

The Experiences Of Women Whose Military Partners Have Been Diagnosed With Posttraumatic
Stress Disorder

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ABSTRACT

This qualitative study explores the experiences of women whose military partners have been diagnosed with Posttraumatic Stress Disorder. I sought to understand how PTSD impacted the day to day life of women, including the personal challenges that they encountered and the influence that PTSD had on family and couple relationships, as well as their ability to manage life stressors. I also wanted to explore whether resiliency was a factor in the overall experiences of the women. Additionally, I sought to gather information on the supports and coping skills that the women found most helpful in managing their day to day experiences.

Six women were interviewed for this qualitative study. From these interviews, 10 themes were developed: 1. Women's recognition of partner's PTSD symptoms was not immediate; 2. Women blamed themselves for their partner's changed behaviour; 3. PTSD caused significant stress to the couple relationship; 4. PTSD affected the family unit; 5. Women bore the burden and took on more responsibility; 6. Women forsake their own needs (personal sacrifice); 7. Women experienced intense negative emotions; 8. Women's health and well-being was negatively impacted by partners' PTSD; 9. Women gained new insights and no longer considered themselves responsible for their partner's illness; 10. Women demonstrated resilience and coping.

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Chapter One: Introduction

It is now widely recognized that soldiers returning from active combat and deployment can experience symptoms related to trauma (Paré, 2013; Zamorski, Rusu, & Garber, 2014). This recognition has led to an increased awareness of mental illness and the development of research and programs, which aid in better understanding combat-related trauma and supporting military members. However, while attention has turned to assisting the soldier, another issue has emerged. The effects of trauma extend beyond the individual and impact the entire family unit, notably female spouses or partners. The primary purpose of this qualitative study is to better understand the experiences of women whose military partners have been diagnosed with Posttraumatic Stress Disorder (PTSD) after returning from deployment.

Absent from early studies was the inclusion of research focused on the impact that this mental disorder had on the female partners of Canadian military members, as a result, the majority of research exclusively concentrated on PTSD and the soldier (Fikretoglu, Brunet, Guay, & Pedlar, 2007; Milliken, Auchterlonie, & Hoge, 2007; Pietrazk et al., 2010; Richardson, St. Cyr, McIntyre-Smith, Haslam, & Elhai, 2012). Overall, military spouses/partners have been excluded from sharing their stories of how mental illness has impacted and changed their lives and intimate partner relationships. Therefore, the main research question is: What is the experience of women whose military partners have been diagnosed with PTSD? Within the context of this broader question, I will concentrate on specific areas of the partner/relationship experience, such as caregiver burden, psychological distress, and violence in the relationship. Additionally, I will attempt to explore the impact that PTSD has had on both marriage satisfaction and the intimate relationship while also focussing on protective and resiliency factors within the couple relationship and how perceived individual and family resiliency and

vulnerability has influenced the experiences of the women. My examination of resiliency and protective factors is guided by the family resilience framework (Walsh, 1996). This framework, which is grounded in a systems theory of family resilience, identifies key processes that are helpful at reducing stress and promoting healing and growth within families facing adversity.

I have chosen to focus on the military community for two reasons. First, as the spouse of a veteran I have both a general interest in the military community and also firsthand knowledge of the unique circumstances and issues encountered by this population. Second, military personnel, like other professionals who serve to protect, often place themselves at considerable risk and may be exposed to combat-related trauma in the process of doing their jobs. Therefore, it is important to understand how to prevent or decrease both the risk of PTSD development and the coinciding symptoms so that military personnel can continue to secure and defend the rights of others while ensuring that military spouses and families remain resilient, healthy, and flexible to the ever-changing environment of military life. A thorough understanding of the spousal experience will allow for the development of supports and programs directed at securing individual and family resiliency while promoting prevention, decreasing symptoms, and lessening the impact that PTSD has on military members and their partners.

This study provides insight into the experience of a historically neglected group and gives voice to their stories and lives while also increasing the understanding of how PTSD impacts spouses/partners. In addition, I anticipate this information will be useful in determining the future of therapeutic intervention for military members and their families, as well as assist in removing the stigma and barriers associated with mental illness, such as PTSD.

Chapter Two of this thesis begins with a discussion of the research problem and the study objectives and significance. In Chapter Three, I present the current literature on the topic of

PTSD and veterans, and the impact on family and intimate relationships and Chapter Four includes a discussion of the methodology I applied to the research, my chosen theoretical framework, and data analysis. In Chapter Five, I present the study results of my research. Chapter Six includes a discussion on the themes and the linkages to current literature; and I present my conclusions and recommendations to social work research and practice in Chapter Seven.

Chapter Two: The Problem

Post-deployment related PTSD has received increased attention in recent years (Hoge, 2010; Wilk, Herrell, Wynn, Riviere, & Hoge, 2012; Worthington, 2012). In particular, media coverage of Canadian overseas deployment and mental health issues facing returning veterans has shed light on how PTSD has impacted Canadian soldiers (Corelli & Howse, 1994; Grant, 2014; McNally, 2002). While trauma associated with both peacekeeping and wartime activities is not a new issue, the increased awareness of how combat trauma influences Canadian military members and the growing need for mental health services that specifically treat and support both military members and their families has only recently been discussed and analyzed. Statistics also show that 41% of Canadian Forces (regular forces) are married/common law and have children (Canadian Forces Newspapers, n.d.). Most recently the Canadian federal government committed \$200 million to addressing mental health issues in the Canadian Forces and the Department of National Defense and the Canadian Armed Forces has promised an additional \$16.7 million to support currently serving military members, veterans and their families (“Mental health in the military”, 2014).

Historically, research and treatment has primarily focussed on PTSD and the soldier and as a result, the impact of the veteran’s mental illness on intimate family relationships and the family unit has been neglected. This omission is problematic as researchers have recently discovered that the consequences of trauma and PTSD extend beyond the traumatized person to negatively impact relationship stability (Monson, Taft, & Fredman, 2009) as well as communication, confidence in the relationship, commitment, marital satisfaction, cooperative parenting, and positive bonding within the intimate relationship (Allen, Rhoades, Stanley, & Markman, 2010). Thus, with increased public awareness of military-related trauma, research is slowly being expanded to include the effects of PTSD on the veteran’s intimate partner

relationships and family members. For example, the National Vietnam Veterans Readjustment Study (NVVRS), a comprehensive study that examined the long-term adjustment of Vietnam-era veterans, also included an assessment of family issues (Sayers, Farrow, Ross, & Oslin, 2009). The results of this study indicate that veterans who had increased levels of combat-related trauma and PTSD had poorer family functioning and increased domestic violence compared to those without trauma. Similarly, research conducted by Riggs, Byrne, Weathers, and Litz (1998) found that 70% of PTSD veterans and their partners reported higher levels of relationship dysfunction, which includes an increased fear of intimacy (due to increased anxiety) and contemplation of marital separation and divorce.

Another problem associated with trauma is emotional regulation. Trauma survivors with PTSD also have an impaired ability to express emotions and are less self-disclosing and research indicates a strong association between PTSD symptom severity and difficulties with emotional regulation (Carroll, Rueger, Foy, & Donahoe, 1985; Cook et al., 2004; Ehring & Quack, 2010; Klemanski, Mennin, Borelli, Morrissey, & Aikins, 2012). The ability to express emotions is associated with more intimate and close relationships and results in better communication and marital satisfaction, whereas veteran avoidance/arousal symptoms tend to decrease couple satisfaction and relationship functioning (Gavlovski & Lyons, 2004). Emotional numbing and avoidance creates a family atmosphere in which the veteran is isolated and removed from the family role of father and husband (Gavlovski & Lyons, 2004). This may result in a stressful family environment with a lack of support not only for the veteran but also for the spouse and children. Furthermore, PTSD reaches beyond interpersonal relationships and impacts the individual's day-to-day successes and functioning. Research indicates an association between

PTSD and higher rates of unemployment, increased failure in college education, and an increase in the onset of suicidal ideation (Kessler, 2000; Richardson et al., 2012).

As noted previously, the primary impact of PTSD extends beyond the veteran to include secondary effects on the veteran's spouse and children. Secondary traumatization (Elwood, Mott, Lohr, & Galovski, 2011; Figley, 1983; Lev-Wiesel & Amir, 2001), a term used to indicate situations in which individuals, who are in close contact with a trauma victim, can become indirect victims of the trauma and experience symptoms of traumatization, has been used to describe the experiences of military wives whose veteran spouses have been diagnosed with PTSD. For example, Solomon et al. (1992) found that combat stress reaction (CSR) and PTSD in Israeli combat veterans were associated with increased psychiatric symptoms, such as somatization, depression, anxiety, hostility, and obsessive-compulsive problems in their wives. The same study also reported that when wives perceived their husbands as suffering from PTSD they exhibited a variety of social difficulties such as loneliness and marital, family and social relationship distress (Solomon et al., 1992). Study results similarly reveal that spouses of PTSD veterans experience emotional and marital distress, increased levels of burden, and are more prone to symptoms of anxiety, depression, and stress (Ben Arzi, Solomon, & Dekel, 2000; Dekel, Solomon, & Bleich, 2005).

Caregiver burden is another problem, along with relationship stress and secondary traumatization, facing military wives whose husbands have been diagnosed with PTSD. Caregiver burden, defined as the extent to which caregivers observe their emotional or physical health, social life, and financial status as suffering as a result of caring for an ill relative (Zarit, Todd, & Zarit, 1986), has been traditionally studied from the perspective of individuals who are caring for family members with dementia or a chronic disease. To date, little research has been

directed at the burden of caring for a veteran family member with a psychiatric illness. The limited research that does exist in this area suggests that caregivers of veterans with PTSD experience many of the same burdens as other caregivers such as crisis and symptom management, social isolation, and strain on the family unit (Beckham, Lytle, & Feldman, 1996). Furthermore, women, more often than men, assume the role of primary caregiver and this is also true within the military culture where males make up the majority of military members deployed overseas and veterans diagnosed with PTSD (Park, 2008; Raphael, 2013).

Many of the issues experienced by military spouses are common to many families. Balancing work and family life, caring for young children, financial concerns and marital difficulties are some of the similarities. However, the life of a military spouse is unique and, therefore, the issues and needs of this population are also unique. Three common stressors - repeated relocations, frequent separations, and the reorganization of family life during reunions, are considered to be distinctive issues related to this population (Drummet, Coleman, & Cable, 2003). Similarly, the military culture also impacts the spouse and determines certain behaviours. For example, the behaviour of family members is widely believed to influence the military member's career advancement and a service member's inability to handle family issues could be generalized into their leadership ability within their unit (Drummet et al., 2003). Therefore, families may not seek out military support and services when they are experiencing problems because they fear it will negatively impact the career of the military member and as a result, any opportunities for career advancement may be lost (Drummet et al., 2003).

Military families tend to move more frequently than the civilian population and relocations can be especially difficult for a military family (Drummet et al., 2003). Not only do military families move within the country, they also can relocate to international military bases

throughout the world. Relocating within the country requires military spouses to have to cope with the reorganization of family life, settling children into new schools, finding local resources (doctors, daycares, etc.), and helping family members adjust to a new situation, while international moves include the additional stress of adapting to a new culture and language (Drummet et al., 2003). Additionally, frequent moving upsets social supports and networks. Relocating means leaving behind established supports and having to once again rebuild friendships and supportive networks. As a result, Drummet et al. (2003) found that frequent moving and the loss of supportive connections may result in the overreliance on the immediate family and isolation from other supports. Frequent moving also disrupts the career development of military spouses who may find employers reluctant to train individuals who may move soon or spouses may find themselves in foreign countries with limited knowledge of the local language or even cultural biases against women working outside of the home (Drummet et al., 2003). The common stressors experienced by military spouses can be further complicated by the inclusion of a partner's PTSD, making these typical challenges increasingly difficult to manage.

Another specific concern is separation from the military member due to deployment. This situation presents its own unique set of issues such as relationship challenges, renegotiating boundaries and family roles, and media coverage of military activities (Drummet et al., 2003). Long-term separation from one's partner combined with limited communication can create relationship stress and lead to decreased couple intimacy (Drummet et al., 2003). The spouse who remains at home may also experience feelings of anger, anxiety, loneliness, depression, and emotional detachment towards the absent partner (Vormbrock, 1993). Finally, financial concerns, role overload, role shifts, separation strain, and increased parenting burdens are common experiences of the remaining spouse (Drummet et al., 2003). All of these feelings and

experiences may be exacerbated when a soldier with PTSD returns and attempts are made by the spouse and military partner to resume previously held roles and responsibilities within the family.

Boundaries within the family often become unclear in the absence of the military partner, therefore, it is necessary to renegotiate family roles and boundaries and for individual family members to assume the responsibilities of the absent family member (Drummet et al., 2003). Unfortunately, it is often the female spouses who assume these responsibilities, which can result in role overload or an unwillingness to relinquish these duties when their spouse returns home (Drummet et al., 2003). Likewise, returning spouses may feel excluded from the family unit if they are unable to resume previous family roles (Drummet et al., 2003).

Finally, media coverage of deployments often adds to the stress already encountered by the remaining partner. This coverage often highlights the negative and destructive activities of deployment and may also include inaccurate or incomplete information, further adding to the partner's distress (Drummet et al., 2003). For example, during the Gulf War, the media focussed on chemical warfare, which further increased fear in military members and their families (Hobfoll et al., 1991).

There is a significant lack of Canadian research on the experiences of women whose military spouses have been diagnosed with PTSD. Similarly, as note previously, the majority of early research on PTSD and veterans excluded the involvement of the intimate partner and thus, not only neglected to examine the impact of PTSD symptomology on the couple and family unit from the partner's perspective but was also quantitative in nature; as result, the unique perspective, insight and rich understanding that qualitative research provides was missing. Furthermore, early studies, which often focused exclusively on the military member, utilized

large sample sizes and a variety of scales and measures, like self-report questionnaires, trauma scales, and depression inventories (Beckham, Moore, Feldman et al., 1998; Benotsch et al., 2000; Solomon, Weisenberg, Schwarzwald, & Mikulincer, 1987). Prior to 2000 it is difficult to find research that is both qualitative in nature and includes the female partner's perception, opinion and experience. Finally, the majority of research focuses on the negative impact of PTSD and fails to consider or examine the role of resiliency in risk reduction and health promotion in women as well as the couple unit.

While there appears to be a significant lack of Canadian research on this topic, one study does provide a unique perspective on the Canadian experience. Mclean (2007), using the life story interview method, examined the experiences of women whose military partners have been diagnosed with PTSD. The primary purpose of her study was to examine the lived experiences of these women. Secondly, she wished to study the differences in the women, the couple relationship, and family functioning before, during and after treatment for PTSD and the final purpose of her study was to determine what would be helpful to both couples and families living with PTSD (Mclean, 2007).

In discussing applications of her research for theory, Mclean (2007) focused on PTSD and secondary traumatic stress (STS), which is the emotional stress that results from secondary traumatization. Mclean (2007) concluded that STS is not the best theoretical fit when examining the experiences of these women because the participants' interviews revealed instances of partner aggression, primary trauma, and issues related to their husband's alcohol abuse but they did not spontaneously comment on experiencing PTSD symptoms related to their husbands trauma; however, Mclean (2007) suggests that as life or external stressors accumulated, the women thought that their partner's coping abilities diminished and PTSD symptoms worsened.

From the spouse's perspective, according to Mclean (2007), the accumulation of stressors, in the form of disappointments and family tragedies, appeared to worsen the military member's symptoms, creating a downward spiral that negatively impacted the marriage. Consequently, it is the military member's descent into chronic disability and the resulting impact on the intimate relationship that provides a better description of the woman's experiences (Mclean, 2007).

There is increasing awareness of how trauma and specifically PTSD has impacted Canadian soldiers and as a result the Canadian government has recently pledged money to assist military members and their families. Studies demonstrate that PTSD impacts not only the soldier but also his spouse and children. Historically, however, research has focussed on the veteran and excluded the spouse from contributing to this growing body of information; as a result, there has been a lack of sufficient research on how the spouses of PTSD soldiers experience this illness. Military families often experience their own unique challenges and stressors related to military duties and life, with frequent separations being common due to deployments. On the other hand, PTSD presents soldier, spouses, and their children with additional issues beyond those typically experienced.

Study Objectives

The purpose of this study is to offer a comprehensive perspective of the experiences of women whose military spouses have been diagnosed with PTSD. The study provides insight into an area of study that has been generally neglected and gives voice to a group that has previously been ignored (i.e., the intimate partners/spouses of military personnel). Importantly, research on this topic has primarily focused on the experiences of American soldiers and their families; however, a major purpose of my study is to allow for the unique Canadian perspective and experience. The overall research question that guides this study is: What is the experience

of women whose (ex) military spouses have been diagnosed with PTSD? Within this larger question I explored specifically the role, if any, that resiliency played in the day-to-day experiences of living with a veteran with PTSD, which includes how PTSD has impacted the veteran's spouse and the couple's relationship. An important purpose of this study is to examine the relationship between the women's resiliency and their observations of their experience. For instance, do women who identify themselves and their families as resilient also perceive their experiences to be less stressful and their adversity as something that can be overcome? It was, therefore, essential to inquire if the women could identify specific protective factors that may contribute to increased individual and family resiliency and improved couple functioning.

Furthermore, I inquired about the extent of spousal risk factors, such as the relationship between PTSD symptom severity and any mental health distress or poor coping experienced by the women. Similarly, I also examined if PTSD symptoms are associated with other risk factors such as decreased emotional intimacy and marital satisfaction, violence in the relationship, interpersonal dependency, lack of social supports/resources, and caregiver burden. Additionally, I considered everyday stressors and the stigma associated with mental illness.

Research has repeatedly found that the secondary effects of PTSD are problematic and negatively impact the veterans spouse and family unit; however, the majority of current research is quantitative in nature. Consequently, there is an overwhelming absence of qualitative research in this area that has resulted in a lack of a subjective and detailed description of the spousal experience. Another purpose of my study is to provide spouses with the opportunity to share their experiences in a manner that allows for the breadth of the personal experience to emerge.

A final purpose of my study is to provide information that may ultimately be useful in the development of interventions and therapy for the military couple and extended family (Sautter,

Glynn, Thompson, Franklin & Han, 2009). Protective factors, which are identified by the spouse, can be incorporated into programs directed at increasing individual and couple resiliency and decreasing the effects of risk factors during pre and post deployment. I hope that by encouraging women to share their experiences this study will illustrate the importance of including spouses in the veteran's recovery process and highlight the need for therapeutic programs that consider the impact of PTSD on the spouse (and other members of the family unit) rather than just the serving military member or veteran.

Study Significance

There exists a wide range of research aimed at furthering our understanding of PTSD and its impact on the veteran. However, it appears that only in recent years has research slowly turned its attention to the wider impact of PTSD on individual members within the family and the larger family unit as well. This has been a significant advancement as military spouses have finally been allowed to share their experiences. This study is significant because it will add to the growing body of qualitative research on the impact that PTSD has had on military spouses of veterans diagnosed with this mental health issue. The experiences of this population are important to explore and understand because as I have noted throughout this paper, the distress and stressors associated with PTSD extend beyond the traumatized individual to include their intimate partners and children. Thus, treatment options for the veteran must involve the spouse and other family members. It is hoped that as more research is conducted in this area, improvements will be made in treatment/therapeutic interventions for both military members/veterans and their spouses and perhaps, more broadly, in military policy.

This study is also significant because, unlike the majority of existing research, it focuses on the unique Canadian experience. As mentioned earlier, most of the research to date has been

conducted by researchers examining the experiences of American veterans. Therefore, a significant gap in the literature is lack of attention to the experiences and voices of Canadian veterans and their military spouses. I believe that it is important to study this topic from a Canadian perspective for several reasons. First, the resources and supports available to Canadian veterans and their spouses may differ from those offered to American veterans and thus, impact the overall experience in a unique way. Important questions arise, such as: Are there unique programs and supports available to the Canadian military community that improve or impede healing and recovery for the couple and family? Are there obvious differences in the experiences of Canadian women compared to their American counterparts, such as domestic abuse or divorce rates that suggest the need for further investigation? Similarly, while Canadian and American cultures share many similarities, the sociocultural and political environment differs between the two countries. For example, the American war on terrorism and the political, economic, and social/cultural commitment to the war differs in scale from Canada's involvement and this may translate to greater social/political support of the military and more funding for pre and post deployment programs for American military members and their families. Consequently, factors such as funding for mental health programs, public opinion of the military, and the peacekeeping vs. active combat role of the military may all impact the overall Canadian experiences of the women.

Additionally, research in this area has tended to rely exclusively on the reports of military members/veterans, and as a result, does not account for the unique perceptions and experiences of military spouses. Riggs, Byrne, Weathers, and Litz (1998) suggested that while veterans' reports are a significant aspect of research and provide important information, they may create a biased view of the relationship issues of individuals with PTSD, therefore, it is essential to gather

information on the relationship concerns of partners as well. While I recognize that there is additional value in gathering information and examining reports from both veterans and their spouses, I believe that my study will nevertheless provide significant information about partner experiences and perceptions that can be useful in future research that evaluates both veterans and their partners and leads to a further understanding of the impact that PTSD has on the couple relationship.

Also, my study used a qualitative approach whereas traditionally a quantitative research approach has been favoured. I believe that a qualitative approach allowed for a deeper and richer understanding of the perspectives and experiences of military spouses whose partners are struggling with PTSD. Finally, the majority of existing research in this area focuses predominantly on the distress or negative aspects that PTSD creates in relationships; however, I examined the strength and resilience that military spouses demonstrate. For instance, are there specific protective factors such as social supports, positive cognitions, and counselling programs that can promote women's resiliency? Research has discovered that there are several characteristics or strengths that are indicators of resilience and these include acceptance, hardiness, hope, mastery, self-efficacy, sense of coherence, and resourcefulness (Zauszniewski, Bekhet, & Suresky, 2010). Are any of these indicators visible in the women's experiences and if so, how have these characteristics impacted their individual and families ability to cope? Similarly, I have previously noted that veteran self-disclosure may positively impact marital satisfaction and improve psychological well-being in the veteran. Have the women experienced partner self-disclosure and if so, has it acted as a protective factor and increased resiliency?

This study is also significant due to recent developments in government funding. In November, 2014, the Minister of Veterans Affairs and the Minister of National Defence

announced funding for veterans, serving military members, and their families in the form of new and expanded mental health initiatives (Veterans Affairs Canada, 2014). Some of these initiatives include the establishment of a new Operational Stress Injury Clinic in Halifax with several additional satellite clinics throughout Canada, increased support for families in the form of peer support programs and expanded access to Military Family Resource Centres for medically released personnel and their families, improved technology to digitize medical health records, and an investment into additional mental health research (National Defence, 2014).

There is also study significance to the profession of social work. As noted throughout the proposal, the impact of trauma extends beyond the veteran to include all members of the family. Social workers, employed by the Department of National Defence and in the civilian community, are often the first contact for veterans and their families struggling with mental health issues and are, therefore, important links in the professional support network. Hopefully, this study will provide a more extensive understanding of how PTSD impacts the intimate partner and further the professional understanding of appropriate individual and couple counselling which contributes towards prevention, healing, creating resiliency and strengthening relationships.

Chapter Three: Literature Review

Research on war-related trauma and PTSD is extensive and includes a wide variety of research topics such as innovative treatment approaches, substance abuse, relationship/family issues and symptoms of the disease. Past research had primarily looked at PTSD and the soldier and neglected to consider how behaviour-related symptoms of PTSD extend beyond the diagnosed individual to impact the family unit. However, it appears that current research has slowly begun to turn its attention to the larger family system, which includes the spouse and children. As my focus extends beyond the veteran, to include family and partner issues, the literature review concentrates on research related to PTSD symptoms, PTSD and military personnel, PTSD and family relationships, PTSD and the military spouse, the impact of PTSD on the spouse, and resiliency. Similarly, the majority of available research has focused on the male veteran and the impact that the mental health diagnosis of PTSD has had on both himself and his personal relationships. For example, several studies on the functioning of intimate relationships have focused exclusively on the wives and female partners of male veterans while other research on emotional distress has entirely relied on reports by female partners of military personnel (Dekel & Monson, 2010). Additionally, research on caregiver burden has also focused on the wives of PTSD veterans (Dekel & Monson, 2010) and studies on family-focused interventions for PTSD have also concentrated on therapy for male veterans and their female partners (Monson, Schnurr, Stevens, & Guthrie, 2004).

Overview of PTSD

War-related trauma has long been recognized and more recently studied. Prior to WWI, however, it was widely accepted that war-related conditions were related to deficits in the individual and uncontrolled processes in the central nervous system (Jones & Wessely, 2005).

WWI saw the introduction of the term “shell shock” as soldiers increasingly presented with unexplained symptoms and the number of psychiatric casualties became epidemic (Jones & Wessely, 2005). Currently, the rates of PTSD among Canadian regular military forces have nearly doubled between 2002 and 2013 (Statistics Canada, 2002, 2013).

In 1980, the American Psychiatric Association (APA) included Post-Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (APA, 1980) and thus, the concept that the cause of the mental disorder was due to sources external to the person (i.e., a traumatic event) rather than individual weakness or deficits emerged. The criteria for diagnosing PTSD included a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms as well as a fifth criterion involving duration of symptoms (Dekel & Monson, 2010). Additionally, the DSM-IV-TR (APA, 2000) notes that PTSD symptomatology is acute (symptom duration of less than three months), chronic (symptoms at least three months or longer) or with delayed onset (at least six months have passed between the traumatic event and the onset of symptoms) (Garske, 2011).

When individuals experience or are witness to events, which are considered outside the norm of human experience, such as actual or threatened death, serious injury, or threatening circumstances, they may experience trauma and the development of PTSD may occur (Garske, 2011). In an effort to forget the traumatic event the individual may develop emotional numbness and event-related amnesia while flashbacks, intrusive dreams and disturbing thoughts and memories expose the person to re-experience the trauma (Bellenir, 2005). Andreasen and Black (as cited in Garske, 2011) suggested that,

The three major elements of PTSD include 1) re-experiencing the trauma through dreams or recurrent and intrusive thoughts, 2) showing emotional numbing such as feeling detached from others, and 3) having symptoms of autonomic hyperarousal such as irritability and exaggerated startle response. (p. 193)

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) has added a fourth element of negative cognitions and mood that includes a reduced interest in activities, persistent blaming of self and others, and an estrangement from others.

Co-morbidity is also associated with PTSD and individuals diagnosed with the illness are at an increased risk for other psychiatric disorders such as depression, substance abuse, and panic disorder (Garske, 2011) while the anxiety disorder has also been linked to an increased risk of health disorders, reduced quality of life and well-being, diminished psychosocial and relationship functioning and professional impairment (Vasterling et al. 2008).

Emotional numbing, considered to be a major symptom of PTSD by the DSM IV, is defined as a group of symptoms that result in “markedly diminished interest in significant activities, feelings of detachment or estrangement from others and a restricted range of affect” (APA, 2000, p. 467). The ability to emotionally connect with one’s partner and family and to express positive feelings is viewed as crucial to healthy and intimate relationships; and conversely, an impaired ability to express emotions inevitably impacts the quality of a relationship (Greenberg & Johnson, 1986). Effective communication impacts both marital and couple functioning and increases satisfaction within the couple relationship; however, a lack of communication results in role ambiguity and behavioural patterns of detachment, isolation, conflict, and withdrawal (Galovski & Lyons, 2004).

PTSD and Military Personnel

Given the nature of their occupation, soldiers are at an increased risk for exposure to traumatic situations and thus the development of PTSD. Friedman (2006) and Ottati and Ferraro (2009) indicated that the trauma encountered by soldiers may be different from the trauma experienced by civilians and that the combat environment presents a unique set of traumatic experiences. For example, soldiers are often on constant alert for hostile and unpredictable situations, like roadside bombs, and they may experience repeated traumatic events, such as the death/injury of other soldiers, the killing of enemy soldiers and civilians, dealing with the remains of other soldiers and civilians, as well as the observation of death and destruction in combat communities, without the ability to process these situations before returning to combat (Friedman, 2006; Ottati & Ferraro, 2009).

The 2013 Canadian Forces Mental Health Survey revealed that symptoms of PTSD were reported in more than 5% of full-time members, while nearly one in six full-time members experienced mental health symptoms in 2013 and that soldiers with PTSD are waiting up to six months for help (Statistics Canada, 2014). Additionally, there have been several studies that have found that armed forces personnel are at an increased risk of developing PTSD as a result of military service (Hoge et al., 2004, Hoge et al., 2007, Iversen et al., 2008).

PTSD and Family Relationships

The development and recognition of PTSD as a mental disorder allowed both professionals and veterans to give a name to trauma-related experiences and behaviour and led to a new field of research. However, after years of research focused exclusively on PTSD and the veteran, research began to slowly turn its attention to the broader impact of PTSD on the immediate family unit, which included the veteran's partner, the couple relationships and

children (Carroll et al., 1985; Jordan et al., 1992; Solomon et al., 1992). As a result, a larger understanding of the extensive effect of PTSD began to emerge.

Research indicates that PTSD can impact the quality of a veteran's intimate and family functioning, including marital satisfaction and happiness, as well as the social supports available to help with healing (Koenen, Stellman, Sommer, & Steelman, 2008). Impaired family functioning and a stressful family environment may also be associated with families in which a member has been diagnosed with PTSD (Dekel & Monson, 2010). PTSD has been found to impact numerous family relationships and domains such as the couple relationship, the veteran's spouse, the veteran's emotional expression, which ultimately affects relationship quality, the parent-child relationship, and the quality of social supports (Gavlovski & Lyons, 2004; King, Taft, King, Hammond, and Stone, 2006). Research conducted by King et al. (2006) suggested that PTSD symptom severity negatively affects social supports while emotional numbing (a major symptom of PTSD) negatively impacts family relationships and creates barriers, prohibiting healing (Ray & Vanstone, 2009). In one study by Riggs, Byrne, Weathers, and Litz (1998), 70% of couples in which the veteran was diagnosed with PTSD, reported relationship distress compared to 30% of couples in which the veteran did not have PTSD.

Emotional numbing also impacts the parent-child relationship. For example, Ruscio, Weathers, King, and King (2002) and Samper, Taft, King, and King (2004) reported that emotional numbing and its associated behaviours of detachment, disinterest, and emotional unavailability decrease a father's ability to actively seek out and engage in interactions with his children. Furthermore, both studies found a stronger correlation with emotional numbing and with poor parent-child relationships and decreased parent satisfaction compared to other PTSD symptoms. Spouses may also attempt to manage volatility by mediating all the interactions

between a PTSD veteran and the children but this behaviour may prevent the parents from working together as a team (Allen et al., 2010). Additionally, Benotsch's (2000) longitudinal study of PTSD veterans found that over time positive methods of coping such as hardiness, which is defined as the characteristic manner in which a person responds to adversity and stress, commitment, control, and problem solving decreased while the negative coping method of avoidance increased dramatically and that high initial PTSD symptomology was linked with more avoidance and less family cohesion over time.

Other research suggests that veterans with PTSD are less likely to self-disclose and be expressive to their partners and are more physically aggressive (Carroll et al., 1985, Glenn et al., 2002, Sherman, Sautter, Jackson, Lyons, & Xiaotong, 2006) while the partners of PTSD veterans are also more likely to report lower levels of happiness and life satisfaction and increased negative communication, such as name calling, criticism, and withdrawal (Allen et al., 2010; Jordan et al., 1992). Similarly, partners of PTSD veterans have also indicated more relationship distress compared to non-PTSD partners and both PTSD veterans and their partners noted that they experienced increased anxiety and fear around intimacy with their partner compared to non-PTSD veterans and their partners (Riggs et al., 1998). Finally, there exists a positive correlation between the degree of relationship distress and the severity of the PTSD symptoms, especially symptoms of emotional numbing (Riggs et al., 1998).

Family reintegration is also impacted by PTSD and problems associated with the veteran's role-related readjustment have been found to be related to PTSD (Sayers et al., 2009). Reintegration and role readjustment are closely related as returning veterans must rediscover their role within the family unit and renegotiate their role with their spouse, who has managed family matters in their absence; however, veterans diagnosed with depression and PTSD are five

times more likely, compared to veterans without these conditions, to have difficulties with readjustment resulting in problems with family reintegration (Sayers et al., 2009). In particular, veterans experience issues with renegotiating their position within the family as it relates to their relationship with their children, as well as parental and spousal responsibilities (Sayers et al., 2009). Withdrawn, anxious, and avoidant symptoms not only act to prevent the veteran from assuming previously held parental and spousal roles within the family but also limit the closeness of family relationships (Sayers et al., 2009).

Normal family functioning is impaired due to the veteran's psychiatric illness and the veteran has difficulty reintegrating into the family because of problems in renegotiating their parental relationship with their children and partnership with their spouse, consequently, many veterans report feeling like a "guest in their own home" (Sayers et al., 2009, p. 169). Ultimately, PTSD and its symptoms extend beyond the veteran to impact family functioning and relationships.

Overall, the health of family members is impacted by poor family functioning and stress. Specifically, research has consistently found that specific circumstances, such as family conflict, which includes anger and aggression and relationships that are cold, unsupportive, and neglectful negatively impact both the mental and physical health of its family members (Repetti, Taylor, & Seeman, 2002). Although not the focus of my study, it is important to briefly point out that children are particularly susceptible to not only immediate risks due to inadequate family functioning and high levels of stress but also long term negative health outcomes. Children exposed to negative family functioning are more likely to participate in risky behaviours such as smoking and alcohol and drug abuse and are at increased risk across their lifespan for depression, aggressive hostility, and chronic illnesses (Repetti et al., 2002). Undoubtedly, spouses are

adversely influenced by the immediate and long-term negative health outcomes that impact their children. Overall, many of the symptoms of PTSD are associated with a stressful family environment, poor family functioning and a lack of family cohesiveness, resulting in increased health risks for family members.

PTSD and Military Spouses

The avoidance cluster of symptoms, which includes emotional numbing, have also been found to impact the couple relationship and are linked with intimate relationship dissatisfaction, impaired intimacy, and relationship dysfunction (Monson, Taft, & Fredman, 2009). Furthermore, male veterans with PTSD have higher divorce rates, are less self-disclosing and emotionally expressive, and have partners/spouses who report more serious and frequent relationship difficulties and poorer family adjustments compared to veterans not diagnosed with PTSD (Monson et al., 2009).

Of all the PTSD symptoms it is emotional numbing that appears to be most associated with couple distress as reported by both veterans (Campbell & Renshaw, 2013, Cook et al., 2004; Lunney & Schnurr, 2007; Taft, Schumm, Panuzio, & Proctor, 2008) and their spouses (Evans et al., 2003). One possible explanation for the relationship between emotional numbing and marital distress is that emotional numbing leads to less intimate disclosure in the form of self-relevant feelings and empathic responses, which ultimately creates less intimacy and relationship satisfaction (Campbell & Renshaw, 2013). Longitudinal research on male veterans diagnosed with PTSD by Lunney and Schnurr (2007) also suggested that emotional numbing is associated with satisfaction in the partner relationship.

Spousal perception of PTSD symptoms and attribution also influences marital and relationship satisfaction. Research conducted by Renshaw, Rodrigues, and Jones (2008) found

that the “spouses perception of the soldiers symptoms were more strongly related to the spouses own psychological and marital satisfaction than the soldiers self-reports of symptoms” (p. 591). When spouses perceived that the soldiers had experienced low levels of combat exposure and the soldiers reported high levels of PTSD symptoms, the spouses reported increased marital dissatisfaction; however, when the spouses perceived high levels of combat exposure in their partner, the partners self-reported symptoms had no association with the spouse’s marital satisfaction (Monson et. al., 2009). Renshaw et al. (2008) suggested that, “this pattern may reflect a tendency for the negative impact of soldiers’ symptoms on spouses’ marital satisfaction to be lessened when spouses can attribute such symptoms to an understandable cause, like excessive combat exposure” (p. 592).

Furthermore, Galovski and Lyons’ (2004) review of earlier research and literature indicated that the emotional numbing symptom of PTSD and the resulting inability of the veteran to express and experience emotions prevented the maintenance of close and intimate relationships. The lack of emotional expression and communication creates an atmosphere of isolation, detachment, conflict, and withdrawal between intimate partners and further aids in marital conflict (Galovski & Lyons, 2004). Consequently, it appears that emotional numbing is the most significant barrier in creating and maintaining intimate relationships and results in increased isolation for both the veteran and his partner.

Additionally, research findings from Nelson Goff, Crow, Reisbig, and Hamilton (2007) revealed that intimate relationship satisfaction, as reported by both soldiers and their female partners, was inversely related to the soldier’s self-reported PTSD symptom severity. Accordingly, high levels of symptoms, such as sleep disturbances and dissociation, significantly predicted lower relationship satisfaction for both the soldier and his partner; therefore, the study

suggests that war-related trauma symptoms can negatively impact marriage/intimate relationship satisfaction (Nelson Goff, Crow, Reisbig, & Hamilton, 2007). Similarly, a study of 434 military couples by Allen, Rhoades, Stanley, and Markman (2010) indicates that PTSD symptoms negatively impact several key areas of marital functioning. These include marital satisfaction, positive bonding between partners, confidence in the intimate relationship, which includes an understanding that the future of the relationship is strong and that the couple can cope with challenges, parental cooperation, and an overall dedication to the relationship, including a personal commitment to the stability of the relationship (Allen, Rhoades, Stanley, & Markman, 2010).

Partners of individuals diagnosed with PTSD also exhibit cognitive, behavioural, and emotional responses that can impact intimate relationships (Brown-Bowers, Fredman, Wanklyn, & Monson, 2012). As an example, partners may believe they are responsible for decreasing the distress of their PTSD partner, and consequently, engage in accommodating behaviours such as assuming more responsibilities and chores and avoiding places and topics that the individual finds uncomfortable or distressing. Spouses may also experience emotional responses to these thoughts and actions such as anger, anxiety or sadness (Brown-Bowers et al., 2012). As a couple, decreased participation in mutually enjoyable activities and emotional numbing can negatively impact emotional and physical intimacy and satisfaction with the relationship (Brown-Bowers et al., 2012).

Recently, research has examined the relationship between the disclosure of traumatic events (self-disclosure) and the manifestation of PTSD symptoms, like numbing and avoidance, which are linked to marital distress. For example, research involving Israeli combat veterans diagnosed with PTSD revealed that the negative relationship between PTSD and marital

intimacy was mediated by the level of self-disclosure to their partners (Solomon, Dekel, & Zerach, 2008). A similar study of American soldiers also found that lower levels of combat self-disclosure were associated with higher levels of relationship distress (Balderrama-Durbin et al., 2013). A military member's disclosure potentially influences the accuracy of a partner's perceptions and attributions; consequently, the negative impact on a spouse's psychological and marital distress is lessened when the spouse can attribute the military member's PTSD symptoms to combat-related trauma (Balderrama-Durbin et al., 2013). These studies also provide support for PTSD therapeutic interventions that promote the disclosure of combat-related trauma within the context of a supportive and empathic intimate relationship and as a result, help to improve both individual and relationship functioning (Foa, Hembree, & Rothbaum, 2007).

Similarly, research by Baddeley and Pennebaker (2011) also recognized that soldiers who participated in expressive writing about their traumatic experiences had increased couple marital satisfaction while soldiers who talked to informal supports, particularly family members, about their trauma experienced a decrease in psychological distress (Greenberg et al., 2003). Thus, it appears that the ability to self-disclose within the confines of an intimate relationship is helpful not only to the soldier but to the partner as well.

Additionally, female spouses of PTSD veterans have reported higher rates of psychological and physical abuse and male veterans with PTSD have reported increased family conflict, hostility and interpersonal violence, compared to those without PTSD (Glenn, Beckham, & Feldman, 2002). Angry outbursts displayed by the veteran as well as emotional withdrawal and avoidance symptoms have been consistently found by research to account for increased family problems (Galovski & Lyons, 2004). Early research conducted by Jordon et al. (1992) focussed on comparing families of PTSD Vietnam veterans and those without PTSD and

found that spouses of PTSD veterans indicated more family violence, both violence by the veteran and the spouse, compared to veterans without PTSD. Another study of Vietnam veterans with PTSD also discovered that their wives experienced increased physical aggression from their veteran partners compared to non-PTSD veterans' wives (Verbosky & Ryan, 1988). More recent research by Sayers et al. (2009) that included self-reports from veterans referred for further psychiatric evaluation after being initially screened for several health issues including PTSD, indicated that over 50% of participants reported mild to moderate rates of domestic abuse and almost a third of veterans reported that their partners were afraid of them.

Furthermore, Williams (as cited in Galovski & Lyons, 2004) found reports of wife battering in 50% of veteran couples seeking treatment for PTSD while research results by Glenn et al. (2003) and Sherman, Sautter, Jackson, Lyons, and Xiaotong (2006) revealed that PTSD veterans display more hostility and are more inclined to physical aggression than non-PTSD veterans. Other research findings have supported the hypothesis that veterans diagnosed with PTSD are more likely to use physical aggression against their closest family members compared to veterans without PTSD (Orcutt, King, & King, 2003) and a positive correlation has been found between the severity of PTSD symptoms and the severity of physical aggression (Byrne & Riggs, 1996; Glenn et al., 2002; Taft, Street, Marshall, Dowdall, & Riggs, 2007).

The four clusters of symptoms associated with a diagnosis of PTSD, according to the criteria in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) are the re-experiencing of the traumatic event (intrusion), arousal symptoms (hyper-arousal), negative cognitions and mood, and the avoidance of stimuli associated with the trauma and numbing of general responsiveness (avoidance). It is these specific symptom clusters, which research suggests, may impact family relations in differing ways (Evans, Cowlshaw, Forbes,

Parslow, & Lewis, 2010; Taylor, Kuch, Koch, Crockett, & Passey, 1998). In particular, the hyper-arousal symptom in veterans diagnosed with PTSD has been associated with demonstrations of anger and that PTSD positive veterans, compared to non-positive veterans, report a heightened anger response, which is associated with both physical and verbal aggression as well as psychological hostility towards partners (Solomon, Dekel, & Zerach, 2008; Taft et al., 2007).

Physical abuse/aggression appears to be an issue that research has identified as a significant concern in the couple relationship, and like other concerns related to PTSD symptoms, requires that immediate support and therapeutic services be made available to the veteran, his partner, and other family members.

PTSD and the Impacts on the Health and Well-being of Spouses and Intimate Partners

Spouses/partners of veterans diagnosed with PTSD are faced with the additional responsibility of caring for their partner. The burden placed on these partners is considerable and research has found that among spouses, whose partners have PTSD, the levels of burden are not only high but are also similar to levels found in caregivers of individuals of dementia and chronic schizophrenia (Manguno-Mire et al., 2007). Furthermore, caregiver burden is an important issue because research data indicates that the family environment and the coinciding psychological health of the veteran's family members directly impacts the veteran's potential for recovery.

Veterans with PTSD are often unable to assume previously held roles and responsibilities within the family because the symptoms of PTSD, as mentioned previously, often lead to detachment, disinterest, and emotional unavailability. Veterans will often have a decreased interest in previously enjoyed activities, a diminished involvement with the external world, a numbing of responsiveness, and may also be preoccupied with themselves and their traumatic

experience (Solomon et al., 1992). As a result of the veteran's diminished participation in the family unit, spouses often undertake additional child care and financial responsibilities, as well as support both the psychological health of their spouse and their children. Solomon et al. (1992) noted that this results in them often falling victim to the "compassion trap" in which they sacrifice many of their needs for the benefit of the family (p. 2).

Additionally, the compassion trap may help to explain why many women feel overwhelmed, anxious, depressed, hopeless, angry, and rejected (Solomon et al., 1992). Spousal perception also appears to be an important factor in the development of a variety of caregiver difficulties. In particular, when wives perceived their veteran partners as suffering from PTSD, they tended to experience an increase in social dysfunction, such as loneliness, impaired marital and family relationships and dissatisfaction with their larger social network (Solomon et al., 1992).

Caregiver burden has many definitions and various models conceptualize caregiver burden in different ways. For example, Zarit, Todd, and Zarit (1986) (as cited in Dekel, Solomon, & Bleich, 2005) defined caregiver burden as the degree to which caregivers observe their emotional or physical health, social life, or financial status to be impacted by their caring for a family member with a disability or impairment. On the other hand, Pearlin et al. (1990) (as cited in Dekel, Solomon, & Bleich, 2005) described it as the caregiver's opinion regarding their energy level, satisfaction with the level of care provided, and the amount of time available to them to do everything necessary, which also includes time for one's self.

Similarly, the understanding of caregiver burden varies with different models. Using the stress model, Pearlin et al. (as cited in Dekel, Solomon, & Bleich, 2005) reported that caregiver burden is a primary stressor influenced by other variables, such as socioeconomic features, thus,

the burden directly affects such outcomes as depression and physical health. On the other hand, Lawton, Kleban, Moss, Rovine, and Glicksman (1989) (as cited in Dekel, Solomon, and Bleich, 2005) stated that according to the appraisal model caregiver burden is a subjective evaluation and that caregiving demands themselves do not become stressors, rather, whether a demand is a stressor is dependent on the subjective appraisal of the partner. Consequently, caregiver burden is often perceived as a complex relationship between the primary stressor of the care recipient's disability and the burden experienced by the caregiver as a subjective consideration (Dekel et al., 2005). However, it has been discovered that the one factor that consistently influences the variability of the caregivers mental health status is the degree of the care recipient's disability or impairment, which is considered a primary stressor, as a result, the more severe the veterans disability the deeper the spouses distress (Dekel et al., 2005).

Research conducted by Dekel et al. (2005) looked at the significance that women, as partners of veterans with PTSD, assign to their lives. Consequently, their phenomenological approach revealed several important issues in the women's lives. These include the understanding that PTSD impacts both the emotional and physical lives of women, blurring the boundaries between the couple and resulting in the women being unable to escape from the PTSD symptoms plaguing the veteran, which ultimately impacts their functioning both in and out of the home (Dekel et al., 2005). Also, the women cite issues between merging and individuation, which indicates the women's struggle to avoid an overly dependent caregiving relationship in the hopes of maintaining their personal space, independence and separation from the role of caregiver (Dekel et al., 2005). Finally, the women defined their partners as present-absent, which reveals the loneliness and emptiness that women experience in living with a partner who is physically present but emotionally absent (Dekel et al., 2005). Research

conducted by Calhoun, Beckham, and Bosworth (2002) found that partners of veterans diagnosed with PTSD experienced increased levels of caregiver burden and had poorer psychological adjustment compared to partners of help-seeking veterans without PTSD and caregiver burden was found to be a significant predictor of partner psychological adjustment. Calhoun et al. (2002) also indicated that PTSD symptom severity and the level of interpersonal violence were connected to increased levels of caregiver burden.

Overall, it appears that partners of PTSD veterans experience a level of caregiver stress and psychological distress that can be relatively high. Solomon et al. (1992) theorized that although women neither experienced nor witnessed their spouse's traumatic event, it is their continued and close contact with their spouse that may serve as a chronic stressor and contribute to psychiatric symptoms among wives. Another explanation discussed by Solomon et al. (1992) involved the concept of secondary traumatization and proposes that the stress experienced by the wives may be uniquely related to spouses of trauma victims and wives, who strongly identify with their spouses, may learn to behave and feel in ways similar to their veteran spouses.

As discussed earlier, the degree of relationship stress experienced by the veteran and his spouse is related to the severity of the veterans PTSD symptoms, with emotional numbing and avoidance behaviours being the largest predictors of relationship strain and distress. It was previously noted that secondary traumatization is one of the problems facing military spouses and is an issue that has only recently been addressed by researchers. As indicated earlier, the theory of secondary traumatic stress suggests that people who are emotionally connected to and live in close proximity with traumatized individuals experience chronic stress and often develop symptoms of traumatization (Figley, 1983).

The realization that spouses or intimate partners are at risk for both physical and mental health issues, as the result of secondary trauma, raises major concerns. Living with an individual diagnosed with PTSD directly exposes women to the mental health symptomology of the illness and research indicates that spouses of PTSD veterans themselves experience chronic stress and distress, as the result of intimacy difficulties, exposure to their partners traumatic stress symptoms, responsibility for the financial needs of the family, child care duties, physical and verbal aggression from their partner, and the responsibility for the maintenance of the partners psychological well-being, all contributing to a negative impact on their psychosocial health (Galovski & Lyons, 2004; Nelson Goff et al., 2009; Solomon et al., 1992). Some postulate that it is the close and prolonged contact with the PTSD veteran that ultimately creates symptoms of trauma and impaired marital, family, and social relationships in the female spouse/partner (Dirkzwager, Bramsen, Ader, & Van der Ploeg, 2005; Figley, 1983, 1995; McCann & Pearlman, 1990; Nelson Goff et al., 2009; Solomon et al., 1992). It is, therefore, important that treatment for PTSD focus on not only the veteran but the couple and family as well (Erbes, Polusny, Macdermid, & Compton, 2008; Sherman, Zanotti, & Jones, 2005).

Resiliency

The majority of research has also focussed on the negative consequences of PTSD on the spouse and couple relationship; however, I primarily focussed on resiliency factors, as identified by the spouse, which may act to mediate the effects of PTSD symptomology. Resiliency within the family has traditionally been studied from the perspective of individual family members; however, recent literature suggests that family resilience also involves interplay between the characteristics of the family unit and the characteristics of individual family members (Simon, Murphy, & Smith, 2005). For example, individual traits such as an optimistic outlook and a

sense of purpose may contribute to family resiliency while family characteristics such as a focus on family time and relationships as well as an emphasis on communication can influence resilience (Simon et al., 2005). As I am interested in identifying resilient characteristics within the overall experience of the women, I have selected the family systems theory of resilience (and its coinciding family resilience framework) as an appropriate theoretical approach because it examines the importance of resiliency in both the individual and the larger family unit (Walsh, 2002).

Zauszniewski, Bekhet, and Suresky (2009) studied the protective and risk factors on resilience in women caregivers of adults with a serious mental illness. The effects of caregiver burden on the resilience characteristics of resourcefulness, defined by Rosenbaum and Zauszniewski (as cited in Zauszniewski, Bekhet, & Suresky, 2009) as a series of behavioural and cognitive skills for managing adversity and optimizing the performance of daily activities, and sense of coherence, defined by Antonovsky (as cited in Zauszniewski et al., 2009) as a global perspective on life that includes cognitive, behavioural, and motivational elements and is expressed in the belief that the world is comprehensible, manageable, and meaningful, were mediated by positive cognitions. As a result, the impact of risk factors, associated with caregiver burden, such as stigma and client dependence, on the women's resilience, were mediated by positive cognitions, which acted as protective factors (Zauszniewski et al., 2009). Similarly, a study of couple functioning and post-traumatic stress symptoms (PTSS) in U.S. army couples revealed that individuals with high resilience scores reported higher couple functioning scores and that despite having high levels of PTSS, couples with high resilience also has higher couple functioning (Melvin, Gross, Hayat, Mowinski Jennings, Campbell, 2012). These studies

highlight the role that resiliency can have in the overall functioning of women as both individuals and as a member of the couple/family unit.

A growing awareness of PTSD and the risk to military personnel has led to an increase in research. The last few decades have seen more research directed at understanding PTSD and its impact on the soldier; however, recently, studies have directed their focus to include the spouse/partner of PTSD soldiers. PTSD is now known to negatively impact family relationships, including couple and parent - child relationships, and cause dysfunction in the marriage. Likewise, PTSD also negatively impacts the health and well-being of spouses and creates additional difficulties, like caregiver burden. However, additional studies exploring the impact of PTSD from the spouse's perspective are still required in order to increase knowledge of this topic. A Canadian perspective is also lacking in current research, with the majority of research focused on the American military. Research examining the role that resiliency and protective factors play in the experiences of women living with a military member diagnosed with PTSD is similarly insufficient. This is an important area that would also benefit from additional research.

Chapter Four: Methodology

The overall research question is: What is the experience of women whose military partners have been diagnosed with PTSD? As noted earlier, I concentrate on specific areas of the partner/relationship experience within the context of this broader question, such as caregiver burden, marital satisfaction, psychological distress, and violence in the relationship. Another goal of this study is to explore any protective and resiliency characteristics, as identified by the women and guided by Walsh's family resilience framework (1996), my chosen theoretical framework. In my opinion, there is a lack of research on the role that resiliency plays in the experiences of women living with military members diagnosed with PTSD and their ability to overcome adversity. Therefore, it is my hope that this study will create a better understanding of the experiences of military spouses overall, as well as gather insight and knowledge into women's resiliency when living with a veteran diagnosed with PTSD. Specifically, I wanted to identify supports and individual and family traits that promote wellness and recovery for both the women and their families. This study will be beneficial in the development of policies and programs to better support women who are living with a veteran diagnosed with PTSD and their families.

Theoretical Framework

Existing research suggests that the burden and stress encountered by intimate partners or spouses of PTSD veterans are considerable. Both the traumatized individual and family members experience multiple issues related to severe mental illness; however, research has also begun to consider the role of resiliency and how families exposed to similar stressors respond. (Walsh, 2003; Zauszniewski et al., 2010). Resilience is not a new concept in the study of families and individuals facing adversity but most of the research on spouses of traumatized veterans has

focused on poor couple/family functioning and the stress of the situation (Evans et al., 2010, Galovski & Lyons, 2004) and not the strengths of both individual family members and the family unit as a whole.

While there are similarities between Mclean`s (2007) previously noted study and my research, I have chosen to focus on factors of resiliency that impact women`s experiences. Like Mclean (2007), I considered secondary trauma, caregiver burden, and marital satisfaction; however, I believe that it is also valuable to consider factors of resiliency in the experience of these women. Therefore, the family resilience framework (Walsh, 1996) and the systems theory of family resilience (Walsh, 2003) may be useful for understanding the lived experiences of women whose military partners have been diagnosed with PTSD.

Walsh`s family resilience framework (1996) was developed as a guide for clinical practice and is used as a conceptual map to help individuals, families, and professionals identify key family characteristics that promote healing, decrease the risk of dysfunction, and guard against stress (Walsh, 2002).

Walsh (1996) noted that the family resilience framework is grounded in the systems theory of family resilience, which according to Walsh (2002) combines an “ecological and developmental perspectives to view the family as an open system that functions in relation to its broader sociocultural context and evolves over the multigenerational life cycle” (p. 131). Thus, problems and possible solutions are viewed from a bio-psycho-social-systems perspective that considers individuals, families, and the larger social system (Walsh, 2002). Similarly, Walsh (2003) has noted that the systems theory of family resilience provides a foundation for the family resilience framework that “serves as a conceptual map to identify and target key family processes that can reduce stress and vulnerability in high-risk situations, foster healing and growth out of

crisis, and empower families to overcome prolonged adversity” (p. 6). According to Walsh (as cited in Simon, Murphy, & Smith, 2005), the theory is based on two key premises. First, individuals are best understood within the context of their family and social systems; and, second, that all families can increase their resiliency when strengths and resources within the family are identified and utilized.

Walsh (2003) defines resilience as “the ability to withstand and rebound from disruptive life challenges” and explains “resilience involves key processes overtime that foster the ability to ‘struggle well’, surmount obstacles, and go on to live and love fully” (p. 1). According to Walsh, these key processes, described in the family resilience framework, can reduce stress and vulnerability in stressful situations while also promote healing and growth and empower families to overcome hardship. These processes are organized into the three key areas of belief systems, organizational patterns, and communication/problem solving.

Overall, family belief systems encourage resilience by making meaning of adversity, increasing a positive perspective and supporting a foundation of transcendence/spirituality and it is the sharing of family beliefs, which increases problem solving, healing, and growth. Family belief systems encourage hope, affirm strengths, and help members to clarify the nature of the problem. Family beliefs also allow families to view adversity as a manageable and shared challenge and can promote a sense of faith, healing, and growth from challenges in addition to a sense of a larger life purpose (Walsh, 2003).

Organizational patterns within the family can also increase resilience (Walsh, 2003). Flexibility, connectedness, and social/economic resources are key processes by which this is achieved. Flexibility, relies on authoritative leadership, and involves being open to new challenges while changing to meet new challenges. Connectedness offers mutual support, family

collaboration, and seeks to reconnect and resolve wounded relationships. The organizational pattern of social resources includes the establishment of extended family, social, and community supports while economic resources involve balancing work and family commitments and building financial security (Walsh, 2003).

The final key process in the family resilience framework is communication/problem solving, which uses clarity, open emotional expression, and collaborative problem solving to increase resilience (Walsh, 2003). Clarity ensures that clear and consistent messages are communicated while the ability to express emotions, have mutual empathy, and take responsibility for one's feelings and behaviour are important emotional expressions that improve resiliency. Finally, the families ability to share decision making, focus on goals, be resourceful in problem solving, and take a proactive approach to decrease/avoid future distress are important collaborative problem solving processes (Walsh, 2003).

Walsh's (2003) family resiliency framework (and systems theoretical perspective) is an important and appropriate approach for examining the lived experiences of a military spouse for several reasons. The National Healthy Marriage Resource Center (2006) reported that half of military personnel in the United States have children. As mentioned earlier, 41% of Canadian Forces (regular forces) are married/common law and have children (Canadian Forces Newspapers, n.d.). These statistics suggests that families are a significant part of military life and military spouses, who live within the structure of the military culture, must cope with issues and problems, as noted previously, that are specific to military life. It is, therefore, important to consider the well-being and mental health of military spouses. Research by Gambardella (as cited in Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010) found that the spouse's physical and mental health is an influencing characteristic in the overall health of the family, soldier retention,

and strong armed forces. Thus, according to Gambardella (as cited in Weiss et al., 2010), it is important to consider the significance of reducing risk, and promoting resiliency and good physical and mental health in military spouses. Similarly, the experiences of the women do not exist in a vacuum; rather, as suggested by Walsh (2003), their individual experiences will be influenced by bio-psycho-social systems.

As the theoretical framework for my study, Walsh's family resilience framework informed the questions that I asked of participants, including the focus on the spousal experience within the family and broader social context while also inquiring specifically about individual and family resiliency. Similarly, the resiliency framework guided the analysis of the interview data which I discuss in great detail later in the chapter.

Through the use of a qualitative exploratory thematic approach (to be discussed later) and reference to Walsh's family resiliency framework (as well as the systems theory of family resilience), it was anticipated that themes would emerge that could identify risk and resiliency factors in the military spouse, her family, and the larger sociocultural system. The family resiliency framework is also a valuable approach because, as Walsh (1996) notes, it provides a better understanding of the individual within the context of the family and social system. Specifically, it is beneficial in helping to better understand if there is a connection between individual and family resiliency, as identified by the women, and the amount of perceived caregiver burden, psychological distress, or other adversities described by the women. Thus, the experience of the military spouses can be examined from the perspective of resilience both within herself and in her relationship with her spouse as well as the larger world.

Research Design

I have chosen to examine the experiences of military partners using a qualitative, exploratory approach. As noted previously, research has predominantly focussed on the experiences of veterans and rarely includes the important stories of their spouses. Similarly, research examining the experiences of military spouses has often been quantitative in nature, i.e., using various scales and subscales to measure depression, anxiety, loneliness and other forms of emotional/psychological distress, and couple dysfunction. While quantitative data is important, a qualitative exploratory approach, and the process of sharing one's experience, allows for a richer and deeper meaning to emerge. Atkinson (1998) noted that "story makes the implicit explicit, the hidden seen, the unformed formed, and the confusing clear" (p. 7). Thus, the data that emerges from an exploratory approach cannot be similarly achieved through the use of scales, observations, or experiments. Similarly Brown (2006) suggests that, "exploratory research tends to tackle new problems on which little or no previous research has been done" (p. 43).

Specifically, I used qualitative research interviewing for my study. As noted by Kvale (1996), qualitative interviews are "attempts to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations." (p. 154). Interviews serve an important purpose in the creation of knowledge but equally important these dialogues also enable people to be heard, recognized, and acknowledged by others (Atkinson, 1998). The experiences of women whose military spouses have been diagnosed with PTSD have largely been overlooked. The qualitative, exploratory approach allows the participants to share their experiences, ultimately allowing for a richer and deeper understanding of how psychiatric illness impacts women whose military partners have been diagnosed with PTSD. Thus, qualitative interviewing is beneficial at giving meaning to people's experiences and can, therefore, be very useful when examining the overall experiences

of women's whose military partners have been diagnosed with PTSD, including exploring aspect of women's resilience. The concept of resilience, as examined from a family systems theoretical perspective, can identify strengths and coping in families (Allison et al., 2003; Patterson, 2002; Walsh, 2002) and qualitative interviewing can help to identify these important areas. Therefore, qualitative exploratory methodology is congruent with both the research question and theoretical framework.

Participant Eligibility and Sample

Because I wanted to obtain information about the experiences of women whose military partners have been diagnosed with PTSD the following eligibility criteria was used for the study: 1.) Women whose military partners (current or former service members) have been formally diagnosed with PTSD; 2.) Participant partners were receiving (at time of interview) or have received treatment for PTSD; and 3) Participants who have been in a relationship with their military partners for a minimum of five years. It was important that the military members have a formal PTSD diagnosis as this ensures that the findings are reflective of spousal experiences related to this mental disorder. Additionally, it was necessary to include military members who have received treatment for the illness, as I believed it is important to consider the impact that treatment may have on the experiences of the women. In order to complete an exploratory interview there must be sufficient relationship experiences from which to draw from and I believe that relationships of five years or more provided a broader range of information.

Because of the thick, rich data yielded from qualitative interviews, qualitative research is typically characterized by small sample sizes (Creswell, 2014, Creswell & Plano Clark, 2011). Qualitative studies typically have sampling sizes of 4 -10 participants (Creswell & Plano Clark, 2011), therefore, I planned to recruit 8-10 participants for my study. However, despite contacting

agencies that work with the participant population, recruitment was difficult and I was only able to recruit six participants. This lack of participant interest may be a reflection of the time commitment that is involved in research study participation. As will be illustrated in this current study, the experience of women shows that they have little available free time to dedicate to their own interests. After meeting with my thesis advisor and committee members it was determined that six participants was an appropriate and acceptable sample size for my study.

Participant Recruitment

Participants were recruited from two social service agencies that work with the military community. I contacted the manager and the executive director of the agencies, requesting I be allowed to post study advertisements (i.e., posters) at both locations (see Appendix G). The posters outlined the purpose of the study, the time commitment required by participants, my contact information, as well as other important information related to the study. Potential participants were asked to contact me on my personal cell phone, which was a confidential phone number. After confirming that the participant met the eligibility requirements of the study, an interview time and location was arranged.

Data Collection

Interviews were conducted with six women, which were guided by a semi-structured, open-ended interview schedule (see Appendix A). The interview schedule provided direction for the interviews, yet provided enough flexibility so that unanticipated circumstances or responses could be pursued. Open-ended questions were used as they maximize discovery and allow for free interaction between the participant and the researcher (Reinharz, 1992). Open-ended questions also enabled the participants to express their perspectives and experiences in their own words. Probing questions were used when participants' responses needed to be expanded on

and/or clarified. As mentioned earlier, the interview questions were informed by Walsh's (2003) family resiliency framework, therefore, although I explored the overall experiences of the women, I focused on individual and couple/family difficulties, coping skills, strengths, and more specifically resiliency.

The interviews lasted from 2 - 2.5 hours and took place in the participants' homes, with two exceptions where the interviews took place at a health and social services community building. All interviews were digitally-recorded and transcribed verbatim (by me). I also made written observations and noted non-verbal behaviour, such as facial and bodily/emotional expressions. Non-verbal behaviours are important to document as they may provide an opportunity for a richer and deeper interpretation of the experience and give clues about meaning (Fraser, 2004). For example, these behaviours, according to Kvale (1996), can support, give nuances to, and even contradict what is said.

Data Analysis and Interpretation

Bryman argued that there are "few well-established and widely accepted rules for the analysis of qualitative data" (as cited in Carey, 2013, p. 174). My study was not guided by a particular qualitative methodology (i.e., grounded theory or phenomenology) so I used generic, or thematic analysis to analyze the participant data. Specifically, I utilized the thematic analysis approach adopted by Tutty, Rothery, and Grinnell (1996). Thematic analysis is a diverse approach that can be applied to a variety of narrative texts, including interviews and written documents. (Reissman, 2008). The central characteristic of thematic analysis is to collect data and then allow patterns of experience and attitudes to emerge that will then be used to identify themes (Carey, 2012). Further, Carey (2013) notes thematic analysis is the most common analytic approach used within social work qualitative methods utilizing empirical data, and

typically uses small sample sizes as well as the involvement of a theoretical framework which may be used to “consider, assess, and evaluate any findings” (p.185).

I did not use any specific qualitative research software in the analysis of data and instead used Microsoft Word to organize (using coloured codes) and manage the data. Utilizing the above noted recommendations and methods for qualitative thematic data analysis and interpretation, I conducted my data analysis in the following manner. First, the interviews were transcribed verbatim and I then read and re-read the transcripts while listening to the recordings. This allowed me to immerse myself in the data (Morse & Richard, 2002). Next, I read the transcripts line by line and important statements and information was assigned a colour code to further assist in organizing the data. Using first-level coding, as defined by Tutty et al. (1996), I further organized the data into initial categories. As analysis progressed, many of the initial codes were revised as new information was discovered. Additionally, I used my handwritten notes from the interviews to assist in data analysis. Using the colour coded data, I was able to establish patterns or categories of experiences and all coded information that related to a specific pattern was identified and placed within the appropriate pattern/category (Aronson, 1994). Moving on to second-level coding, I determined what each category meant and made note of any similarities or differences among the categories in an effort to identify themes (Tutty et al., 1996). Memoing (Alston & Bowles, 2003) was also included in the data analysis stage and allowed me to reflect on the information and insight I gathered from the collection of data as well as the continued refinement of codes and categories and the linking of categories. I was then able to develop themes from the patterns of experiences. The family resiliency framework also influenced my analysis of the data. The key processes of the framework guided the refinement of data at each level of coding. The identification of patterns and the meaning given to categories

of experiences were also guided by the key processes in the framework. Finally, the family resiliency framework influenced the development of themes related to resiliency.

Importantly, during the process of my preliminary data analysis, I also met with my thesis committee and was given suggestions on refining my coding process and recommendations to ensure that the data analysis was congruent with my research question and qualitative thematic research analysis methods.

Through the process of data analysis and interpretation, I identified 10 broad themes in the analysis of the data. 1. Women's recognition of partner's PTSD symptoms was not immediate; 2. Women blamed themselves for their partner's changed behaviour; 3. PTSD caused significant stress to the couple relationship; 4. PTSD affected the family unit; 5. Women bore the burden and took on more responsibility; 6. Women forsake their own needs (personal sacrifice); 7. Women experienced intense negative emotions; 8. Women's health and well-being was negatively impacted by partners' PTSD; 9. Women gained new insights and no longer considered themselves responsible for their partner's illness; 10. Women demonstrated resilience and coping. Many of these themes also include important sub-themes. These themes are discussed in detail in Chapter Five.

Quality and Verification of Results

Fortune, Reid, and Miller (2013) maintain "the 'trustworthiness' of narrative accounts cannot be evaluated using traditional correspondence criteria. There is no canonical approach to validation in interpretive work, no recipes or formulas" (p. 184) and Reissman (2008), who used validity and trustworthiness interchangeably, concurred with this statement and equally stated that there are no standardized rules or procedures for validation.

Morse, Barrett, Mayan, Olson, and Spiers (2002) recognized several verification strategies for qualitative research. Two important strategies identified include: methodological coherence, which ensures congruence between the research question and the methodology; consequently, the research question, method, and data and analytic processes must all match and “the fit of these components with data to meet the analytic goals must be coherent, with each verifying the previous component and the methodological assumptions as a whole” (Morse et al., 2002, p. 18). Next, the participant sample must be appropriate. This means that the women selected for my study must have knowledge of the research topic or best represent the topic (Morse et al., 2002).

To maintain both dependability and confirmability I also worked with my research advisor and thesis committee to ensure that my data collection and analysis were appropriate, carried out accurately, and adhered to the proper qualitative thematic analysis methods. As mentioned previously, I shared my coding process and analysis methods with my committee and was directed to make suitable changes to my data analysis in order to ensure that my methods and findings were consistent with my theoretical framework and methodology. Also, throughout my research, preliminary findings were shared with my advisor and committee to guarantee that my analysis was consistent and exact. Furthermore, using the method of triangulation, I cross-checked several sources of data. Using information from the literature and the data obtained from multiple interviews, I was able to determine that no new findings or information were emerging and that saturation was reached.

The credibility of the researcher is another important component in ensuring the quality of a research study (Tutty et al., 1996). As the spouse of a veteran, I am very familiar with the military community as well as the struggles and challenges that are unique to this population. In

particular, I am aware of the stressors that wives of soldiers encounter and how these difficulties impact both individuals and families.

Ethics

The study received ethics approval from the Psychology/Sociology Research Ethics Board at the University of Manitoba. Participants were made aware that their participation in the study is completely voluntary; that they have the right to withdraw at any time, and that their identity will be made anonymous through the use of pseudonyms. The consent letter (see Appendix E) was also provided to all participants and outlined the studies process and procedures, the time commitment involved, and issues related to confidentiality and anonymity. All of the participants received a \$25.00 honorarium for their participation in the study. Upon completion of the interview, the women were provided with contact information for professionals whom they could call if they experienced any distress (see Appendix F).

Study Limitations and Strengths

Because of the small sample size (N=6), one limitation of this study is the lack of diversity among the participants. Overall, the women represent a homogeneous group with very little variation in demographics. As a result, it is unclear how the research findings relate to the experiences of other, diverse populations such as those from different socio-economic and racial backgrounds.

Another limitation of the study is that to be eligible to participate in the study, women had to have military partners with a formal diagnosis of PTSD. Consequently, women whose partners were not diagnosed with PTSD or have not participated in PTSD treatment were excluded from the study. These two groups of women may differ in many important ways. First, having a partner in treatment may not only engage the veteran in recovery but also impact

the couple relationship by providing opportunities and support for healing and risk reduction as a couple/family and individuals. On the contrary, women whose military partners have not participated in treatment may have differing experiences without the presumed benefit of PTSD counselling/treatment. For instance, the degree of caregiver stress, couple distress, and marital satisfaction may differ between the two groups of women.

Finally, I recruited from a military program and agency; consequently, these participants may not reflect the experience of women who do not access these services. For example, spouses connected to military programs may have a greater opportunity to learn about mental health services available to them and their families and also have the support of others in similar situations within the military community. On the other hand, military spouses who do not have access to military programs may have different experiences due to different pathways of support outside of the military. Overall, the addition/omission of formal support in the form of PTSD treatment may have a considerable impact on the experiences encountered by the two groups of women. As a result, my study did not reflect the experiences of all women whose military partners have been diagnosed with PTSD.

One significant strength of this study is that it gives participants the opportunity to voice their experiences, which may have been previously unavailable. As discussed earlier, the current body of literature has largely ignored the female partners of military members diagnosed with PTSD. Consequently, any opportunities to share their stories have been very limited. This opportunity may provide the women with greater insight into their personal challenges and provide them with an opportunity to recognize their individual and family strengths. Also, this study may provide the needed information to further aid in policy/program development aimed at promoting resiliency in military families. In identifying characteristics of resiliency that

encourage healing, growth, and recovery from adversity, military programs can be designed to teach individuals, couples, and families how to incorporate elements of resiliency into their experiences and lives.

Chapter Five: Study Results

In this chapter, I provide the results of the interviews with six women whose military partners have been diagnosed with PTSD. I begin with demographic descriptions of the study participants and then provide information on each of the themes that emerged from the interviews. I identified 10 broad themes in the analysis of the data. These are: 1. Women's recognition of partner's PTSD symptoms was not immediate; 2. Women blamed themselves for their partner's changed behaviour; 3. PTSD caused significant stress to the couple relationship; 4. PTSD affected the family unit; 5. Women bore the burden and took on more responsibility; 6. Women forsake their own needs (personal sacrifice); 7. Women experienced intense negative emotions; 8. Women's health and well-being was negatively impacted by their partners' PTSD; 9. Women gained new insights and no longer considered themselves responsible for their partner's illness; 10. Women demonstrated resilience and coping. Many of these themes also include important sub-themes.

Study Participants

Seven women expressed interest in participating in my study. However, one participant had to withdraw from the study, as she was unable to meet for the interview due to personal issues. In total, I interviewed six women for my study.

To summarize the sample of participants, five of the women self-identified as Caucasian and one as Filipino. The age of the participants ranged from 32 years to 47 years (mean age is 41). Four of the women were married at the time of the interview and two of the women were legally separated. The range of relationship involvement for married participants was from 5 years to 23 years while the two women who were legally separated had been in a relationship

with their partners for 10 years and 15 years respectively. The average length of relationship for all women was 13 years.

Four of the women in the study had completed post-secondary education, two had completed some post-secondary education and all of the women had full-time employment with the exception of one who was employed part-time. The annual family income reported by the women ranged from \$70,000 - \$110,000.

All but two of the participants were mothers: three women had two children and one woman had one child. The participants' children's ages ranged from 2 to 21 years old (mean age was 13).

The number of deployments experienced by the women's partners range from 1 to 4. Four of the military partners were diagnosed with PTSD within the last six years, one diagnosed in 2006, and the other in 2000. All of the military partners had participated in a wide range of treatment for PTSD which included cognitive behavioural therapy, group and individual counselling, treatment by a psychiatrist and/or psychologist, exposure and vision therapy, substance abuse treatment, and participation in peer support groups. At the time of interview, all but one of the spouses continued to participate in some form of treatment for PTSD. Likewise, the participants themselves engaged in various forms of support such as individual and couples counselling and spousal support groups.

The women spoke of their early experiences with the first signs of PTSD. Bonnie shared her memory of the moment that marked the beginning of her daily experience with her husband's illness:

There wasn't really any big thing until he started having anxiety attacks and I can remember his first one very clearly... I took the boys to a kids' group thing - a moms

group, and I got home and he was curled up in a chair rocking back and forth crying and I was like, “o.k. so what’s happening? I’m going to make some phone calls and get rid of the kids” [i.e., take them to the neighbours] cause that was my first thought, cause I didn’t know much about PTSD....

According to Bonnie’s accounts, her husband’s PTSD has resulted in very volatile behaviour: “He gets angry very easily, he....is very impatient...my husband’s not a violent man but when he gets angry, he’s explosive but he’s not physically violent but he’s explosive”. She further noted, “He was never a patient man ...but like now he will get angry a lot faster like he can’t handle the noise in the house or the roughhousing”.

Karen’s experience with the manifestation of her spouse’s symptoms was described as, “he was very tired, found everything exhausting, didn’t want to go anywhere there were people”.

While Amy recalls the moment when she experienced symptoms of her husband’s PTSD and things changed for her:

He deployed to Afghanistan in 2002, 2006, 2009, and it was after 2006 where I noticed he would come home and our son was born by that point our son was two and he would come into the living room where we were playing and he would burst into tears and walk out of the room and when I asked him about it he said he didn’t feel that he deserved to be here, he didn’t deserve to have a family and be at home so that was the start of it and then from there it progressed.

Mary described her experience with the first signs of her spouses PTSD:

“He was not the man I knew, he wasn’t part of the family, he would come home from work and just go to our bedroom and we wouldn’t see him for the rest of the evening”.

Mary too spoke of her husband's changes and his unpredictability, citing, "he was unpredictable, angry, he could go from 0-60 just like that. He wasn't like that before".

Nicole first experienced her husband's PTSD in the following way:

The biggest thing was he was a big talker, he would, we talked about everything, talk, talk, talk and suddenly he comes home and he's quiet, silent, I couldn't engage him in any conversation, short of a few words, he would use as few words as possible to converse with me.

Nicole also noted her husband's erratic and angry behaviour:

I didn't know what would set him off whereas before he was someone who rarely expressed anger, in fact I don't remember, he never expressed anger in a negative way, in an abusive way and now he was yelling, punching holes in the walls, throwing stuff. He was so extreme with his emotions, there was no middle ground.

Finally, Sarah sums up how she first experienced the manifestation of her partner's PTSD:

Looking back I can see that almost right away he was having a hard time sleeping, he wouldn't sleep, he would be up most of the night, if he slept it was maybe for a little while, he was having a hard time sleeping. If he slept, he would have nightmares and wake up yelling, breathing hard, sweating. He just couldn't relax so he was alert all the time...and so then there were other things, he'd avoid going out either with me or by himself...he was becoming more distant, there but yet like not there you know.

Sarah further described the changes in her husband, stating, “He just wasn’t himself, he would snap at me for little things like I’d forget to buy something at the grocery store and his reaction was way over the top, he’d be like yelling and swearing because I forgot the bread”.

All of the women describe meeting their partners through mutual friends and initially three of the women had long distance relationships because their partners were living on a Canadian Armed Forces base located elsewhere or were deployed during some part of their courtship. The majority of the women described their courtships as typical and spent time going to movies or out to dinner with their partners. This period in their relationship was also characterized as romantic and good with many of the women portraying their partners as kind, responsible, funny, interesting, sharing similar values and beliefs, and companionable. Two of the women who had long distance relationships did not describe this as a hindrance to the development of the relationship, in fact Nicole noted that, “I think maybe we talked, we discussed everything and really got to know each other in a different way compared to other couples”. All of the women met their partners prior to a diagnosis of PTSD and there was no indication of any PTSD symptoms during this period in the relationship. In general, all of the women highlight this part of their early courtship as positive, happy, and had hope for a good relationship with their partner in the future.

Theme One: Women’s Recognition of Partner’s PTSD Symptoms was Not Immediate

A major theme that emerged during the interviews was that the women did not immediately associate the different or uncharacteristic behaviour exhibited by their husbands to PTSD. Instead, their realization was slow and gradual. Most of the women reported that their partners displayed atypical behaviours upon returning from deployment but they attributed them to common problems associated with re-adjusting to civilian life. Others attributed their partner’s

odd behaviour to a potential drinking problem or simply to the difficulty of re-establishing an intimate or married relationship and reintegrating back into the role of husband and/or father. Regardless of the many reasons, none of them immediately recognized that their partners were dealing with a major mental illness, such as PTSD. It was only after their partners had received a formal PTSD diagnosis and the women themselves had become more knowledgeable about PTSD, through counselling and other professional supports, that they recognized these strange behaviours were early warning signs of PTSD.

Bonnie first noticed something was different with her husband's behaviour when they were driving, yet still considered his behaviour as typical of returning from a deployment to Afghanistan:

He was always a really good driver and all of a sudden he became a very nervous driver, right? So a car approaching a stop sign on the side street made him tense up - made him slam on the brakes - just made him react totally differently. He started driving really slow, enough to drive you insane...I just thought maybe this is normal, right, this is just him getting used to being back in life so he was maybe more impatient, he isn't really a patient person any ways. I wouldn't have expected him to come back more patient.

Bonnie's experience of not associating early changes in behaviour to PTSD is shared by other women. Nicole, too, noticed a change in her husband after he returned from deployment, but considered it to be due to problems of re-adjustment and considered it to be normal. She stated:

We hadn't been together for very long, married I mean and actually hadn't spent really any time living together so when he first came home, and we were together, I thought, well okay, a lot of his behaviour was just us getting adjusted to being in the same place,

living together and also him adjusting to coming home, so at first I thought this is normal behaviour.

Sarah shared a similar perspective about her husband's behaviour after he returned from deployment:

We had that period of adjusting so I never thought anything different. He was, you know, it was him being back and our son getting used to Dad being around a lot again and me too. And so maybe I thought that it was just like harder to adjust this time. It was always hard so I didn't know...I didn't think that maybe it was something different. I just thought he is having a harder time adjusting to being back, being with us and getting back into being a father and husband.

Karen likewise speaks about her experience with her spouse's changing behaviour. Like the other participants, she attributed her husband's behaviour to normal adjustment issues, not on the initial symptoms of PTSD:

He was very tired, found everything exhausting, didn't want to go anywhere there were people. That's normal coming back from tour but not snapping out of it eventually isn't, and not getting better on your own isn't. Like, it's normal to have issues when you come back because of the culture shock.

Amy recognized changes in her husband's behaviour after he returned from a second tour of Afghanistan and shared the following incident:

Our son was two [years old] and you know he [husband] would come into the living room where we were playing and he would burst into tears and walk out of the room and when I asked him about it, he said he didn't feel that he deserved to be here, he didn't deserve to have a family and be at home, so that was the start of it.

When asked if she suspected that PTSD might be responsible for her husband's change in behaviour, Amy responded:

At that point I knew nothing about PTSD really other than just kinda little bits, more out of the States [media coverage of PTSD in American military] and I thought he had a drinking problem truthfully and that's as far as I thought it was at that point.

From the women's accounts (as noted above), their initial reaction to their partners' behaviour changes was perceived as an issue of readjustment and typical given the length of separation encountered by a veteran and his family. None of the women made the connection between these changes and the possibility of PTSD. Rather it was understood that on some level these behaviours were normal and part of the process of reintegration into the family, home, and culture. However, as the interviews unfolded it became clear that these early PTSD symptoms were the beginning of much more complex experiences for the women and that PTSD was going to have a significant impact on both their day to day lives and the relationships with their spouses.

Theme Two: Women Blamed Themselves for Their Partner's Changed Behaviour

As noted previously, the participant's initial reaction to behavioural changes in their partner was one of relative minor concern with the general understanding that it was a normal reaction and an issue of readjustment. However, as symptoms progressed and behavioural changes intensified, the women's perceptions changed. Many of them began to realize that PTSD was a problem; however, they blamed themselves for their partners' mental state. Consequently, they assumed personal responsibility for the partners' difficult behaviour.

Amy articulated this:

I first blamed myself, you know? We had a son and I put on weight and I thought that maybe it was me because he wasn't attracted to me anymore and then I just, I put it all on myself, I thought that it was my problem, that it was my fault.

Amy's explanation illustrates her sense of responsibility for her husband's behaviour and that this was failure on her part – that she failed to keep her husband attracted to her. Similarly, Karen blames herself and takes responsibility for her husband's illness:

I pegged him for probably getting PTSD before he went but there is nowhere where you can report that because he's an emotionally sensitive person and I know that... In the beginning, I thought that it was my fault that he got PTSD because I figured that he would and I wasn't sure how I could have supported him in better processing the information that he was seeing and so I felt like I could have tried harder.

Mary also took responsibility for her husband's illness and like Amy and Karen, expresses that if only she was somehow better her partner would improve. During the early onset of her husband's symptoms, she naively thought:

You know, I was going to be his saviour... I made sure that he didn't have to do anything that would cause him distress so if I did everything, looked good, I took on everything because, well, I blamed myself... I thought if only I was good enough, worked hard enough at our marriage, he would get better, it would be all he, we needed.

While the participants understood their husband's illness initially in terms of self-blame and personal failure, other participants noted that in the beginning it was their role to make things easier for their partner and, therefore, took on more responsibilities and adapted their behaviours (this will be discussed later themes). Other participants downplayed their partner's

behaviour and went along with how their partners were feeling as a way to make it easier (and, therefore, support) their partners. Consider Sarah's situation:

In the beginning I think I tried to make things easier. I would say, when he wasn't going [somewhere], I'd say, "Okay, so you don't want to go, okay. Let's not go then." And it was easier to just not go.

Bonnie also noted, "When he was really sick it was often, "That's ok I'll do it, don't worry about I'll do it".

The discussions above note how a sense of personal failure and blame on the part of the women caused them to assume responsibility for their spouse's behaviour. These women were willing to do anything to decrease their husband's distress and some viewed their own personal sacrifice as the only thing needed to help the situation. Theme Five discusses the added responsibilities that were assumed by the women in order to eliminate the distress experienced by their partners and families while Theme Six demonstrates how the women sacrificed their own needs for that of their spouses and families.

Theme Three: PTSD Caused Significant Stress to the Couple Relationship

Another major theme that emerged during the interviews with the women was the significant impact that their spouse's PTSD had on the marital relationship. For these women, living with a partner with PTSD profoundly changed how they lived and the relationship with the man they once knew. The participants sadly recalled the transformation in their partners. Bonnie expressed, "it does bother me that he isn't the same person that he used to be" and "he was very different when he came back anyways". While Mary similarly shared, "he was not the man I knew" and Sarah noted, "he just wasn't himself... he was so different...his personality was

different". The participants noted key indicators of dysfunction and stress in their couple relationship: detachment, avoidance, a decrease in marital satisfaction, and lack of intimacy.

a.) Detachment

During the interviews the women spoke of feeling isolated from their spouses. Living with a partner who is emotionally withdrawn, and in some instances both physically and emotionally absent, created distress in the relationship. Nicole spoke of her relationship dysfunction:

The biggest thing was he was a big talker, he would, we talked about everything, talk, talk, talk and suddenly he comes home and he's quiet, silent, I couldn't engage him in any conversation, short of a few words, he would use as few words as possible to converse with me. It was like it was almost painful for him to be around me, to talk to me about anything...he also was emotional, well different emotionally compared to before deployment... now he wasn't able to or rather didn't express his emotions, didn't share with me... it was like it was almost painful for him to be around me, to talk to me about anything.

She went on to share, "he became so isolated and even when he was home, he wasn't engaging with me, we weren't spending time together". Sarah also identified how PTSD impacted her marriage:

I mean he'd be there, he was physically there but yet he wasn't emotionally and you know how does that help? He'd be gone emotionally and I just eventually focussed on the kids, well, when your marriage isn't good.... He was becoming more distant. [He was] there but yet like not there, you know? He would just withdraw even more, become upset and go to the bedroom or basement.

Mary shared the following about the stress that she experienced in her relationship:

It was like he was there but not, do you know what I mean? He couldn't come back from where he was and be with me, us. He wasn't interested in doing his normal things, things that he liked before, like watching sports, working on his cars, playing hockey that was another big one with our son, his family, his parents and brothers, he was always close to them and suddenly he cut off contact with them, so he wasn't interested in those relationships.

She articulated well the drastic transformation in her relationship with her husband:

As a husband, partner, we'd spend time together. We would cook meals and he helped with household stuff, laundry, cooking, helped with parenting. We spent time together in the evening, watching TV, going out for dinner, movies, normal stuff that couples do. But he isolated himself, really removed himself from the family.

Amy also elaborates on how detachment symptoms negatively impacted her relationship with her partner, "He was really confrontational when I would try to discuss things with him, it quickly went from me trying to talk to him to us yelling at each other" and when asked if her husband was able to share his feelings or experiences from deployment, she responded "No complete detachment, he blamed it on work, he blamed it on his peers, they needed him there and I had no idea what was going on my husband".

Nicole too talked about her experience with her husband's withdrawal from their relationship:

He also was emotionally different compared to before deployment. He was always very good at expressing his emotions, very in touch with his emotions, which is unusual for most men, but now he wasn't able to or rather didn't express his emotions, didn't share

with me...So now he not only wasn't expressing those feeling, he wasn't or didn't seem to have feelings. It was like he was void of a wide range of normal emotions and now there was only anger, which was completely new for him cause he was not an angry person, and anxiety and sadness, crying.

Women noted that their husband's detachment left them feeling lonely and withdrawn. For example, Mary talked about how her husband's lack of involvement resulted in her "trying to deal with everything alone". Nicole also spoke of the impact of her partner's detachment, "How can you have a marriage when one person can't share themselves, isn't emotionally or even physically involved and the other feels that they are alone?" Sarah shared how she began to withdraw from the relationships herself as a way to cope with the disintegration of her marriage:

Sometimes it was easier just to not talk about something especially when I didn't know how he would react or not react cause it was hard to talk to someone who didn't respond in any way, he avoided stuff and it was hard and we had two young kids and he completely checked out, just checked out.

b.) Avoidance

The majority of the women explained that their spouses' anxiety was problematic and often resulted in issues because their husbands would avoid situations that were anxiety-provoking. These women acknowledged that extreme anxiety, as well as the avoidance of triggering situations that acted as a reminder of her husband's trauma, had negative consequences for the couple relationship. Nicole summed up her experience and the impact on her marriage: "We stopped doing anything together that was fun, his anxiety prevented us from going out, going out and enjoying life really". Bonnie was forced to alter her expectations of what the couple relationship was going to be like, due to her husband's anxiety and avoidant

behaviour, “I was told when I went to counselling that I needed to get over that and just say, ‘This is what we are doing but you don’t need to come’. But that’s hard because like, ‘I want you to come’”. For Amy, her husband’s avoidant behaviour caused her to experience anxiety as well. Consequently, PTSD put additional strain on the relationship as Amy had to cope not only with her husband’s symptoms, but also her own:

I have to do a lot of self-talk ...because of course my anxiety comes up and immediately I think what can I do to fix this? I can’t do anything to fix this; it has nothing to do with me. It’s his issue - [he should] go deal with it.

When discussing how PTSD symptoms added stress to her marriage, Mary explains:

I was anxious, always worried, what is he going to do, right? How is he going to act, maybe, you know, we need to not go somewhere cause he is going to be triggered. What if I say something and that sets him off? I was anxious all the time.

c.) Decrease in Marital Satisfaction

The majority of women cited marriage and relationship difficulties when discussing their experiences of living with a veteran diagnosed with PTSD. When discussing the impact that PTSD has had on their marriage, four of the participants openly shared how mental illness has significantly altered the relationship with their husband and consequently, negatively impacted their feelings and satisfaction with marriage. For Sarah, she described how her husband’s illness has changed her marriage:

He was physically there but yet he wasn’t emotionally and how does that help, he’d be gone emotionally and I just eventually focussed on the kids, well, when your marriage isn’t good.

She also explained how her spouse's behaviour created relationship conflict and caused her to do things without her partner, stating, "When I was tired, so tired of his behaviour and the fighting and we'd end up not going...or you know I would pack up the kids and go alone. I did so much on my own". Sarah recalled the early years of her marriage and the strain that her husband's symptoms put on their relationship:

When he was first diagnosed and we had a young family cause he didn't have the tools to express himself, I would get angry and frustrated because he wasn't responding, he wasn't sharing so we spent a lot of time avoiding stuff and not talking, blaming each other...and I had the kids to look after so I didn't have time to sit with him and say let's process this and share that. I didn't have the time...or really care to at that point.

Recalling her husband's emotional withdrawal symptoms, Sarah voiced, "he was physically with me but emotionally or whatever he was gone, checked out". When asked how her spouse's behaviour made her feel, Sarah responded, "alone, pretty much alone and frustrated and angry and sad. I think that I wanted to...needed to understand right? But how do you make someone tell you those things, those really horrible things".

Amy's description highlights the extent of marriage dissatisfaction that women experience as the result of living with a partner diagnosed with PTSD, "He pulled away from me and I pulled away from him, emotionally, physically we were at that point more like roommates than anything else". Mary explained how PTSD impacted her relationship in the following way, "Well...we are separated so I guess it ultimately destroyed our relationship...PTSD changed him, us, me too and...I don't know how couples make it right?" Nicole, too, described her feelings and relationship difficulties:

He was the child and I was the parent, there was no equal, adult relationship, it wasn't a happy, a fulfilling marriage because we never really had the opportunity to have that, from the beginning we were dealing with PTSD.

Nicole also questioned, "How can you have a marriage when one person can't share themselves, isn't emotionally or even physically involved and the other feels that they are alone and solely responsible for getting their partner better".

Like many of the other women, Mary expressed feeling alone in her marriage and her description provided insight into how PTSD impacted marriage satisfaction and created relationship dysfunction:

We were avoiding each other. Because he was so angry and unpredictable, I would avoid engaging with him...so if we were invited to a friend's house or if maybe something was happening at our son's school, I just learned not to ask him to go because I knew it would end in us fighting because well...I wanted to be a family right? Do things together and we would just fight about him not being able to go and really I would be the one hurt and disappointed and either not go or you know go alone if it was something that I really needed to go to. But it became easier to just not to bother and there was no connection, no intimacy whatsoever so we couldn't have been more distant but living in the same house...I didn't have a partner, I had a roommate.

d.) Lack of Intimacy

While voicing their experience of living with a veteran diagnosed with PTSD, all of the women shared stories of how PTSD symptoms altered the relationship with their husband, resulting in impaired intimacy. The majority of the women expressed ongoing relationship challenges and the decline in marriage satisfaction as being closely connected to impaired

intimacy. Nicole's earlier discussion about the dissatisfaction in her marriage illustrates this connection:

There was no intimacy in our marriage, we weren't close, like I said I felt like a parent to him, a huge responsibility for doing anything to get him better but we didn't have a relationship that a couple, especially a newly married couple should have.

Sarah shared a similar experience, noting:

He wasn't participating in family life or helping me to parent the kids or do stuff around the house, that really put a strain on us...How can you be intimate with someone who is so detached. I mean he's improved, we've improved and it's much better but it's taken its toll.

Amy recalled how substance use impacted the intimacy in their relationship:

He was still going away a lot at that point so he wasn't home all the time, the time we spent together when he was home was pretty much a lot of drinking, we would drink - that's what we did together at that point.

She notes the relationship dysfunction and impaired intimacy that resulted:

We fought a lot mainly because you know I was finding alcohol bottles hidden all over the house and he was really confrontational when I would try to discuss things with him. It quickly went from me trying to talk to him to us yelling at each other. At that point we had no relationship other than we lived together that was the extent of things and we had a son and that was it.

When discussing the impact that PTSD has had on her relationship Mary noted, "We were avoiding each other, he was so angry and unpredictable, I would avoid engaging with him". Mary went on to explain the consequences of this avoidant behaviour as, "there was no

connection, no intimacy whatsoever so we couldn't have been more distant but living in the same house. I didn't have a partner, I had a roommate".

Amy voiced, "The medications he's on, he has lost all desire for intimacy". Karen similarly shared the following when asked about other difficulties experienced by her husband, stating, "No appetite, no sex". While Bonnie shared:

This is the embarrassing part, there is no [physical] intimacy in my marriage anymore. It's just he smokes weed every day, every evening after the kids go to bed. So after the kids go to bed, he usually falls asleep in his chair and all the medication he's on....there is nothing there.

Nicole's story highlights the extreme impact that PTSD and a lack of intimacy can have on women lives and their marriages:

When I realized that things weren't improving I met someone at work and I had an affair. It was at a point when I just couldn't stand my life, the situation anymore and maybe there was a part of me that I really wanted to hurt my ex-husband, make him hurt in a way that he had hurt me. I gave up hope and didn't care about him or us and we were so disconnected from each other we didn't have any kind of relationship. I really felt alone and I turned to someone else, for comfort, for a connection, to feel like I belonged to someone, like I was part of a relationship with someone who cared about me. I wanted to be someone's partner not their parent, not their caregiver.

During the interviews, the women openly shared how PTSD negatively impacted the couple relationship and created significant relationship distress. Detachment and avoidance created a distance between the women and their husbands, resulting in a lack of both physical and emotional closeness. As their relationships transformed due to PTSD, the women

encountered their own struggles with anxiety and had to redefine what their marriage would be like in the future. Living with a partner, who is emotionally absent, increased relationship dysfunction and led to a decrease in marital satisfaction and intimacy for the women.

Theme Four: PTSD Affected the Family Unit

Participants also noted the impact of PTSD on the family unit. For many women, their husbands struggled with re-integration into the family. The PTSD symptoms of withdrawal and isolation effectively removed their spouses from the role of father and husband in the family unit and resulted in his lack of participation in daily family life. Importantly, two of the participants also noted that they had concerns for their physical safety and that of their child due to behaviour related to PTSD. The following quotes illustrate how their partners' PTSD impacted their families.

Sarah expressed how PTSD removed her husband from participating in family life:

I think one of the biggest is his detachment from the family, from me, from everything that he used to be interested in. So like he wasn't interested in taking the kids out to the park or out you know for lunch to McDonalds or going out with friends, with me or playing hockey. He would rather stay in the house, in the bedroom alone, he'd do as little as possible, anything to avoid people and places he would have gone to before.

Like Sarah, Bonnie discusses her husband's detachment and withdrawal from the family and his issues with reintegration and isolating behaviour:

The kids don't...you know Saturday night movie night, they don't expect dad to come and watch a movie. If he does then it's a bonus, right? It's like, "Oh I'm going to go sit on dads lap". To them it's a treat; it's almost like, "Hey dads hanging out with us!" I think for me, I've adapted to just not having that sort of atmosphere in our house.

Bonnie continued by stating, “He’d be downstairs watching TV and he was a person but not really a part of the family”. She and her children learned to cope with her husband’s withdrawal:

We have definitely adapted in the way that it’s, “Just leave him alone, just leave him alone”. “Where is dad?”, “Dad’s in the kitchen”, “Where is dad?”, “Dad’s in the bedroom. You know where to find him if you need him but just leave him alone”.

Amy also discussed how her partner “checked out” of the family:

He just kind of isolating himself from us [the family], he’d hide in the garage and spend a lot of the time in the garage or a lot of time at work and he isolates [himself], he doesn’t want to have anything to do with anybody.

Mary also noticed changes in her husband’s behaviour and she interpreted these changes as his unwillingness to be a participating member of the family:

He was not the man I knew, he wasn’t part of the family, he would come home from work and just go to our bedroom and we wouldn’t see him for the rest of the evening. It was like he didn’t know how to be with us anymore, he didn’t want to be a husband, a father, right? He wasn’t interested in being around us, the things he did before as a father and husband, he wasn’t doing those things. He always was the dad who spent time with our son, he’d come home from work and like... “Hey, let’s go shoot some hoops” or “how was your day”, help with homework... just there right?...But he isolated himself, really removed himself from the family.

While the majority of the women did not express any concerns for their safety or the well-being of their family due to their partner’s PTSD, two women did share that they were afraid and fearful because of their husband’s aggressive and unpredictable behaviour.

For Amy, not only was she dealing with a husband, who is an alcoholic, she also had to cope with a potentially dangerous situation:

He was very drunk one night and he told me that he was going to, he could kill me and the kids... my husband hunts, he said, "You need to get all my rifles out of the house" and I said, "Ok, well where are they?" and he had put them all in the back of the truck and so I called a friend and our friend came and took all his rifles and the axe we use for cutting firewood and that sort of thing out of the house and my husband by this point had gone and passed out and I was scared. The next day, that was where I said to him, 'Ok, you need to go in and you need to go to your mental health services and you need to tell them that you need to go away for treatment and or I am leaving with the kids cause I no longer feel safe with you'. So that was the big event and he didn't think that there was anything wrong.

This marked a changing point in Amy's experience as she realized that she was no longer willing to accept the damaging and potentially unsafe consequences of PTSD on her family and was willing to leave her marriage as a result.

Nicole also explained how her ex-husband's PTSD - related behaviour made her feel unsafe in her own home, stating:

His emotions, anger, anxiety, depression whatever was only made more pronounced with the alcohol and there were times when I was afraid. Although he never hit me there were times when I really feared for my safety, he had guns in the house and for hunting, but I worried because he was so volatile emotionally.

The previous discussion emphasizes the impact that PTSD had on the family as a whole. The women expressed how PTSD prevented their husbands from fully interacting and engaging

as fathers and impeded their ability to effectively co-parent. Consequently, the women were forced to adapt, which meant that they managed their children and parented alone, without the involvement and support of their partners. The potential for physical violence was also evident for two women and further impacted the family unit, creating an environment of fear and concern for the women. While the majority of the women did not experience fear in their relationships, it is important to include Amy and Nicole's experiences because they demonstrate the far-reaching impact that PTSD can have on the family.

Theme Five: Women Bore the Burden and Took on More Responsibility

The women expressed the overwhelming responsibility that they felt towards not only alleviating their husband's PTSD symptoms but also helping with symptom management and decreasing or eliminating any distress that her partner or family experienced as the result of PTSD. Consequently, the women adopted new behaviours in order to better manage their daily lives. Subthemes in this discussion are: women take responsibility for managing their partner's PTSD, women take responsibility for managing their children's reactions, and women assume primary responsibility for managing the home and parenting.

a.) Women Take Responsibility for Managing their Partner's PTSD

As noted above, the women assumed responsibility for their partner's symptoms and were compelled to improve the situation. Amy spoke about assuming responsibility for her partner's feelings, stating, "I want everyone to be happy, I don't want him to [suffer] I...I take on a lot, I try to take on a lot of his unhappiness. I try to do things so that his boat doesn't get rocked so to speak".

During Mary's interview, she, too, expressed her feelings of responsibility for her partner's mental health:

At first, initially, I felt that it was my job, my responsibility as his wife, I mean who else was going to be the one to help him? I felt an immense responsibility to do it and I felt hopeful too. I believed that I could make him better but it was harder than I ever thought it would be.

Each woman indicated that she had altered her behaviour in order to accommodate her husband's symptoms and felt responsible for decreasing his symptoms. For many of the participants this meant trying to manage almost every activity of daily life as well as being constantly aware of potential triggers for their spouse's PTSD. Sarah explained how she attempted to limit her partner's volatility and reduce its impact on her family, stating, "I tried to avoid having him upset because if he was upset then everyone was upset". She further explained, "I would try to almost micromanage everything, it was like staying 10 steps ahead, trying to predict what he needed before it became a blow up".

Mary provided insight into her daily experiences and how she became responsible for decreasing distressing emotions and impulses in her partner; she also shared instances of when she adopted new behaviour due to her husband's mental illness:

I also managed him. That was a full time job, I became very alert to any of his triggers.

Our son couldn't have friends over when he was home because the noise was too much or

I was never, ever sure when he would just blow up. You know blow up at any little thing

right? So how could our son have his friends over? I would pre-screen movies that we

watched at home to make sure there were no scenes that would trigger him, we didn't go

to his brother's wedding because he couldn't fly. Are you kidding? A busy airport, the

noise and confined to an airplane for hours. It's about controlling, me controlling the environment so he is ok, so he's not anxious, angry... whatever.

When asked what she did to save her husband, Mary responded:

What didn't I do? I made sure that he didn't have to do anything that would cause him distress so if I did everything, [I made sure I] looked good, I took on everything because, well, I blamed myself. I thought if only I was good enough, worked hard enough at our marriage he would get better, it would be all he, we needed.

Amy offered a similar perspective on her day to day management, stating:

I have to learn how to let go because I am so used to micromanaging everything because for so long I was managing his illness or trying to manage his illness for him because he wasn't doing anything to manage his illness.

Amy also noted how she attempted to reduce impulsive behaviours and emotions in her partner:

I find myself hyper-vigilant trying to make sure if we do go somewhere or do something, that he isn't going to be triggered so like even watching TV, watching the news, they show a clip about ISIS fighting, immediately I get panicked because I think is this going to set him off or not?

Amy explained that everyday activities require planning to limit potentially distressing situations and behaviour: "If we had to go into Winnipeg for a doctor's appointment or something, it's go in and get out, it's a strategic plan". She went on to add:

We need to go here, here, here, we make sure that we are there as soon as things open so that there are as little people as possible and try not to go on weekends when things are really busy and it's get in and get out for the most part.

Nicole similarly alluded to assuming responsibility for decreasing her partner's volatility: I always needed a plan if we needed to go somewhere. So if we had to go into the city for an appointment then I would drive because he would, well couldn't drive in the city and I wanted to avoid him maybe getting into a fight when another driver pissed him off so I drove and I would call ahead to the office, because he couldn't sit in a doctor office for long because of his anxiety, so I would call ahead to make sure that the doctor was on time.

She further stated, "I managed the environment, the situation to minimize his issues", and, "I was always aware of what was happening around him, around us, trying to diffuse situations, make excuses for his behaviour".

Like the other women, Karen cited an example when she assumed responsibility for reducing her spouse's PTSD symptoms at the grocery store, explaining:

So at some point I would say I need you to go outside and have a cigarette and he would stop fighting me on that and I've never actually had to abandon the cart and just leave cause I never let it get to that point but I did a lot of managing of feelings, of his feelings.

Karen also explained how she made efforts to reduce the potential for a distressing situation during daily activities:

Prior to leaving the house we would talk through where we were going, what we were doing, why we were going there. I would prioritize the way we were going to places so at any point we could cut and run and go home so that the most important things were done first before any of the coping ran out.

Karen described the daily management of her partner's impulses and volatility in the following manner, "I don't mean to be manipulative but if I can manipulate so it becomes a positive experience, if I can manipulate the situation so it's not so stressful".

b.) Women Take Responsibility for Managing Their Children's Reactions

For two of the women, daily living included overcompensating for their partner's illness by being more affectionate with the children and spending more time with them. Bonnie articulated this when she stated:

I don't know if it's just him but like if he's in a bad mood I will try my hardest to offset that maybe not for him but for the kids. I will be like super positive and super happy and super energetic and super fun and I'm like, "I just worked all day and I'm tired but that's ok.

Sarah also talked about her experience as a mother:

When the boys were younger I would try to make things better...like if their dad was angry, yelling because the kids were loud or just being kids, playing and excited so I would take them somewhere else, I'd say, "O.k. boys lets go to the park", and try and make it a fun outing. I tried to give them a normal childhood and be a good mother cause their dad couldn't...he just couldn't...I think I was trying to be both mother and father to make up for him not being there ...not being there emotionally especially.

Bonnie also discussed how she takes on the responsibility of explaining her spouse's behaviour to her sons and attempts to reduce her partner's volatility by managing her children's behaviour:

I talk to them and they say "Why does Daddy yell and why is Daddy always angry with us?" I just tell them, "Sometimes he's not yelling but he does have a really loud voice"

and he does he has a really deep loud voice and I said, “The noise really bugs him, when you guys really get excited the noise really bugs him, you don’t have to stop that, you know if you are playing and you’re being good you don’t have to stop that but it will bother him, so sometimes it might be best just to take it to your room, take it outside, he’s not angry with you, it’s usually just the noise right? You’re not being bad you’re just being noisy”.

Like Bonnie, Sarah also made attempts to explain her husband’s behaviour to her children, citing, “When they got older I really tried to explain that it was their dad’s issues and that as kids they were just being kids”.

c). Women Assume Primary Responsibility for Managing the Home and Parenting

Another difficult aspect of managing day to day is caregiver burden. The women universally expressed that they became the sole caregiver for the children, ensuring that the needs of every family member was attended to. All six women similarly shared that their spouses were not actively involved in sharing the responsibilities of daily life; rather the women were forced to become the sole caregivers due to their partner’s inability to cope with day-to-day life. Amy articulated why she had to take on the role of sole caregiver:

I did everything because he was at work or sleeping that was basically how things were for the most part things. Grocery shopping, he just doesn’t do those things, I do that stuff, I do the majority of everything. Appointments with the kids, specialist appointments, he doesn’t, if he doesn’t have to, leave the house, he won’t.

She further explained:

I did more around the house, took on more responsibility, I did as much as I could just so he wouldn't have to do that. I took full responsibility for most of the parenting that went on...I would tiptoe and try to make sure the kids were quiet and we didn't bug daddy.

Nicole expressed why she took on the role of caregiver, stating:

I made most of the decisions because I didn't want to burden him with day-to-day decisions. I took over all those responsibilities, it was part of that management, part of my attempt to decrease his distress, make things easier for him.

Mary explained how her role of caregiver extended to all areas of her life and, for her, managing was a struggle. This is evident when she compares herself to a juggler:

I, of course did everything so all the housework, shopping, looking after our son, working full time...I'm like a juggler right? I have all these balls in the air and I can't drop any of them...just keep juggling, just keep juggling, don't drop the balls.

Sarah provided insight into how she became the caregiver, noting, "someone had to parent, someone had to look after the kids, the house, all the day to day stuff that goes on and I was working full time as well and doing everything alone". Sarah also talked about the struggle to manage life and care for others.

At the time it was just coping, keeping my head above water and you know probably doing what I just had to do for my kids mostly, he wouldn't go place, do things and so I took on more responsibilities...I was taking care of the house, kids, him, working and then trying to manage his behaviour, his anxiety, his crap.

She also talks about parenting alone:

I did a lot of parenting because he was there but yet he wasn't right so like he had a hard time with managing the kids...disciplining them and making decisions and the chaos of a household with young children...I had to parent mostly alone.

Bonnie talked about the full extent of her caregiving responsibilities as well as the absence of her partner:

I would work from home in the morning, look after the boys, do breakfast, lunch and then I would go to work for the afternoon when they went down for a nap. Then I would work and then come home and he'd make supper and then he'd just disappear again into the bedroom and so then I'd clean the house, do the laundry, play with the boys, put the boys to bed and do whatever I did. He'd be downstairs watching TV and I mean he was a person but not really a part of the family so I just, I did all the shopping, the grocery shopping, the entertaining of the children.

The following statement by Mary highlights well the full extent of the burden and responsibilities experienced by the women. She explains how she assumed responsibility of the care of her husband and children, the management of the home, and the emotional and physical well-being of her family. Every detail of her personal life was consumed with the responsibility of managing the effects of PTSD:

I spent most of my time caring for others, ensuring that everyone was okay, well as okay as was possible given what was happening but I was the one managing everything, everyone and that's a lot, right? I was not only caring for the physical well-being of everyone, doing the housework, grocery shopping, laundry, cooking but I was, I felt responsible for the emotions of everyone, my son, my husband so I thought that...I took on the job of managing their emotions, does that make sense? I didn't want my husband

to suffer, to be in pain so I would do anything to make it easier for him right. “You can’t go to the store to pick up a few groceries, no problem I will do it, you can’t take our son to the dentist cause you’re depressed today, no problem, I will do it, you can’t go to a friend’s house for dinner, no problem, I will stay home so your depression doesn’t get worse, so you don’t drink more”.

The women’s stories demonstrate the significant responsibility they had to take on as the result of living with a partner diagnosed with PTSD. Along with managing the household and their children, they also had to manage the immediate environment (i.e., to minimize triggers) and their spouse’s PTSD symptoms. Not surprisingly, taking on the burden of these profound responsibilities resulted in the women sacrificing their own needs.

Theme Six: Women Forsake Their Own Needs (Personal Sacrifice)

Four of the women spoke about the significant sacrifices they made for the needs of their spouses and families. While attempting to take responsibility for their partner’s recovery and limit the distress experienced in the family, the women sacrificed their own needs for that of their partner and family. For example, women sacrificed employment opportunities, personal friendships, and time with extended family.

I took on the responsibility for getting him better and if I had to leave my job, not see my family, friends or do anything else other than care for him well so be it, that’s what I needed to do. I also took a leave from my job and thank goodness that I had a great boss because she was very supportive and I took a leave to try and get him better, I thought, “Okay, we can fix this, as long as I am there for him, working hard to help him, everything will be okay”. (Nicole)

I sacrificed a lot for him, a lot of me. I was offered a job but there was travelling involved and how could I take it? Who was going to care for my son, my husband, do everything? I knew that I couldn't depend on him for support. I was the caregiver, the one responsible. I wanted to have another child but how do you bring a baby into that right? I just let that dream go. (Mary)

I didn't realize how exhausted I was. I didn't realize how much it took out of me. I kept shrinking my world 'cause I was too tired to deal with things. I didn't see anyone, I came to Winnipeg a lot because I'm close to cousins here and in the last two years I haven't really seen them and I didn't see my mom who I see very regularly. I didn't see friends, I didn't seek out new ones [volunteer activities]. I didn't have a job. I just stayed at home 'cause I didn't have the energy to do other things besides just keeping both of us alive, I spent a lot of energy managing. (Karen)

I had to think about what I wanted 'cause it was tough and I was so burnt out and I was so tired. I felt, I don't know, I felt sorry for myself like I was feeling very sorry for myself. I had to bare this all, I had to be a parent to four different people and to make sure everything is taken care of and then whether it's true or not I don't know but that's how I felt. It's just like I want to go home, go home to my mummy and I want someone to take care of me, so that's what I did. (Bonnie)

Theme Seven: Women Experienced Intense Negative Emotions

Several women in this study spoke about their own negative emotions, such as anger, resentment, sadness, loneliness, and despair. The participants acknowledged that the experience of living with a military partner diagnosed with PTSD created these intense emotions. These feelings were not immediately visible, rather they evolved over the many months and years of

coping with PTSD in their relationship. Sarah talked about her anger in relation to her husband's avoidant symptoms:

Initially, I was just trying to understand why he didn't want to go places, do things and then later I'd get angry and tell him, "Too bad we're going, so like just get it together buddy." Because friends or you know whoever wants us over or the kids want to go out.

Sarah also described her husband as "checking out" when his emotions became too intense. When asked how it made her feel when her partner disengaged Sarah stated, "alone, pretty much alone, and frustrated and angry and sad". She also discussed her feelings of anger around the lack of intimacy in her relationship, stating, "For the longest time I was really, really sad and, so angry about that lack of closeness because it's important... so important". Nicole also shares: "I eventually became angry and resentful. I thought why should I have to sacrifice so much when he doesn't? He wasn't willing to get better, I really felt like he was just a drain on me". She also spoke of her feelings of loneliness, "I gave up hope and didn't care about him, him or us, and we were so disconnected from each other, we didn't have any kind of relationship, so I really felt alone". Amy spoke of the emotional struggles that she experienced, including her feelings of resentment:

I was responsible for caring for him but at the same time I was so upset with him that I didn't care what he did. He could kind of do... "you want to, whatever". At that point I didn't know that he was drinking as much as he was, he was hiding it from me... there is a lot of resentment, I'm working on letting that go.

Mary also spoke of being angry at her ex-partner and herself, stating:

I'm hopeful, now, but for a long time I wasn't. I'm working on myself, I'm trying. I'm working on getting healthy, not feeling ashamed about my failed marriage, letting go of the anger at him and me too and blame.

Mary, when speaking about the extent of her negative feelings, noted, "[I was] trying to deal with everything alone, at times it seemed so hopeless."

Negative emotions were experienced by several of the women as a response to the daily and ongoing stress of managing life with a partner diagnosed with PTSD. For some women, these intense feelings were directed at the military partner and the situations that they were forced to deal with, while others were angry with themselves.

Theme Eight: Women's Health and Well-being Was Negatively Impacted by Their Partners' PTSD

As the women shared stories of managing day-today with a partner diagnosed with PTSD, they expressed how their own health and well-being was affected by everyday challenges. For example, women talked about being physically and emotionally exhausted, feeling overwhelmed, stressed, depressed and at times distressed. Sarah shared the following when speaking about managing her spouse's symptoms and behaviour early in the marriage:

I would try to almost micromanage everything, it was like staying 10 steps ahead, trying to predict what he needed before it became a blow up. That was in the first few years, early years. But you can only do that for so long before you start to fall apart because of the pressure to control everything, I guess to cope.

She went on to share that, "I really didn't know if I could stay, I guess I was unhappy, stressed, I didn't know if I could stay". For Sarah, the daily struggle of caring for her husband,

children, and home was expressed as, “at the time it was just coping, keeping my head above water”.

Bonnie also spoke of feeling overwhelmed:

I had to think about what I wanted ‘cause it was tough and I was so burnt out and I was so tired. I felt, I don’t know, I felt sorry for myself like I was feeling very sorry for myself. I had to bare this all, I had to be a parent to four different people and to make sure everything is taken care of and then whether it’s true or not I don’t know but that’s how I felt. It’s just like I want to go home, go home to my mummy and I want someone to take care of me, so that’s what I did.

During the interview, she also went on to discuss her day-to-day caregiving within the family and the toll that it took on her:

I’d go to work and I was in management but I knew that I couldn’t stay past 4:00 p.m. so I’d have to go get the kids from daycare, come home, do the bedtime routine and sometimes I’d go back to work to finish my work cause like I was busy and I just didn’t have enough time so you know come home, fall into bed, get up and do it all over again. I just got totally burnt out.

Karen’s summed up her feelings related to her increased responsibilities and self-sacrifice in the following manner:

I didn’t realize how exhausted I was. I didn’t realize how much it took out of me. I kept shrinking my world because I was too tired to deal with things. I didn’t see anyone, I came to Winnipeg a lot because I’m close to cousins here and in the last two years I haven’t really seen them and I didn’t see my mom who I see very regularly. I didn’t see friends, I didn’t seek out new ones [volunteer activities]. I didn’t have a job. I just stayed

at home 'cause I didn't have the energy to do other things besides just keeping both of us alive, I spent a lot of energy managing.

Unlike the other women, Karen did not consider her caregiving to be a burden and when asked whether she viewed helping her husband to manage his feelings as a burden, she noted:

It was but I didn't view it like that, I was in a very co-dependent position and didn't recognize how enmeshed I was, so I didn't, I was exhausted all the time but I thought that it was because I needed to try harder and I thought that it was because of things that I needed to do so I didn't realize how much I was doing.

While all six women discussed how difficult it was to live with a military member diagnosed with PTSD, three experienced significant mental health problems. In fact, one woman tried to commit suicide by overdosing on medication and one woman sought professional treatment for her deteriorating mental and emotional state. Karen shared how her mental health was impacted by her attempts to cope with her spouse's illness and symptoms, stating:

I called my doctor's office and said I need to see the doctor and they said what's it for and I said I feel like driving in front of a truck and they said you can come in in two hours there's an opening in two and so then I started Prozac and that shit is amazing cause it just takes the struggle away, it doesn't make you happy it just takes the part where you hate yourself it just like shuts that little voice so you can get on with your life...it wasn't like I was actively suicidal, I was just like what if I didn't wake up? It would be easier.

Mary's story, too, emphasized how the ongoing day-to-day management of her spouse's symptoms adversely impacted her mental health:

I was anxious, always worried, what is he going to do? How is he going to act? Maybe we need to not go somewhere cause he is going to be triggered. What if I say something and that sets him off? I was anxious all the time and then depressed. I became depressed. It was too much. I was doing everything, looking after everyone, making sure our son was o.k. I was trying to protect him from all the stuff that was happening right? And I took on everything, the house, my job...oh thank God I had a great boss, great workplace very supportive... but being alone, trying to deal with everything alone...at times it seemed so hopeless right?

Managing her husband's symptoms and behaviour also created mental health concerns for Nicole who voiced, "I would try to make sure that he wasn't worried, wasn't distressed and I didn't tell him that I was depressed, very depressed because of our marriage, really because of him". She further explained how her daily responsibility for managing his mental illness and her ongoing focus on her husband's needs caused her mental health to suffer, "That constant vigilance, it caused me to become anxious, I was always watching, waiting, managing always and that meant that I could never just relax". Nicole also spoke about her feelings of hopelessness when she realized that she was alone in the struggle to help her husband recover, stating:

That lack of hope probably impacted my mental health...definitely my depression became much worse when I felt hopeless, that things weren't going to improve, even a bit, and so I was then having trouble managing because I had no hope, no point really. Notably, the severity of her mental health issues cumulated in a suicide attempt and Nicole explained:

I became very depressed and one day I overdosed on my meds and my mom...I was lucky because my mom just happened to stop by and found me. She called 911 and as bad as that was it was a turning point for me because it really made me realize that I wasn't coping.

Nicole articulated well the experience of managing a veteran's illness on a daily basis, stating,

Taking on that much responsibility for someone else's problems, it takes a toll. I then became the person who needed help, my own health suffered and I wasn't coping because of it, because I had focussed too much on making him better.

As noted above, the day-to-day exposure to their spouse's PTSD presented these women with many responsibilities and life stressors. In their attempts to manage the tremendous caregiving burden, the women sacrificed their own needs for the sake of their partner and family.

Theme Nine: Women Gained New Insights and No Longer Considered Themselves Responsible for Their Partner's Illness

All of the participants, over the course of months and years (for some women), developed new insights about their partner's illness. Through formal supports, like individual and group counselling for spouses of military members diagnosed with PTSD, their faith, and the support of family and friends, each woman developed a new understanding of PTSD and their own situation. Five of the women interviewed discussed how their understanding of their spouse's illness changed from one of self-blame and personal failure to a realization that they were not responsible for his PTSD or recovery. During Nicole's interview, she shared:

When I learned that I wasn't responsible [through group and individual therapy] for my ex-husband getting well and that he was responsible for his own wellness that

helped... When I learned that it wasn't my fault, his illness wasn't my fault, it wasn't because of something lacking in me, that made me stronger.

Importantly, this realization helped to bolster her ability to cope with the situation: "I think a lot of my strength came from how I changed my perspective, I had to look at things differently and stop the guilt and shame".

Similarly, Amy describes her eventual realization:

I'm not the problem here I'm not the one who... I didn't do anything to make you act this way. I thought that I wasn't a good enough wife, I thought that I wasn't a good enough mother... If he is having a bad day and you know [I say], "is there anything that I can do? No? Okay, then you have your bad day by yourself [and] go sulk in the corner, whatever. It has nothing to do with me or the kids.

Karen also speaks of a shift in her understanding of the problem: "It's not my fault, it's not something I did that made you this angry". Like the other participants, Mary describes a similar change in her understanding of her partner's illness and behaviour. While she initially felt personally responsible for his recovery and discussed how she was willing to do anything to make him better she goes on to explain, "I eventually realized that I couldn't do enough, it wasn't about me". When asked what she learned about herself in relation to living with someone with PTSD, Mary states that:

I've learned to take care of myself first, I'm not willing, I will never put someone else before me again, especially if they aren't, if he isn't willing to get help to make things better. You can't change someone - help someone if they don't want it, right? I think that I learned that I can't save someone else; my responsibility is to myself and only what I can do in the relationship, his issues are his, not mine, right? I also learned that I put up

with too much, I sacrificed too much of myself for the marriage, for him and staying in the marriage too long.

Like the other participants, Bonnie experienced a change in her understanding and explained, “Because I had enough, I just had enough, it’s like no - I’m not going to do it [take on more responsibilities]. I don’t want to do it.” Bonnie not only refused to take on the additional responsibilities, she also developed a deeper understanding of her partner’s illness and noted “I try to tell myself, I know it’s a mental illness”.

As discussed, the women expressed an eventual shift in perspective, with the help of formal and informal supports, and were no longer willing to bear the sole burden of their husband’s symptoms or behaviour. Many of the women gathered personal strength from this new insight and were able to relinquish their feelings of guilt.

Theme Ten: Women Demonstrated Resilience and Coping

As noted previously, the women’s physical and mental health suffered as the result of their partner’s PTSD. The above themes illustrate how the veterans PTSD symptoms negatively impacted every aspect of the women’s lives, including their own self-perception, their marriage, their relationships with their children, their career, their relationships with family and friends, and their own physical and mental health. They experienced daily challenges and struggles related to managing the behaviours of this illness. However, the women voiced that they eventually learned to cope with their situation and their partner’s illness. When asked about resilience and coping, women attributed their ability to manage with self-care, new understandings of PTSD and their role, their faith, informal and formal supports, commitment to their marriages, and having hope for the future.

a.) Self-Care

Three women identified self-care as important to bolstering their ability to cope:

I also started to take better care of myself, exercise, eating right, self-care. (Nicole)

Lots of self-care, exercise, healthy eating, yoga. (Mary)

Self-care, self-care, self-care, getting out of the house, away from my kids. Sometimes it's just coffee with friends or going shopping. Sometimes I take an afternoon and I'll go shopping by myself... coffee with friends and bubble baths and I like to run. Running helps me with stress relief... for me it's just keeping on top of self-care. When I start to get short with my husband or the little things start to irritate me the first thing I do is ok where is my self-care at? Because 90% of the time my self-care is out of whack. I haven't done enough for myself and that's why things are starting to build up to the point where I am being irritated by my husband or by my kids and usually by my kids because my husband isn't around. (Amy)

b.) New Understandings of PTSD and Their Role

For some women, gaining a different understanding of their partner's PTSD and their role in managing it, led to better coping.

My anxiety comes up and immediately I think what can I do to fix this? Well, I can't do anything to fix this, it has nothing to do with me, it's his issue, go deal with it. (Amy)

I think that when I eventually learned to let things go that helped...when I learned that I wasn't responsible for my ex-husband getting well and that he was responsible for his own wellness that helped. (Nicole)

It's like it may not be the answers you want, they [counsellors] aren't telling you he should be fine and he should do this you should expect that and you have a right to this.

It's like, okay well your husband has this and that's a reality, it's where you want to go with that reality, that's all that you can do. (Bonnie)

I used to sleep a lot and I at some point I feel like I ran out of fucks to give so I just stopped and I didn't think that there was so much stuff that I could let go of cause I've always been very controlled and controlling and this is the way things are, there is just so much stuff that doesn't matter to me now. (Karen)

c.) Faith

Faith was also discussed as another level of support that helped the majority of the women to cope with living with a veteran diagnosed with PTSD. For some women, faith was expressed as support they received from attending a place of worship, while others noted that they had no connection to formal religion but nevertheless considered faith to be an integral part of their coping.

I have a strong faith so for me it was about prayer and going to church. (Mary)

I go to church, we go, so that is a big, big thing for me. (Amy)

My faith for sure has made me stronger. My faith gave me strength but mostly to realize that things would pass, nothing lasts forever, good or bad, everything is temporary so faith, it helped me understand that nothing is permanent and I think that's what helped me to leave the marriage. (Nicole)

We don't have any formal religious beliefs but for me I meditate and I guess I feel that it's a form of spirituality, it is part of my life and helps to make sense of things or maybe I guess deal with stuff better. It's something that is very important to me and well without it I don't know if I would have coped as well. (Sarah)

I think for me, I don't understand enough to explain it but I take great comfort in the Buddhist theory that nothing exists and that this is nothing and there is nothing and nothing has ever been or will ever be. (Karen)

d.) Informal Supports

Several women also talked of how careers, support groups, and family and friends were important in their daily lives. Social relationships at the workplace allowed the women to temporarily escape from the issues at home and interact with co-workers, who were noted as being supportive. Four women noted the importance of their careers in providing informal support and helping them to cope with the daily challenges in their personal lives.

I worked, that is important for my sanity cause it allows me to interact with others, I could really focus on the work and not have to deal with PTSD for a few hours, hopefully but I have always had a really supportive work place. (Sarah)

Oh thank God I had a great boss, great workplace, very supportive. (Mary)

I also think that working is really important because my career, my workplace is important to me and I have supportive co-workers too. (Nicole)

Lastly, Bonnie, when asked how she coped noted, "I go to work".

Three women specifically noted that their involvement with support groups created a deeper understanding of their experience. Mary noted, "I know that, I've learned from my spouses group that spending is an issue right?" Nicole recalled how group support helped her to cope, stating, "I also was able to connect with a support group for spouses. I think other spouses feel the same way, I know from group that my experiences are similar to other women and other couples too".

As noted previously, Amy's perspective changed as the result of her involvement with a support group and she expressed the importance of the group's support in helping her cope, noting, "...going to my support group...what I've taken from that is it really isn't about me, it's his illness, it's his injury".

Family and friends were also cited as important informal supports by all the women in this study.

I have some good friends so if I need to talk, I talk, I have friends, my boy's keep me grounded, they keep me busy and focussed... my parents are a big support. (Bonnie)

My parents, they were as supportive as they could be... they are still my best supports. I wouldn't be here without them...literally. (Nicole, who attempted suicide)

I have a lot of friends in the area that are really supportive and then we don't hide his PTSD, our close friends know and they understand that ok you know we might be doing something and all of a sudden he might disappear and that's fine. (Amy)

My mother-in-law is so good, she understands that she and I are both adults and she tells her husband how it's going to be and I tell my husband and she's very supportive.

(Karen)

We eventually moved near my in-laws and they have been so amazing, there is no doubt that we would have struggled much, much, more without their help. (Sarah)

My son, he's the most important person in my life, we talk daily...I've also reconnected with friends, family. (Mary)

e.) Formal Supports

Women noted that accessing formal supports was helpful in learning how to cope with a military partner diagnosed with PTSD. All six women were involved with some type of

counselling. Bonnie stated, “I go see a good counsellor”, and Sarah shared, “I eventually went to counselling myself so that was great, I don’t know...maybe that was the biggest help cause you know I got a good therapist and that helped with coping”. Karen also explained her experience with counselling as, “I wasn’t regularly seeing my counsellor before, I mostly go to him for like specific issues when something comes up and then goes away again”. Nicole, too, noted, “I got connected to a great counsellor and had a safe place to discuss all the things that were happening in my marriage and with me too”. Other women sought the formal support of their physician for the treatment of depression.

f.) Commitment to Their Marriages

The majority of women demonstrated a strong commitment to their marriages. This gave them strength, helped them to cope with adversity, and encouraged them to continue with the relationship despite the challenges. Sarah noted, “We take our vows seriously and that means till death do us part, there are no other options and well maybe that keeps us together or stronger you know”. She also included, “We’ve been in this together. There are times when I carry the heavy load and times when he will carry the load, that’s how it works”. Amy discussed commitment in her marriage:

It’s definitely manageable (symptoms of PTSD) ‘cause we have made the commitment to each other, yes this is difficult but it’s ok that its difficult and we will get through it together and I’m not going anywhere and he’s not going anywhere so we are just going to have to figure it out.

Bonnie also expressed how she and her husband were committed to working together, “We were willing to do that, take that journey together as hard as it was and I mean it’s a

rollercoaster ride”. While Karen voiced, “It will get better and I know that and I’m okay with that cause we’re in this together.”

g.) Having Hope For The Future

Having a hopeful outlook on their situation also helped the women to cope with daily challenges and four women talked about feeling hopeful that the future would be better. Sarah openly talked about her hope:

You have to have hope or you can’t move forward. You have to feel that tomorrow will be better than today and he has gotten better...oh God, compared to where he was...we have gotten better, so I am very hopeful for the future.

She continued to state, “We always believed that things would get better even when things were bad.”

When asked about the role that hope plays in her families ability to manage adversity, Karen responded, “Oh it’s daily, it’s minute to minute, it could be so much worse, it could be so much worse.” For Bonnie, hope is related to continued improvements in her husband, “There is still hope cause he’s always a little bit better”. While Amy spoke of how hope is connected to the commitment in her marriage and this gave her the strength to overcome adversity, “Things are going good, I know that they aren’t going to go good forever but we are committed to each other.”

All of the women in this study provided important insights into what helped them cope with a military partner diagnosed with PTSD. Over time, all of the women developed their own coping strategies; however, self-care, new understandings of PTSD and their role, faith, informal and formal supports, commitment to their marriages, and having hope for the future, were seen as vital to the daily management of their experiences.

Summary of Study Findings

This study offers insight into the experiences of women whose military spouse has been diagnosed with PTSD. The women talked about how their experience of living with a PTSD-inflicted partner was a burdensome journey. For many, they eventually developed coping skills and have been able to manage their personal and family situation. They talked about how initial changes in their husband's behaviour were viewed as normal and they were hopeful that a period of adjustment would resolve any issues. When their partner's situation did not improve, women's perceptions shifted – they blamed themselves and assumed considerable responsibility for helping their husband and “fixing” the situation. All of the participants believed that they alone could help their spouse and decrease his distress. But they eventually acknowledged the severity of PTSD and realized that they could not fix the situation.

The daily struggles and challenges that women experienced were immense. Not only did women talk about how PTSD seriously strained (and in some cases, destroyed) their relationship with their spouse, they spoke of the tremendous burden of taking on essentially sole responsibility for their family and household. Further, women had to balance all of this while managing their partner's PTSD symptoms. Not surprisingly, women talked about the negative toll that this had on their marriage, on their own social relationships, career aspirations, and their own physical and mental health. For some women, the only escape was substance use and suicidal thoughts.

However, as the women's journey continued, they came to realize that they were not responsible for the partner's illness. As a result, the women spoke of relinquishing responsibility and their increased unwillingness to assume the burden of care for their spouse. All of the women discussed how self-care, new understandings of PTSD and their role, faith, informal and

formal supports, commitment to their marriages, and having hope for the future, provided the necessary guidance and support for them to manage their daily situation.

Chapter Six: Discussion

The purpose of this qualitative study was to explore the experiences of women whose military partners have been diagnosed with PTSD. Six women shared their personal stories of how PTSD impacted their relationships with their intimate partners, their families, and their own physical, emotional, and mental well-being. Overall, women discussed the difficulty of seeing their partners change from the men whom they fell in love and the pain of eventually having to come to terms with their illness. Not only did women experience the deterioration of their own intimate relationships but they saw firsthand how mental illness, such as PTSD, can damage family and parent/child relationships.

Despite the difficulty of having a spouse diagnosed with PTSD, women demonstrated an ability to cope and manage the impact of PTSD on themselves and their intimate relationships. Women's resilience was fostered by a commitment to their marriage and having hope for the future. The family resilience framework offers a way of understanding resilience and coping with adversity for this particular population. Several women identified a strong commitment to the marriage and this could be considered a form of connectedness. According to the family resilience framework, connectedness promotes resiliency and enhances individual and family functioning. Resiliency is strengthened when family members can work together collaboratively and there is a sense of commitment and mutual support in the relationship. Likewise, having hope for the future further helped the women to cope. This optimistic perspective is considered an aspect of positive outlook. The family resilience framework suggests that a positive outlook increases resiliency as it allows individuals and families to envision a better future, focus on strengths, and build confidence in overcoming adversity.

The themes identified in the study reveal that the experience of living with a veteran diagnosed with PTSD can be both complex and difficult. The themes are: 1. Women's recognition of partner's PTSD symptoms was not immediate; 2. Women blamed themselves for their partner's changed behaviour; 3. PTSD caused significant stress to the couple relationship; 4. PTSD affected the family unit; 5. Women bore the burden and took on more responsibility; 6. Women forsake their own needs (personal sacrifice); 7. Women experienced intense negative emotions; 8. Women's health and well-being was negatively impacted by their partners' PTSD; 9. Women gained new insights and no longer considered themselves responsible for their partner's illness; 10. Women demonstrated resilience and coping.

The 10 themes are discussed below and linkages are made to existing research and also to my chosen theoretical framework, the family resiliency framework proposed by Walsh (1996).

Theme One: Women's Recognition of Partner's PTSD Symptoms Was Not Immediate

This study involves women who met their husbands prior to the development of PTSD symptoms and a diagnosis. Thus, these women had the experience of getting to know their partners before the onset of the disease and the majority of the women, throughout the interview, made reference to the man they knew during the earlier period in the relationship. For the women in this study, initial behavioural changes, prior to a diagnosis of PTSD, in their husbands were viewed as normal and there was no suggestion, on the part of the women, of a more serious problem. The women spoke specifically about their initial understanding of their spouse's behaviour and how, despite noticing some changes, they assumed that these changes were typical given the circumstances (i.e., a partner returning from military combat). Women attributed their partners' atypical or strange behaviour to issues with re-integration and readjustment but expected that a return to normality would occur eventually.

Military families often experience unique relationship challenges due to the nature of military work. Frequent separations/deployments, issues of reintegration, and the reorganization of family life during reunions are unique stressors to this population that can affect relationship functioning (Drummet et al., 2003; MacDermid Wadsworth, 2010). Given the stressors on returning soldiers, it is understandable that the participants in the study did not immediately associate behavioural changes in their partner with PTSD.

Instead, when their husbands returned home, many of the women determined that issues with readjustment and the challenge of returning to previously held family roles and boundaries was responsible for their partner's behavioural change. Thus, while daily tasks such as driving, interacting with family, and resuming the roles of husband and father were seen as problematic upon their husband's immediate return to the family, the women understood these changes within the context of being a soldier and the difficulties of the occupation. The women did not ignore or diminish the risks to their husbands and understood that the very nature of their job exposed them to difficult situations; however, they fully anticipated that their partner would resume his roles and responsibilities within the family. Many of the soldiers had also participated in previous deployments or training away from home and had in the past experienced similar issues upon their return home. Consequently, several women shared that their concerns were minor since their husbands had returned to "normal" functioning after past deployments. They did not attribute these difficulties to PTSD.

Therefore, because PTSD symptoms may not be readily identified, education and support for spouses and other family members of returning soldiers may be warranted. Programs directed at educating spouses about the signs of PTSD may prevent women and couples from delaying seeking help. Furthermore, supports for spouses may provide the necessary early intervention

needed to reduce distress and encourage healthy coping and resiliency. This will be discussed later in the thesis.

Theme Two: Women Blamed Themselves For Their Partner's Changed Behaviour

Interestingly, as time went on and their husbands' difficult and erratic behaviour did not change after being at home for a period of times, women began to see themselves as the problem. For some women, they believed that their husbands' behaviour had more to do with their inability to please their male partners (i.e., were no longer physically attractive), their inability to make things perfect, or simply not trying hard enough. For example, Amy believed that her failure to keep her husband attracted to her resulted in his increasingly avoidant behaviour. Mary thought, "if I did everything, made things perfect, then it would be better for us". While others, even though they understood that PTSD could be a concern for their partners, saw themselves as ultimately responsible – that they failed to protect their partners from developing PTSD in the first place or failed to help their partners manage their PTSD symptoms. This was demonstrated by Karen who assumed that her spouse's distress was the direct result of her failure to better support him in processing his trauma.

One could attribute the participants' sense of self-blame on our society's culture of women's caring. For decades, feminists have argued that our society deems women to be natural caregivers and should be able to nurture their family, including male partners (Finch & Groves, 1983). When women fail (or perceive they have failed) to fulfil this strong societal obligation, they often judge or blame themselves. However, interestingly the literature regarding the experiences of spouses whose partners have PTSD suggest that self-blame is common. In their study on PTSD, Brown-Bowers et al. (2012) found that intimate partners often held the belief that they are responsible for reducing their partner's distress. Further, Brown-Bowers et al.

(2012), note that spouses of military veterans diagnosed with PTSD can engage in accommodating behaviours, such as taking on more responsibility and avoiding distressing topics, in an attempt to decrease the distress of the PTSD partner. All of the women in the study displayed similar behaviours. They took on additional household and parenting responsibilities, avoided situations that posed as potential triggers for their spouses, and sacrificed their own needs to better support their partners in managing PTSD symptoms. This will be discussed further in Themes Five and Six.

For these women, self-blame and personal faults translated into the underlying belief that they were responsible for the development and management of the husband's illness and the women spoke of their willingness to do anything to decrease their spouse's pain and discomfort, even if it meant that they had to make personal sacrifices (this theme will be discussed later). Mary believed that if only she was good enough, worked hard enough, her husband would get better. Clearly, these women believed that, with self-sacrifice, taking on increased responsibilities, and making daily adaptations for their partner's behaviour, any issues related to PTSD would be resolved. However, as noted by Brown-Bowers et al. (2012), these responses only served to further increase individual and relationship problems because the non- PTSD spouse may respond to these ongoing accommodations with negative emotions, such as anger, anxiety, or sadness. These self-blaming responses by the women set the foundation for future relationship distress and personal struggles.

Women require support to recognize that they are not to blame for their partner's illness or behaviour. Research suggesting that women engage in "accommodating" behaviours in order to decrease their spouse's distress and manage difficult situations further contributes to the blaming of women. Spousal/partner programs focused on the development of healthy coping

skills and education about what to expect when living with a soldier diagnosed with PTSD along with counselling to help military spouses process their feelings of self-blame and build on their strengths would be beneficial.

Theme Three: PTSD Caused Significant Stress to the Couple Relationship

As it became obvious that PTSD symptoms were responsible for the changes in their spouses and the impact of the illness became more problematic, the women talked openly of how PTSD altered their couple relationship and contributed to dysfunction and distress in their marriage. The women spoke of how their partners had transformed into someone who no longer resembled the man they once knew. This is evident in their descriptions of their husbands as “different” (Nicole), “not the man I knew” (Mary), and “his personality was different” (Sarah).

Throughout the interviews, women expressed how their husbands became increasingly isolated, detached, and withdrawn, resulting in an emotional and physical distance in their relationship. They also spoke of their feelings of anger, resentment, and loneliness and of how they eventually became dissatisfied within their marriages. Overall, the women noted that their marriage relationship underwent a profound change as the result of PTSD symptoms and they identified several key elements that were associated with relationship stress. These include detachment, avoidance, a decrease in marital satisfaction, and lack of intimacy.

One possible explanation, as noted by Allen et al. (2010) and Campbell and Renshaw (2013), for the relationship between emotional numbing and marital distress is that emotional numbing leads to less intimate disclosure in the form of self-relevant feelings and empathic responses which ultimately creates less intimacy and relationship satisfaction. Mary, Nicole and Sarah all spoke of their husband’s lack of emotional expression, his emotional withdrawal, and the increased relationship dysfunction that they experienced. Monson, Taft, and Fredman (2009)

discuss how the avoidance and numbing symptoms associated with PTSD have also been found to impact the couple relationship and are linked with intimate relationship dissatisfaction, impaired intimacy, and relationship dysfunction.

The importance of emotional expression to the maintenance of healthy adult relationships is further supported by other research. In their article, Greenberg and Johnson (1986) stress that the ability to emotionally connect with one's partner and family and to express positive feelings is viewed as crucial to healthy and intimate relationships; and conversely, an impaired ability to express emotions inevitably impacts the quality of a relationship. Similarly, an article by Ainsworth (as cited in Greenberg & Johnson, 1986) also suggests that the ability for partner's to respond in an affectionate and considerate manner encourages more secure couple bonds while the ability to express and explore one's emotions not only clarifies needs but also allows for the partner to respond to those needs. The findings of these studies clearly demonstrate the importance of healthy emotional expression to the overall health and satisfaction of the couple relationship. The experiences of the participants of this current study closely resemble that of current research and each woman openly shared how their partner's limited emotional expression severely damaged their relationship, causing distress and a lack of marital satisfaction.

Another subtheme of this current study was the decrease in marital satisfaction experienced by the women. The women in this study similarly spoke of how PTSD symptoms created relationship difficulties and caused them to decrease support and avoid their husbands. In Mary's case, she stated that she eventually avoided her spouse due to his symptoms; this left her feeling alone in a marriage void of intimacy. She expressed that "I didn't have a partner, I had a roommate." In their study of marriage quality, Klaric et al. (2011) found a clear relationship between the veterans PTSD and decreased marriage quality in their wives. In

particular, as indicated by Klaric et al. (2011), avoidant symptoms appear to be most associated with the wife's impaired marriage satisfaction. Their results mirror that of the research conducted by Campbell and Renshaw (2013) and Erbes et al. (2012) that also indicates a close relationship between emotional numbing and decreased marriage satisfaction in partners of PTSD individuals. Findings by Campbell and Renshaw (2013) reveal that emotional numbing, via a lack of emotional disclosure, contributes to relationship dissatisfaction for military couples. Interestingly, this study by Campbell and Renshaw (2013) further supports the suggestion by other research that PTSD symptoms and decreased couple/family functioning is reciprocal. Their results indicate that emotional numbing results in decreased marriage satisfaction, which in turn further limits emotional disclosure (in both partners) (Campbell & Renshaw, 2013). In Nicole's interview, she expressed how a lack of emotional disclosure created distance in her marriage and led to her feeling alone and solely responsible for getting her partner better. Nicole's dissatisfaction with her marriage resulted in her having an affair and she openly explained how a lack of hope and connection with her husband, combined with her feeling alone led her to seek comfort and connection outside of her marriage. Amy also shared that both her and her husband pulled away from each other, creating a physical and emotional distance between them, which resulted in Amy feeling as though she was living with a roommate, rather than an intimate partner. As noted previously, it is very possible that the emotional and physical separation experienced by the women created a worsening of avoidant symptoms in their husbands which led to increased relationship stress for the couple.

An additional subtheme includes the impaired intimacy experienced by the women. As numerous studies have found, emotional numbing and its cluster symptoms have a profound impact on the closeness and intimacy experienced by intimate partners and the women in this

current study similarly expressed difficulties with relationship intimacy. Specifically, avoidance symptoms have been noted as significantly contributing to a lack of intimacy in the marriage. Riggs (2014) explained that PTSD impairs emotional expression, resulting in relationship and intimacy difficulties and ultimately discomfort with intimacy in the relationship. In the present study, Sarah questioned how she could have been intimate with someone who was so detached while Mary also shared that her husband's avoidant behaviour and unpredictable emotions resulted in a lack of a connection and intimacy within her marriage. In her interview, Amy discussed how her husband's impaired emotional expression and confrontational behavioural resulted in impaired intimacy and her feeling as though she was living with a roommate.

Current literature indicates a relationship between intimacy and relationship satisfaction (Greeff & Malherbe, 2001; Zerach et al., 2010) and findings correspond with the experiences of the women in this present study. Greeff and Malherbe (2001) found a positive correlation between intimacy and marital satisfaction in their study of couples and in their research of ex-POW's with PTSD and the association between PTSD, couple adjustment, marital intimacy, and sexual satisfaction, Zerach et al. (2010) reveal a significant relationship between these variables and PTSD, which suggests that marital adjustment is negatively impacted by symptoms of PTSD. As noted by the current study, PTSD symptoms caused significant stress to the couple relationship.

The experiences shared by the studies participants closely resemble those of other research and it is clear that emotional numbing and its cluster symptoms account for much of the relationship distress experienced by the women. It is important to note that the women universally expressed the significant impact that PTSD had on the couple relationship and how

symptoms altered not only their husbands but also their experiences and satisfaction in the marriage.

Theme Four: PTSD Affected the Family Unit

As indicated, the symptoms of emotional numbing, which are part of the avoidance cluster of PTSD symptoms, impaired the participants' marriage relationship; however, research also indicates that emotional numbing may also impair the parent-child relationship. Frederikson et al. (1996) found that between the veteran and his family members, the symptoms of emotional numbing decreased communication and feelings of trust and affection while also creating a perception in family members that he did not care for his family. Mary specifically notes that her husband's withdrawal and avoidance behaviour left her feeling as though her husband was no longer interested in being a father and husband.

As should be noted, while this current study does not focus on the experiences of the soldiers' children, it is, nevertheless, important to consider the impact of emotional numbing on the veteran-child relationship in the context of the woman's experience. In particular, all of the participants with children made note of how emotional numbing negatively influenced family functioning. These women spoke of their spouse's detachment and isolation from the family and the lack of participation in everyday family activities such as taking the children to the park, participating in family movie night or helping the women with parenting. In her interview, Sarah talked of her husband's complete detachment from her, the family, and everything that he was interested in previously; this resulted in both his physical and emotional removal from the family. Bonnie too spoke of how she and her children have had to adapt to not having her spouse present during family activities and that if he does participate it is considered a bonus for her and the children. Other women expressed that their husbands were no longer interested in family

relationships and did not seek out interactions with his children or engage in previous enjoyed activities with his children. As a result, the women had to overcompensate for their partner's emotional absence and were responsible for explaining their spouse's unusual behaviour to their children.

In their study, Baptist et al. (2011) discuss that spouses of soldiers exposed to trauma during deployment reported an increase in emotional reactivity and withdrawal in the veteran. Amy and Mary both spoke of their partner's lack of involvement in family. In Amy's experience, she described her husband as "checking out" and of isolating himself from the family. She interpreted this as him not wanting to have anything to do with anybody. Likewise as noted previously, Mary shared that her husband was not part of the family and his avoidant behaviour was seen as his unwillingness to be a husband and father. This resulted in both women assuming more responsibility for parenting and household duties and further contributed to a decrease in relationship satisfaction experienced by the women. While this current study did not interview the military members, it is clear from the women's interviews that the veteran did not participate fully in family life and that the closeness of family relationships were affected by the avoidant behaviour.

A subsequent subtheme is that PTSD caused the women to fear for their family's safety. While the majority of the women in this present study did not indicate that they feared for their safety, two women did reveal instances where safety was an issue. Their spouse's unpredictable and volatile behaviour combined with excessive alcohol use created potentially dangerous situations for both Amy and Nicole. Each of these women noted that their partner's use of alcohol further exacerbated PTSD symptoms and caused them to fear for their safety. Nicole shared that there were times when she feared for her safety due to her husband's alcohol use and

unstable emotions. For Amy, a turning point in her relationship occurred when her husband threatened to kill her and their children while he was under the influence of alcohol. Literature shows that co-morbidity is also associated with PTSD and individuals diagnosed with the illness are at an increased risk for other psychiatric disorders such as depression, substance abuse, and panic disorder (Garske, 2011). A study of Iraq and Afghanistan veterans revealed that PTSD and alcohol use disorders (AUD) are highly comorbid with 63% of veterans who met the criteria for AUD also meeting the criteria for PTSD (Kaysen et al., 2014).

In their examination of family reintegration, Balderrama-Durbin et al. (2015) and Demers (2011) found evidence to suggest that alcohol misuse impairs family functioning and limits successful family reintegration. In Marshal's (2003) review of over 60 studies that examined the relationship between alcohol use and marital satisfaction, interaction, and violence, it was found that a history of alcoholism (by either both or one partner) is associated with decreased marital satisfaction, stressful family interactions, and increased violence in the marriage. Similar to these findings, Amy and Nicole both expressed impaired and stressful family functioning due to unpredictable behaviour, volatility, and alcohol use by their partners and Amy openly shared that she was willing to end her marriage if her husband refused to get professional help.

PTSD had a profound impact on the women because it altered the family unit. Their partners were no longer actively involved in parenting or family activities and this left the women to bear the burden of parenting alone. In order to compensate for the lack of fatherly attention and nurturance, the women were forced to assume more parental duties and at times overcompensated for their husbands, who checked out from the role of father.

Theme Five: Women Bore The Burden and Took on More Responsibility

It is clear from the participants' stories that they bore a heavy burden when their husbands developed PTSD. Women assumed significant responsibilities in an effort to keep their family from experiencing distress. Women talked about their roles and responsibilities around alleviating their spouse's distress, protecting and caring for their children, managing daily tasks, and decreasing family and couple stress caused by PTSD.

All of the women in this study talked at length about all of the many ways they had to manage their husband's behaviour to minimize his stress and to keep their family functioning. Many of the women talked about always having to predict situations that may cause their partners distress and doing everything they could to avoid disturbing situations. In this study, the women spoke about how the symptoms of PTSD caused them to adapt their behaviour in response to their husband's emotional reactions and often unpredictable and volatile behaviour, with many of the women describing how they had to manage nearly every aspect of daily life in order to avoid or control the potential for triggers. Sarah explained how she has to always be several steps ahead of her husband so that she could predict his needs and avoid having him become upset. Amy also spoke of how "micromanaging" her spouse's behaviour became a necessary part of her life. She became hypervigilant to her spouse's triggers and attempted to control his environment and distressing behaviour by developing elaborate strategies for when they had to leave the house to run simple errands. Other women also spoke specifically about avoiding places, like busy grocery stores or family/social functions, having to constantly manage their partner's environment to decrease triggers, and of having to strategically plan outings or appointment so as to decrease volatility and challenging behaviours. One woman discussed how prior to leaving the home to do errands, she and her husband would talk about where they were

going, what they were going to do, and why they were going to certain places. This was part of her plan to minimize her partner's distress and control the environment.

As previously discussed, spouses may believe they are responsible for decreasing the distress of their veteran partner, and consequently, are placed in a situation where they have to assume more responsibilities (Brown-Bowers, Fredman, Wanklyn, & Monson, 2012). Gerlock, Grimesey, and Sayre (2014) discuss that caregiving was a common theme in their study of PTSD and intimate relationships. They observed that partners of veterans expressed a significant responsibility for the day to day activities of the veteran as well as his physical and emotional well-being and that they perceived their caregiving duties to include reducing the potential for triggers despite the possibility of sacrificing their own self-care and their loss of self to the role of caregiver (Gerlock et al., 2014). Interestingly, Gerlock et al. (2014) further suggests that emotional numbing, which impedes couple communication, also influences caregiving responsibilities as spouses are unable to determine what their soldier partners feel, need, or want, which results in the spouse becoming increasingly hypervigilant as to anticipate and avoid any potential trigger. As was noted earlier, returning soldiers in this study experienced significant emotional numbing (according to the participants' statements) that resulted in a lack of connection and communication in the couple relationship and this may have also contributed to increased caregiving responsibilities and hypervigilance for the women as they were unable to predict the needs of their partners.

Several women in the current study also expressed how they became increasingly responsible for managing and minimize the impact of her husband's emotional distress and volatility in the context of his interactions with the children. Both Bonnie and Sarah talked about their attempts to offset their partner's anger or yelling by being especially happy and positive and

spending extra time with the children while Amy took on full responsibility for parenting due to her husband's anger and the fear of his volatility, especially as it related to his reaction to their special needs child. These experiences mirrors that found in Allen et al.'s (2010) research which indicate that spouses may attempt to manage volatility by mediating all the interactions between a PTSD veteran and the children but this behaviour may prevent the parents from working together as a team. This current study further illustrates that the women had to protect their children's emotional well-being. A father who was emotionally (and at times physically absent) forced the women to overcompensate their mothering in order to provide emotional stability for her children. This is an area that would benefit from further research.

In addition to taking on responsibility for the management of their husband's PTSD symptoms, the women also discussed how they accepted responsibility for managing the home and caregiving. As their spouse's PTSD impaired his ability to participate in family life, the women shared that they took on additional roles and responsibilities within the family. The women spoke about being responsible for all household tasks, childcare/parenting, and family decision making. For some women, they also had to manage employment outside of the home. Overall, the participants noted that they were forced to assume these responsibilities because their partners, who were physically present but emotionally absent, could not manage family life. Bonnie discussed how her husband would disappear to his room after the evening meal, leaving her to manage household duties and parenting after she returned from work. Amy, too, spoke of how she managed everything, including grocery shopping and children's doctor appointments, because her spouse avoided leaving the house. Consequently, the majority of women were left to manage on their own and became overburdened by their caregiving responsibilities. Interestingly, only one woman (Karen) noted that she did not feel burdened by her added

responsibilities. Rather, she considered her extra responsibilities as part of what she just needed to do.

Taking on responsibility for the veteran's illness as well as the management of the home and family not only creates significant caregiver burden but also further impairs the marital relationship. In their study of spouses of PTSD veterans, the findings by Dekel et al. (2005) suggest that the overwhelming responsibility that spouses assume for their partners care creates a situation in which the women have difficulty in maintaining their own independence and individuality. As a result, spouses feel more like mothers to their husbands and less like intimate partners which results in attempts to break from the primary role of caregiver and create boundaries and limits in the relationship (Dekel et al., 2005). In their interviews, both Nicole and Bonnie spoke about feeling like a parent to their husbands. Nicole shared that assuming responsibility for all aspects of their life left her feeling less like a wife and more like a parent while Bonnie, who discussed her burnout at having to "bare this all", was left feeling as though her husband was an additional child whom she had to parent. Mary also spoke about her overwhelming caregiver role and how she became enmeshed with her husband and the disease, which led her to question "who was I? Where did I stop and he begin?" Another important finding from Dekel et al.'s (2005) study was the women's perception that their husband's illness influenced their physical and emotional lives as well as their ability to have a life outside of the home. As a result, their lives, both in and out of the home, were largely governed by the physical and emotional states of their husbands to the point where their entire lives were reduced to managing and living with the symptoms of PTSD (Dekel et al., 2005). Lyons (2001) also found that the women in her study responded in the same manner and organized their lives around the veteran's PTSD. Like the results of Dekel et al.'s (2005) and Lyons' (2001) studies,

this present study also illustrates how the lives of the participants were governed by PTSD with their lives becoming increasingly smaller and revolving around the needs of their spouse and his symptoms. A discussion in the following theme will show how the increased responsibility assumed by the women and the coinciding caregiver burden resulted in significant self-sacrifice on their part. For the women, forsaking their needs further limited their world and prevented them from have a life outside of the management of PTSD symptoms.

Theme Six: Women Forsake Their Own Needs (Personal Sacrifice)

Another significant theme in the experience of the participants was the accommodations, in the form of self-sacrifice, which they were willing to make for the perceived benefit of their partners, the family and the couple relationship. The women spoke of sacrificing their own needs and future plans in exchange for minimizing the impact of PTSD on her husband and family. As a result of their personal sacrifice, the lives of the women were limited to the care of their husbands and families and the management of the illness.

For four of the women this meant making significant sacrifices in order to manage their partner's PTSD. Nicole talked of her willingness to leave her job and not see her family or friends in order to dedicate all of her time to the care of her husband and ultimately she did take a leave from her job. Mary, too, spoke of declining a job offer and forgoing having more children because she assumed full caregiving responsibility for her husband and the family. She sacrificed her desire and dream for more children. Karen talked of her "shrinking world" and of no longer engaging with friends and family or being able to have a job as her time was dedicated to managing her husband's illness. Finally, Bonnie spoke of her self-sacrifice as a burden and how it eventually caused her to be the one in need of care due to caregiver burnout. The personal sacrifices expressed by the women in this present study correspond with the findings by Gerlock

et al. (2014). In their study, spouses of veterans reported that caregiving responsibilities resulted in their needs, desires, feelings, and overall health becoming secondary to PTSD and the care of their partners (Gerlock et al., 2014). I explore the impacts on women's health and well-being in Theme Eight.

Solomon et al. (1992) also found that as spouses increase their responsibilities in the home, due to the veteran's decreased participation in the family, they fall victim to the "compassion trap" in which they sacrifice their needs for the sake of the family.

Looking at other literature on spouses of PTSD veteran, Fredman et al. (2014) found that self-sacrificing behaviours, which often take the form of accommodations, are positively associated with the spouses' anger, depression, and veteran PTSD severity while the spouses' relationship satisfaction is negatively associated with accommodating behaviours. The accommodating behaviour most often made by spouses includes "tiptoeing" around their partner to prevent him from being angry and additional self-sacrificing behaviours, such as changing their routine, taking on additional chores, and avoiding places or people that are known to cause distress to their partner were also common accommodations made by spouses (Fredman et al., 2014). The women in this current study participating in many of the same self-sacrificing behaviours documented in Fredman et al.'s (2014) study.

In general, the participants in this study talked about how their lives revolved around PTSD. They made adaptations for the illness which often resulted in them having to sacrifice their needs and wants for the benefit of their husbands and the family. Unfortunately, for these women, the personal sacrifices contributed to a decrease in their marriage satisfaction and negatively impacted their own health, as will be discussed in a later theme.

Theme Seven: Women Experienced Intense Negative Emotions

As noted previously, research by Brown-Bowers et al. (2012) suggests that spouses can often experience anger, sadness or anxiety as a response to their thoughts and accommodating behaviours. Many of the women in this study did express feelings of anger, loneliness, despair, and resentment towards their partners, the situation and at times, themselves. For example, Sarah openly talked about her anger in trying to understand her partner's unwillingness to go places and engage with others and also how emotional detachment and lack of intimacy in the marriage further added to her feeling of anger. Sarah also shared the following about how she felt when her husband "check out", "alone, pretty much alone and frustrated and angry and sad". Other women similarly expressed anger and sadness both with the loss of intimacy in their relationships and also at the loss of the partner they once knew. Several women spoke of their anger and resentment at having to make life changes, in the form of personal sacrifices and additional responsibilities, in order to manage their partners PTSD. Nicole felt these negative emotions when she perceived herself to be the only one in the marriage willing to make sacrifices in order to get her husband better and Amy expressed resentment at being responsible for a partner who was hiding his problem drinking.

Research findings by Fredman, Vorstenbosch, Wagner, Macdonald, and Monson (2014) support the experiences of the women in this study. They found that self-sacrificing behaviours, exhibited by spouses of veterans diagnosed with PTSD, are positively associated with the spouse's anger (Fredman et al., 2014). In their study of how caregivers of mentally ill individuals manage their emotions over time, Karp and Tanarugsachock (2000) suggest that family members experience emotions at four different points over time. It is during the phase when family members realize that the individual's illness is chronic that they experience frustration, anger, and resentment. According to Karp and Tanarugsachock family members can

also experience these negative feelings if they feel that the mentally ill person is not taking responsibility for their recovery. Both Mary and Nicole expressed anger because they perceived that their husbands did not want to get better. Nicole also spoke of the despair in life, “when I realized that things weren’t improving I met someone at work and I had an affair. It was at a point when I just couldn’t stand my life, the situation anymore”. In talking about the difficulties she experienced because of PTSD Mary shared, “(in) trying to deal with everything alone, at times it seemed so hopeless”. Several women also noted that their anger, despair, loneliness, and resentment was not evident immediately, rather it evolved over the course of time. It was only after many months or years of having to deal with PTSD symptoms that they began to have these feelings. The women in this study experienced negative emotions due to the experiences of living with a military member diagnosed with PTSD. These intense feelings appear to be common reactions to the challenges and stress encountered in daily life; as a result, spouses of PTSD veterans may benefit from supports to help them recognize and deal with these emotions.

Theme Eight: Women’s Health and Well-Being Was Negatively Impacted By Their Partners’ PTSD

A significant theme identified in the interviews with the women was the impact that their experience of living with a military member diagnosed with PTSD had on their physical and mental health and well-being. As will be discussed below, the women in this study shared how the daily struggle to manage their husband’s symptoms and behaviour eventually resulted in their inability to cope and, as a result, they became the person who required support. The women experienced both physical and mental exhaustion. An increase in substance use, depression, and also a suicide attempt by one of the women were indications of the significant negative impact experienced as the result of their partner’s PTSD.

The impact of increased responsibility and caregiver strain on the health of military spouses whose partners are diagnosed with PTSD is well documented. Research has suggested a connection among increased partner caregiving burden, the severity of PTSD symptoms, and poor emotional and physical outcomes for the caregiving partner. Klaric et al. (2010), in their study of caregiver burden and burnout in partners of veterans with PTSD and without PTSD, found that spouses of PTSD veterans had increased caregiver burden as well as more physical, emotional, and psychosocial difficulties.

Likewise, Manguno-Mire et al. (2007), in their study of partner burden and psychological distress, found a strong connection between caregiver strain and PTSD symptom severity and their findings also suggest that as the spouse's perceived self-efficacy or control over the veterans emotional difficulties increased, which included the degree of influence the partners have over the veterans emotional difficulties, caregiver burden decreased. Finally, their study revealed that spouses who perceived the veterans emotional symptoms as a threat to the relationship or to their own physical and emotional well-being, reported increased psychological distress (Manguno-Mire et al., 2007).

Other research has found similar relationships between caregiver strain and poor mental health outcomes for spouses of PTSD individuals (Beckham, Lytle, & Feldman, 1996; Calhoun et al., 2002; Westerink & Giarratano, 1999).

Caregiver burden is a strong predictor of a spouse's psychological adjustment with caregiver strain being associated with increased depression, anxiety, hostility, and obsessive-compulsive behaviour in spouses of PTSD veterans (Beckham et al., 1996). A study of Australian PTSD veterans and their partners found that spouses suffered from lower self-esteem and increased social dysfunction, and perceived their families as having less cohesiveness, more

conflict, and less expressiveness (Westerink & Giarratano, 1999). These results are related to the finding by Gerlock et al. (2014) discussed earlier in which it was suggested that emotional numbing, with its lack of emotional expression, may impact caregiver burden as spouses are unable to determine the needs and wants of their veteran partner. A study by Calhoun et al. (2002) also revealed increased levels of both caregiver burden and psychological distress in spouses of PTSD veterans and a positive relationship between PTSD severity and caregiver burden. The level of caregiving experienced by the women in the current study was considerable and, like the participants in other research, they also spoke of how their emotional well-being and mental health suffered as the direct result of their spouse's PTSD symptoms.

In this study, the women spoke of how over time the combination of increased responsibilities, caregiver burden, and self-sacrifice caused their mental health, specifically, to suffer. Caring for their partners, children, careers, and home while also trying to predict and manage potential triggers of distress day after day resulted in a struggle to cope and feelings of depression, anxiety, and hopelessness in the women. Over months and years, PTSD caused the women to sacrifice their own needs in an attempt to focus on their husband's recovery and well-being, however, as noted by one participant, assuming that much responsibility for someone else eventually took its toll and her own health and well-being was compromised.

The term "compassion trap" was noted by Solomon et al. (1992) to describe the significant personal sacrifices that female partners of PTSD soldiers make for their partners, children, and families. In dealing with the impact of PTSD symptoms, women become burdened with additional responsibilities and caregiving duties, resulting in a neglect of their own needs and well-being. Thus, compassion trap is a useful term to explain the circumstances in which women are compelled to make personal sacrifices for family members despite the negative

consequences to their own physical and psychological health. According to Solomon et al. (1992) the compassion trap may also provide insight into why many women feel overwhelmed, anxious, guilty, depressed, hopeless, angry, and rejected. The secondary traumatization theory suggests that although women neither experienced nor witnessed their spouse's traumatic event, it is their continued and close contact with their spouse that may serve as a chronic stressor and contribute to psychiatric symptoms, such as depression and anxiety, among wives (Solomon et al., 1992).

Other studies have similarly found that caring for someone with a mental illness can negatively impact on the well-being and mental health of the carer. Researchers have found an increase in stress, anger, and dissatisfaction in care providers who assumed responsibility for the care of unstable family members (Chang & Horrocks, 2006) while caregivers also experience lower levels of subjective well-being (Van Dor Voort, Goossens, & Van Der Bijl, 2007). Subjective caregiver burden also impacts the ability to cope with a family member's mental illness with the three areas of stress, coping, and appraisal being connected (Van Dor Voort, Goossens, & Van Der Bijl, 2007). In their study, Van Dor Voort et al. (2007) suggests that mental illness is an important source of stress for family members and the ability to cope with this stress is influenced by the beliefs and perceptions (appraisals) of the carer. These caregiver appraisals are determined by the level of care demands and coping supports perceived by the carer, consequently, the caregiver's appraisals and perceived level of burden and supports can impact the ability to cope (Van Dor Voort et al., 2007).

Theme Nine: Women Gained New Insights and No Longer Considered Themselves

Responsible for their Partner's Illness

Over time the women's initial understanding that they were responsible for the veteran's illness was replaced by a new understanding. Involvement with support groups, individual counselling, their faith, and support from family and friends, resulted in this new realization. This gradual change in perception resulted in a shift in how they viewed their husbands, the illness, and their role in their husbands' management of their symptoms and recovery. The women expressed how this new insight reduced their sense of personal failure and self-blame as well as the immense responsibility that they felt for managing their partner's distress and symptoms. Some women also shared how their new perception gave them strength, helped them to cope with the situation, and reduced the guilt that they previously felt. Equally important, the women talked about how they responded differently to their situation and spouses compared to earlier in the diagnosis. Sarah illustrates this gradual realization well:

I had to let go of what my idea of marriage was, what a family should be like and recreate a new reality...I can't change my husband but I've had to work to change me, how I react, how I choose to react.

The literature on marital relationships and PTSD does not talk about the shift in female spouses' perspectives over time. This represents a significant gap in the literature and is an important topic that warrants further study. The present study findings show how a change in perception and new insight can encourage better coping and increase resiliency for the partners of soldiers diagnosed with PTSD. The discussion also illustrates how important informal and formal supports are to the development of new insight and improved coping skills. Additional research into the role that supports/programs play in the development of improved attitudes and perceptions, and increased resiliency would be helpful to spouses whose partners have been diagnosed with PTSD and possibly encourage the development of early intervention programs.

Theme Ten: Women Demonstrated Resilience and Coping

Another major theme identified was the coping and supports that the women utilized to better manage their lives. Initially, the women experienced difficulty in managing their daily stressors and challenges but eventually they each developed their own manner of coping. These supports helped the women to develop new insights into their situations and gave them the opportunity to feel connected and less alone in their struggle to manage. The women talked about coping in terms of self-care, new understandings of PTSD and their role, their faith, informal and formal supports, commitment to their marriages, and having hope for the future.

Key processes of the family resilience framework were identified as impacting resiliency in the lives of the women. Connectedness and positive outlook contributed to increased resiliency and helped the women to cope with the distress that they experiences. A commitment to the relationship is an aspect of the connectedness process while having hope for the future is an element of the positive outlook process.

Unfortunately, studies examining the effectiveness of coping behaviours and supports for military spouses are lacking, with the majority of research focussing on the adverse impact of PTSD symptoms on the lives of military spouses (Allen et al., 2010; Galovski & Lyons, 2004; Monson, Taft, & Fredman, 2009). This is discouraging as this study demonstrates that positive coping and supports are clearly important aspects in the experiences of spouses living with a veteran diagnosed with PTSD. Similarly, there are no studies examining the role that resiliency plays in the recovery from adversity and health promotion for the spouses of soldiers diagnosed with PTSD. This is an area of research that warrants further investigation. Research on resiliency in military spouses, specifically, as well as couples and families can shed light on

those factors that are most useful in promoting strength and the ability to recover from adversity for individual, couples, and families.

Half of the women in the present study identified self-care as an important aspect of their individual coping skills. For example, exercise, healthy eating, time with friends, and time alone were all noted as valuable activities for the participants. They helped the women to better manage their distress and research has shown that caregivers (not specific to those living with PTSD) who have decreased distress are more likely to engage in active coping and to seek out more social support (Goossens, Van Wiljngaarden, Knoppert-Vanderklein, & Van Achterberg, 2008).

Also, literature shows that family members who live with a mentally ill individual develop self-preservation strategies over time (Hansen, & Buus, 2013). Over time living with and caring for a mentally ill family member results in the caregiver undergoing a psychosocial transformation from the initial development of a sense of self or “absorbed” identity, where they lose their sense of self to their commitment and caregiving responsibilities, to the eventually transformation of an integrated identity that learns how to manage the demands of the “absorbed” identity (Hansen, & Buus, 2013). As noted in a previous theme, the women in this study also spoke of how they became completely committed to caregiving responsibilities and that their lives revolved around PTSD. However, over months and years the women developed a new realization which was based on the understanding that they could not control the situation or their spouse’s behaviour, consequently, they developed coping skills aimed at self – preservation.

New understandings of PTSD and their role also helped several women to cope. The realization that they could not control the illness and that their husband was responsible for his

own well-being led them to let things go and to place responsibility for recovery with their spouse. For instance, Amy expressed that when her partner is having a bad day she initially falls back into the role of caregiver and wants to fix the issue but immediately turns her focus to the fact that her husband's PTSD related behaviours are not her issue and he had to deal with it. Amy's new insight is also reflected in research by Karp and Tanarugsachock (2000) who found that once caregivers come to the realization that despite their best efforts they cannot control the disease they abandon attempts to fix the illness and person. Bonnie also suggested that a change in her reality of the situation caused her to cope better. She let go of what she perceived to be the ideal relationship/family and instead focussed on redefining her expectations. This change in perspective coincides with a study on the phases of coping that caregivers of family members with a mental illness experience (Muhlbauer, 2003). It describes that eventually caregiving family members move towards a stage of stability characterized by a change in their thoughts, values and behaviours (Muhlbauer, 2003). Although this body of literature is not specific to spouses of PTSD-inflicted veterans, the concepts are useful to understand their experiences. A change in perspective brings about a sense of increased control over the situation and better management of feelings of guilt and helplessness related to caring for a mentally ill family member (Muhlbauer, 2003).

Informal supports also helped the women to cope and perhaps allowed them to develop an identity separate from that of caregiver to their husband. Working and careers were identified by many of the women as important in their lives because they had the support of coworkers and working was also seen as an escape from PTSD and the issues of their home life. Although the women in this study did not specifically suggest that work allowed them to develop an identity separate from that of caregiver, I believe that in the workplace the women could separate

themselves from the role of caregiver and interact with others in a way that was meaningful to them, without the constant reminder of the burdens and challenges that they faced at home. The literature examining the experiences of spouses of PTSD veterans suggests that spouses have expressed the need to define a separation between their husband's needs and their own. Dekel et al. (2005) referred to this as the struggle between merging and individuation and the women in their study also noted that work helped them to establish independence and separation, which is seen as important to negotiating boundaries and maintaining individuation.

Family and friends were also noted as valuable supports by all the women. The participants shared that children, parents, and friends all provided additional support for the women and helped them to cope. Confiding in friends who understand the symptoms of PTSD and are accepting and non-judgemental is seen as helpful by Amy while parents and in-laws were similarly viewed as important to the women's well-being and coping. In the interviews, Bonnie and Sarah shared that they moved closer to parents and in-laws in order to get the support that they need and that without this family support the women would have struggled so much more. Studies examining the role of informal supports on the coping of spouses living with a military member diagnosed with PTSD are lacking. This is an area that requires additional consideration as this present study clearly demonstrates that informal supports were key to the well-being and coping of the participants.

Formal support also provided another avenue for coping and individual and group counselling/support groups were seen by all six women as important to their own well-being, while also providing them with the knowledge to better understand their experiences. Psychoeducational groups are viewed as important resources for spouses of PTSD veterans as they provide education around mental illness and help spouses make sense of their experiences

while providing validation that their experiences, no matter how challenging or distressing, are shared by others (Nelson & Wright, 1996). Citron, Solomon, and Draine (1999) note that self-help groups provide families of persons with mental illness with important supports in the form of imparting of information, group cohesion/sense of belonging, universality (an opportunity to meet others with similar challenges), identification, altruism, catharsis, installation of hope, interpersonal learning, self-understanding, ideology, and advocacy. The women in this study spoke of the benefits of attending spousal support groups and experienced many of the same advantages discussed in the literature by Citron et al. (1999). Three women talked of attending spousal support groups and Nicole, in summing up her experience with the group, shared that she learned that other women have similar experiences to hers. This corresponds with the group cohesiveness and universality in Citron et al.'s (1999) study. Amy also learned in her group that the illness is not about her, it is her husband's injury and her growing awareness aligns itself with self-understanding and the promotion of hope (Citron et al., 1999).

Other women talked about the role of spirituality and faith in their progress towards coping. Whether guided by formal religion or a more general sense of spirituality, women shared how faith was essential to their coping. For some, attending church provided them with the connection to their faith and was noted as a significant part of their and their families' lives. Meditation and Buddhism also helped women to achieve a deeper understanding of their experiences and, in fact, one participant (Sarah) noted that meditation was such an important coping skill that she doubted if she would have coped as well without it.

While there is a lack of literature on the role that faith has on the coping skills of spouses of PTSD veterans, specifically, literature on spirituality suggest that it can improve mental health, well-being and quality of life and religion can have a positive influence on feelings of

hope and optimism (Koenig, 2004). Literature also suggests that religion and spirituality can decrease symptoms of depression (Bonelli, Dew, Koenig, Rosmarin, & Vasegh, 2012) and lessen the perception of stress (Arévalo, Prado, & Amaro, 2008). Bonelli et al. (2012) reviewed over 444 studies examining depression and religion/spirituality and revealed that 60 % of those studies reported that individuals who are more religious or spiritual have less depression. While my study did not specifically inquire if religion and spirituality had any impact on their depression or levels of stress, the women were clear in identifying that religion and spirituality played a role in the coping.

The majority of women also expressed that a commitment to their marriage and hope for the future significantly impacting their ability to cope. Commitment is a characteristic of the process of connectedness. Commitment to the relationship fosters resiliency as it encourages collaboration and mutual support between the couple and among other family members. Commitment also creates family cohesion, which improves family functioning, and demonstrates to family members that they can depend on each other during difficult times (Walsh, 2003). Hope for the future is an aspect of the positive outlook process. A positive outlook affirms couple and family strengths, encourages optimism, and instills confidence in the ability to overcome adversity (Walsh, 2003).

Using Walsh's (1996) family resilience framework, which is grounded in the systems theory of family resilience, key resiliency indicators were observed in the interviews with the women. Connectedness and positive outlook were factors that appeared to impact resiliency and consequently, their overall experiences. We can see these when women talked about commitment to their marriage and hope for the future.

At the time of the interviews, four of the six participants were married to their partners. In their interviews, these women identified a strong connection and commitment to the couple relationship. For Amy, hope was connected to the commitment that she and her husband had to the marriage and allowed her to feel that they could overcome any challenge. Within the family resiliency framework, the organizational pattern of connectedness offers mutual support and family collaboration that seeks to respect individual member's needs and boundaries and to reconnect and resolve wounded relationships (Walsh, 2003). There was a strong understanding that as a couple they could overcome challenges because both partners were committed to the relationship and willing to do whatever was needed to make life better. A dedication to their marriage vows, a sense of collaboration, mutual support for each other, and an acknowledgement that their spouses were willing to get better also contributed to a greater sense that the relationship would improve and that the women could continue to manage. Mutual support, collaboration, and commitment are recognized as factors that strengthen resiliency (Walsh, 2003).

On the other hand, the two participants who were legally separated from their husbands had very different perspectives on their relationship connectedness. Both of these women specifically talked about their husband's lack of commitment to the marriage and getting better. There was a lack of mutual support as well and Mary observed that she was doing all the work in the relationship while she perceived her husband as lacking the commitment to improve. Similarly, an unwillingness to be fully involved in and committed to the relationship, a lack of similar goals, and an inability to support each other were viewed as significant flaws in the marriages of these women, whose relationships eventually ended in separation.

A positive outlook and acceptance were two factors that further impacted both the experiences of the women as well as their belief that adversity was manageable. Many women noted that having hope for the future was a critical element in their coping with a partner with PTSD. A positive perspective, which includes hope and confidence in overcoming odds (Walsh, 2003) and an acceptance of what cannot be changed were noted by several women. The women, who were still in a relationship with their spouses, expressed that they were hopeful, even during the most difficult of times, that things would improve. For example, Sarah shared that hope allowed her to move forward each day. Bonnie acknowledged that some things in her life cannot be changed, like having her husband return to the man he was before PTSD, but she had hope because he was improving. She saw potential and strength in her husband. Women with a positive outlook illustrated what Walsh (2003) refers to as mastering the art of the possible. This important element in resiliency allowed the women to accept what could not be changed and to instead focus on future possibilities (Walsh, 2003).

Meanwhile, in her interview, Mary recalled feeling hopeless throughout her marriage and that no matter how hard she tried or what she did, it was never good enough because she felt alone in the relationship. She was left with a feeling that she could never overcome the struggles and adversity of her life because of a lack of commitment from her spouse and this left her feeling overwhelmed and desperate in the marriage. Nicole noted similar feelings of hopelessness and despair as her efforts to help her husband were met with resistance. It appears that a commitment to the marriage and having hope for the future are connected to resilience.

In this current study, there were notable differences in connectedness and positive outlook between the women who remained in their marriages and those who eventually separated from their military partners. The findings of this study are supported by those of

Melvin et al.'s (2012) research on U.S. army couples in which the military member had PTSD. Their findings reveal that couples with high resilience also had higher couple functioning. Overall, it appears that these characteristics of resiliency impacted the experience of living with a military partner diagnosed with PTSD. For several women these elements promoted an increased sense that they and their families could overcome the adversities of living with PTSD and gave the women a feeling that they had a spouse who was willing to navigate the future of their relationship with them. However, for two women, these characteristics demonstrated how a relationship lacking in resiliency can decrease confidence in the relationship and create further distress which may contribute to a negative outcome for the couple relationship.

Research on the role that resiliency plays in the ability to recover from adversity and the maintenance of healthy relationships for women and their military partners is wanting. In particular, studies examining resiliency in spouses and their soldier partners diagnosed with PTSD are necessary as this present study demonstrates that elements of resiliency are considered to be valuable assets in the experiences of women. In identifying key processes of the family resiliency framework that are most helpful in creating and sustaining resiliency for individuals, couples, and families, it is possible to further create supports/programs that will directly improve recovery, reduce dysfunction and distress for women and support stronger and healthier individuals and families.

Summary of Discussion

This current study illustrates how the experience of living with a military member diagnosed with PTSD presents significant challenges and burdens for their female intimate partners. The participants shared how their marriages, families and, most importantly, they themselves were impacted by the difficulties that PTSD created in their lives. However, they

also talked about their individual growth and personal strength. They spoke of their journey from initially knowing nothing about PTSD, to their personal self-sacrifice and added burdens, to their growing personal awareness that they alone were not responsible for their spouse's recovery and symptom management. The women discussed how PTSD altered their husbands and ultimately led to the loss of the man they once knew. However, for most of the women, this loss, combined with their daily experiences, resulted in the eventual creation of a new, redefined relationship with their partner, while others spoke of the eventual dissolution of their marriages due largely to the insurmountable challenges of PTSD.

The experiences shared by the women demonstrate how PTSD progressively impacted their lives. Initially, they believed that their spouse's unusual behaviour was temporary and a return to normal functioning and family life was expected. However, as symptoms worsened, they blamed themselves for their partner's illness and every woman gave examples of the added responsibilities and daily burdens that she assumed in order to alleviate her partner's and family's distress. This is also reflective of the overwhelming sense of personal responsibility and self-sacrifice that the women experienced. For these women, daily life increasingly revolved around attempts to manage PTSD-related behaviour and symptoms and their experiences demonstrate how living with a partner diagnosed with PTSD resulted in a complete immersion in the management of the disease, with little or no separation from their role of caregiver or opportunities to enjoy previously held interests. Consequently, many of the women expressed a loss of self and a blurring of the boundaries between herself, her husband, and his illness.

Furthermore, the women expressed how PTSD symptoms altered the couple relationship and created both a physical and emotional distance between her and her spouse. They spoke of how their partner's changing behaviour resulted in a removal from family life and the role of

husband and father. Some women expressed a sense of being alone within their marriage and how their children also suffered because of a father who was largely emotionally and physically absent. To protect their children from the emotional hurt, women had to overcompensate for their husband's withdrawal, further complicating their lives and adding to their burden.

As PTSD symptoms created difficulties and distress in the lives of the women, each willingly discussed the feelings of anger, despair, loneliness, and resentment that she experienced. For some women, these negative emotions were directed at her partner, his symptoms, or the daily struggles that she encountered, while others were angry at themselves for making too many personal sacrifices in exchange for managing the illness and helping her spouse recover.

In addition to negatively impacting their daily life and couple/family relationships, the women also talked of how their own mental health and well-being suffered as the result of their experience. They discussed caregiver burnout and examples of how living with a soldier diagnosed with PTSD ultimately resulted in their own mental health issues. On the other hand, they also spoke of how they eventually developed more effective coping skills and strong supports in order to better manage their experiences. These women talked of the importance of strong coping skills/activities and expressed how vital these are to their continued well-being.

Women demonstrated amazing resilience and were able to identify ways they were able to overcome adversity. In particular, aspects such as connectedness and a positive outlook (all integral aspects of the family resilience framework) were found to have significant influence in the lives of the women. For most of the women, the commitment to their marriage was an essential element in their ability to overcome adversity. The sense of collaboration, mutual support, and a strong understanding that, as a couple, they could overcome difficulties enabled

the women to remain in their relationship and fostered a belief that their adversity was manageable. Likewise, hope for the future promoted an optimistic outlook, helped the women to envision a better future, and to accept what could not be changed in their lives. Hope instilled confidence in their relationship and helped the women to plan for a future with their partners.

While the discussion section was able to link previous research to this present study and the resulting themes, it is also useful at highlighting the gaps in the literature as well as implications for social workers and recommendations for future research.

Chapter Seven: Conclusion and Recommendations

This study examined the experiences of women whose military partners have been diagnosed with PTSD. In sharing their experiences of living with a soldier diagnosed with PTSD, six participants provided insight into the unique challenges and issues of this population. Ten themes were identified and are valuable as they can be used by professionals to further understand the experiences of women living with a military member diagnosed with PTSD. Below is a discussion of the implications of this research for social workers and professionals who work with military families, as well as recommendations for future research.

Implications for Social Workers and other Professionals Working with Women Whose Military Partners Have Been Diagnosed with PTSD

Social workers and other professionals working with military families may find the results of this research useful as it illustrates that many experiences are commonly shared by women whose military partners have been diagnosed with PTSD. It appears that there are characteristics of this experience that are common to most women and which provide conclusive information of how PTSD impacts the lives of women. All of the women in this study shared that specific symptoms of PTSD, such as avoidance and detachment, were more problematic and had the greatest negative impact on their lives and relationships. Also, the women universally described the personal sacrifices they made and the added responsibilities and caregiver distress that they experienced. Furthermore, the women talked of how PTSD altered their husbands, resulting in a man they hardly recognized. Consequently, the couple relationship underwent significant changes. Equally important, they all spoke of their gradual progression from assuming responsibility for their spouse's symptom management to eventually realizing that they were not to blame for his illness or responsible for his recovery. While this progression took

many months or years, it illustrates a typical experience in the lives of the women. Finally, the importance of coping and supports were equally shared by all the participants. Family, faith, self-care, a new understanding of PTSD, and support groups were all noted as important methods of coping during stressful times and provided the support the women needed to manage their experiences.

These uniting threads of common experiences can be useful for professionals. It can increase their knowledge of some of the common challenges that women are expected to encounter and also allow them to be more mindful, when working with this population, of the stressors and immense daily difficulties that women experience. Furthermore, when professionals are more cognizant of what their clients are likely to experience, this increases the ability to be proactive and plan for appropriate therapeutic interventions to better support women and decrease distress. Similarly, the results of this current study clearly demonstrate that PTSD extends beyond the soldier to impact his spouse and family. This, too, is valuable information for professionals as it highlights the necessity to treat and support the couple, family, and individuals members as well. As a result, it is necessary for professionals to take a broader approach when working with this population and to recognize that effective treatment extends beyond the women, to include the couple and family as well. As noted in the discussion section, the women in this study spoke of the importance of healthy coping behaviour and supports; however, it was only after months and years of daily struggles with their partner's symptoms of PTSD that the women finally developed better coping skills and connected with informal and formal supports. Professionals must be aware that early interventions, such as spousal support groups and education around healthy coping, may be useful in diminishing the negative effects of PTSD on spouses and their families early on while encouraging women to establish informal

supports may provide them with additional assistance in managing daily stressors and improve functioning.

At an organizational level, the findings of this present study may be helpful in the development of resources and programs to better support women of military members diagnosed with PTSD. Organizations that have a clear understanding of the experiences of this population are more able to develop policies and programs directed at effectively supporting women and their families and social workers who are supported by their organizations are more efficient at providing necessary services as well. In the interviews, several women noted that initially they had no knowledge of PTSD or education around what to expect when their husbands returned from deployment. This lack of education around the signs and symptoms of PTSD resulted in the women assuming that they were to blame for their husbands change in behaviour and may have caused them to delay in seeking help and support. It is important for social workers and organizations to understand how women process their spouse's change in behaviour, particularly when they lack knowledge about PTSD, and to also provide better education around PTSD symptoms while their partners are deployed.

This study identified several resiliency factors which acted as protective factors for many of the women and improved their ability to overcome adversity and manage their daily lives. Professionals, who are acquainted with the role that resiliency plays in the overall experience of military spouses, can assist women and their partners in developing healthy elements of resiliency to promote better individual, couple, and family functioning. For example, participants in this study identified that a commitment to their marriage, combined with mutual collaboration and support, contributed to a greater understanding that they could overcome hardship and they were more willing to continue with the relationship. Consequently, social

workers and other professionals who are aware of how to promote increased couple support and improve characteristics which contribute to a stronger sense of relationship commitment may be helpful to this client population.

Finally, these study findings have practical applications for military programs and policy. The experiences of the women exist within the context of the broader military community as well as the military as a larger, formal government organization. Therefore, programs aimed at educating both new recruits and currently serving military members as well as their civilian partners about the risks of deployment and PTSD are necessary. This ensures that both military members and their partners make informed choices with regards to assumed risk and the potential negative impact of PTSD on the couple and family. Similarly, providing spouses with appropriate and confidential supports for reporting any concerns that they may have regarding their military partners mental health is crucial and helps to encouraging an environment of transparency. In general, the development of military programs/policies that recognize that PTSD extends beyond the soldier to include the spouse and family will benefit the entire military community and help to remove the stigma associated with PTSD.

Recommendations for Future Research

While this study contributes to a better understanding of the experiences of women whose military partners are diagnosed with PTSD, there exists the necessity for additional research. As noted in the literature review, previous research has largely focussed on the military member and the impact that PTSD has had on his life, as a result, research that focussed exclusively on the experiences of women was omitted. While previous research has determined that PTSD has a significant impact on the lives of veterans and their families as well as a negatively influence on their spouses, these findings were mostly based on the opinions,

perspectives, and experiences of the soldiers. What is required of future research is to focus exclusively on the spouses of PTSD soldiers and to give voice to their experiences which may be uniquely different from that of their husbands. Unlike previous research, future studies must not rely on the experiences of PTSD veterans to provide information on the potential struggles and challenges that their partners encounter.

As noted earlier in this thesis, research claiming that women engage in “accommodating behaviours” in order to manage living with a military partner diagnosed with PTSD is problematic as this suggests that women somehow willingly contribute to the problems and distress experienced in their lives. This promotes a perception that women are to blame for the situation. Therefore, future research needs to examine the experiences of women whose military partners have been diagnosed with PTSD from a strengths -based perspective.

Similarly, research has also largely focussed exclusively on male PTSD soldiers and their female partners, however, suggestions for future studies may involve the inclusion of female PTSD soldier and their male partners as well as same sex couples to determine if their experiences differ from that of other spouses/partners. Another important recommendation is the need for research aimed at the Canadian military. There exists a lack of research examining the experience of women of Canadian soldiers diagnosed with PTSD. Canadian culture, government and social policies, and military involvement differ from that of other countries and research may demonstrate experiences which are unique to Canada. Future research examining the Canadian perspective may also be useful in highlighting the need for specific policies and programs to support the spouses of military members diagnosed with PTSD and their families.

Another important consideration for future research is the need to include women from a variety of ethnic, cultural, and socioeconomic backgrounds. Five of the six participants in this

study identified as Caucasian and all of the participants were in higher income brackets. The inclusion of women from many different backgrounds would further increase our understanding of the experiences of women living with military members diagnosed with PTSD.

Finally, it may be useful for future research to explore the role that resiliency, informal supports, coping behaviours, and a shift in perspective play in the experiences of women living with a military member diagnosed with PTSD. This research would provide insight into how or if these factors influence the experiences of women and what characteristics of resiliency and behaviours have the greatest impact on the promotion of individual, couple, and family wellness. Findings from this research could contribute to the establishment of treatment programs aimed at increasing resiliency, decreasing distress, and assisting women, the couple, and families in overcoming adversity.

This thesis has provided insight into the experiences of women who live with a military member diagnosed with PTSD and illustrated that while there are many similarities in the experiences of the women, there also exists differences. It is important that research continues to examine the experiences of these women and to learn how to support not only them but also their families.

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Appendix A

Interview Questions: These questions will be supplemented with probing questions as required.

1. Can you tell me how you met your partner and describe your early relationship/marriage years? (prompt: How did you first meet? What was your courtship like?)
2. When was your partner diagnosed with PTSD? What was going on with him and your relationship at that time?
3. Can you tell me about the difficulties that you and your family have faced in relation to your partners diagnosis of PTSD?
4. How has PTSD affected your relationship with your spouse?
5. How do you manage to cope with difficulties/problems? How do you think your family copes?
6. Do you think that you and your family are stronger now? If so, what are the things which make you/your family stronger/more resilient? If not, what things would you need to help make you/your family stronger/more resilient?
7. In relation to your experience in living with a partner diagnosed with PTSD, what have you learned about yourself? Your family?

Belief systems questions:

Making meaning of adversity

8. Do you see adversity as a shared challenge between you and your partner? (prompt: Is the adversity manageable, understandable given the situation?)
9. Have your struggles made your relationship stronger? If so, how? If not, why?
10. Given your situation do you think that your reactions are normal/typical of other families experiencing similar challenges?
11. If you were asked to explain why this happened to your partner and your family what would you say? (optimistic vs. pessimistic explanatory style)

Positive outlook

12. Are you hopeful for the future? Why or why not?
13. What role does hope and optimism play in your family and how you manage?
14. Are there things about your situation that you feel you can't change? How do you deal with this?

Transcendence

15. What role, if any, does spirituality or faith have in your experience? (This could be more formal religious beliefs or informal such as the spiritual connection found in nature or music)
16. Has spirituality/faith helped you to make sense of your experience?

Family organizational patterns:

Flexibility

17. Can you give me any examples of how your family has adapted to meet new challenges?
18. How has your family life changed with the difficulties experiences? How has your typical day/week changed with the diagnosis of your partner? (Stability during crisis?)

19. How do you manage to maintain stability and routine in your family? (ie. regular bedtime and schedules, shared family meals, family rituals such as celebrations.)
20. What rules govern your family? (ie. Older children help younger siblings, no cell phones at dinner table, no t.v. until homework is completed etc.) How are rules enforced? By whom?
21. As a family, how do you make decisions? Who are the leaders in your family? (ie. Parent(s), grandparents, other extended family?) How do they show leadership?
22. Do you feel that you and your partner co-parent and function as a parenting team? Examples of why or why not?

Connectedness

23. Do you share interests and activities as a family/couple?
24. Do you encourage independence in family members?

Social/economic resources

25. Do you belong to any social groups/organizations/support groups? (ie. Peer groups, other families, local agencies, mentors)
26. Have you experienced economic hardship because of your family's challenges? (ie. Loss of job, had to work part-time, difficulty finding child care?) How have you managed?

Communication process:

Clarity

27. Does your family talk openly about your challenges, do you acknowledge your challenges? (or do you avoid talking to possibly protect each other)

Emotional expression

28. Do family members share and express emotions? What happens when family member's feelings are intense? How do you show support for a member sharing their emotions?
29. What does your family do for pleasure and fun?

Collaborative problem solving

30. How does your family manage decision making and solve problems?
(Collaborative, proactive, setting goals and concrete plan)
31. How do you prepare for future challenges? (Proactive, plans to avert crises)
32. What have you learned about your family's successes? (building on success)
33. What have you/your family learned from your mistakes/failures?
34. Is there anything else that you would like to share with me about you and/or your family?

Appendix B
Demographic Face Sheet

1. Case ID:
2. Pseudonym:
3. Age of Participant:
4. Current Employment:
 - Full time.....1
 - Part-time.....2
 - Casual.....3
 - Not Employed.....4
5. What is your education level?
 - Grade nine or less.....1
 - Some high school.....2
 - Completed high school.....3
 - Some post-secondary (technical).....4
 - Completed post-secondary (technical).....5
 - Some post-secondary (university).....6
 - Completed post-secondary (university).....7
6. What is your current level of annual income approximately?
7. What is your racial background?
 - Caucasian (white).....1
 - Aboriginal origin (Native Descent).....2
 - Black.....3
 - Asian (Chinese, Japanese, Korean, Vietnamese).....4
 - South East Asian (East Indian, Pakistani, Bangladeshi).....5
 - Middle Eastern (Lebanese, Syrian, Iraqi, Afghani).....6

	Pacific Origin (Filipino).....	7
	Central/South American (El Salvador).....	8
	Other, describe please _____	9
8.	What is your marital/relationship status?	
	Married.....	1
	Legally Separated.....	2
	Common Law.....	3
	Boyfriend.....	4
9.	What is the length of your involvement with your partner?	
10.	How many children do you have? Ages?	
11.	How many deployments has your partner had?	
12.	When was your partner diagnosed with PTSD?	
13.	What type of treatment has your partner participated in?	
14.	How long was your partner's treatment?	
15.	What, if any, type of treatment have you participated in?	



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Appendix E

Informed Consent

Research Project Title: The experiences of women whose military partners have been diagnosed with posttraumatic stress disorder

Principal Investigator and contact information: Colleen Collins, 204-XXX-XXXX

or XXX@wrha.mb.ca

Research Supervisor and contact information: Dr. Kendra Nixon, 204-XXX-XXXX or

XXX@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Research: The purpose of this study is to better understand the experiences of female partners of active and non-active members of the Canadian military who have been diagnosed with PTSD. The information gathered from this study will be published in a thesis document, and will be available for the general public, as well as professionals to review. It is also a possibility that the findings from this research will be referenced in other articles or publications as well. However, identifying information, including your name, and specific information about you, will not be shared in the research.

Study Procedures: The study will involve approximately a two hour interview. Initially you will be asked to fill out a demographic questionnaire that will ask for information on your age, employment and education level, income, racial background, relationship status, including the length of your relationship,

number and age of any children, when your military partner was diagnosed with PTSD and his deployment history as well as the treatment history of both you and your partner. You will also be asked to complete a participant contact information sheet and you will be provided with a pseudonym. You will be asked several questions that will focus on your relationship with your partner and the impact that PTSD has had on you, your relationship with your partner, and your family. The interviews will be digitally-recorded and written notes will also be taken during the interview. This is for me to get a thorough examination and understanding of your experience. I will then transcribe the interviews verbatim. Neither the transcribed data, nor the digitally recorded interviews will contain your real name, but instead will be assigned a pseudonym and code number. The interviews will take place at your home if it is safe and convenient for you or at a community agency if you wish. If any answer or statement is shared in my thesis, it will be under the pseudonym, and it will not be accompanied with any additional information that could be linked to you directly.

Description of Recording Devices: The interviews will be digitally recorded and later transcribed verbatim.

Description of Benefits: The interview will give you the opportunity to share your experience and to contribute valuable information to a growing area of research. The interview may also provide you with the opportunity for self-reflection and to gather new personal insight into your experience. Finally, it is hoped that this research may ultimately influence program and policy development which would assist military families in the future.

Description of Risk: While there is minimal risk to you for participating in this research, I recognize that in the telling of your experiences you may encounter questions which are upsetting or troubling. At any time you may stop the interview process should you feel uncomfortable with a particular question and we will proceed to the next question when you are ready to do so. Also, if you indicate that you can no longer proceed with the interview, it will be terminated and you will still receive the honorarium. Similarly, upon completion of the interview, you will have the opportunity to debrief about the interview

and reflect on your experience. Finally, I will provide you with a list of counselling services so that you may contact a professional if you feel that you require additional support.

Description of Confidentiality: The information that you provide will be kept confidential. Agencies involved in your recruitment will never have access to your specific responses, nor will they know that you participated in the study unless you tell them. An exception to this is if you choose to complete the study at a community organization, the service providers may become aware of your participation in the study because of your presence at the organization.

All data collected (demographic questionnaire, consent forms, written notes and transcripts) will be kept confidential and secured in a locked cabinet in my home that only the principal investigator (myself) will have access to. Digital recordings of the interview will be erased from the recorder when the information has been transferred to a computer for transcribing and analysis and this information will be password protected. Only I will have access to this password. Following the completion and publication of this research project, which will be no later than September 2016, all digitally recorded interviews and transcripts as well as hard copy data will be destroyed.

The information gathered from this study will be published in a thesis document and will be available for the general public, as well as professionals to review and there is a possibility that the findings from this research will be referenced in other articles or publications as well but any identifying information, including your name, and any other specific information, will not be shared in the research. For example, only your pseudonym will be used when you are referred to or directly quoted. Also, the study findings may be disseminated, in the form of a research summary, to interested participants and to the two agencies that are assisting with participant recruitment; however, your pseudonym will be used and your participation will remain anonymous.

There are limits to confidentiality, which you must be aware of. Researchers are required by law to report current and past unreported child abuse or situations dangerous to children or harm to persons in care to the legal authorities. These are the same laws followed by service providers.

Participant Credit or Remuneration: For your participation in the study, you will be given a \$25.00 research honorarium at the beginning of the interview and it is not dependent on you answering all the questions or completing the interview. The honorarium can be used to help cover the cost of your time, childcare, and transportation costs.

Right to withdraw: Participation in this research project is voluntary and you may withdraw at any time without being penalized. If at any point, you decide to discontinue participating, the interview will be stopped and you may choose whether the information obtained at that point can be used or not. Your decision not to participate will not affect the services you receive in any way.

Debriefing: At the end of the interview you will be provided time to reflect on your thoughts, and debrief about the interview. You will be invited to ask questions and I will offer to answer any questions or concerns that you may have. Also, you will be provided with a list of no-cost counselling services.

Dissemination of Research Results: The information gathered from this study will be published in a thesis document, and will be available for the general public, as well as professionals to review. There is a possibility that the findings from this research will be referenced in other articles or publications as well the findings may be disseminated, in the form of a research summary, to interested participants and to the two agencies that are assisting with participant recruitment.

Feedback to Participants: If you would like to be notified of the findings for this research, please provide the information for how you would like to be contacted below. A brief 1-3 page summary can be emailed to you or a hard copy mailed with information on the findings of this study, which is anticipated to occur after May 2016.

I would like to receive information about the study findings: Yes NO

I would like to receive the information by:

Mail (please provide complete mailing address):

Email (please provide email address):

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence.

Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature _____ Date _____

Can a message be left? _____

Researcher and/or Delegate's Signature _____ Date _____

Appendix F

Script for Counselling Services

Thank you for sharing your personal experiences and participating in the research interview. Do you have any questions? If you feel that sharing your experiences has been upsetting or distressing and that you would benefit from talking to a professional about your feelings and thoughts, please find below a list of resources for Winnipeg counselling services.

Crisis Services:

Crisis Response Centre: 817 Bannatyne, Winnipeg. Please attend in person

Mobile Crisis Unit: 204-940-1781

Crisis Stabilization Unit: 204-940-3633

Seneca Help Line: 7pm-11pm daily 204- 942-9276

Klinic – 786-8686 or 1-888-322-3019

24 hour crisis line which offers counseling and crisis/suicide intervention

Manitoba Suicide Line – 1-877-435-7170

Winnipeg Emergency Services Operator – 911

Counselling Services:

Klinic Community Drop-In Counseling Service – 784-4067

Call for locations

Aulneau Renewal Centre – 987-7090

228 Hamel Avenue

Aurora Family Therapy Centre – 786-9251

University of Winnipeg

Fort Garry Women’s Resource Centre – 477-1123

1150-A Waverley Street

Appendix G

STUDY PARTICIPANTS NEEDED**Exploring The Experiences Of Women Whose Military Partners
Have Been Diagnosed With Posttraumatic Stress Disorder**

I am a social work student at the University of Manitoba conducting research that explores the experiences of women whose military partners have been diagnosed with PTSD. I am interested in hearing about your day-to-day experiences in living with a partner with PTSD and how this illness has impacted you, your intimate relationship, and your family. In particular, I am interested in learning about resiliency and the role, if any, that it plays in your experience. I hope that this research will assist professionals and researchers to better understand the experiences and needs of women whose partners have PTSD. If you are interested in participating and meet the following criteria, please contact me at the number listed below for more information.

You may be eligible for the study if:

- 1. You are a woman whose male partner is either a currently serving or former Forces member who has been formally diagnosed with PTSD at any time in the past.**
- 2. Your partner must be receiving or have received treatment for PTSD.**
- 3. You and your partner have been in a relationship for a minimum of five years.**
- 4. You are able to participate in a face-to-face interview which will last approximately 2 hours.**

For your participation, you will receive a \$25.00 honorarium in appreciation of your time and effort. Your participation is completely voluntary and confidential. If you are interested in participating in the study or would like more information, please contact me at the confidential number or email:

Colleen at 204-XXX-XXXX or XXX@wrha.mb.ca

