanding of STS.

Conclusion

Since the War on Terror began, following the attack on the United States on September 11, 2001, there has been a significant increase in deployments for Reservists

and members of the National Guard (Polusny et al., 2015). Cohen et al. (2015) reported that the rate for PTSD among Reservists and members of the National Guard was 9.8%, compared to 8.9 % reported in active duty soldiers. Polusny et al. (2015) reported that prior to September 11, 2001, it was uncommon for Reservists to experience extensive deployments, particularly to a combat zone. Additionally, Polusny et al. reported that typically, Reservists are older than their active duty counterparts, more likely to be married, and are more likely to have children.

In this qualitative, hermeneutic, phenomenological study, I explored the lived experiences of spouses of Army Reservists, who returned from Iraq or Afghanistan with combat-related PTSD. My study consisted of eight female participants from various parts of the Continental United States. All participants reported some level of psychological distress, which they attributed to be in direct response to the PTSD symptoms and behaviors from their respective spouses. Although none of the participants reported any concern for the lack of support from family and friends, most participants reported limited support from the military and had limited (if any) resources for appropriate mental health services. In this qualitative, hermeneutic, phenomenological study, I identified the existence of Secondary Traumatic Stress among the participants and provided recommendations for interventions and future research.

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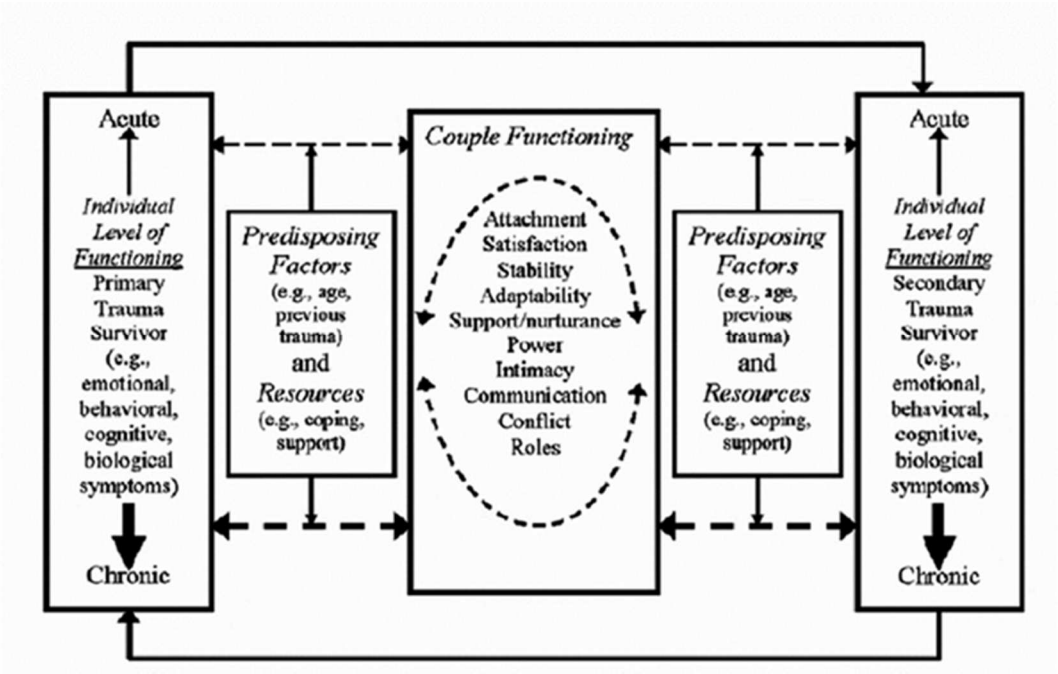
Appendix A: The Couple Adaptation to Stress



Appendix B: Letter of Invitation to Participate in the Study

Hi!

Thank you for permitting me to join your Facebook group. Allow me to introduce myself: My name is Wendy Whinnery and I am a licensed mental health counselor in the State of New York. As a doctoral candidate with Walden University (and the spouse of a retired Army Reservist), I am conducting a study among spouses of Army Reservists who returned from Iraq or Afghanistan with combat-related PTSD. My IRB approval number is 07-09-18-0346021.

Spouses of soldiers affected by combat-related PTSD often develop mental health symptoms of their own, similar in nature to those of the soldier. This is referred to as "Secondary Traumatic Stress." It is important to increase awareness among the military and mental health professionals that this problem exists, (and is more common than previously considered) in order to receive appropriate mental health interventions.

If you are a spouse of an Army Reservist who returned home from Iraq or Afghanistan with combat related PTSD, I would very much like to speak with you! I invite you to participate in a study where we will engage in a personal interview to talk about your experiences. The interview will last approximately 45-60 minutes, which I will conduct by phone. Please feel free to message me here or email me at: wendy.whinnery@waldenu.edu with any questions.

Thanks so much! I look forward to hearing from you!

Warm regards,

Wendy Whinnery, M.S., LMHC, NCC, CCMHC, CCTP, CASAC-T, Doctoral Candidate

Walden University

Wendy.whinnery@waldenu.edu

Appendix C: Withdrawal Letter

Researcher's Name: Wendy Whinnery, M.S., LMHC, NCC, CCMHC, CCTP, Doctoral Candidate, Walden University

Title of Study: Army Reservists Spouses' Perceptions of Secondary Traumatic Stress: A Phenomenological Study.,

Dear Wendy:

I want to end my participation in this study. Ending my participation means the research team may only use and share the information as indicated below:

I want to (please choose one):

[ ] End my participation in the study and not let the research team collect any more information about me (revoke my Authorization). My future health information may not be used by the research team. In rare cases, the research team may need to use my information even after I revoke my authorization, such as to notify me of safety concerns.

[ ] End my active participation in the study, but let the research team continue to

collect my information. The research team may continue collecting information from my medical record as needed for the study.

Optional:

I am ending my participation in this study because: _____

I will receive confirmation of this notice.

_____ _____

Signature of Participant Date

Appendix D: Interview Questions

1. What were your experiences when your spouse first came home from combat?
2. Tell me about your relationship with your spouse after he or she returned from combat.
3. Tell me about your soldier's experience with PTSD.
4. If his or her behavior changed since returning home, how has this behavior affected you?
5. Tell me about your experiences as you coped with his or her changing behaviors.
6. Describe your symptoms and tell me what steps you took after you started noticing these symptoms?
7. What resources were available to you as a military spouse?
8. What kind of mental health treatment did you receive, if any?