

“WALKING ON EGGHELLS”: A QUALITATIVE STUDY ON THE EFFECTS OF  
TRAUMA AND DEPLOYMENT IN MILITARY COUPLES

by

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B.A., Tougaloo College, 2001  
M.S., University of Southern Mississippi, 2003

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services  
College of Human Ecology

KANSAS STATE UNIVERSITY  
Manhattan, Kansas

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## **Abstract**

The purpose of this qualitative study was to gain an in-depth understanding of the systemic effects of trauma, particularly war-related traumatic stress as a result of military deployments to Iraq and Afghanistan, in a sample of recent war veterans and their spouses. With recent military deployments and redeployments of soldiers, empirical and clinical research is needed to eliminate further deterioration and retraumatization caused by personal and interpersonal traumatization that can lead to severe PTSD and other trauma-related symptoms. Much of the research on previous wars focused on the individual trauma survivor overlooking the impact on the couple and family system. This study focused on explaining the systemic effects of trauma as it specifically impacts couple relational systems. By employing qualitative analysis, six couples (12 participants) were selected from the original data set of 45 couples (90 participants). Participants completed questionnaires and separate individual standardized open-ended interviews about their traumatic experiences. The interviews were transcribed, coded, and analyzed producing four themes: positive impact of deployment on the couple's relationship, the negative impact of deployment on the couple's relationship, soldiers' war-related trauma, and issues of secrecy. Two groups were identified (high trauma/high relational satisfaction group and high trauma/low relational satisfaction group), based on the quantitative measures that were completed by all participants. Participants reported both war deployment related and non-deployment related traumatic experiences. Many participants reported feeling as though they restarted their relationship upon returning home, while some described feeling closer to their spouse at redeployment. Participants reported having a common worry of if the soldiers would return home alive, soldiers' missing many life events (i.e., child birth, etc.), and soldiers' worry about the safety and health of their spouses. An interesting finding was that some couples with

high levels of trauma can maintain high levels of relational satisfaction when they have knowledge and understanding of each other's trauma history and have open, on-going communication, while some couples with high levels of trauma tend to have low relational satisfaction due to limited communication about their trauma history. Strengths and limitations of the study, research implications, and clinical implications were discussed.

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Approved by:

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This dissertation is dedicated to all of the couples who were willing and eager to participate in this study sharing their traumatic experiences and its affects.

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# CHAPTER I

## INTRODUCTION

While growing up, I witnessed my father having difficulty in many aspects of his life. My father experienced sleep disturbances due to nightmares about his war experiences, distressing memories, avoidance of particular events and activities, irritability, being easily angered, and mood swings, all of which affected the dynamics of my family. My father is a Vietnam War Veteran. As a young person, I always wondered what was wrong with my father. Later, he was diagnosed with posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000).

Living with my father allowed me to experience his illness, which affected my relationship with him, particularly, his inconsistent mood. I would often attempt to assess his mood before saying or doing certain things, because I feared his reaction. My mother and sister often did the same. My father was constantly apologizing for his actions by saying, “I can’t help it baby...Daddy’s sorry.” Then, he would take my sister and me to eat at our favorite fast food restaurant or give us money. My mother would have talks with me and my sister about my father’s behavior, even before we knew that it was a diagnosable illness. She encouraged us to remain calm and treat him with respect, regardless of his actions, because we did not know what was causing his undesirable behavior at times. His diagnosis eventually provided my family with some answers and understanding.

### **Impact of Trauma**

Understanding traumatic events can be difficult for both the primary survivor and family members. Traumatic events, particularly military combat, are extreme life stressors, which may be experienced by anyone. Trauma may be defined as “any experience that by its occurrence has threatened the health or well-being of the individual” (Brewin, Dalgleish, & Joseph, 1996, p.

675). A stressor may be defined as a transition in life (e.g., death, childbirth, family separation) in which change may occur in the family system as a result of the stressor (Figley, 1989). Several generations of men and women in the United States have served in military combat. Much of the examined literature on the impact of military combat, war-related trauma, and veteran relationships has focused on the psychological symptoms and the divorce rates among veterans, mainly Vietnam War Veterans.

Clinical treatment and research investigation can provide a better understanding of the effects of trauma. The inclusion of PTSD as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. (DSM-III, APA, 1980) reduced much political debate about the inclusion of the post-war unclassified traumatic symptoms (Shatan, 1985, as cited in Shalev, Yehuda, & McFarlane, 2000). PTSD was once conceptualized as individual traumatic responses/reactions known as traumatic war neurosis (Bloom, 2000). The inclusion of PTSD in the DSM has advanced the psychotherapy field by providing a universal, clinical reference for the commonly experienced symptoms by survivors of various traumatic events. In addition, the inclusion of PTSD as a diagnosis has enabled the field to become aware of other traumatic events and develop effective treatments. Several clinical instruments have been developed as a result of this diagnostic inclusion to assess PTSD. These instruments have provided clinicians with a standard of testing for PTSD symptoms that has enhanced clinical treatment and research outcomes.

Treating PTSD includes spouses/partners, family members, and others close to the trauma survivor. The psychotherapy field has recognized through clinical experience and empirical studies that traumatic events affect not only the individual who experienced the trauma, but also others who have significant relationships with the traumatized individual. The

impact on significant others is known as secondary trauma (Solomon, Waysman, Levy, et al., 1992). This inclusion of secondary trauma has enabled the field of traumatology to understand the effects of traumatic events on secondary trauma survivors to provide more effective systemic treatment.

Researchers have studied war-related trauma and PTSD to determine its impact on intimate (couple) relationships (Maloney, 1988; Nelson & Wright, 1996; Rohall, Segal, & Segal, 1999; Solomon, Waysman, Levy, et al., 1992). However, most often studies (Brown, 1984; Hoge et al., 2004; Hoge, Auchterlonie, & Milliken, 2006; Hunt & Robbins, 2001; Iowa Persian Gulf Study Group, 1997) seem to focus on the symptoms of the primary trauma survivors (the deployed soldier), while overlooking the impact of the traumatic events on those close to the primary survivor, such as a spouse/partner. Traumatic events affect not only the individual who experienced the trauma, but also the people who have significant relationships with the traumatized individual (e.g., spouses/partners and children). In fact, the literature suggests that war-related stress and trauma may be experienced individually, as well as systemically (Dekel, Goldblatt, Keidar, Solomon & Polliack, 2005; Rohall et al., 1999; Solomon, Waysman, Belkin, et al., 1992).

Recognizing the impact that trauma has on groups or systems, the purpose of this study is to determine the impact of trauma and post-traumatic stress on the couple relational system by explaining the intrapersonal and interpersonal dynamics of couple relationships, also referred to as dyadic adjustment. Expanding the view of trauma, in the field of Marriage and Family Therapy (MFT), to include those close to a trauma survivor is referred to as a systemic view of trauma. This includes how the influence of what one member experiences impacts the whole family system. Much has been done to identify the need for professional therapy and other

services for the primary trauma survivors. However, because spouses/partners, children, and others close to the trauma survivor are often overlooked, they generally do not receive the help they need to cope with the problems they may experience. Also, there has been limited empirical investigation on the systemic and secondary effects of past traumatic experiences.

### **Theoretical Models of the Secondary or Systemic Effects of Trauma**

To understand the relational or systemic effects of trauma, four theories/theoretical models will be considered: Secondary Traumatic Stress Theory (Figley, 1983); Family Stress Theory [ABC-X model] (Hill, 1949); Double ABC-X model (McCubbin & Patterson, 1982); and the Couple Adaptation to Traumatic Stress (CATS) model (Nelson Goff & Smith, 2005). The first model, Secondary Traumatic Stress Theory (Figley, 1983), incorporates the idea of couple and family systems into the traumatic stress field. It suggests that if one member of the system is exposed to a traumatic event, then each member of the system will share that experience due to the emotional connection that exists within these systems (Figley, 1983). Since the Vietnam War soldiers returned home, this concept has traditionally been applied to their spouses' or partners' experience of increased psychological symptoms, such as depression, anxiety, and anger as a result of the soldiers' traumatic experience (Soloman, Waysman, Levy, et al., 1992).

The second model to consider is the Family Stress Theory and the ABC-X model (Burr, 1973; Hill, 1949). This theoretical model seeks to explain how systems, such as couples and families, interpret stress and crisis. The systems' ability to adapt or adjust to the occurrence of stress or crisis is dependent on the available support and resources for the couple and/or family system. Traumatic events are often very stressful, causing the system to deviate from its normal daily functioning. The related stress and crisis of a traumatic event may lead to dysfunctional relational patterns within couple/family systems that further exacerbate the impact of the trauma.

The third theoretical model to consider is the Double ABC-X model (McCubbin & Patterson, 1982). This theoretical model is derived from observing how families respond and adapt to stressors and/or traumatic events over time, such as war (specifically the Vietnam War). This model examines how the variables (e.g., multiple stressors, resources within the family, and coping mechanisms) interact to assess how the family may adapt when a spouse or partner and/or parent is a prisoner-of-war or missing-in-action due to the war. This model adds these post-crisis variables to the original ABC-X model to investigate how families can successfully create positive adaptations to crisis (McCubbin & Patterson, 1982).

The fourth theoretical model to consider is the Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005), which describes the systemic effects of trauma as it impacts both primary and secondary trauma survivors. Including the principles of secondary traumatic stress theory, this model supports the idea of secondary traumatization, specifically in couple relational systems. However, this model goes a step further to provide a visual framework for explaining how the primary trauma survivor's individual functioning will initiate a reaction in their spouse or partner causing a secondary traumatic stress reaction. The model portrays and supports the idea that traumatic stress is systemic in nature, and that traumatic experiences affect each individual and the couple or dyadic functioning. Hence, the couple's adaptation to the stress is based upon three factors: (1) the individual level of functioning, (2) predisposing factors and resources, and (3) overall couple functioning. These three factors differentiate the CATS model from secondary traumatic stress theory.

### **Statement of the Problem**

United States military personnel have been involved in major ground combat or security duties in Iraq and Afghanistan since March of 2003. Operation Enduring Freedom (OEF) in

Afghanistan and Operation Iraqi Freedom (OIF) in Iraq are the first ongoing ground combat operations initiated by the United States since the Vietnam War (Infoplease, 2006). Nelson Goff, Crow, Reisbig, and Hamilton (2007) conducted research with 45 male Army soldiers and their spouses/partners of the OEF and OIF Wars upon return from deployment to learn more about the interpersonal impact of war trauma. In accordance, the current study will utilize participants of this same group to further understand impact of war deployments on military couple relationships. Currently, there is limited research examining these effects on OEF/OIF soldiers/veterans.

With recent military deployments and redeployments of soldiers, empirical and clinical research is needed to eliminate further deterioration and retraumatization caused by personal and interpersonal traumatization that can lead to severe PTSD and other trauma-related symptoms. Maladjusted coping and isolation are common for individuals and their families after traumatic events; hence, Anderson (1991, as cited in Ford et al., 1993) mentioned that an “ecology of alienation” (P. 75), which refers to individual isolation, often develops among soldiers and their families. Ford et al. (1993) stated that deployment separation and reintegration back into the family system may promote individual isolation, while dampening the re-socialization back into their respective communities, which, in turn, could perpetuate clinical disorders.

Treating trauma victims individually may cause the couple symptoms to be ignored and the interactional patterns may be symptomatic of the primary trauma. Therefore, systemic treatment is recommended in several studies (Ford et al., 1993; Nelson & Wampler, 2000; Riggs, Byrne, Weathers, & Litz, 1998; Wexler & McGrath, 1991). Understanding how trauma affects the couple relationship will improve clinicians’ ability to intervene successfully and advance the

psychotherapy field in bridging the gap of individually-focused treatment with systemically-focused treatment of trauma.

### **Purpose of the Study**

The purpose of the current study is to gain an in-depth understanding of the systemic effects of trauma, particularly war-related traumatic stress as a result of military deployments to Iraq and Afghanistan, in a sample of recent war veterans and their spouses. The study seeks to explain the systemic effects of trauma as it specifically impacts couple relational systems. Much of the research on previous wars focused on the individual trauma survivor. However, as mentioned previously, trauma not only impacts the individual who was deployed, but it also impacts the couple and family system (Dent et al., 1998; Figley, 1993; Laufer & Gallops, 1985; Rosenheck & Nathan, 1985; Shehan, 1987; Solomon, 1988; Solomon, Waysman, Levy, et al., 1992).

This study seeks to illuminate the systemic effects of trauma, while providing empirical support for theories of traumatic stress through individually assessing trauma symptoms and relationship satisfaction (dyadic adjustment). A thorough review of the existing literature will be described in Chapter II.

## **CHAPTER II**

### **REVIEW OF THE LITERATURE**

During the past 25 years, the scientific study of war-related traumatic stress has flourished according to the clinical and empirical literature. Psychotherapy has begun to focus on

individual traumatic stress and issues of secondary traumatic stress for spouses or partners, family members, or others close to a trauma survivor, particularly in the treatment of couples who have experienced traumatic events, such as war-related traumatic stress (Maloney, 1988; Nelson & Wright, 1996; Rohall et al., 1999; Rosenthal, Sadler, & Edwards, 1987; Solomon, Waysman, Levy, et al., 1992). Traumatic stress can be described as a symptom or response to an extreme stressful event or circumstance that does not occur in everyday life. According to the American Psychiatric Association guidelines (APA, 2000), psychological disturbance or impaired social functioning that is persistent after experiencing a traumatic event is characteristic of posttraumatic stress disorder (PTSD).

PTSD is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text-revised (DSM-IV-TR) (APA, 2000) as an individual experiencing, witnessing, and/or being confronted with event(s) that pose a threat or actual death/injury that involves “intense fear, helplessness, or horror” (p. 467). Trauma includes any extreme or stressful experience or event that does not occur in everyday life in which the individual feels a threat to his/her survival (Brewin et al., 1996). Traumatic events include, but are not limited to, natural disasters, military combat, violent assaults, and automobile accidents. To meet the criteria for PTSD, the individual must experience one or more of the following re-experiencing symptoms (Criterion B):

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
2. recurrent distressing dreams of the event
3. acting or feeling as if the traumatic event were recurring
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (APA, 2000, p.468)

The symptom category of persistent avoidance and numbing of general responsiveness is indicated by three or more of the following (Criterion C):

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. efforts to avoid activities, places, or people that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities
5. feeling of detachment or estrangement from others
6. restricted range of affect
7. sense of a foreshortened future (APA, 2000, p.468)

The final symptom category, persistent symptoms of increased arousal, is indicated by two or more of the following (Criterion D):

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response (APA, 2000, p.468)

The duration of these symptoms (Criteria B, C, and D) must be more than one month to meet the diagnosis of PTSD (APA, 2000).

The recognition of war-related traumatic stress, which often exists in the form of PTSD, has stimulated research investigations to provide increased understanding and effective treatment. Military trauma is the focus of this study due to the author's personal interests in

understanding the impact of military-related traumatic stress on relational systems. Hence, this study will primarily focus on recent wars and military deployments. The literature purports two significant contributing factors (addressed in Chapter I) that have influenced the focus on war-related traumatic stress: the inclusion of the diagnostic criteria for PTSD and the inclusion of secondary trauma for spouses or partners, family members, or others close to a trauma survivor. The key sections of this chapter include a historical review of the impact of war on soldiers, including the psychological and relational impact of previous wars; a summary of previous wars; the individual impact of war-related trauma on soldiers or veterans; the three stages of deployment separation; the systemic impact of war-related trauma; and the theories of systemic traumatic stress.

### **Historical Impact of War Trauma on Soldiers**

Introducing a brief historical overview of recent wars in U. S. history helps conceptualize the nature and impact of war-related traumatic stress to understand the context of the subject matter. The nature of war involves exposure to a range of extreme events and circumstances ranging from physical injury to death. Due to the prolonged intensity of war, impaired psychological functioning is characteristic of the war-related traumatic stress response. The response may be acute, an immediate impairment, or chronic, a long-term impairment, depending on the degree of combat exposure. Thus, considering the war cohort of veterans is important in studying the differences of psychological, physical, and social experiences.

**World War II.** World War II began in 1939 and ended in 1945 (Infoplease, 2006). Trauma-induced symptoms were initially observed in studies of World War II soldiers and veterans. The trauma-induced symptoms were referred to as “neurosis” (Weathers, Litz, & Keane, 1995). These symptoms increased more than 300% after World War II in comparison to

World War I. The increase was a result of war-related stress, fatigue, and harsh environmental circumstances (Rosenthal et al., 1987). It was believed that World War II would be different from World War I having less psychological impact on soldiers. However, that prediction was shown to be incorrect with significantly more combat soldiers reporting trauma-induced symptoms (Dobbs & Wilson, 1960). Dobbs and Wilson (1960) conducted a study with mostly World War II veterans and discovered that the stress reactions were not transient, but continual, indicating that veterans experienced stress reaction years after the return from war. This finding disputed the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM, APA, 1952), which reported that the stress reactions were non-persistent (Dobbs & Wilson, 1960). Further studies of war and its effects began to be investigated, once again due to the increase in symptoms, but were discontinued until the Vietnam War era (Weathers et al., 1995).

**Vietnam War.** The Vietnam War is one of our nation's most memorable wars beginning in 1964 and ending in 1975 (Infoplease, 2006; Verbosky & Ryan, 1988). The Vietnam War began with a focus on territory and later became focused on body count due to the rapid increase of war fatalities (Peret, 1990). Soldiers of the Vietnam War endured prolonged exposure to life-threatening circumstances, such as witnessing and participating in the abuse of noncombatants and having to kill civilians. These trauma-inducing experiences strongly affected the veterans' lives upon returning from war to civilian life. It was suggested that the severity of the trauma that the veterans experienced might determine how difficult the transition was to civilian life, directly impacting social lives and relationships (Verbosky & Ryan, 1988). Although, the psychological aftermath of the Vietnam War had a lasting effect, the severity of the war impact varied over the years from minimal to significant. However, due to the length of the Vietnam

War, the severity of the impact varied over time. Hence, the psychological aftermath of the war has had a lasting effect.

For combat soldiers of the previous wars (i.e., World Wars I and II), the psychological problems increased as the intensity of the wars increased (Dobbs & Wilson, 1960). However, for the Vietnam War, the psychological problems were exacerbated due to several contributing factors, including the lack of appreciation, support, and intense hostility expressed by the American citizens both during and after the war; the absence of a clear mission for military personnel, which promoted a lack of unit cohesion; and the fact that veterans repressed memories and/or discussions of their experiences in fear of negatively affecting appraisal of the war (Armfield, 1994; Brown, 1984; Hunt & Robbins, 2001). Consequently, Vietnam veterans began to isolate themselves from social events and experienced delayed stress reactions (Brown, 1984; Hunt & Robbins, 2001). The report of symptoms began to increase beginning in the early 1970s, which was near the end of the war (Goodwin, 1980).

***Psychological impact.*** As the proliferation of varied symptoms continued to be reported by veterans many years after Vietnam, researchers began to focus on the psychological effects and the continuous onset of symptoms years after the ending of the war (Fairbank, Keane, & Malloy, 1983; Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004; Hunt & Robbins, 2001). The commonly reported psychological symptoms of Vietnam veterans include numbing of affect, avoidance, anxiety, panic attacks, depression, anger, isolation, sleep disturbances, intrusive thoughts and memories, cognitive deficits in memory and attention, and increased arousal (Bremner, Southwick, Darnell, & Charney, 1996; Brown, 1984; Chemtob, Novaco, Hamada, Gross, & Smith, 1997; Fairbank et al., 1983; Hendrix, Jurich, & Schumm, 1995; Hunt & Robbins, 2001). Substance abuse was also a commonly reported symptom (Hoge et al., 2004).

These symptoms or complaints were increasingly reported at higher rates by Vietnam veterans as they recollected various types of incidents. Vietnam veterans described brutality, mutilated bodies, dead children, and loss of fellow soldiers, while World War II veterans described physical injuries and captivity (Davidson, Kudler, Saunders, & Smith, 1990).

The focus on psychological symptoms soon diminished due to the nature of the changing war, as well as moral and political reasons. Laufer and Gallops (1985) noted that the American participation in the war increased between 1965 and 1968. The nature of the war changed from guerilla warfare to regular North Vietnamese combatant soldiers. Additionally, the American outlook of the war changed morally and politically creating increased stress for the soldiers. After 1968, the added pressure left the soldiers with feelings of ambivalence during an intense period of the war due to the reduced support of the war by American citizens. Laufer and Gallops (1985) postulated that the impact of the traumatic experiences for soldiers may have been more severe after 1967 due to moral and political pressures. Studies have found that war veterans who provided service between 1965 and 1968 demonstrated having more PTSD symptomatology and more difficulties with post-service adjustment than veterans who provided service prior to 1965 (Laufer, Yager, Frey-Wonters, & Donnellan, 1981; Stretch, 1985).

The National Vietnam Veterans Readjustment Study (NVVRS) revealed a diagnosis of PTSD in approximately 500,000 Vietnam veterans 15 years after their military service, with a prediction that 1.7 million veterans would have delayed stress reactions during their life course (Kulka et al., 1990). The study also conducted clinical interviews with the veterans and spouses or partners of the veterans. Of the 403 veterans selected to participate in the clinical interviews, 344 completed the interviews. In addition, 557 spouses or partners were selected for interviews, with 474 actually being interviewed for the NVVRS. The results of the analysis of the interviews

concluded that there was a higher reported incidence of problems in families of Vietnam veterans with PTSD, compared to a lower reported incidence of problems in families of Vietnam veterans who did not have PTSD. Additionally, spouses or partners of veterans with PTSD reported less relational satisfaction, decreased overall happiness, and more overall stress than spouses or partners of non-PTSD veterans. These problems seem to be typical of veterans with PTSD (Kulka et al., 1990).

The continued investigations of combat stress impact led to the development of a “point system” by military personnel for soldiers to accumulate a certain amount of points to earn leave to return home. During the Vietnam War (Kormos, 1978), the “point system” was termed “date of expected return from overseas” (DEROS). DEROS guaranteed that combat soldiers could leave the war after serving 12 or 13 months (depending on their rank), irrespective of the presence of physical or psychological issues. DEROS was also thought to lower the incidence of psychological problems and reduce the onset of symptoms. Unfortunately, DEROS presented disadvantages to the war because individual soldiers began to view their tours as individual periods of service, based on when the individual soldier arrived at the combat zone and returned home. Therefore, military unit cohesion and networks of support suffered, which was important for unit survival during such a difficult time (Kormos, 1978).

There were other factors that contributed to the horrific nature of the Vietnam War. One of these factors was that the enemy was unrecognizable. Unlike in World War II, uniforms were seldom worn by the enemy, resulting in numerous deaths of women and children combatants by the American troops. Attacks were made in various areas because there was no delineation for grounds of attack. Therefore, with no delineation of territories and unrecognizable enemies, the war forced American troops to fight for their own lives. At the conclusion of the soldiers’ tour,

they fantasized about returning home. The excitement involved with returning home often temporarily suppressed any psychological symptoms (Goodwin, 1980). Shatan (1978) noted that many veterans began to notice symptoms and changes within themselves after returning home.

***Relational impact.*** Delayed stress reaction and postwar adjustment caused not only psychological problems, specifically PTSD, but also impacted marital and family relationships (Carroll, Ruger, Foy, & Donahue, 1985; Hendrix & Anelli, 1993; Hendrix, Erdmann, & Briggs, 1998; Hendrix et al., 1995; Riggs et al., 1998; Ruger, Wilson, & Waddoups, 2002; Solomon, 1988). For many families of Vietnam veterans, the traumatic experience continues in their daily lives. Many veterans and their families did not know or understand the origins of their stress reactions or how to cope with the stress reactions. More research was initiated to investigate the stress reactions and to provide implications for treatment. Investigations would continue for more than a decade before the Persian Gulf War would commence. However, current research on the long-term psychological trauma of the Vietnam War continues to be a major focus in the field of traumatic stress. This collection of research will be reviewed in a later section of this chapter.

**Persian Gulf War.** The Persian Gulf War, commonly referred to as Operation Desert Shield/Storm (ODS), was the first major war for the United States since Vietnam. It commenced in January 1991 and ended in April 1991 (Infoplease, 2006). Jamil, Nassar-McMillan, and Lambert (2004) mentioned that socially and politically Americans believe that this war was primarily fought by American troops in collaboration with Kuwait against Iraq. ODS was perceived by American citizens as a short-lived, successful, 100-hour war with minimal physical and psychiatric casualties. However, ODS presented significant stress on the veterans and their families due to separation and the dangerous conditions of war (Scurfield, 1992). ODS troops

were exposed to and involved in numerous atrocities, such as dead bodies surrounding military equipment after military operational activities; repeated findings of dead civilians; accidental explosions of undetonated mines; visual physical disabilities among military and civilians; and estimated thousands of malnourished and/or ill children. These experiences have resulted in negative psychological problems, such as PTSD (Barrett et al., 2002), depression, and anxiety (Jamil et al., 2004; Iowa Persian Gulf Study Group, 1997). Scurfield (1992) noted that the PTSD symptoms were not nearly as prevalent in ODS veterans as found among the Vietnam veterans.

***Psychological impact.*** Acute traumatic stress reaction was found among 55 of the first 328 Persian Gulf soldiers upon returning from deployment in the Gulf War (Department of Veterans' Affairs, 1991). Ten of the first 328 soldiers exhibited psychological problems (Department of Veterans' Affairs, 1991) and other soldiers returned with various complaints. The "Gulf War Syndrome," described by ambiguous health-related illnesses, has been reported by ODS veterans. These symptoms include: headaches, pain in joints, exhaustion, problems with memory, chronic fatigue, skin rashes, unusual hair loss, neurologic signs or symptoms (nervous system disorders which could cause numbness in one's arm), upper or lower respiratory system signs, sleep disturbances, gastrointestinal signs or symptoms (including recurrent diarrhea and constipation), cardiovascular signs or symptoms, menstrual disorders in females, and the inability to concentrate (Doebbeling et al., 2000, p. 695). Unfortunately, there is no single diagnosis for these symptoms and the single diagnosis of PTSD does not explain all of the symptoms reported by ODS veterans (Department of Veterans' Affairs, 1991).

Several studies have examined the psychological symptomatology in Gulf War soldiers or veterans (Barrett et al., 2002; Black et al., 2004; Iowa Persian Gulf Study Group, 1997; Orcutt, Erickson, & Wolfe, 2004; Perconte, Wilson, Pontius, Dietrick, & Spiro, 1993; Stretch et

al., 1996; Sutker, Uddo, Brailey, & Allain, 1993). The studies revealed more PTSD symptoms (Barrett et al., 2002; Black et al., 2004; Perconte et al., 1993; Stretch et al., 1996; Sutker et al., 1993), more stress reactions, less social adjustment (Barrett et al., 2002), more depression, more comorbid cognitive dysfunction, more anxiety disorders, more substance use disorders (Black et al., 2004; Iowa Persian Gulf Study Group, 1997), more anxiety, and more sexual discomfort (Iowa Persian Gulf Study Group, 1997).

The increased PTSD, increased stress reaction, and decreased social adjustment symptomatology are consistent with the results of Vietnam veterans (Barrett et al., 2002). The results of these studies revealed that the occurrence of psychological symptoms increased due to the war-zone stress. Of 215 activated, deployed Army National Guard and Army Reserve troops of ODS and 60 activated, non-deployed troops, the levels of distress presented in 16-24% of the troops. Of the deployed troops, 19% met the criteria for PTSD, while symptoms were less frequent in the activated, non-deployed ODS troops (Sutker et al., 1993). The authors failed to mention the actual percentage rate of symptoms in the activated, non-deployed ODS veterans in this study, as ODS deployed veterans' symptomatology was the focus of the study (Sutker et al., 1993).

Five years postwar, Black et al. (2004) examined the psychological impact of the Gulf War in 602 military veterans deployed and non-deployed veterans who served as regular active military, activated National Guard, or activated U.S. Reserve during the Gulf War. The results of their study were similar to the results from a study by the Iowa Persian Gulf Study Group (1997). The results of both studies revealed a higher incidence of depression, comorbid cognitive dysfunction, anxiety disorders, PTSD, and substance use disorders in deployed soldiers. The results of Black et al. (2004) revealed that 192 (32%) of the veterans interviewed met the criteria

for depression. The rate of lifetime depression was higher in non-deployed veterans (36.6%) than deployed veterans (30.3%). However, deployed veterans who met the diagnostic criteria for depression had greater lifetime rates of comorbid cognitive dysfunction (55% vs. 35%), anxiety disorders (59% vs. 33%), PTSD (33% vs. 10%), and substance use disorders (70% vs. 52%) than non-deployed veterans. The majority of the deployed veterans who reported depression symptoms were male and members of the Army (77.2%).

Similar results were also found in a study by Perconte et al. (1993) and a study by Stretch et al. (1996). Perconte et al. (1993) examined 591 Gulf War reservists of the Army, Navy, and Marines for psychological distress. The combat-deployed reservists experienced a higher level of psychological symptoms than non-deployed reservists. Stretch et al. (1996) investigated active duty and reserve ODS veterans from Pennsylvania and Hawaii for the prevalence of PTSD symptoms. The sample included 1,524 deployed and 2,727 non-deployed veterans. The findings indicated that 8% of deployed active duty veterans and 9.3% of deployed reserve veterans reported PTSD symptomatology. The prevalence rate of psychological distress among non-deployed veterans was 1.6%.

The prevalence rates of psychological symptoms may fluctuate over time. Orcutt et al. (2004) utilized growth mixture modeling, a structural equation modeling strategy, to study the course of PTSD symptoms in Gulf War veterans at three separate time periods. Employing the growth mixture modeling approach allowed the researchers to assess if a change in PTSD symptoms is due to one or more growth curves. The sample included 2,949 subjects at time 1, 2,313 subjects at time 2, and 1,327 subjects at time 3. The original 2,949 subjects participating in Time 1 were veterans returning from the Gulf War in 1991. The original sample was contacted to participate in Time 2 (1993-94) and in Time 3 (1997-98) via mail. Not all of original cohort

participated in Time 2 and 3. The results revealed that there were two significant growth curves: (1) low PTSD symptomatology with little increase across time and (2) high PTSD symptomatology with greater increase across time. Therefore, the researchers concluded from the data that the effects or reactions to the Gulf War were not “homogeneous” (Orcutt et al., 2004, p.198).

The effects of war are often minimized by veterans and the military to repress the possible occurrence of war-related stress and/or psychological reactions to their war experiences. Veterans minimize and repress their reactions to war experiences in an effort to avoid revisiting traumatic memories due to the supporting myth behind these behaviors for many veterans of many wars, which is “that heroes do not or should not have any problems” (Scurfield, 1992, p. 506). Therefore, this commonly perceived myth lessens the likelihood of veterans and their families seeking help at the onset of symptoms. Many believe the saying that “time heals all wounds.” Given the effects of the Gulf War and the Vietnam War, mental health and traumatic stress reactions will likely remain a significant area of study, with additional cases from the present war.

**Operation Enduring Freedom and Operation Iraqi Freedom.** United States military personnel have been involved in major ground combat or security duties in Iraq and Afghanistan since March of 2003. Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq are the first ongoing ground combat initiatives by the United States since the Vietnam War (Infoplease, 2006). After the attacks on the World Trade Center and Pentagon on September 11, 2001, national security was violated and discussions of military action began. The United States government accused Iraq of ignoring the terms of the 1991 cease-fire by producing and possessing weapons of mass destruction that could support continued terrorism.

The war began on March 19, 2003, with an airstrike against Saddam Hussein and the Iraqi leadership (Infoplease, 2006).

Over 1.6 million troops have been deployed to OEF/OIF (Batten & Pollack, 2008) with over 30,000 U.S. soldiers injured and over 4,000 deaths (Sammons & Batten, 2008). The state of mental health for returning military members from Iraq and Afghanistan is at high risk based on previous research outcomes of past combat military deployments that indicated an increase in mental health effects. Additionally, the inability to distinguish the enemy from civilians, use of improvised explosive devices, and the absence of a “front line of combat operations” further compromises the mental health of returning military soldiers (Sammons & Batten, 2008, p.922). The three most common mental health problems of the OEF/OIF veterans include symptoms of PTSD, substance abuse (including tobacco abuse), and depression (Veterans Health Administration Office of Public Health and Environmental Hazards, 2008).

The noticeable difference in reviewing and comparing each war is having the knowledge and understanding of the psychological impact of war on soldiers, particularly PTSD symptoms, due to pre and post war assessments.

***Psychological impact.*** A few empirical studies have been published to investigate the impact of OEF/OIF on soldiers (Daly, Doyle, Radkind, Raskind, & Daniels, 2005; Gondusky & Reiter, 2005; Hoge et al., 2004; Hoge et al., 2006; McNulty, 2005; Nelson Goff et al., 2007; Ruble et al., 2005). This research reveals that war-related stress and combat duty results in psychological problems, such as PTSD, major depression, substance abuse, impaired social functioning, inability to work, and an increased use of health care resources in OEF/OIF soldiers (Hoge et al., 2004). McNulty (2005) and Nelson Goff et al. (2007) noted that OEF/OIF

deployment also results in family and marital stress. Additionally, Daly et al. (2005) reported that recurrent nightmares are a common symptom of OIF combat soldiers.

Psychological distress was also investigated by Hoge et al. (2004) using a cross-sectional design examining male and female military personnel from three Army units and one Marine Corps unit to study the prevalence of mental health problems before and after deployment to Iraq and Afghanistan. The Marine Corps unit did not participate in the predeployment phase of data collection. The sample included 2,530 military personnel before their deployment and 3,671 military personnel after their deployment.

Significantly more soldiers were exposed to combat in Iraq than those who were deployed to Afghanistan (Hoge et al., 2004). The participants whose ratings revealed symptoms on the screening assessments yielded a higher percentage (15.6 - 17.1%) of symptoms after the deployment to Iraq than after deployment to Afghanistan (11.2%). A recent population-based, descriptive study by Hoge et al. (2006) revealed the rates of symptomatology also were higher before deployment to Iraq (9.3%). The study revealed that after returning from deployment, 35% of the soldiers and Marines utilized mental health care services with 12% diagnosed with a mental health illness. More soldiers and Marines reported having mental health issues after deployment to OIF (19.1%) than OEF (11.3%) and other locations (8.5%). In both studies (Hoge et al., 2004; Hoge et al., 2006), the greatest difference was found in the rates of PTSD. There was a strong correlation between exposure to combat and the occurrence of PTSD symptoms for all groups after deployment. Hoge et al. (2004) reported that of the participants who met the criteria for a mental disorder, only 23- 40% made the decision to seek mental health care. The participants reported not wanting to seek mental health care because of their concern about others' (e.g., peers) perceptions of them and other barriers, such as lack of trust in mental health

professionals, no transportation to mental health facilities, mental health care costs, fear of mental health issues negatively affecting their career, and fear of being seen as weak.

Of active duty military service members assessed for having mental health problems, 18.4% scored positively for mental health issues in comparison with 21% of National Guard service members and 20.8% of Reserve service members (Hoge et al., 2006). By gender there was a small difference with 23.6% of women and 18.6% of men reporting mental health problems (Hoge et al., 2006). In addition to mental health problems, 17,364 (79.6%) of the 21,822 OIF soldiers and Marines reported direct engagement with weapons or witnessing others being wounded or killed. According to Gondusky and Reiter (2005), of the 120 injured Marines sampled in their study, there were a total of 32 attacks resulting in 188 injuries to various body parts, including upper body parts such as arms, hands, wrists, shoulders, head, and ears and lower body parts such as legs and ankles. The upper body parts accounted for 70% of the injuries, whereas the lower body accounted for only 11% of the injuries. These researchers did not elaborate on the psychological dimensions of combat-related injuries; however, it is important to be aware of the psychological impact due to the stress that an injury may cause for the soldiers and their families.

***Relational impact.*** The psychological impact for the injured soldiers and their families is often exhibited through isolation, depression, relational distress, adjustment issues, dysphoria, and anxiety issues (Beckham, Lytle, & Feldman, 1996; Brown, 1984; Monson & Taft, 2005). The combat-related injury and mental stressors may have a psychological impact on the family as they adapt not only to the soldier's return, but also to his/her injury. For instance, an injured soldier returning home from deployment may face various stressors due to his/her injury/impairment affecting his/her ability to transition back into various relational systems. The

various stressors may include the inability to reclaim past roles in their relational systems, a change in job duties, delay in receiving promotion within their unit, and a change in plans within their relational system. Despite the significant rate of psychological impact and physical injuries for the soldiers and their families upon returning from deployment, challenges continue to exist, such as utilizing mental health care services, eliminating barriers to treatment, guaranteeing sufficient mental health resources, and meeting the general health care needs of the returning service members.

Nelson Goff et al. (2007) studied the impact of individual trauma symptoms of 45 OIF/OEF deployed soldiers and their partners on relationship satisfaction. The findings indicated that the increased individual trauma symptoms (such as sleep disturbances, dissociation, and severe sexual problems) of male soldiers resulted in lower relationship satisfaction for both soldier and spouse/partner. Hence, these results suggest that interpersonal/systemic functioning is affected by trauma. The OEF/OIF deployment experience was identified by 82% of the soldiers as their most traumatic experience, while 24% of their female spouses/partners rated their husband's deployment as their most traumatic experience. Prior to this study, no empirical research had been conducted with OEF/OIF soldiers to review the impact of trauma on relationships and relationship satisfaction. Nelson Goff et al. (2007) strongly support the rationale for the current research study to further explore the impact of deployment on relationships.

### **Summary of War Experiences**

In summary, this historical review of war trauma supports the long history of its impact on health and functioning of military soldiers. Each war era contributed to American history, in both positive and negative ways, with some similarities and differences. World War II was a

more traditional war, in that it was a battle over tyranny and dictators, while the Vietnam War began was a war for territory and later became a war focused on daily body count. The Vietnam War did not receive the American public support that World War II received. Additionally, Vietnam veterans have been found to have the poorest mental health, overall functioning, and well-being, faring much worse than veterans of any other war era (Villa, Harada, Washington, & Damron-Rodriguez, 2002).

The Persian Gulf War received a considerable amount of praise and sense of achievement with U.S. citizens glorifying the conflict, contrasted with the American reaction to the Vietnam War. Other distinctive differences of the Persian Gulf War were the brief length of the war and the fear of biological and chemical warfare that was not as much a part of past wars (Lehman, 1993).

The wars in Afghanistan and Iraq (OEF/OIF), the nation's most current and on-going war, is a war that has received much attention across the world. The OEF/OIF War has a limited number of published research articles to date. However, this war has involved soldiers in extended/prolonged major combat deployments with repeated deployment tours and complex missions in harsh environments. OEF/OIF is similar to the Vietnam War and Persian Gulf War in terms of the major combat exposure, but with the absence of a front line (Hoge et al., 2004). Additionally, although there are some areas of dissent, soldiers of the current war are generally supported by the American citizens, often receiving welcome home celebrations upon returning from deployment. The notable contrast between the OEF/OIF war and preceding wars is that the American citizens and citizens of other countries are supporting the troops for their hard work and dedication, regardless of their position for or against the war.

This chronological review provides a brief summary of the wars and the many similarities, as well as differences that are shared by each. Since the Vietnam War, the subsequent wars have received increased national attention due to technological advances. Video footage displayed on television, internet, and newspapers have provided spouses/partners and other family members in the U.S. with images that may trigger psychological distress, also referred to as war-related stress (Hobfoll et al., 1991). The historical review of the impact of war on soldiers described some of the common symptoms of psychological distress that have been reported by a number of soldiers or veterans, which will be described next.

### **Specific Symptoms of War-Related Trauma on Soldiers/Veterans**

One of the most common symptoms related to war-exposure, PTSD, has been reviewed. Additional symptoms of war-related traumatic stress response include sleep disturbances, nightmares, intrusive thoughts and memories, flashbacks, depression, anxiety, isolation, and anger issues (Brown, 1984; Hoge et al., 2004; Hoge et al., 2006; Hunt & Robbins, 2001; Iowa Persian Gulf Study Group, 1997; Nelson Goff et al., 2007; Thorp & Stein, 2005; Woodward, 2004). Many veterans experienced these symptoms before and after PTSD were defined, when there was no known relation between the impact of war and their concurrent symptoms. Therefore, these symptoms experienced by veterans were often not reported or treated. For the following review, the PTSD symptoms are classified in three key categories (APA, 2000): re-experiencing (e.g., flashbacks, intrusive thoughts and memories), avoidance (e.g., loss of interest, isolation from others), and arousal (e.g., anger outbursts, startle response).

**Re-experiencing symptoms.** Re-experiencing symptoms include various types of intrusion, such as sleep disturbances, nightmares, intrusive memories, and thoughts of the traumatic event as if the event is reoccurring again (APA, 2000). The veteran is powerless over

the re-experiencing (Solomon, 1988). Many veterans have reported having less control over their memories and thoughts of the war. This lack of control has resulted in poor coping, such as self-blame and isolation (Fairbank, Hansen, & Fitterling, 1991).

***Sleep disturbances.*** Sleep disturbances or nightmares have been reported by many combat veterans (Brown, 1984; Iowa Persian Gulf Study Group, 1997; Nelson Goff et al., 2007; Ross & Wonders, 1993; Shehan, 1987; Southwick et al., 1995; Woodward, 2004). Veterans report difficulty getting to sleep and remaining asleep due to having nightmares of past war events. Recurrent dreams, flashbacks, intrusive thoughts, and memories of combat experiences disrupt the ability to sleep. Flashbacks and intrusive thoughts can be provoked by other harmless stimuli, such as fireworks or a fire alarm, as these triggers serve as reminders of noises experienced in the war-zone. Woodward (2004) reported that the assessment and treatment of PTSD-related sleep disturbances is a “continuing evolution,” noting that new clinical research is investigating the relation between fear and sleep systems in the human brain. War combat involves difficult, life-threatening situations, which may cause fear. A Vietnam soldier described his recurring nightmares (Ketwig, 1985, pp. 295-296):

I dream I am leaning over the bed to kiss a forehead goodnight, and there is a stir,  
and a beautiful, trusting face has been transformed into the bubbled, flaking,  
disfigured black horror of the kid I once saw in the hospital.

***Intrusive memories.*** An estimated 20% of Vietnam combat veterans meet PTSD diagnostic criteria, with 50% experiencing difficulty with past disturbing war memories. The memories manifested over the years impact everyday life (Egendorf, 1982). These memories, also referred to as intrusive thoughts and flashbacks, can be provoked in everyday life by inoffensive stimuli, such as a car back-firing or a helicopter flying nearby. For example, a car

back-firing at night outside the home of a soldier that has been deployed might be reminder of the sounds of war, which may lead to other flashbacks or nightmares. These sights or sounds may remind the veterans of the sights and sounds of war, allowing them to have flashbacks (intrusive memories or thoughts) of their past experiences. The intrusive memories can lead the veteran to be preoccupied with self, which results in isolation and avoidance (Dent et al., 1998; Riggs et al., 1998).

**Avoidance symptoms.** Avoidance symptoms are characterized by isolation, loss of interest in activities, and emotional withdrawal or detachment (APA, 2000). Trauma survivors use avoidance symptoms as a way to cope with their traumatic experience often by disengaging with others. Avoidance of people and situations has been used by trauma survivors as a way to survive traumatic situations, such as survival of military combat (Brown, 1984).

**Isolation.** Trauma survivors often report feeling alone, isolated, detached, and emotionally numb due to their traumatic experiences. Egendorf, Kaduschin, Laufer, Rothbart, and Sloan (1981) revealed that Vietnam combat veterans reported more isolation than veterans from any previous war. Carroll, Rueger, Foy, and Donahue (1985) reported Vietnam veterans had “constricted responsiveness” and less interaction (isolation) with others in general (p.336). Similarly, Carroll, Foy, Cannon, and Zweir (1991) reported that Vietnam combat veterans avoided discussing emotional subjects that contributed to relational problems, sometimes resulting in divorce (Ruscio, Weathers, King, & King, 2002).

Solomon, Dekel, and Zerach et al. (2008) studied the PTSD key symptom categories and reported that a significant amount of ex-prisoners-of-war indicated suffering from avoidance symptoms, such as isolation, avoiding emotional discussions, and emotional numbing. The results of this same study also revealed a correlation between avoidance and intimacy.

Avoidance affects the levels of intimacy and decreases the trauma survivors' desire to share their thoughts, which leads to emotional numbing (Solomon et al., 2008).

**Arousal symptoms.** Arousal symptoms are characterized by difficulty with concentration, startle response, irritability, and hypervigilance (APA, 2000). Arousal symptoms can lead to problems with anxiety and anger, which are common PTSD symptoms in veterans (Riggs et al., 1998). Soldiers may return from war experiencing symptoms of arousal in day-to-day living with some difficulty adjusting to civilian living. These symptoms can be damaging after enduring a traumatic event, particularly in marital relationships due to the increase in marital conflict (Dent et al., 1998; Riggs et al., 1998). Researchers have provided empirical findings of this sub-category of PTSD symptoms to be correlated with decreased intimacy and marital adjustment in both partners post-deployment (Jordan et al., 1992; Solomon et al., 1992).

**Anxiety.** As mentioned, anxiety has been a common complaint of veterans. Anxiety and depression, which can lead to social isolation, have both been observed in many veterans after returning from deployment to Iraq and Afghanistan and other deployments (Hoge et al., 2006; Iowa Persian Gulf Study Group, 1997; West & Weeks, 2006) with postdeployment rates of OIF = 7.9% and OEF = 7.4% (Hoge et al., 2004). Veterans may return to their civilian life and experience difficulty in participating in social gatherings or interpersonal relationships due to their anxiety (Brown, 1984).

**Anger.** Anger is another common complaint associated with many veterans after returning from war deployment (Novaco & Chemtob, 2002). Anger often results in veterans isolating themselves from others because they feel that they cannot control their emotions (Knight, Keane, Fairbank, Caddell, & Zimmering, 1984; Van der Kolk, Boyd, Krystal, & Greenberg, 1984). Anger has also been reported as a major concern of combat veterans in

epidemiological studies (Kulka et al., 1990; Laufer et al., 1981). Combat veterans often report higher levels of anger and hostility than nonveterans and soldiers who did not experience combat (Novaco & Chemtob, 2002). Vietnam combat veterans were reportedly involved in more violent arguments, had more violent dreams, and fewer close relationships than veterans who were not involved in combat (DeFazio, Rustin, & Diamond, 1975). Increased irritability and anger outbursts often coexist (Solomon et al., 2008), which contributes to fewer close relationships and marital intimacy problems (Mills & Turnbull, 2004). Additionally, antisocial behaviors may develop as a result of the soldiers being trained to think of combative solutions to problems (Gimbel & Booth, 1994).

Novaco and Chemtob (2002) viewed the relationship between anger and PTSD “as a result of trauma,” explaining that “anger occurs as part of a dyscontrol syndrome activated by threat sensing” (p. 125). “The engagement of anger in PTSD involves hostile appraisal, heightened arousal, and antagonistic behavior as ‘survival mode’ responding in contextually inappropriate conditions, whereby the person becomes dysregulated in reacting to the demands of the environment” (Novaco & Chemtob, 2002, p. 125). These thoughts prompted the authors to examine 143 male Vietnam combat veterans to investigate the correlation between anger and combat-related PTSD. The overall conclusion indicated that anger is a key component of combat-related PTSD.

### **Other Symptoms**

**Depression.** While anxiety and anger have been common symptoms of war-related traumatic stress, many veterans experience symptoms of depression. The following is a quote describing an OIF/OEF veteran’s experience of depression: “At times, she couldn’t summon any emotion at all, while at other times she would become upset for no reason” (Kersten & Nicastro,

2005, p. 1). Black et al. (2004) noted that depression is likely to be seen in deployed Gulf War military veterans. Black and colleagues' revealed that 192 of 602 (32%) Gulf War veterans met the diagnostic criteria for depression. In another study, Hoge et al. (2004) reported that the prevalence rate of depression was significantly higher (15.6 -17.1 %) in deployed military personnel after returning from duty in Iraq than after returning from Afghanistan (11.2 %). The higher prevalence of depression in soldiers deployed to Iraq was reportedly due to more combat exposure. A recent study by West and Weeks (2006) concluded that higher levels of depression and anxiety were found in younger patients seeking services at Veterans Affairs centers than in older patients.

In summary, the three key PTSD symptom categories (re-experiencing, arousal, and avoidance) and symptoms of depression characterize the psychological impact of trauma in soldiers or veterans. These symptoms are commonly reported not only in soldiers or veterans, but in others close to the trauma survivors during and after war-related deployments. The levels of functioning due to the effects of these symptoms in soldiers or veterans range in severity and often result in re-experiencing, arousal, and avoidance behaviors. In order to understand and conceptualize the impact of war on the psychological well-being, health, and/or functioning of those involved and their spouses/partners, the three stages of deployment separation will be reviewed next followed by a review of the literature on couple/family systems and war trauma.

### **Deployment Separation Stages**

Deployment separation is an inherent aspect of military life. In recent years, the possibility that a soldier will serve in a deployment has significantly increased. Deployments may be as short as one month or as long as one year depending on the nature of the military duty (i.e., specialized training, overseas peacekeeping or military warfare) and may be extended due

to ongoing warfare (Blount, Curry, & Lubin, 1992). Deployment can be stressful for individuals, couples, and families. The separation presents the majority of the stressors resulting in psychological, behavioral, and physical problems within the military couple and/or family system. Military spouses or partners often are left to assume sole responsibility of daily tasks and activities (Albano, 1994). Military-related separations often involve decreased emotional support, distant relationships, and increased responsibilities for childcare and the household (Kelley, 1994).

Deployment separation for spouses or partners can be considered to have three stages: (1) pre-deployment, (2) survival, and (3) reunion (Blount et al., 1992; Figley, 1993; Rotter & Boveja, 1999; Ursano & Norwood, 1996). The pre-deployment stage entails the initial notification of deployment, concluding with the separation of the spouse/partner and soldier (Blount et al., 1992). This stage marks the onset of anxiety and stress. The survival stage often consists of role shifts, adjustment issues, disruption of daily routines and schedules, difficulty planning for the future, learning new skills, social and emotional changes, parenting difficulties, and the onset of depressive symptoms (Blount et al., 1992; Rotter & Boveja, 1999).

Psychological and behavioral problems may begin to occur in this stage due to the intensity of stress related to the separation, anxiety, and fear of the soldier's survival and safe return (Figley, 1993). During the survival stage, a study by Rohall et al. (1999) revealed that support from personal (i.e., higher income, higher rank, and more experience in family separation) and organizational resources (i.e., higher levels of morale, perceived leader support, and satisfaction with resources to communicate home) can improve or lessen the effects of family separation due to deployment. The reunion stage is the final, most anticipated stage of deployment separation. This stage includes the happiness of reunion, reintegration of a spouse or partner, the strain of

recovery from deployment-related experiences, possible changes in family and society, and role negotiation and/or dyadic adjustment issues (Blount et al., 1992). After reunion, some issues may resurface and there may be grievances, arguments, and conflicts relevant to the separation and reintegration. The manner in which families are impacted by separation and reintegration will be referred to as systemic impact.

War involves physical separation of loved ones, broken daily routines, and anxiety surrounding the return of the soldier, each of which can seriously impact marital relationships (Figley, 1993; Laufer & Gallops, 1985). The marital relationship may endure many stressors throughout life, including war, which may result in physical and emotional disorders in each partner. Laufer and Gallops (1985) noted that military service during wartime can result in unexpected interruption in both civilian and domestic life, such as an interruption or delay of marriage. A notable negative effect of military deployment mentioned by Laufer and Gallops (1985) is readjustment. The authors reported that the spouse left behind may have to make adjustments due to the loss of partnership, which may not be reversed upon the soldier's return. Incidences such as this may disrupt the marriage and/or cause relational problems. Much of the literature has described the increased self-reliance and independence resulting from having to live in other countries and role shifting of the spouse or partner during the military separation from their soldier (Bell & Schumm, 1998; Blount et al., 1992; Figley, 1993; Hobfoll et al., 1991; Kelly et al., 1994; Laufer & Gallops, 1985; Solomon, Waysman, Levy, et al., 1992), which provides support for the discussion of the systemic impact of war-related trauma.

### **Systemic Impact of War-Related Trauma**

The effects of war-related trauma on soldiers and their spouses or partners have been a subject of focus for many years, but empirical research is limited. Much of the empirical research

has been preoccupied with the individual psychological health of the soldier/veteran giving limited attention to the psychological health of the spouse or partner of the soldier/veteran (Nelson & Wright, 1996; Solomon, Waysman, Belkin et al., 1992; Solomon, Waysman, Levy, et al., 1992). Current literature suggests that war-related trauma may be experienced individually, as well as systemically. Including individuals close to a trauma survivor and viewing the whole family system to understand the experiences of one member describe the basic principles of family systems theory (White & Klein, 2002) and the concept of a “secondary traumatization” (Figley, 1983, p. 12). Family systems theory focuses on relationships and the interaction patterns of those relationships. This theory seeks to emphasize reciprocity, recursiveness, and shared responsibility of an interaction instead of linear causality. Individuals are viewed in the context of mutual interaction and influence within the whole system (Becvar & Becvar, 1996; White & Klein, 2002). Secondary trauma refers to others close to the traumatized victim who become indirect victims of the trauma after experiencing significant emotional or mental distress themselves.

**Spouse or partner symptoms.** The individual symptoms, particularly PTSD symptoms, reported by trauma survivors, such as anger, isolation, sleep disturbances, and intrusive thoughts and memories, often affect the spouse or partner (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Nelson & Wright, 1996; Shehan, 1987). Research studies have revealed that the spouses or partners of veterans, particularly veterans with PTSD, are often chronically distressed during and after deployment (Hendrix et al., 1998; Rohall et al., 1999; Shehan, 1987; Solomon, 1988; Solomon, Waysman, Avitzur, & Enoch, 1991; Solomon, Waysman, Belkin, et al., 1992; Solomon, Waysman, Levy, et al., 1992; Verbosky & Ryan, 1988). In fact, many wives reported feeling “overwhelmed, helpless, hopeless, depressed, anxious, guilty, worthless, hurt, rejected, or

angry” (Solomon, Waysman, Levy, et al., 1992, p. 291). In a recent qualitative study by Schwerdtfeger et al. (2008) trauma survivors reported feeling anxious much of the time, while partners reported being careful of what they say and do. One trauma survivor shared feeling “nervous inside most of the time” (Schwerdtfeger et al., 2008, p. 196). These descriptions are very similar to those of the veterans during and after deployment.

Other commonly reported feelings and thoughts of spouses of veterans included: feeling that their relationship is in a crisis, grief about their dysfunctional relationship, disruption in achievement of relational goals, feeling overprotected and ostracized from the external world by the veteran, and loss of assertion and confidence (Brown, 1984; Dent et al., 1998; Shehan, 1987). One spouse shared being cautious about firearms due to her husband sleeping with a loaded gun under his pillow nightly (Brown, 1984). The spouse stated that in an effort to be cautious and gain some sense of comfort for herself and her husband, they slept with the light on in case their child entered their room at night causing the husband to mistake their child as an intruder or enemy and shooting the child.

This example is similar to the author’s personal experience of living with her father, a Vietnam veteran diagnosed with PTSD, recalling memories of episodes of frustration, anger, disorientation if awakened suddenly, confusion, avoidance, and isolation for periods of time. On one occasion, he was awakened from sleep and rushed to the closet to get a gun. After experiencing episodes such as these, spouses or partners may begin to experience their own increased somatic and psychological symptoms (Dent et al., 1998; Solomon, 1988; Solomon, Waysman, Levy, et al., 1992), which are consistent with the reports of increased levels of stress reported by spouses (Shehan, 1987; Solomon, 1988; Rosenheck & Thomson, 1986; Verbosky & Ryan, 1988). Renshaw, Rodrigues, and Jones (2008) conducted a study with soldiers and their

spouses upon return from Iraq and revealed that the spouses' perceptions of their soldiers' symptoms were positively related to their own symptoms, even when the soldiers indicated having low levels of symptom severity. For example, if the spouse perceived a higher level of symptom severity in the soldiers, the spouses reported having higher levels of symptom severity, too. Thus, the experiences of the spouses seemed to be related to the soldiers' symptom levels. However, the strikingly opposing result of this study when compared to previous studies was when the spouses perceived the soldier to have an increase in PTSD symptom severity, the soldiers' report of their own PTSD symptoms became negatively related with the spouses' PTSD symptom severity. Spouses reported having the greatest distress when they perceived their soldier to have increased symptom severity, while the soldiers fail to acknowledge any symptoms or problems.

Therefore, reviewing the characteristics of spouses and partners of veterans may be helpful in understanding the response to veterans' PTSD. Nelson and Wright (1996) focused on the characteristics and experiences of the spouses or partners of veterans with PTSD. The four primary characteristics presented were caretaking, gender roles, survivor skills, and psychological symptoms. Caretaking has been found to be an assumed role of most spouses or partners of PTSD veterans and occurs in response to the veterans' PTSD. Thus, caretaking is symptomatic of the PTSD diagnosis in veterans for the spouses or partners, which creates interpersonal problems, such as "coping with the veteran's PTSD symptoms, unmet needs of female partners, violence, and emotional abuse" (Nelson & Wright, 1996, p. 457). Survivor skills are often learned and implemented daily by spouses or partners to effectively cope and manage living with the veterans' PTSD. Psychological symptoms refer to findings that revealed that the spouses or partners and veterans both have comparable symptoms of PTSD, such as

somatization, depression, anxiety, hostility, obsessive-compulsive issues, paranoid ideation, and social isolation (Solomon, Waysman, Belkin, et al., 1992). Each of these primary characteristics illustrates the concept of secondary trauma.

Additionally, Dekel and Monson (2010) reviewed existing literature to broaden the understanding of PTSD and its impact on families. They reviewed several constructs and models including: secondary traumatization (Rosenheck & Nathan, 1985), vicarious traumatization (McCann & Pearlman, 1990), ambiguous loss, caregiver burden, CATS model, and cognitive-behavioral interpersonal model. Their findings support the relationship between PTSD and family functioning and highlighted that PTSD has “multi-directional” effects on families, as it can be transmitted in multiple directions between family members, including spouses (Dekel & Monson, 2010).

Other studies have been conducted to examine the existence of secondary traumatic stress in spouses of veterans. Secondary traumatization was investigated in Dutch couples of World War II veterans by Bramsen, van der Ploeg, and Twisk (2002). The authors hypothesized that symptoms of PTSD may be present in either spouse due to war experiences. The results of 444 couples participating in the study revealed that the number of war-related events and the level of PTSD symptoms reported by the veteran were the most significant predictors of PTSD symptoms in the spouse. A similar finding was reported in a study of 708 partners and 332 parents of Dutch peacekeeping soldiers experiencing secondary traumatization (Dirkzwager, Bramsen, Ader, and van der Ploeg, 2005). Their results revealed that partners of peacekeepers with PTSD symptoms experienced more sleeping and somatic problems, more negative levels of social support, and less satisfaction with the marital relationship. The authors concluded that

spouses of peacekeeping soldiers would likely be affected by the stress reactions of the soldier with PTSD (Dirkzwager et al., 2005).

Responses to Dirkzwager et al.'s (2005) article by Fals-Stewart and Kelley (2005) and Figley (2005) discussed the significance of the effects of deployment on spouses/ partners. Fals-Stewart and Kelley noted that it was the partners, instead of the parents, that were found to be most affected by the peacekeepers' traumatic stress (2005). This suggests a qualitative difference about intimate partner relationships, such as the vulnerability that is present in couple relationships that may not be as present in parent-child relationships because the partners are the main source of support once the deployed peacekeepers return home (Fals-Stewart & Kelley, 2005). Taft, Schumm, Panozio, and Proctor (2008) reported that higher combat exposure resulted in higher PTSD symptoms and poorer family adjustment, which supports the idea that the family is affected. Riggs et al., (1998) reported that more than 70% of Vietnam veterans with PTSD and their partners indicated significant relational distress, while only 30% of non-PTSD couples indicated significant relational distress.

Figley (2005) shared a statement from an interview conducted with an army wife about the adverse effects of the Iraqi war on her and her husband. The army wife stated, "he brought the war home like an STD. He did not mean to, but knows he never had these problems before the war, and now we both have problems" (Figley, 2005, p. 227). Figley mentioned that statements similar to this are common for many spouses or partners of combat veterans and noted that Dirkzwager et al.'s research (2005) was a "wake-up call" or a "reawakening for the veterans and their families". Figley concluded his commentary by utilizing the principles of systems theory, which proposed that the disturbances of one member of a system will have repercussions on the other members of the system.

**Relational issues.** Nelson Goff et al. (2007) analyzed the effects of individual trauma symptoms of OIF/OEF soldiers who recently returned from deployment and found that the soldiers' trauma symptoms significantly predicted lower marital satisfaction for both the soldier and his or her spouse/partner. An interesting finding by Renshaw et al. (2008) revealed that the wives' level of marital satisfaction seemed to primarily be based on her perception of the soldiers' PTSD symptoms. They concluded that higher levels of combat exposure are related to higher levels of marital satisfaction. Thus, the levels of marital satisfaction may help to determine if relational issues develop.

The relational issues seem to occur with the incidence of secondary traumatic stress in female partners. However, secondary traumatic stress in female partners is an area of research that has not been examined until recently. Nelson Goff, Crow, Reisbig, and Hamilton (2009) investigated the impact of OIF/OEF Army soldiers ( $n=45$ ) and the individual symptoms on their female partners. The results of the study indicated that the soldiers' trauma symptoms did significantly predict trauma symptoms of their female partners. These results support the theory of secondary traumatic stress. Relational conflict, impaired communication, lack of trust, issues of interpersonal control, emotional and sexual intimacy problems, and antisocial behaviors (Gimbel & Booth, 1994; Nelson Goff et al., 2006) are frequently reported by trauma survivors and their spouses/partners (Solomon, Waysman, Belkin, et al., 1992). Intimacy issues may occur due to decreased cohesion and expression between partners, increased marital discord, decrease in overall marital satisfaction (Jordan et al., 1992), and increased marital violence (Carroll et al., 1985; Riggs et al., 1998). For example, a qualitative study by Nelson Goff et al. (2006) noted one participant's comments about relational distress:

Um...just that you know, there's, there's that split second where I don't know if he's [current partner] gonna hit me, I, you know, I, even though consciously I can say, 'No, he would never do that,' but subconsciously there's always that fear (Nelson Goff et al., 2006, p. 457).

Military training and the trauma of combat exposure may alter the soldiers' idea of appropriate ways of dealing with others, especially their spouse (Gimbel & Booth, 1994). Spouses or partners may become apprehensive about their partners' symptoms and try to adapt to living and coping with the symptoms. In fact, the apprehension may be a significant risk factor for interpersonal relational problems (Riggs et al., 1998).

Interpersonal problems may arise due to the combat veteran experiencing significant "psychological breakdowns during the war" known as combat stress reaction (CSR) that may affect the marital relationship (Solomon, Waysman, Belkin, et al., 1992, p. 316). CSR is considered an acute reaction that can later develop into full or partial posttraumatic stress disorder. The onset of CSR may lead to the abovementioned interpersonal problems, in which the individual trauma symptoms are exacerbated resulting in increased relational system dysfunction. For example, if the primary trauma survivor isolates him/herself after having anger outbursts and the spouse or partner withdraws and begins to ignore the trauma survivor by offering no support, there is an chance for increased relationship problems. Another example was noted in a study by Blalock Henry et al. (in press) when a participant shared his reactions to his partner's trauma by stating:

Probably just watching what I say or do. In the past, if there was a certain item or certain things that would intrude or something in like a memory, she'd let me know, what were some triggering effects so I could make sure that I didn't say

something or do something that would trigger some old memory (Blalock Henry et al., in press).

Hence, the dysfunction of the relational system, at this point, is symptomatic of the primary trauma survivor's individual symptom of isolation (Riggs et al., 1998).

To examine the effects of CSR, Solomon, Waysman, Belkin, et al. (1992) conducted a study to investigate the effects of the 1982 Lebanon War on marital relationships by examining trauma-related stress and the stress related to normal life transitions. The study revealed less marital happiness and togetherness and more conflictual patterns immediately after the war in the CSR group than in the non-CSR group. By the fourth measurement (6 years after the war), the stress levels began to dissipate. This phenomenon is similar to the "stress evaporation perspective, which posits that combat stress may cause temporary emotional distress, but that these effects fade over time" (Figley, 1978, as cited in Solomon, Waysman, Belkin, et al., 1992, p. 323). The authors suggested that marital issues may be exacerbated in times of combat stress if marriage partners are less caring and emotionally connected prior to war combat.

CSR was also investigated in a study conducted by Solomon, Waysman, Levy, et al. (1992) examining the impact of deployment-related combat trauma of 120 wives of Israeli combat veterans in a CSR group and 85 wives of Lebanon War soldiers in a non-CSR group. The results of the study revealed that CSR and PTSD were both linked to the increased psychological symptoms in wives of soldiers or veterans. Particularly, PTSD was a contributor of impaired social functioning in the wives, such as feelings of loneliness in marital and family contexts. The study's findings also support the concept of secondary traumatization.

**Relational disruption.** The impact of the on-going OEF/OIF war, particularly the impact of trauma and PTSD, has disrupted marital relationships (Riggs et al., 1998). There have been

several reports of increased divorce rates (Burgess, 2005; Jelinek, 2008; Miles, 2005; Zoroya, 2005). These rates, however, are not results of empirical research and have been refuted by the empirical research report of Karney and Crown (2007). Some reports have stated that adverse effects have resulted in higher divorce rates among active-duty soldiers (Burgess, 2005; Jelinek, 2008; Miles, 2005; Zoroya, 2005). According to Miles (2005), 10,477 divorces were granted among active-duty soldiers during the fiscal year of 2004.

Laufer and Gallops (1985) reported that Vietnam soldiers exposed to more combat have higher rates of divorce, while soldiers exposed to less combat have lower rates of divorce. Military soldiers with occupations or duties, such as combat and military police, have been found to have a higher rate of divorce averaging 66-75 % (Miles, 2005). Of Vietnam soldiers exposed to low levels of combat, 11% divorced or separated. Of those Vietnam soldiers with moderate exposure, 18% divorced or separated, and 32% of those exposed to higher levels of combat divorced or separated (Laufer & Gallops, 1985). It was reported by Jelinek (2008) of the Associated Press that the divorce rate in the military has surprisingly remained at 3.3% over the past year. Defense officials contribute this finding to the recent efforts they have rendered to support couples during deployment separation. Between October 1, 2006, and October 1, 2007, 25,000 of 755,000 married active duty military soldiers reported divorces (Jelinek, 2008). The Army has the largest number of troops in the current OEF/OIF War, for which a 3.2% divorce rate (8,748 divorces of 275,000 married soldiers) has been reported. It was noted that these rates only account for the number of divorces that have occurred, not the number of troubled marriages in which the partners are planning a divorce (Jelinek, 2008).

Reported statistics in the press and media suggest that military deployments have led to an increased number of divorces, but these statistics lack rigorous documentation. The National

Defense Research Institute analyzed significant amounts of data from the Defense Manpower Data Center (DMDC) of members of the United States Armed Forces beginning with fiscal year 1996 and concluding with the last quarter of fiscal year 2005 to investigate the effects of military service on marriage (Karney & Crown, 2007). Overall, there has been a trend in active duty military marriage increases and divorce increases. For example, as rates of marriage increased and then declined between 1999 and 2000, the divorce rate increased and declined. In 2001, the rates of marriage and divorce began to steadily increase again. Later in 2005, 3.1% of active duty military members were divorced. Undeniably, the rates of divorce have increased since the onset of OEF/OIF, but not at the higher rates reported by much of the press and media (Karney & Crown, 2007).

Systemically, war-related trauma may result in PTSD symptoms, relational difficulties, impaired communication, intimacy problems, marital conflict, and divorce. According to family systems theory, the amount of psychological stress in one part of the system (the veteran) will affect all parts of the system (the spouse/partner). Hence, current literature supports the idea of systemic traumatic stress in the relationships of veterans and their spouses/partners (Rosenheck & Nathan, 1985; Solomon et al., 1991). The issues reported by trauma survivors and their spouses/partners are significant because they support the importance of expanding the description of trauma to include the interpersonal or systemic processes that occur. The next section of the literature review will provide an overview of the theories of systemic traumatic stress.

### **Theories of Systemic Traumatic Stress**

General family systems theory informs us that the actions or experiences of one member affect the entire family system or unit (Becvar & Becvar, 1996). Therefore, family members are

mutually influenced by each other. The residual psychological symptoms of deployment separation and war trauma experienced by combat veterans will have an impact on the couple relationship. The theoretical bases for this current research study will be explained according to Family Systems Theory, Family Stress Theory (ABC-X model) (Hill, 1949), Double ABC-X model (McCubbin & Patterson, 1982), Secondary Traumatic Stress Theory (Figley, 1983), Couple Adaptation to Traumatic Stress (CATS) model (Nelson Goff & Smith, 2005), and Symbolic Interactionism (Blumer, 1986).

**Family Systems Theory.** Family systems theory primarily emerged in the 20<sup>th</sup> century based on the work of general systems theorists in the fields of biology, mathematics, and cybernetics (White & Klein, 2002). The basic premise of this theory is that the family is viewed as a system, in which all parts are interconnected and interrelated like a complex machine or biological organism (von Bertalanffy, 1968; White & Klein, 2002). Members of the family system and the environment are mutually influenced. Applying family systems theory to the study of military couples and deployment separation provides understanding beyond the individual level (Kerr, 1981). For the purpose of the current study, family systems theory will assist in conceptualizing how family systems process new information, respond, and cope with family stress specifically related to deployment, experience disruption in daily functioning, and attempt to return to homeostasis. In addition, family systems theory serves as a general theoretical paradigm that is integrated across the other theories described next.

There are a number of basic assumptions and concepts of family systems theory. The most basic assumption is derived from the cybernetic principle that all parts of a system are interconnected, which means that changes in one part of the system will bring about changes in all other parts of the system affecting the system in a recursive manner (von Bertalanffy, 1968;

White & Klein, 2002; Wiener, 1948). In the current study, the occurrence of secondary traumatic stress should be considered, because a traumatic stressor for one person in a system affects others in the system. For example, a married soldier is deployed for combat. The deployment separates the couple with the separation affecting both parties because each person endures that change.

A second basic assumption is the whole is more than the sum of its parts, suggesting that systems are not only comprised of the elements contained within them, but they are also comprised of the relatedness between those elements (Boss, 2002; White & Klein, 2002). Therefore, to understand any system, the entire system with all its parts must be considered and understood. In the current study, this assumption clearly supports the notion that a system, or the couple, must be viewed as a whole to understand how all parts are affected. For example, a couple is comprised of two people that function as one, as a couple, and when a part of that system or a part of that couple is deployed, the whole system is affected by separation and both parts must be viewed to understand how the whole system is affected.

A third basic assumption is that a “system’s behavior affects its environment, and in turn the environment affects the system” (White & Klein, 2002, p. 123). The environment exerts an influence on the system and the system responds by producing feedback, which exerts an influence on its environment. In the current study based on the third basic assumption, deployment may affect the system (the couple) and the systems’ behavior (the couple) would affect the deployment. For example, a soldier is deployed and returns home after enduring the experiences of war to a system or a relationship that has functioned in his or her absence. The absence due to the deployment impacts the system and that impact results in a response or reaction on the system’s behalf to the deployment and to the soldier’s return.

The three basic assumptions of family systems theory provide an understanding of how families respond and may react to system behavior/changes. Family systems theory promotes the notion that any change in a family results in a systemic change. Family system theory will help to understand the effects of deployment beyond the individual level, such as the stressors of war deployment on families.

**Family Stress Theory.** Family stress theory was developed to provide a foundation for conceptualizing stress and crisis within a system (Burr, 1973; Hill, 1949). While general stress theories focus on the individual, family stress theory examines all family members (McKenry & Price, 1994). Hill's (1949) ABC-X model and the Double ABC-X model (McCubbin & Patterson, 1982) have been used to study crisis in families, including those separated by war deployment. The goal of the ABC-X model is to reveal factors that contribute to family survival during stressful circumstances and to discover the relationship between adaptation to stress and available support and resources for the family. The Double ABC-X model expands Hill's ABC-X model to include pre and post-crisis factors focusing on family events over time rather than single events. The Double ABC-X model provides a theoretical basis for examining the mediating variables (i.e., war deployment, socioeconomic status, and availability of support) that contribute to family stress.

**ABC-X model.** The underlying principle of the ABC-X model is that the level of family (system) adaptation/adjustment to family stress is contingent upon the availability and support of adaptive resources for meeting the family's needs. The ABC-X model can be described as follows: "A (provoking or stressor event), interacting with B (the family's resources or strengths), interacting with C (the definition or meaning attached to the event by the family), produces X (stress or crisis)" (McKenry & Price, 1994, p. 6). The X factor represents the end

result or effect of experiencing a stressor or crisis, which is a product of various other moderating variables of the affected family system. The model below represents Hill's (1949) ABC-X model (Figure 2.1).



**Figure 2.1 Hill's ABC-X Model (1949).**

The stressor event is an unusual or irregular occurrence that stimulates change within the system. The stressor event may cause the stress levels to increase within the family. It is usually classified according to its intensity or level of severity. For the sake of the current study, the stressor events will be identified by the participants in relation to war deployment. The resources or strengths of the family moderate the impact of the stressor event on the family system. Therefore, it is more likely that the stressor events have a decreased impact if the family system has sufficient resources or strengths prior to the event (Burr, 1973). The definition and perceptions of the event are based on the family's meaning of the stressor and the level of stress that the family endures as a result of the stressor. McCubbin and Patterson (1982) noted that the definitions/perceptions given by families are subjective, ranging from positive views to negative views of the stressor event. Families who identify the stressor event as positive (often done by reframing the event) cope and adjust better by clarifying the issues and implementing problem solving strategies, decreasing the emotional stress related to the stressor event, and encouraging

each member to support one another while continuing their daily lives than those who do not identify the stressor event as positive (McCubbin & Patterson, 1982). For example, a female spouse identifies the separation with her husband (soldier) due to war deployment as the stressor, which has reportedly affected their family-owned business that the husband co-supervised, leading to an increase in workload duties for the wife in the husband's absence. The children and spouse may begin to have negative views about the military mission and the absence of the spouse/father due to fear of his death, resulting in increased stress, disruption in the family, and decreased family cohesion. Another example of the ABC-X model in relation to war deployment may be the family receiving news from the deployed soldier of possible early return from war. This news may result in an increased sense of hope and positive view of the war in the family, which results in reorganization within the family system.

Stress or crisis is identified to be a change within the homeostasis of the family system (Boss, 2002). However, much of the literature uses these two terms inconsistently. Boss (1987) defined crisis as an acute interruption that causes the system to be incapacitated from normal functioning. Stress was by defined by Boss (1988) as a state of interruption or change. Stress is considered to be a continuous variable (level of stress) and a crisis can be considered as a dichotomous variable (a crisis or no crisis exists). Stress and crisis are not an innate part of a stressor event. Stress or crisis, however, might serve as a reaction to the stressor event by the family (Hill, 1949). For example, a crisis might be one being involved in physical altercation with their spouse, while an example of stress might be on-going military deployment duty.

In *Family Stress Management: A Contextual Approach*, Boss (2002) defined and provided guidelines for utilizing family stress theory and the original ABC-X model with families. Boss explained that a system does not function in isolation and that stress occurs in an

external context (i.e., economics, history, developmental maturation, heredity, and culture) and an internal context (i.e., structural, psychological, and philosophical contexts of the family). Boss defined the external context as the components that the family cannot control and the internal context as the components that the family can control. Of the external and internal context, Boss discussed the need to understand the family's internal context primarily because it provides an opportunity for change and understanding the family's perception of the stressor, because the family can control its internal components. In considering implementing change, when faced with a family stressor, the stressor itself may foster change in the family system's equilibrium as a response to the actual stressor and the family's perception of the stressor (C). Hence, change may occur as a direct reaction to the stressor.

In reviewing family stress theory and the ABC-X model, Boss (2002) emphasized the importance of distinguishing the difference in the meaning of the terms stress, crisis, and strain that are so often incorrectly used synonymously. She defined family stress as change in the family's equilibrium; stress does not equate to a crisis. Family crisis may be caused by severe stress that immobilizes the family and is a state of disequilibrium. At the point that the family becomes immobile or loses its ability to function is when the stress should be considered a crisis. Strain was described as "being likened to a bridge shaking but not collapsing. The structure is still functional- at least minimally- but it is bent out of shape, creaks, and shakes under pressure" (Boss, 2002, P. 68). Boss (2002) considered clearly defining these terms to be essential in understanding her explanation and adaptation of Hill's (1949) ABC-X model.

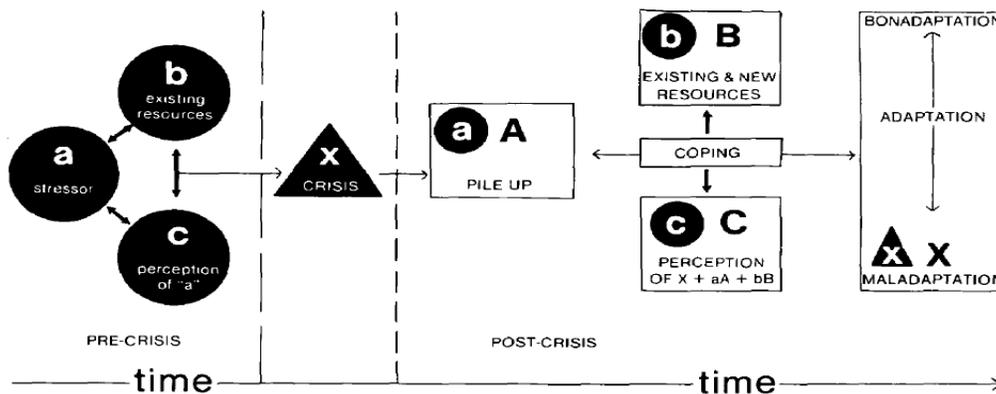
***Double ABC-X model.*** The ABC-X Model was expanded to the Double ABC-X Model with the addition of pre and post-crisis factors to explain how families successfully adapt to a crisis (McCubbin & Patterson, 1982). Family stress theory has been applicable to the many

families adjusting to stressful events, such as war separation. McCubbin and Patterson (1982) utilized the Double ABC-X model to conduct and analyze longitudinal research of families experiencing separation due to the Vietnam War. The Double ABC-X model proposes the idea that nothing occurs in isolation. The Double A factor focused on the family's adaptability to the onset of role changes and hardships that occur, in most cases, at the absence of a husband or father.

The Double B factor represents the two kinds of family resources, the available resources that decrease the effect of the initial stressor and the coping resources, which are developed as a stress reaction. McCubbin and Patterson (1982) concluded that self-worth, family integration, and social/group support were the notable Double B factors. The Double C factor represents the family's view of the initial stressor event and the crisis. The family's view of the event and/or crisis includes the family's perception of associated hardships, the pileup of events, and the meaning the family gives the situation. McCubbin and Patterson's (1982) research findings revealed that post-crisis perceptions included religious beliefs, re-classification of the crisis/event, and offering meaning to the crisis/event. The Double X factor represents the family's response and adaptation to the outcome of the original event and/or crisis. Adaptation merely means that the normal routine of the family system has resumed. Crisis and adaptation are on a continuum with a positive and negative end (McCubbin & Patterson, 1982). "Where a family is along the continuum of adaptation influences its vulnerability to the impact of a subsequent stressor event or transition, but the important characteristic of the family before the impact of a stressor event or transition is the general sense of satisfaction and stability about the family structure and patterns of interaction" (McCubbin & Patterson, 1983, p. 19). Adaptation

was viewed as the most favorable outcome of a stressful crisis event by Boss (1988) because families adjust to the event or crisis due to the change in one or all parts of the system.

The Double ABC-X model has been applied in several family studies. There have been a few studies utilizing the Double ABC-X model to analyze families with children who have disabilities (Saloviita, Italinna, & Leinonen, 2003; Xu, 2007). However, a literature review revealed that with the exception of the work of McCubbin and Patterson introducing the model (Fig. 2.2) and focusing on familial adjustment to war separation, there is no known research on the application of the model specifically with military populations.



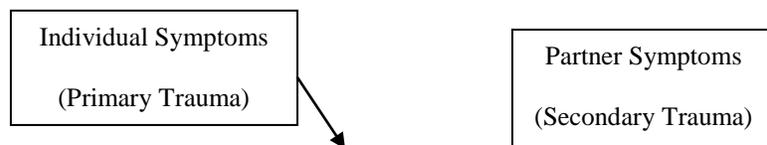
**Figure 2.2 Double ABC-X Model (McCubbin & Patterson, 1982).**

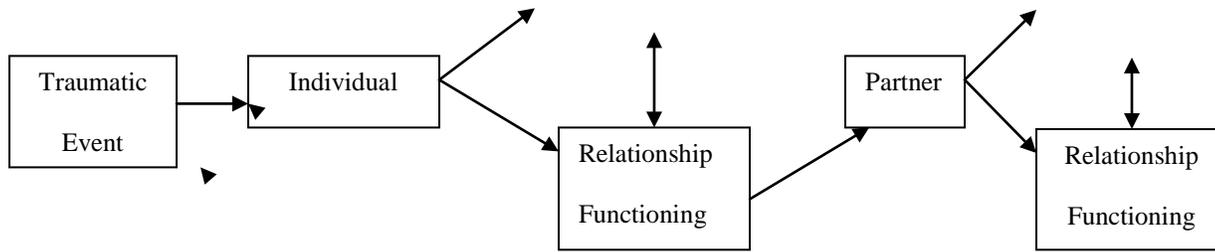
**Secondary Traumatic Stress Theory.** Figley (1983) introduced the concept of secondary traumatic stress. This concept describes the effects on others close to the traumatized victim who become indirect victims of the trauma themselves after experiencing significant emotional/mental distress. “Indeed, simply being a member of a family and caring deeply about its members makes us emotionally vulnerable to the catastrophes which impact them. We, too, become ‘victims,’ because of our emotional connection with the victimized family member” (Figley, 1983, p. 12).

Additionally, Figley's (1983) idea of indirect traumatization was further supported in the DSM- IV (APA, 1994) as it was incorporated into the PTSD diagnostic features section. Criterion A1 specifically supports the idea that trauma may indirectly affect the spouses/partners of soldiers or veterans who have experienced war combat (APA, 2000). Criterion A1 includes learning about a family member's or other's experience resulting in indirect traumatization. The rate of development of PTSD increases as the stressor strengthens and/or the distance of the stressor increases (APA, 2000).

Secondary traumatic stress theory proposes that couples and families are systems, which "induces stress" (Figley, 1983, p. 11). Therefore, the system will experience symptoms similar to the trauma survivor due to the closeness or emotional connection that exists within the system. This has been referred to as an "internalization process" for the spouses or partners or family system (Maloney, 1988), when the spouses/partners identify very strongly with their soldier/veteran.

**Secondary Traumatic Stress model.** The secondary traumatic stress model portrays the response of experiencing trauma through being a spouse/partner or someone close to a trauma survivor. The model depicts the initial occurrence of the traumatic event by an individual followed by the onset of individual symptoms (primary trauma) and relational functioning, which may mutually affect the partner resulting in partner symptoms (secondary trauma) and impacting relational functioning. Thus, the underlying principle of secondary traumatic stress theory is that traumatic experiences adversely affect those close to a trauma survivor (Figley, 1983). The model below represents Nelson's (1999) interpretation of secondary traumatic stress theory (Figure 2.3).





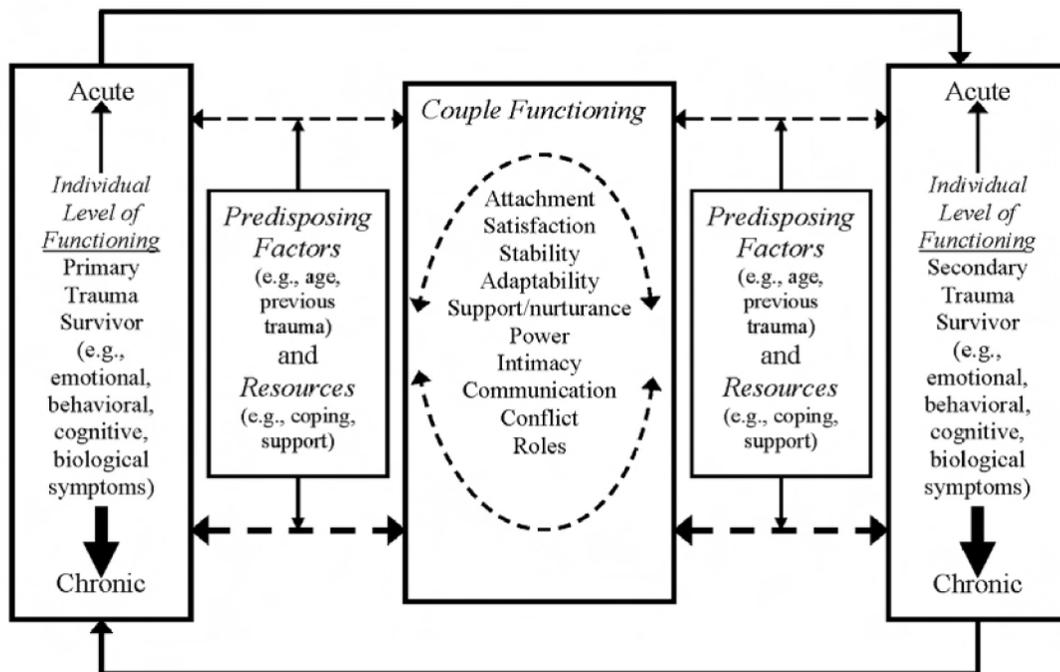
**Figure 2.3 Secondary Traumatic Stress Model (Nelson, 1999, p. 34)**

According to Figley (1983), trauma symptoms can be displayed by the family system in four different ways, including simultaneous effects, vicarious effects, intrafamilial trauma, and secondary traumatization. The first, simultaneous effects, is described as all individuals of the system being affected simultaneously by the same traumatic event, such as a natural disaster like Hurricane Katrina. Vicarious effects are described when one member of the system has experienced a traumatic event away from the system, such as when a soldier deployed to Iraq is severely injured. The third, intrafamilial trauma, is described as more than one member of the system experiencing a traumatic event that occurred within the family (i.e., various forms of abuse). Finally, secondary traumatization, can be described as all members of the system experiencing trauma symptoms after having contact with the traumatized victim of the system. These behaviors aid in describing the manifestations of indirect traumatization. Secondary traumatic stress research has investigated the effects of trauma in couple relationships.

**The Couple Adaptation to Traumatic Stress (CATS) model.** The Couple Adaptation to Traumatic Stress (CATS) Model was developed by Nelson Goff and Smith (2005) to illustrate the systemic effects of traumatic stress in couple systems, including both primary and secondary effects for individuals. The CATS model was an attempt to expand and improve the current theoretical support of secondary traumatic stress in the field by providing an empirically-based theory of traumatic stress in couples. The model is comprised of the following components:

individual level of functioning for primary trauma survivors, individual level of functioning for secondary trauma survivors, predisposing factors and resources, and relational functioning and dynamics within the couple system. The primary and secondary trauma survivors' symptoms range from acute to chronic (Nelson Goff & Smith, 2005). Although it includes both primary and secondary traumatic stress in trauma survivors and their partners, the authors sought to provide a more thorough empirically-based theory of the systemic effects of trauma, to include individual effects on the trauma survivors, secondary trauma effects on partners, and the systemic effects on the couple relationship.

The model demonstrates the reciprocal relationship between the individual level and couple functioning level of the primary and secondary trauma survivors. The CATS model provides a framework to illustrate the systemic nature of how trauma affects individuals and couples, and this component of the model seeks to explain how the couple may be affected (Nelson Goff & Smith, 2005) (Figure 2.4).



**Figure 2.4 The Couple Adaptation to Stress (CATS) Model (Nelson Goff & Smith, 2005).**

The underlying principle of the CATS Model proposed that the individual level of functioning symptoms, whether it is for the primary and secondary trauma survivor, and whether it is acute or chronic, impacts the couple system. The predisposing factors and resources are illustrated in the model to reveal that these factors and resources impact the symptoms and functioning of the system. The couple functioning component of the model is centered to identify variables that may be affected by the predisposing factors and resources. Also, the couple functioning component of the model is centered with arrows to depict the variables that may be affected by the primary and secondary trauma survivor symptoms (Nelson Goff & Smith, 2005).

In military couples, the CATS Model implies that the primary trauma survivor's individual level of functioning (i.e., trauma symptoms) will directly affect a systemic response which will likely result in secondary traumatic stress symptoms because of the circularity of the model. For example, a military soldier (primary trauma survivor) who has chronic PTSD (individual level of functioning) makes contact with his/her spouse after having a severe traumatic experience while deployed. The spouse then becomes a secondary trauma survivor after becoming severely depressed and unable to report to work each day after learning about the experience and experiencing her spouse's symptoms. In addition, the spouse had predisposing factors (i.e., losing a brother in a past war) and having inadequate resources (i.e., no support from family/friends), the couple experienced relationship problems due to these factors.

**Symbolic Interactionism.** In the current study, symbolic interactionism will be utilized to examine the meanings and to understand the participant's view of how his/her traumatic experience of deployment separation affected the couple relationship. Herbert Blumer coined the term "symbolic interactionism" in 1937 (Blumer, 1986). Symbolic interactionism is a fundamental, conceptual framework for understanding how human beings create symbolic

meanings or symbols of interaction (e.g., roles, language, rituals, and rules) and how those symbolic meanings/symbols of interaction generate human behavior (Boss, 2002; White & Klein, 2002). According to symbolic interaction, it is believed that families under stress construct their own reality, a symbolic reality, based on the communal roles and meanings in the family (Boss, 2002). Family members interpret or define each other's actions instead of reacting to other's actions. Interpretations are not made due to the actions of others, but instead, the interpretations are based on the meanings that one attaches to such actions (Blumer, 1986).

Blumer (1986) developed three core principles of symbolic interactionism. The core principles of meaning, language, and thought provide understanding about the creation of a person's being and socialization into a larger society (Griffin, 1997). The core principle of meaning states that humans act toward things based upon the meaning that they have given to those people or things (i.e., a spouse of a soldier being frightened by knocks at her front door early in the morning due to fear of hearing unpleasant news about her soldier). Symbolic interactionism deems the principle of meaning central to human behavior. The core principle of language gives humans the ability to negotiate meaning through symbols. George Mead's influence on Blumer becomes apparent as Mead believed that naming assigned meaning. By engaging in speech acts with others through symbolic interaction, humans began to identify meaning, or naming, and develop discourse (Griffin, 1997). For example, a soldier develops or names code words to use with his wife to protect his children from anxiety of his combat duty participation when he called home to speak with his family while on deployment. The core principle of thought alters each individual's interpretation of symbols because thought, when based on language, is a mental dialogue that requires role taking, or considering different points of view (Griffin, 1997). For example, a trauma survivor considers the thoughts of other trauma

survivors in support group meetings in an effort to cope and heal from the traumatic event. This consideration will likely alter one's interpretation while considering different points of view.

In investigating the impact of systemic effects of trauma on couple relational systems, the meaning, the language, and thought that the individuals of that couple relational systems give to their traumatic experience is necessary to gain an in-depth understanding. Thus, symbolic interactionism seems most appropriate because it will provide guidance to interpret and understand the meanings, the language, and the thoughts of individuals' traumatic experiences. The application of symbolic interactionism will guide the development of research questions for interviews and it will guide the coding of themes for qualitative research methodology.

In conclusion, family systems theory provides the basic explanation that all parts of a system are interconnected, which assists in understanding the effects of a spouse/partner being deployed. Family stress theory, ABC-X model and Double ABC-X model each are specifically applicable to the current study, as they each conceptualize stress and crisis within a system. Each theory and/or model also conceptualizes the effects and adaptation/adjustment of a system. Secondary traumatic stress theory and the CATS model specifically illustrate the effects on others close to the traumatized victim (spouse/partner) who become indirect victims. Symbolic interactionism will provide guidance in learning more about the meanings of the individual's trauma experiences and behaviors.

Each of these theories of systemic traumatic stress are applicable to the study through their common description of the systemic effects of traumatic stress in relational systems. These theories provide a foundation to increase the level of understanding of the effects of trauma on individuals and others close to the traumatized individuals. Specific emphasis has been given to war deployment and war-related stress in couple relational systems.

The field of secondary traumatic stress has recognized the effects of indirect trauma to family members and individuals close to trauma survivors, which is evident through the increase in literature on the topic. The field has also begun to give clinical attention to the symptoms of the effects of war deployment in behavioral health, as described in the literature review. The goal of the current study is to increase the awareness of secondary traumatic stress and provide qualitative research on the effects of the recent ongoing war and its effects on the couple system.

### **Conclusion**

The published literature reveals a clear association between the effects of military war deployment and soldiers' reintegration to family life. Physical and psychological problems have been observed in veterans of past wars, some of which have been classified as psychiatric disorders, such as PTSD. Psychological problems as a result of war, also referred to as the "invisible trauma," are the most complicated to distinguish and are the least understood by the veterans, their families, clinicians, and researchers (Wild, 2003). As described in the literature review, researchers have recently begun to examine the effects of these psychological disturbances on the partners of primary trauma survivors. The interpersonal dynamics of trauma in military couples has received limited attention in the literature, compared to the focus on the individual soldier. Hence, empirical findings and supporting theories are limited.

Recognizing the probable adverse impact of traumatic events, particularly military war deployment, on the spouses/partners of soldiers or veterans, the current study is devised to investigate the impact of these events on the couple relational system, including both the soldiers and their spouses/partners. The couple relational system provides a unique context for examining the interpersonal/systemic impact of trauma and understanding how trauma exposure can impact both the primary trauma survivor and the spouse or partner. In addition, the couple relational

system is the chosen focus of investigation due to the need to expand the current research and clinical awareness in this area of study.

Conducting an investigation to understand how trauma affects the couple relationship has implications for improving clinicians' ability to intervene successfully with these families in clinical practice. In recent years, the ongoing wars in Afghanistan and Iraq have impacted many soldiers and the lives of many Americans related to the soldiers, whether it is a spouse or partner, a child, a loved one, or others close to a soldier. This study may increase the awareness of the systemic effects and help to minimize the barriers to seeking mental health treatment. It is the particular interest of the researcher to gain an in-depth understanding of the lived experiences of each partner. Hence, the purpose of this basic research study is to identify individual trauma symptoms (such as PTSD symptoms), levels of relationship satisfaction (dyadic adjustment), and other variables related to the impact of trauma on each individual and on the couple relational system in explaining the intrapersonal and interpersonal dynamics. The focus of the study can be described as an in-depth study to understand the systemic effects of trauma in couples where one or both partners have experienced a traumatic event(s), specifically war-related trauma.

Two research questions were formulated according to the current literature review and supporting theories to investigate the systemic affects of trauma of both the primary and secondary trauma survivors:

1. How does war-related trauma and non-war related trauma affect the relationships of military couples in which one or both report high trauma symptoms?
2. In military couples where one or both partners report high trauma symptoms, what are the similarities and differences between those couples who report high relational satisfaction and those who report low relational satisfaction?

## **CHAPTER III**

### **METHODS**

A team-based approach was utilized to collect the data of the current research. The Trauma, Research, Education, and Consultation at Kansas State University (TRECK) Team focuses on conducting research, providing education, and clinical consultation about issues related to trauma and traumatic stress (<http://www.k-state.edu/treck/home.htm>). The TRECK Team provides marriage and family therapy and educational services to trauma survivors and those close to trauma survivors. The team is comprised of a faculty advisor, graduate students (both doctoral and master's level), and undergraduate students in the School of Family Studies and Human Services and members of other programs at Kansas State University. Many of the students are graduate students in the Marriage and Family Therapy (MFT) program.

The TRECK Team conducted two phases of research utilizing qualitative methodology research design. The focus of Phase I was to examine the secondary effects of trauma in clinical couples where one or both partners reported experiencing a previous traumatic event. The focus of Phase II was to investigate the impact of recent military deployment to OIF/OEF on soldiers and their spouses/partners. The research procedures were approved by the Institutional Review Board for Research on Human Subjects at Kansas State University.

#### **Research Questions**

Originally, the study sought to focus on military war-related trauma, but as the analysis began and themes emerged, it was determined that other non-war related traumas were also reported by all participants to have a major impact on their lives. The two research questions were formulated to investigate the systemic effects of trauma of both the primary and secondary trauma survivors:

1. How does war-related trauma and non-war related trauma affect the relationships of military couples in which one or both report high trauma symptoms?
2. In military couples where one or both partners report high trauma symptoms, what are the similarities and differences between those couples who report high relational satisfaction and those who report low relational satisfaction?

**Research participants.** The current study is part of the larger TRECK Team Phase II research project examining the systemic effects of trauma in couple relational systems. All participants of the larger study were soldiers and their spouses/partners who were affiliated with the Fort Riley Army Post in Fort Riley, Kansas, Fort Leavenworth Army Post in Fort Leavenworth, Kansas, and Army Guard and Reserve units in the state of Kansas who recently returned from deployment to Iraq or Afghanistan. All couples were dating, married, or cohabitating for a minimum of one year prior to participating, and all participants were over the age of 18.

**Data collection.** Participants were recruited in 2004 based on the deployment of one or both partners to Iraq (OIF) or Afghanistan (OEF). Each couple received a \$50.00 incentive for their participation. The total study group was comprised of 45 couples who were recruited by public fliers, newspaper advertisements, and/or word-of-mouth. Purposeful sampling and criterion sampling methods were combined and utilized to obtain information-rich cases (Patton, 2002). The strength of these combined strategies of sampling is the creation of an information-rich sample that will yield new information and bridge the gap in the field of MFT in systemic traumatic stress treatment interventions.

Participants who were interested in the larger study contacted the primary researcher and/or the graduate research assistants to schedule a research appointment. Participants were

asked the following screening questions before scheduling an appointment: (1) Are you currently married or cohabitating? If yes, how long? (2) What are the dates of your or your partner's deployment? (3) Is there any current domestic violence or substance use/abuse for you or your partner? The screening questions help to ensure that the participants meet specific criteria of the researcher's interest, such as being married or cohabitating for a minimum of 1 year, deployed recently to OIF/OEF, and having no current domestic violence or substance use/abuse. A spreadsheet was compiled with name, contact information, and screening responses for each couple participant. The participants were also advised to allot a two-hour period of time to participate in the research appointment.

Couple participants were scheduled for a research appointment with the faculty advisor, primary researcher, and/or graduate research assistants. At the appointment, the participants received and signed two informed consent forms (one copy to keep and one copy to return to the researcher) that explained the purpose of the study, benefits, and risks of participating, and extent of confidentiality. The researcher or graduate research assistant thoroughly reviewed the informed consent with the participants and answered any questions regarding the research participation prior to completing any questionnaires or research-related information. The participants were given a form to be completed for the payment of the \$50.00 incentive. The participants could voluntarily complete a contact form if they were interested in receiving a general summary of the research findings to be mailed approximately 12-15 months after the completion of the study. The participants were advised that the general summary findings would not identify any participant with respect to confidentiality, as the summary would be an overall conclusion of the findings.

The participants were asked to complete individual questionnaire packets without discussing their answers with their spouse/partner. The estimated time to complete the packet was 15-20 minutes. The questionnaire packet included demographic questions, the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994), Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996), and the Dyadic Adjustment Scale (DAS; Spanier, 1976).

After completing the questionnaires, the recruited couples participated in separate individual standardized open-ended interviews (see Appendix A) with the faculty advisor, primary researcher, and/or other graduate research assistants. A standardized open-ended interview was used to consistently address identified issues/topics, to reduce interviewer bias due to several interviewers being used, and to assist with the arrangement of and analysis of the data (Patton, 2002). The interview questions were developed with the consensus of all TRECK Team members. The interviews were conducted with each partner separately in an effort to clearly record the data and to assist in the verbatim transcription. Additionally, separate interviews may have prompted a more genuine report of the thoughts and feelings related to the traumatic event from the participants than if the spouse/partner was included in the interview. The interview question guide is in Appendix A. The duration of each interview ranged between 45- 60 minutes. Each interview was audio-taped and transcribed verbatim for data analysis by undergraduate and graduate research assistants with the TRECK Team. At the conclusion of the research appointment, the participants were brought back together to complete the debriefing, to acknowledge possible reactions of revisiting past traumatic experiences, and to provide handouts about trauma symptoms and redeployment and local referral resources.

The TRECK faculty advisor supervised the primary researcher and the research assistants. At the time data were collected, all students on the TRECK Team were masters and doctoral students enrolled in the marriage and family therapy program at Kansas State University, which is accredited by the Commission on Accreditation for Marriage and Family Therapy Education. The TRECK Team has several research projects underway with contributions made by several team members to this study.

## **Measures**

**Purdue Post-Traumatic Stress Disorder Scale-Revised.** The Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996) is a 17-item scale that assesses symptoms of posttraumatic stress disorder, but does not diagnose or have a cutoff score. Each item of the PPTSD-R corresponds to one of the DSM-III-R (APA, 1987) PTSD symptoms. The scale has three subscales with three symptom categories, including Re-experiencing (4 items), Avoidance (7 items), and Arousal (6 items). The respondents indicate how often a symptom occurred in the previous month. Respondents rate the frequency of occurrence of each symptom on a Likert scale ranging from 1 (not at all) to 5 (often), with continuous total scores ranging from 17 to 85, with higher scores indicating greater PTSD symptoms. The PPTSD-R is internally reliable, with a coefficient alpha for the total score of .91 and subscale alphas for Re-experiencing, Avoidance, and Arousal subscales at .84, .79, and .81, respectively (Lauterbach & Vrana, 1996), although the PPTSD-R does not include a clinical cut-off score (e.g., scores above a specific score indicate a diagnosis of PTSD). The PPTSD-R is comparable to the Post-Traumatic Stress Disorder (PTSD) Checklist (PCL) (Weathers, Litz, Herman, Huska, & Keane, 1993). The PCL is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD. The respondents rate how much they were “bothered by that problem in the past month.” Items are

rated on a 5-point scale ranging from 1 (“not at all”) to 5 (“extremely”), with total scores ranging from 17-85. In the current study, the purpose of the PPTSD-R was to distinguish between participants with high and low levels of PTSD symptoms.

**Dyadic Adjustment Scale.** The Dyadic Adjustment Scale (DAS; Spanier, 1976) is a 32-item rating instrument completed by one or both partners to measure the quality of adjustment to marriage and similar dyadic relationships. The DAS includes four subscales: dyadic cohesion, dyadic satisfaction, dyadic consensus, and affectional expression. Total scores range from 0 to 151, with higher scores indicating higher relational satisfaction. In the current study, the higher DAS scores and lower DAS scores were used to select participants to have a information-rich sample. The DAS has shown good overall reliability (Cronbach’s  $\alpha = 0.96$ ) and subscale reliability: .81 on dyadic cohesion, .94 on dyadic satisfaction, .90 on dyadic concensus, and .73 on affectional expression (Spanier, 1976). Convergent validity correlations are high (.86-.88) as assessed with the Locke-Wallace Marital Adjustment Scale (Locke & Wallace, 1959).

**Traumatic Events Questionnaire.** The participants’ history of reported exposure to trauma was identified by the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994). The TEQ assessed for the type of traumatic events that each individual or partner experienced. The TEQ assesses experiences with 9 specific types of traumatic events (accidents, natural disasters, crime, child abuse, rape, adult abusive experiences, witnessing the death/mutilation of someone, being in a dangerous/life threatening situation, receiving news of the unexpected or sudden death of a loved one) reported in the DSM-III-R (APA, 1987) and the empirical literature as having the potential to elicit posttraumatic stress symptoms. In addition, two residual categories were included, allowing respondents to report any other very traumatic event not

listed (Vrana & Lauterbach, 1994). In the current study, affirmative answers on the 17 TEQ items were tallied to provide a “TEQ total” score, ranging from 0 to 17, with higher scores indicating more types of traumatic events experienced. The current study included questions directly related to war events (“Did you ever serve in a war zone where you received hostile incoming fire from small arms, artillery, rockets, mortars, or bombs?”), questions to assess for traumatic events in childhood (“As a child, were you the victim of physical abuse?”), and questions about other traumatic events (“Have you been a victim of a violent crime such as rape, robbery, or assault?”). The reliability of the TEQ measurements is good with test-retest reliability coefficients of .72 to 1.00 (Vrana & Lauterbach, 1994).

**Description of the participants.** A combination of convenience sampling and criterion sampling methods were utilized to obtain 6 couples (12 participants) to comprise this current, information-rich sample (Patton, 2002). The demographic information of each couple is reported below. The individual scores from the instruments for each participant are provided in Figure 3.1.

**Couple 1.** The couple has been married for approximately three years, and has spent all but approximately six months separated due to the male’s military duty. The male is a 26-year-old European American and the female is a 29-year-old European American. Both have been in the military and both have been deployed (male to Iraq; female to Korea). The female is no longer in the military. Both participants expressed that their role in their relationship could be better if “he” was home more. Both identified their deployment experience as being traumatic, with the female being shot in the leg, while witnessing another soldier be killed by a sniper. She shared that she feared the same thing happening to her husband while he was deployed as a result of witnessing her friend’s death. She also shared that her husband’s deployment was traumatic

for her due to compulsively watching the news on the television, limited communication, and hearing about other soldiers being killed during deployment. Conversely, she mentioned that having been in the military provided her a better understanding of war and deployment, which allowed her to cope more effectively. The male stated that his deployment to Iraq was traumatic due to the separation from his family and the family events that he missed (i.e., births of all three children). He shared about the nightmares, triggers of war that he experienced since returning home, and his wife being raped while he was deployed. The soldier mentioned that he and a few more soldiers meet with each other to talk about their experiences for support.

***Couple 2.*** The couple has been married for approximately 2.5 years. The male is a 25-year-old European American and the female is a 24 year old European American. Both participants shared that they are satisfied with their current role in the relationship. The couple met in the military. Both have been deployed; the female has not been deployed in a war zone. She discharged from the military approximately six months after the September 11<sup>th</sup> attacks on the United States. She shared that they were separated at the beginning of his deployment and reunited mid-deployment. The male soldier shared that being deployed for a year “led up to” it being traumatic. He shared how he was calm prior to deployment and returned with an “insane” temper and stated that his “rage is just nuts.” He shared that he is also “more emotional,” has less tolerance, and reported PTSD symptoms, such as anger issues, nightmares, flashbacks, decreased sleep, watchful, very paranoid, cold sweats, and loss of sexual of desire. He stated that his anger is affecting his marriage. He reported growing up with an abusive mother. He also shared that his cousin died, while he was deployed and that he has felt emotionally numb and did not care if he lived or died after losing him. The female spouse shared that his deployment was traumatic for her in that she was affected by whatever affects her spouse. She stated that when he is

emotionally distraught, angry, and stressed, she gets “angry and stressed out.” She shared that she was most affected by his anger. She reported that her mother’s death has been her most traumatic experience. Interestingly, he will not speak of his deployment as he feels that she will not understand, even though his spouse is was previously in the military, but he listens and comforts her when she shares her experiences. The female spouse reported experiencing role shifts in her husband’s transition to home.

***Couple 3.*** The couple has been married for six months. The male is a 23-year-old African American and the female is a 24-year-old American Indian/Alaska Native. Both participants expressed that they are not satisfied with their current role in their relationship. The male soldier shared that he really did not consider his deployment to be traumatic, but later in the interview he stated that he does consider it to be traumatic. Hence, the male soldier shared that his deployment experience changed him a lot and that he still does not really understand how the deployment changed him. He stated that he did not care if he lived or died. He seems to have some conflicting feelings about the war and how he was affected. He stated that he experienced a lot of stress while deployed. The female spouse shared that the deployment was traumatic to her at the time, as it was unexpected. She shared that not knowing what to do or say when he returned home sharing about his experiences. He shares that he was in an explosion while deployed, of which he now has PTSD symptoms, such as triggers, flashbacks, trouble sleeping, trouble concentrating, irritability, anger, and being cautious. Both seem to have a negative view of the deployment and its purpose. Both stated that the male soldier is not who he used to be prior to the deployment. The female spouse indicated being a victim of sexual abuse and the unexpected death of her mother as her most traumatic experiences. She stated that she tried talk to her husband about the sexual abuse, but she believes that he does not understand. Interestingly, he

does not share about his traumatic experience with his wife because he fears that she will not understand. While she will share her traumatic experiences with him, she also believes he does not understand.

***Couple 4.*** The couple has been married for approximately six years. The male soldier is a 31- year-old European American and the female is a 22-year-old European-American. Both participants shared that they are not satisfied with their current role in the relationship. The male soldier shared that as a result of his deployment experience, he is “very alert,” but calmer, of which he reported that he was the opposite prior to deployment. He identified his deployment experience as traumatic. He also shared that he was sexually abused as a child by his mother and babysitter, but that he did not identify the abuse as traumatic. The soldier shared that he has a sexual addiction because of his past childhood sexual abuse. Even though the soldier did not identify the sexual abuse as traumatic, much of his interview focused on discussing the sexual experiences. The female spouse identified her husband’s military deployment as traumatic for each of them. She shared being affected emotionally due to the deployment separation, the anxiety about his wellbeing, watching the news compulsively, and watching her children scream and cry for their father. She also reported being angry, having insomnia, stress, loss of appetite, and frequent migraines. She shared that the most negative effect of his deployment was his having an extramarital affair and being told by the Family Readiness Group leaders to have his funeral arrangements prepared in case of his death. The female spouse shared that she was raped while her husband was deployed. She stated that the most negative effect of her rape is that she “doesn’t like sex,” which causes problems in their marriage. Overall, she reported that her relationship is affected by the lack of trust.

***Couple 5.*** The couple has been married for three years. The male is a 31-year-old European American and the female is a 33-year-old American Indian/Alaska Native. Both participants reported that the deployment was traumatic. The male soldier shared having nightmares about his experience as a medic. He described the vivid nightmares and images of the injuries he saw. He shared that he is in therapy for his anxiety, depression, and sleep. He shared that overall the deployment was traumatic, but that he learned a lot. The female spouse shared that the deployment had the most negative effect on her when a soldier in her husband's unit died and she was concerned about her husband being in danger and not returning home. She also reported being sexually abused as a child and receiving news of an unexpected death of her uncle. She identified both experiences as being "extremely" traumatic. She mentioned that the negative effects of the sexual abuse were that she "hated sex." She stated that the negative effects of the unexpected death were her fear that everyone in her life would die after losing most all of her family members. The male soldier shared that when he first returned home, he would not talk about the deployment, but later began to share everything about his deployment experience. The female spouse shared that the deployment made their relationship "stronger" and the male soldier shared that they are "closer" due to the deployment.

***Couple 6.*** The couple has been married for two years. The male is a 40-year-old European American and the female is a 32-year-old European American. Both participants reported that they are not satisfied with their current role in the relationship. The male soldier shared that the deployment was "very hard" because 30% of his mother's body was burned in a house fire while he was deployed, of which he was called to return home. After returning home, his pregnant spouse miscarried. He stated that he blames himself for the loss of his child. The soldier stated that the stress of these events in addition to being away from his child while

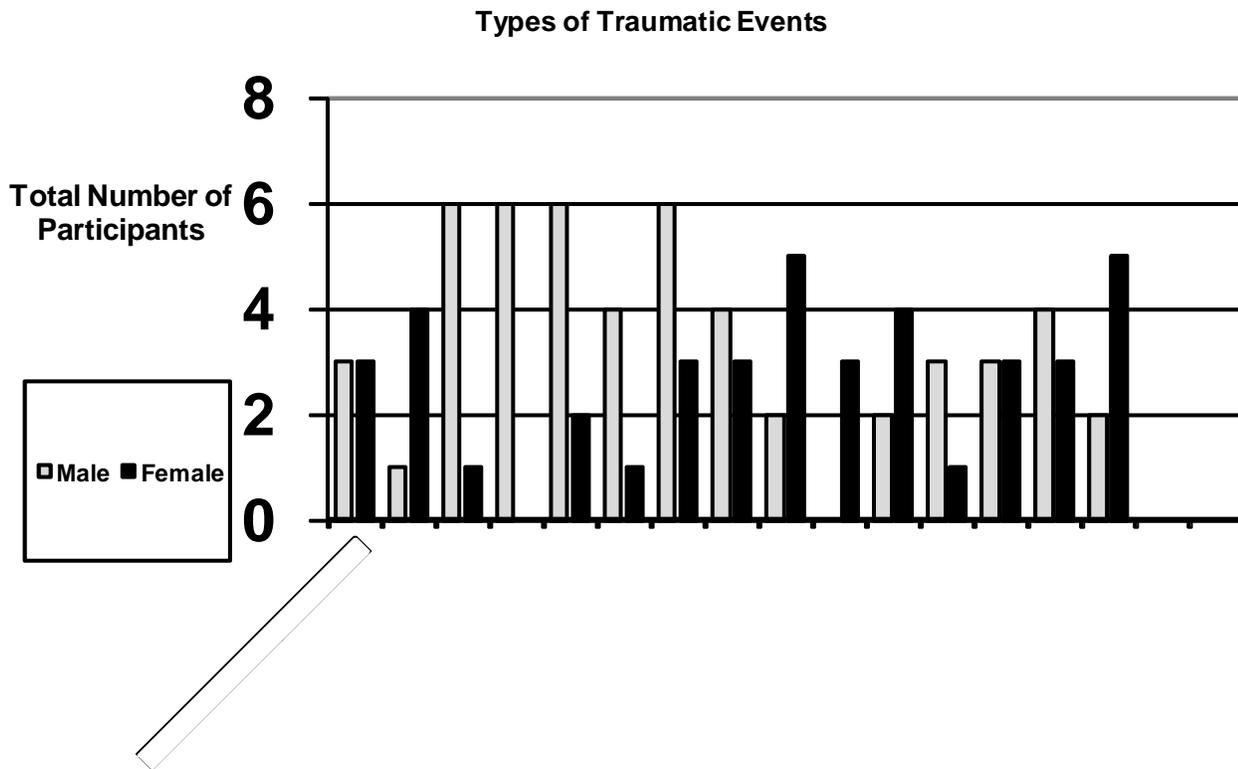
deployed was difficult. He was previously deployed to Operation Desert Storm and later deployed to OIF, but returned after a few weeks due to family emergencies and did not redeploy. The soldier stated that his first deployment to Iraq was traumatic, but that his recent deployment to Iraq was not traumatic, just stressful due to the relocation, no time to get settled in, and being separated from his family. The soldier shared that seeing his mother burned was “very traumatic” and that he has had a few nightmares about what he saw. He also mentioned having constant worry about his parents, wife, and family now. He mentioned worrying about his spouse committing suicide while he was deployed, since she previously attempted. He stated that his main worry while deployed was that he would get notification that something was wrong with his wife. The soldier stated that he has not shared much about his deployment or other traumatic experiences with his spouse. The female spouse shared that the deployment was “not really” traumatic for her. She stated that the constant “big changes,” such as the relocation, having a young child, and her husband’s post-war behavior (jumping up at night and going after her, having nightmares, yelling, and how he reacts to noises and things since being home). She reported being robbed three times as her most traumatic event. She shared that she does not “feel secure anywhere.” She also mentioned the loss of the baby and her mother-in-law being burned as traumatic. She stated that she does not really want to talk about the deployment or other traumatic events with her husband.

Next, Table 3.1 will provide a visual layout of the demographics of each couple within the sample.

**Table 3.1 Demographic Information.**

Participant Number	Couple 1		Couple 2		Couple 3		Couple 4		Couple 5		Couple 6	
	M	F	M	F	M	F	M	F	M	F	M	F
	HRS		LRS		HRS		LRS		HRS		LRS	
Age	26	29	25	24	23	24	31	22	31	33	40	32
Race	E	E	E	E	AA	AI	E	E	E	AI	E	E
Length of Marriage (yrs)	3 Years		2.5 Years		.5 Year		6 Years		3 Years		2 Years	
Deployed	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	No
Location of Deployment	Iraq	Korea	Iraq	Japan	Iraq	-	Iraq	-	Iraq	-	Iraq	-
Length of Deployment	13.5mo	N/A	12 mo	N/A	11 mo	N/A	12 mo	N/A	11.5 mo	N/A	.5 mo	N/A
Job in Military	Guard, Search, & Seize Weapons	N/A	Military Infantry	N/A	Dispatch, Patrols, Security Guard	N/A	Truck Driver, Patrol, Detain Prisoners	N/A	Medic	N/A	Infantry	N/A
PPTSD-R scores	61	70	66	28	53	66	52	68	53	47	53	51
DAS scores	102	119	89	88	111	110	77	63	105	101	69	74
TEQ scores	9	9	10	0	6	7	8	9	7	10	11	6
TEQ Most Traumatic Event	Wife's Stroke	In/Witness Atrocities	Child Physical Abuse	Sudden Death of Mother	In/Witnessed Serious Accident, Fire, Explosion	Victim of Sexual abuse, Unexpected death of mother	Child Sex Abuse, Served in War Zone, Danger of losing Life, Witnessed Mutilation or Violent Death	Victim of Rape	Received News of Mutilation Serious Injury, Unexpected death	Child sexual abuse, Witness death	Mother in Fire, Sister died, Wife Miscarried	Victim of Rape
Was Deployment Traumatic?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No

E=European-American, A=African-American, AI=American-Indian/Alaska Native, HRS=High Relational Satisfaction, LRS=Low Relational Satisfaction



**Figure 3.1 Types of Traumatic Events Experienced by Participants**

Figure 3.1 provides a visual aid of the types of traumatic events that each participant identified in the TEQ questionnaire. The sample consisted of many different types of trauma.

## **Design and Analysis**

**Data selection.** For the current study, the analysis was conducted and both couples and individuals were used as the unit of analysis. Couples were the primary source of data collection. Data collection began in August 2004 and concluded in September 2005. Participant data selection was determined by reviewing each participant's Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996), Dyadic Adjustment Scale (DAS; Spanier, 1976), and Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) scores of the original data set. Of the 45 soldiers in the original sample, 10 soldiers with the highest PPTSD-R scores were identified. Selecting the soldiers with the highest PPTSD-R scores provided an information-rich sample. Although there is not a cut-off score with the PPTSD-R, all of these soldiers had scores over 50 points, indicating higher levels of PTSD symptoms. Secondly, the DAS scores and the TEQ responses were reviewed for each soldier. The TEQ responses and the item that each soldier indicated as their most traumatic experience were reviewed to determine if they all identified their OIF/OEF deployment experience or other non-deployment related events as their most traumatic. Lastly, the PPTSD-R, DAS scores, and the TEQ responses of the spouses/partners of these ten soldiers were reviewed. Of the ten spouse/partners, seven indicated high PPTSD-R scores (over 50). Of those seven couples, four had high DAS scores (over 100) and three had low DAS scores (under 100; Eddy, Heyman, & Weiss, 1991). However, one transcript was incomplete, leaving only six transcripts for use in the study. Therefore, six couples (12 participants) with high PPTSD-R scores were identified, with three couples' scores indicating high PPTSD-R scores and high DAS scores and three couples' scores indicating high PPTSD-R scores and low DAS scores (below 100 in the DAS).

With having three couples scoring high levels of DAS and three couples scoring low levels of DAS, an investigation to note any differences was completed by comparing the groups. The demographics of the six selected couples included six male soldiers and six female partners, all of whom were married. There were two American Indians or Alaska Natives, one African American (Black), and nine European American (White) participants. Participant ages ranged from 22 to 40 years old, with a mean age of 28.33 ( $SD = 5.297$ ). The length of marriage ranged from 6 months to 6.5 years, with a mean length of 3.08 years ( $SD = 1.75$ ). The six soldiers were deployed between the months of March 2003 and September 2004. The duration of their deployment ranged between 5-13.5 months. All six of the soldiers had been deployed to Iraq as part of Operation Iraqi Freedom.

**Qualitative analysis.** Qualitative analysis was employed in this study through the use of individual qualitative interviews. Questionnaires were utilized to assess the symptoms of PTSD, relational satisfaction, and to review the reported trauma history. Qualitative methodology provided both depth and breadth to articulate the intrapersonal and interpersonal dynamics and developmental processes from the raw data and standardized methods. The data were analyzed through a process of coding and finding patterns, themes, and/or categories within the interview data that are characteristic of DAS, PTSD, and other relevant thematic categories. For qualitative analysis, NUD\*IST (N6) qualitative computer software (Richards & Richards, 2002) was utilized to assist with organizing, dividing, and entering all themes into groups. The plan of analysis included the following steps:

1. Read the purpose and research questions of the study and determined what to look for in the data.
2. Read the transcripts and highlighted any unique or relevant phrases and sentences.

3. Read and re-read highlighted portions to develop key words (themes, patterns, or categories).
4. Divided the themes, patterns, and categories into groups by the research questions.
5. Examined the convergence/divergence by completing the following steps:
  - a. Convergence was examined by determining what themes fit together to develop the internal homogeneity and external heterogeneity.
  - b. Internal homogeneity was determined by analyzing the themes to see which are more similar and external heterogeneity was determined by analyzing the themes to see which ones are distinctly different from each other (Patton, 2002).

These processes enhanced the credibility of the research. Divergence revealed some of the patterns within the categories and helps to make connections among the themes for categorical saturation (Patton, 2002). Divergence also helped to determine which themes to keep.

**Phenomenology.** In examining the systemic effects of trauma in military couple relationships as a result of war deployment, phenomenology provided a method of reviewing the participant's data and assisted in gaining a deeper understanding of the meaning of the participants' lived experiences. The term phenomenology was originally coined by Ulrich Sonnemann in 1954 (Patton, 2002). A phenomenological theoretical framework seemed most appropriate for this study in exploring the systemic effects of trauma of military deployment. Phenomenology's essential concepts include knowing and interpreting the experiences of others and that in order to know the experiences, one must experience the phenomenon himself/herself (Patton, 2002). To understand the meanings of a particular phenomenon, qualitative data were obtained through interviews from the participants who have experienced the phenomenon (trauma) (Patton, 2002).

Considering the purpose of this study, the collection and analysis methods coordinated well together. For example, qualitative methodology obtained detailed descriptions in order to understand the effects of trauma in couple relationships. The collection method yielded specific cases to study and phenomenological analysis provided an understanding of each participant's lived experience.

### **Researcher as a Measurement Tool**

In qualitative methodology, I have two major roles: the role as the researcher and the role of being the instrument (Patton, 2002). Therefore, the credibility of the researcher is important. My personal history of living with a father who is diagnosed with PTSD and the training I have received influenced the credibility of this study. I am a new researcher, with several publications, but with limited training in qualitative methodology. I have participated in several research studies at undergraduate and graduate levels, both quantitative and qualitative, with the most experience in qualitative analysis. However, my research experience overall is limited. I received a Bachelors of Arts in Psychology from Tougaloo College in Jackson, MS, and I received a Master of Science degree in Marriage and Family Therapy from the University of Southern Mississippi in Hattiesburg, MS. Currently, I am doctoral candidate in the department of Family Studies and Human Services in the College of Human Ecology for a degree in Marriage and Family Therapy at Kansas State University in Manhattan, KS. I am a licensed Marriage and Family Therapist with eight years of clinical experience. As a clinician, I have treated various behavioral health issues with individuals, couples, and families (such as depression, schizophrenia, trauma, conduct disorders, and mood disorders) and addictions (such as drug and alcohol dependence, sex addiction, and eating disorders). I have a particular interest in facilitating group therapy in the treatment of addiction. I also enjoy providing weekly

psychoeducational lectures on various behavioral health topics to adult populations. I currently teach Marriage and Family courses at Pearl River Community College and have taught The Helping Relationship and Body Image: Family and Cultural Context courses at Kansas State University. I have facilitated reintegration trainings for soldiers returning from deployment at Fort Riley Military Base in Fort Riley, KS. Most recently, as a contract therapist, I provided vocational rehabilitation testing for veteran benefits for the state of Mississippi through the Department of Veterans Affairs.

As the measurement tool, the strengths include: a sincere personal interest in this area; a personal history of living with a father who has PTSD; having an apprenticeship at the Veterans Affairs Hospital in Gulfport and Biloxi, MS, in the PTSD units; and experience in conducting qualitative interviews, coding, and analyzing qualitative data as a member of the TRECK Team. As the measurement tool, the weaknesses include a limited amount of experience in conducting or analyzing qualitative data and the dual role of being the researcher and an analyst. The dual role of researcher and analyst may also be a strength because it affords the opportunity to be very knowledgeable of the research data, which is credible in qualitative methodology (Patton, 2002).

While conducting and analyzing this research, I have increased my understanding from the perspective of males/females and spouses/soldiers of military life and the effects of various types of stressors and traumas. As a daughter of a father with PTSD, a Marriage and Family Therapist, a facilitator of reintegration trainings with soldiers, and a contract therapist for the Veterans Affairs, I feel that I have the experience and the passion to assist individuals, couples, and families in learning more about secondary traumatic stress.

The analysis investigated the rich detail of the participants' reports of their experiences. Phenomenology, as the theoretical framework, assisted in summarizing and structuring the

findings. The research questions are validated through investigating the data for common experiences (themes) among the participants. This study examined the systemic effects of war trauma in military couple relational systems, and attempted to expand the knowledge of secondary and systemic traumatic stress.

## CHAPTER IV

### RESULTS

Researchers have focused on war-related trauma and PTSD addressing the symptoms of the primary trauma survivors (i.e., the deployed soldiers), while less research has been conducted to investigate the impact of the traumatic events on those close to the primary survivor, such as the spouse/partner. The purpose of this study was to gain an in-depth understanding of the systemic effects of trauma, particularly war-related traumatic stress, as a result of military deployments to Iraq and Afghanistan, in a sample of recent war veterans and their spouses. The study examines the systemic effects of trauma as it specifically impacts couple relational systems.

This chapter provides descriptive narratives of six couple participants (12 individual participants), in which the male partner had been deployed. Each participant completed individual questionnaires and participated in separate, individual standardized open-ended interviews. The participant interviews produced qualitative data, which allowed the study of the experiences of both the male soldiers (primary trauma survivors) and their female spouses (primary or secondary trauma survivors). Participants were identified with a letter for male (M) or female (F) and a participant number. For example, Participant 6 female was identified as 6F or Participant 2 male is 2M. The process of coding and finding patterns, themes, and/or categories within the interview data that were characteristic of relationship satisfaction, trauma symptoms and other relevant thematic categories emerged from the analysis of the interviews. The thematic categories are summarized in the next section.

## **Thematic Categories**

The collected data and analysis of this study resulted in four thematic categories. The four thematic categories include the positive impact of deployment on the couple relationship, the negative impact of deployment on the couple relationship, soldiers' war-related trauma, and issues of secrecy. These thematic categories provided rich examples of the systemic effects of trauma. In addition to the four thematic categories, the data were used to identify two groups (high trauma/high relational satisfaction group and high trauma/low relational satisfaction group), based on the quantitative measures of the quantitative assessments that were completed by all participants. These groupings allowed for some group comparisons between the participants. The participants reported many common experiences, both war-related and personal, that will be shared below.

**Positive impact of deployment on the couple relationship.** Upon reviewing the 12 participant interviews, themes began to form and were coded for the specific impact of war deployment on their relationships. The participants each reported information that was indicative of the positive impact of their war deployment experiences on their couple relationship. All 12 participants described the positive impact the deployment had on their relationship, such as positive role changes due to the deployment, providing/receiving support during the deployment, and positive communication. For example, communication was mentioned by every participant and appeared to be important to all participants. Communication was a key factor within the sample in identifying the positive aspects of the war deployment separation. Many couples seemed to rely on any means of communication to endure the war deployment separation. The following are verbatim examples of the positive systemic effects of communication during the deployment:

*Interviewer: How did your husband support you during his deployment?*

*Participant 5F: He wrote letters. He would call me whenever he could. Thank God for e-mails. Yahoo messenger...that's what really kept me going.*

In some cases, the internet was the only source of communication for most soldier participants, which can either positively or negatively affect relational adjustment, but was positive in this example. Thus, deployment separation may initiate positive changes in the couple's communication during and upon their return home. Another spouse shared about the communication and support that positively impacted her relationship:

*During his deployment, he was loving and comforting, letting me know everything was okay. He wrote me regular e-mails, you know, just to say hi and, I mean, we got back together in the middle of his deployment...we were separated when he first deployed actually right before he deployed, we were separated [and] talking divorce. So, we got back together right in the middle of that. And I think it was a shock for him. Because honestly we had been so tacky to one another during the separation, it was horrible. But when we decided to get back together and make things work due to the baby. I mean, it, was like a complete 180 [turn around]. (2F)*

In this example, the deployment separation might have had a negative impact due to the state of this couple's relationship prior to the deployment; however, communication during the deployment separation resulted in positive changes in their relationship and reunited the couple prior to the soldier's return home. Additionally, all couples described communication and receiving support during the deployment in the same context, as communication was commonly mentioned as a way to provide and receive support during the deployment.

The participants generally reported feeling supported through their communication, such as sending letters, phone calls, emails, and other methods of communication. One soldier described the support he received from his spouse:

*She listens when I talk about the deployment. She listens without a problem ...she knows everything,' cause when I first went over there she wasn't in the FRG (Family Readiness Group) now she's nothing but family readiness. (5M)*

Participant 5M described how his wife increased the level of support due to joining the FRG support group, which he described as enhancing her ability to support him during the deployment. Support was reported by several participants as having had a positive impact on the couple's relationship during the deployment.

While communication and support were important factors in this sample of couples, role changes were also found to be a common positive result from the deployment on the couple relationship within the sample. Role changes in this study were identified as any changes within the participants' behavior that affected their role in the relationship or any changes in their relationship related to changes in responsibilities or duties. Positive role changes were shared in the sense of accomplishment and empowerment by the participants. Many role changes directly resulted from the deployment separation. Deployment seemed to produce role changes (i.e., strengthening relationships, personal growth, and increased independence) that positively affected the participant's relationship primarily due to the separation. The soldiers generally shared that they were satisfied with their role and that the deployment allowed them the opportunity to evaluate their role (i.e., personal qualities) in their marital and family relationships. For example, one soldier described the personal growth he experienced:

*That changed me a lot because the first things I saw, I kid you not, was my family- my*

*wife and my kids. Like flashed...I need to change, and that's what I thought about 'til after we got to our destination point and after the big firefight and everything. I just sat there and thought about it, and was like, I've been an ass for most of my life, towards my marriage. I was like, now I need to change. (4M)*

The spouses generally described the positive changes that they noticed in the soldiers, such as demonstrating more care and concern. Participant 5F shared:

*He was a lot more caring. I mean [Husband's name] cared about me but when he got back it was more, there was more lovey dovey stuff. He was always holding my hand. We used to briefly hold hands before, I mean barely. I used to hate holding hands. And when he got back that's all he wanted to do was hold hands. He always wanted to cuddle. He was just more affectionate when he got back. (5F)*

When asked how her relationship was affected by her husband's deployment, Participant 5F replied by stating, "*made [it] stronger.*" Likewise, another spouse shared that she was expecting her husband to return as the same person he was before he deployed:

*I expected him to be the same old, the old [Husband's name] you know... just the way he was when he left is the way he'll come back. Since the deployment occurred, he's grown up a whole lot. You know, before he was all me, me, me, and it was all about him. And now it's not. It's about us as a whole, as a family. (2F)*

The deployment separation provided an opportunity for personal growth for some soldiers. Spouses also experienced positive changes and personal growth as a result of the deployment separation. For instance, one spouse shared, "*I'm more independent. I can deal with things by myself and not have to have him there to pretty much hold my hand and tell me to do*

*certain things*” (1F). Several spouses described their increased self-sufficiency and independence due to acquiring more responsibilities during the deployment. These spouses described the benefits of becoming more independent, with having had the experience of practicing independence in case of future deployments being the most common benefit.

The positive impact of deployment on the couple relationship was a theme that all participants described as having positive effects during a time in their lives when they each mentioned enduring limited communication and separation from their spouses. Interestingly, being “satisfied” at some level in their role in the relationship, having support during the deployment, and communicating during their deployment experiences seemed connected to having more positive effects from the deployment. However, participants also described the negative impact of the deployment on the couples’ relationships, which will be described next.

**Negative impact of deployment on the couple relationship.** While all participants described positive ways that their relationship was impacted by the deployment, the interviews also revealed ways that their relationship was negatively impacted by their deployment experiences. The negative impact of war deployment on the couple relationship was described in all 12 interviews. The negative effects of deployment resulted in several subthemes based on the participants’ reports, including increased responsibilities and duties, soldiers missing special events and having difficulty transitioning home, negative communication (i.e., decreased communication and lack of communication), and spouses reporting difficulties with supporting the soldiers upon returning home.

The first subtheme, increased responsibilities and duties, was reported by all participants as having a negative impact on their relationship. Increased responsibilities and duties were described as fulfilling parenting roles, fulfilling household chores and related tasks, and

managing all finances alone. The female spouses talked about having to take on the responsibilities that the soldier could no longer take on due to being deployed. Spouses emphasized the negative impact of having to learn how to do some things alone for the first time, which presented some stress and dissatisfaction. Participant 1F gave an inclusive description of these subthemes of the negative impact of the deployment on the couple relationship:

*Interviewer: How has your husbands' recent deployment most affected you personally?*

*Participant 1F: I've had to raise a set of twins without him. He wasn't home for their birth, he left when I was five months pregnant, came back when they were eight months old and having to deal with them and him not being there and not being able to come home, it's stressful. (1F)*

Changes such as these were a common theme throughout the sample as the spouses shared the negative impact of the deployment, particularly related to the increased responsibilities spouses assume when soldiers are deployed. Likewise, Participant 1M shared that the deployment affected him in similar ways, in that he missed some special events and had difficulty transitioning back into the marriage and parenting, while feeling like a stranger in the house. This subtheme was reported by several soldiers. The quote below provides a description of the soldiers' experiences:

*I never got to see my kids when they were born. I never got to see any of the three children's first steps. Well, I take that back, I saw my twins just turned a year, I got to see their first step, but I never saw their birth. I missed a lot. And it hurts when I came back I had to learn who my wife was all over again. We had to work things out all over again. I had to slowly work my way back in. It's kind of like a next door neighbor trying to live in the house. (1M)*

This soldier shared that the deployment had the most negative effect on his relationship during the initial days of being home. The soldier's spouse described the relationship congruent to her husband's description by sharing that she and her husband had to basically start their relationship all over due to his deployment schedule of "*gone for eight months, back for six weeks, gone for six months, back for a month, gone for three months, back for two months, and gone for a year*" (1F). This is a clear example of the negative impact deployment has on couple relationships, as this couple endured stress, role changes, and less support particularly during the deployment separation.

Whereas, the female spouses commonly reported the stress related to the role changes and receiving less support, the male soldiers of this sample often reported similar negative effects of the deployment, such as missing special events, changes in their roles, and having to transition back home and into their relationships. Participant 4F shared how she reacted to her husband's approaching departure date. The arguing, fighting, and distancing within the relationship began the transition from living as a couple to living separately as the couple would during deployment. Her spouse described his transition:

*[It's] been very hard. Difficult, I mean you're over there and you just drive and you're constantly on guard and you're always looking every which way, and then hope I don't hit nothing, or hope I don't hit a bomb, or somebody don't shoot me. When I got back here it's just like the first night in the house I kept looking out the window, you know looking around. It was a pretty hard transition. (4M)*

Eight of the 12 participants specifically reported difficulties related to their roles changing due to the deployment, illustrating the negative impact of the deployment in their couple relationship. Participant 2F reported:

*I would say that's been the most difficult part because, I mean, I handled everything anyway. You know I did all the finances. [Child's name] and I had a routine. We'd wake up at a certain time, we'd do this, we'd do that. She had her television time, when he came home, (laughs) I still did the finances, but between mine and [Child's name] routine got thrown all into bits. He's been home since September, and we're really just now getting into the swing of things. (2F)*

Several female spouses reported becoming more independent during the deployment separation. The spouses became solely responsible for all areas, which becomes problematic upon the soldiers' transition home when roles and responsibilities are realigned. Several soldiers mentioned noticing their spouse's increased independence upon returning home:

*She pretty much became independent and she always relied on me, that's what I felt like. I'm like, yeah, she needs me and now when I got back, it's like she don't need me. You know it's like she was so independent and I didn't try to change any of that it's just, it was hard for me. It's like, you know, she always needed and asked me to do everything for her and now she's like, that's hard for me. (4M)*

While it was hard for some soldiers to adjust to their spouses' increased independence, some spouses shared being overwhelmed upon their husband's return by not knowing what to say or how to react to the soldiers sharing their war deployment experiences. Participant 3F shared:

*I think when he came back is when like you know how they come back they tell you everything that happened and you're just like, "Wow," you know. And it's as it's just a*

*lot to take in and it's like you don't know what to say, you don't know what to do, you don't know to hug them, cry, lay down, go to sleep, start all over again. You just don't know. And it was like okay when he was there and I was talking to him knowing he was fine but now he's here, I see his face, he's talking to me and he's telling me what he seen and what happened to him and stuff. It's really hard, it is, it's really hard. (3F)*

Another spouse shared her lack of trust and difficulty knowing how to help her soldier upon his return home:

*So, you have this traumatic stress disorder that you see your spouse going insane, scared out of his mind, jump to the ground and hiding. I feel that it destroys a part of them inside because they went through something that they had never gone through before. We, as the spouses, are trying to deal with them and trying to figure out how to help them. In the long run, all it kind of does is destroy your relationship 'cause you want to help but they don't want you to help and they want you to stay out of it. They don't want you to ask questions. They want you to just stay far away from it. (4F)*

While some soldiers may return and share their war deployment experiences with their spouses quite well, other soldiers share little to no information. There seem to be two varying extremes of communication among the soldiers and spouses, with one extreme involving much information/details about the war deployment experience and the opposite extreme being limited to no information/details at all about their war experiences. Communication and support are necessary to have positive dyadic adjustment. However, negative or poor communication may lead to negative dyadic adjustment as evident in one particular couple who shared that their

marriage was suffering due to the poor communication. Couple 4 described the lack of communication:

*Interviewer: How would you describe your relationship with your husband?*

*Participant 4F: No communication. He's had no desire since he's been home to do anything but for himself, which makes me angry. So overall our marriage is on the rocks in some way. Him being a dad is perfect. And him being there for them is perfect and, I know he would never let anything happen to the three of us. It's just his mind is not in the right place sometimes. (4F)*

And the male reported:

*Participant 4M: We didn't really talk. No communication whatsoever and that's mostly my fault... things she needed to hear and things I thought, I always kept them in. Sometimes we do and I always talk about things I want to and when she starts talking for some reason I always, you know, change the subject. I don't try to it's just I'm not a very good communicator, or listener I should say. (4M)*

Even though all participants reported having positive effects from the deployment, the participants also reported specific negative effects from the deployment on their relationship. These findings illustrate how couple relationships are both positively and negatively affected by war deployment. The two major themes were formulated based on the participants' report of the impact of deployment on their couple relationships. Thus, the specific effects that have been described are a direct result of the soldiers' war-related trauma. The next section will reveal the impact of the war-related traumatic experiences of the soldiers, which will help to understand the connection between the individual experiences and the effects of the deployment on couple relationships.

**Soldiers' war-related trauma experiences.** The impact of the soldiers' war-related experiences was reported by all of the participants. In the questionnaires completed by the participants, both soldier and spouse participants were asked questions specifically about their trauma history and each participant completed a posttraumatic stress symptom assessment to determine their levels of trauma symptomatology. The emergent theme enveloping trauma symptoms was predominately reported as it related to soldiers' war-related trauma. Thus, the soldiers' war-related trauma was identified as a thematic category, with the soldiers' traumatic stress symptoms and spouses' secondary traumatic stress as subthemes. However, it is important to note that all participants, both soldiers and female spouses, reported some type of personal trauma history, such as a sudden or violent death of a loved one, victim of abuse, and witness to atrocities/serious accidents that occurred prior to their deployment experience that has impacted their lives. However, the soldiers war-related trauma experiences were identified as the primary experience connected to individual symptoms in both soldiers and spouses.

*Soldiers' traumatic stress symptoms.* The recognition of trauma experiences and symptoms and its impact on couple relationships helps to illustrate the meaning of each individual's perspective of the systemic effects of war deployment in general. Examining the individual reports of their trauma history resulted in classifying the symptoms of trauma as posttraumatic stress disorder symptoms (i.e., sleep disturbances, nightmares, intrusive thoughts and memories, flashbacks, depression, anxiety, and anger issues), specifically, the data revealed two of the three key PTSD symptom categories: re-experiencing (i.e., flashbacks, intrusive thoughts/memories) and arousal (i.e., anger outbursts, startle response). The following verbatim data described the effects of war-related trauma on couple relationships. Participant 1F described her husband's PTSD symptoms (i.e., re-experiencing) as she recognized and observed them:

*He has several flashbacks. One of the first, actually the first night he was home, I was coming out of the shower and I had my hair wrapped up in a towel, and he hit me not knowing, he forgot I was his wife. The only thing he saw was a towel, and, and thought I was an Iraqi. He clocked me. So it's little things I have to watch out for, he still has his flashbacks. When the kids are screaming and stuff, it reminds him about the kids screaming over there. You've just got to walk on egg shells sometimes around him. (1F)*

Interestingly, her husband described the same experience when asked how his deployment affected him: “occasionally something will click in the house, or I'll leave the TV on downstairs and something will shoot or bang, or whatever and I'll sit up, get out of bed and I'll search the whole house”(1M).

Another participant shared her use of caution with her husband due to his PTSD symptoms, particularly arousal symptoms:

*You can be walking somewhere and he'll see something or hear something that triggers him and he'll suddenly put his back up against something so nobody can get in behind him...if he hears me come into the room, sometimes he'll jump up and come after me but he's still asleep. You don't know what he's gonna do when you come in the room. (6F)*

Similarly, another spouse shared how helpless she felt due to her husband's traumatic experiences:

*I've seen this grown man jump to the ground. I've seen him in a corner. I've seen things I don't even want to see. About a month and a half before they left again, it started all over again. (4F)*

Surprisingly, her husband, Participant 4M, reported being “calmer” after deployment, but he also described symptoms of hyperarousal:

*I'm very alert. If there's a noise, I look around. Sometimes I look out the window and it just I'm more of calm-calmer person. Yeah, very calm, but alert. It's just like I'm laid back, nothing really affects me if you call me every name in the book, I'm just sitting there like, "Yeah, whatever..." I've always had a huge temper and it takes a lot to get it up now. And it just, in that aspect I've just calmed down. (4M)*

These examples reveal the real-life experiences that were shared by the majority of the sample. As mentioned by 1F, *"you just got to walk around on egg shells sometimes around him."* This verbatim data revealed the effects that the soldiers' war-related deployment trauma has had on both the soldiers who directly experienced the war, and the spouses who are dealing with the effects of the soldiers when they return home.

*Spouses' secondary traumatic stress.* The effect on the female spouses, or secondary traumatic stress, was described by five of the six spouses of this sample as continuous fear and worry about the fate of their deployed spouses' lives. Some spouses shared about the phone calls made to their husbands during the war and hearing the bombings or the phone calls that were disconnected due to being in a war zone. The female spouses described their reactions after hearing about their soldiers' traumatic war experiences. Many spouses shared their intense fear and worry about if their husband would call back, which sometimes took several days. The spouses described being affected by anything that affected their husbands due to their war deployment experiences. Thus, the spouses described having their own secondary traumatic stress symptoms, including sleep disturbances, hypervigilance, appetite disturbances, and other difficulties. The following quote describes the ways in which spouses commonly reported experiencing secondary traumatic stress:

*I think it's all traumatic, but when you don't get a phone call until like six weeks and you hear all this stuff with his Unit or his Brigade on TV about people getting killed, people getting injured, stuff you don't hear from your husband. It is getting, it is traumatic, you kind of wait by the door or by the phone to see if that green car is going to pull in your driveway and they'll tell me that he's dead. That's pretty much everyone, every woman, every wife's nightmare. (1F)*

Many spouses shared that their anxiety was increased due to the media coverage and constant waiting for a notice that their husband was killed in action. Spouses reported that hearing news of an injury or death of another soldier in their husband's unit usually led to tremendous anxiety and worry. In addition to the stress of watching the television and accounts of the war, the spouses were also told to have the funeral arrangements prepared, which terrified the spouses. Having to go through the process of preparing for the unforeseen death of their husbands was traumatizing, but was directly related to being a military spouse.

Many spouses also reported experiencing anger at some point during the deployment.

One spouse shared how she was most affected by the deployment:

*Whatever affects him affects me. You know if he's emotionally distraught or angry or stressed, that reflects on me and I get angry or stressed out. I believe any trauma he has persevered over there, it does reflect on me because I feel what he feels. (2F)*

This section illustrated the real-life experiences of war-related trauma and secondary traumatic stress. Nightmares, anger, depression, anxiety, hypervigilance, and sleeping problems were the most commonly reported symptoms within the sample for the soldiers and spouses. The data revealed the direct effects of war-related trauma on both the soldiers and their spouses.

While some participants revealed their traumatic experiences, some refrained which will be discussed in the next section.

**Secrecy.** Soldiers and spouses within the study reported withholding information and details about their trauma experiences in general, both military and non-military related experiences. A theme of secrecy emerged from the data about the traumatic experiences specifically related to their war deployment. Some secrecy seemed to be in an effort to protect their spouses, while some secrecy seemed to be in an effort to avoid re-experiencing traumatic memories. While very few female spouses described issues related to secrecy, several of the male soldiers described sharing little information about their war experiences. When Participant 2F was asked, “How would you rate [on a scale of 1 to 10] your ability to talk to your partner about the deployment,” she replied:

*I think I'd say two because he doesn't want to speak of anything over there...he'll say I don't understand, I was not there. I can agree with him, I wasn't there, I don't know what happened or what went on. (2F)*

Interestingly, four of the six soldiers reported withholding information and/or details about their deployment experience due to fear of their spouses' emotional reaction, not understanding, or disbelief. Participant 3M shared:

*We just never really talk about it. I don't think she knows how it really affected me. And I don't, I look at it like. I don't know if she would understand...even if she would believe me. (3M)*

When coping with traumatic events, several of the participants in this study withheld information initially about their traumatic experiences until they decided to share the information. Participant 5M shared:

*When I got home I wouldn't talk to her the first couple of weeks about it... I told her everything that happened with the soldier dying and everything with a counselor there so she could understand how I felt about the deployment, what I saw. So she could ask questions to me and to the counselor on if her response would be correct or if she was over respond-overreacting of how she worried. (5M)*

Many spouses reported “walking on egg shells” in response to their spouse’s war-related trauma. Likewise, the male soldiers also reported not knowing what to do in response to their spouse’s own trauma experiences. One participant shared the following in reference to his spouse’s rape, which occurred when he was deployed:

*I really don't know what to say...If she wants a comment, and I don't say one, she yells at me and then when I do say one she's like, “Why would you say that?” It's like a lose-lose situation. I try to be supportive, but I don't know what to say. And I don't know what to do and it hurts. It's like you know, what the hell can I do about it?... It's gonna take her a long time to get over everything, everything that happened in her past and I don't know if she ever can. (4M)*

As Participant 4M shared, several male spouses reported that they did not know how to discuss their wife’s past trauma, but wanted to offer support. All of the participants within the sample reported other non-war-related trauma that affected their couple relationship during and after the deployment, which is important to discuss because the female spouses may have been affected by their own traumatic experiences. Two of the female participants (1F and 4F) reported the traumatic experience of being raped while their husbands were deployed. Interestingly, neither spouse identified the rape as their most negative effect of the deployment. However,

Participant 1M mentioned that it was difficult to hear when he was deployed due to thinking that he may have cheated. Several other participants (3F, 4M, 5F) reported a history of sexual abuse. Participant 3F did not provide any specific details about her previous sexual abuse; however, she indicated that it continues to directly affect her:

*Interviewer: How about the sexual abuse? How has that most affected you personally?*

*Participant 3F: Actually, I try to talk to [spouse's name] about it half of the time but it doesn't seem like it works. He doesn't understand at all and it happened so long ago, but it's like it happened yesterday, you know. It's like it's right there, you don't forget anything like that. It's, it's like you close your eyes you see it, you blink you see it. It's, it's real hard to deal with. (3F)*

Participant 5F shared the effects of her past childhood sexual abuse:

*Interviewer: How has [your previous sexual abuse] affected you?*

*Participant F: I didn't find myself getting into relationships easier. I was very cautious. And then there was times that, I don't know it was, it just depends on what the mood was. If a guy was trying to hit on me, my barrier would go up, and there's times my barrier would go down.*

Participant 5F shared examples of re-experiencing and arousal types of PTSD symptoms as a result of being sexually abused. She identified the sexual abuse as being “extremely” traumatic. She reported that the negative effects of the abuse were that she “hated sex,” which impacts her marital relationship. Thus, this data supports the conclusion that the couple relationships were affected by both the war deployment and non-deployment related traumatic experiences.

In summary, the thematic categories revealed the real-life traumatic experiences of the soldiers and spouses within this sample. The data provided positive and negative effects of war

deployment on the couples' relationships. The next section will compare the participant's responses to reveal any similarities and/or differences within the sample.

### **Group Comparisons**

**Demographics.** The participants were placed into two groups based on their high relationship satisfaction score (HRS) or their low relationship satisfaction (LRS) score to be compared and to explore any differences between the groups within this sample. Of the six couples identified in the present study, all six of the soldiers and spouses had high trauma symptoms, half of the couples had high relationship satisfaction scores, and half had low relationship satisfaction scores. Demographic data were reviewed to examine the general characteristics of the participant groups to reveal possible similarities and differences. Interestingly, within the age demographics, for the couples who indicated low relationship satisfaction, all of the females were younger than their husbands. In the high relationship satisfaction couples, the females were all older than the male soldiers. The high relationship satisfaction group couples were more racially diverse with African-American, American-Indian/Alaskan-Native, and European-American participants, while the low group couples were all European-American (white). There did not appear to be a difference or comparison in the length of marriage or the number of marriages for each participant between the two groups. As a result, factors that may differentiate the HRS and LRS groups could be that the HRS group female spouses were older than the LRS female spouses and the HRS females were older than the male soldiers, which may mean that they are more mature and more experienced in dealing with traumatic events that have occurred. The LRS females were all younger than their male soldiers, with two spouses (ages 22 and 32) being eight or more years younger than their husbands. Maturity could be a defining factor in anyone's ability to cope in difficult situations,

such as trauma and/or war deployments. Additionally, maturity may be the mending element in marital relationships to assist in being able to relate, connect, and achieve a positive level of satisfaction; thus, age may be a defining difference between the HRS and LRS groups. In the next section, the trauma history of each participant was examined and compared to provide possible explanations of why the HRS has higher levels of relational satisfaction than the LRS group.

**Analysis of trauma history in both partners and both groups.** The responses to the types of traumatic events experienced were reviewed to determine if the OIF/OEF deployment was the participants' most traumatic event. For some of the participants, the OIF/OEF deployment was identified as most traumatic to them. For instance, participant 4M (LRS) identified the deployment as one of his most traumatic experiences:

*I had to pretty much run over people, shoot people and watch them die. It was an experience and when I did, there goes a human road block. We would call them up saying these dudes are blocking the road and we got word before that saying somebody's blocked the road. And because it was human road blocks, people can start firing RPG's and throwing grenades and everything else at us, so [the commander]'s like "Run their ass over" and I said, "ok." Just the crunching sound you would hear... it's pretty graphic. (4M) (LRS)*

Interestingly, several soldiers in the sample indicated other traumatic experiences (non-deployment related) as their most traumatic event. While all participants described deployment-related experiences, some of the participants focused more on these other traumatic events that were non-deployment related, such as deaths/severe injury of family members and abuse (rapes).

Participant 6M (LRS) identified the non-deployment related traumatic event of his mother having 30% of her body burned in a fire:

*Seeing her in a hospital with tubes in her throat, just the doctors saying she might not come out of it. And my dad wanting to disconnect the life support. That was really hard. My dad just kept her hooked up and he decided to keep it and so she's come out of it and all her skin didn't need graft or anything. She's done really good. (6M) (LRS)*

For this sample, non-deployment related experiences may have been identified as more traumatic by the participants, with the deployment being described as stressful. The stress of the deployment seemed to exacerbate the events that occurred during the deployment or soon after the deployment and may be a possible reason for half of the sample reporting lower relationship satisfaction scores. This possibility may indicate the difference between the two groups in the sample in understanding why half of the sample indicated high levels of trauma and high relational satisfaction, while the other half indicated high levels of trauma and low relational satisfaction. For example, the female spouses of Couple 2 and Couple 6 (both LRS) were the only two spouses of the sample who did not report a history of rape or sexual abuse, but they did report other non-deployment related traumatic experiences. Four female spouses of the sample reported being raped and/or sexually abused, with three of the four spouses being in the high relationship satisfaction group.

Generally, the rape, sexual abuse, or other non-deployment related traumatic experiences may have had a negative effect on relational satisfaction, but according to these spouses, who were in the high relational satisfaction group, it may be that their high levels of trauma provided them a personal level of understanding, the ability to relate and connect with their male soldiers because of experiencing their own history of trauma. As mentioned in the previous sections, the

male soldiers also reported having non-deployment related traumatic experiences, such as mother being burned in fire, death of a family member, child physical abuse, sexual abuse, and yet three of six soldiers indicated high levels of relational satisfaction. Thus, it may be the personal experiences of enduring high levels of trauma that contributes to high relational satisfaction in these couples by providing “common experiences.” This conclusion may be one difference between the HRS and the LRS groups.

In addition to reviewing the types of traumatic events experienced by the HRS and LRS groups, analyzing the total number of traumatic events reported by participants on the Traumatic Events Questionnaire (TEQ) scores may provide some understanding of how the groups differ. Multiple traumas were reported in both high and low relational satisfaction groups. Overall, four of the six female participants reported experiencing more traumatic events than their male partners. For example, Participant 5F (HRS) reported 10 different traumatic events on the TEQ measure. When the interviewer asked what her most traumatic event was, she indicated that being a victim of sexual abuse as a child was one of her most traumatic experiences. The participant shared that she has communicated with her husband about her abuse:

*Yes he's the one I go to when I have nightmares. He's the one when I have a flashback that I don't understand I'll go and ask him. I have blackouts and I don't even know I have them. He's there, he'll tell me what I did or what I said. (5F)*

Participant 5F also reported high relational satisfaction and in her traumatic experiences, and the above example reveals the relationship between high levels of relational functioning in couples with high levels of trauma. As mentioned previously, she reported multiple traumatic experiences according to her TEQ score; yet, she was able to communicate about her trauma with her husband.

With the occurrence of a history of sexual abuse/rape among the female participants, the high TEQ scores support the high trauma scores in the female participants. The male participants of the high relational satisfaction group reported fewer traumatic experiences than their spouses, while two of three males in the low relational satisfaction group reported more traumatic experiences than their wives. Overall, the events mentioned were considered to be extreme and traumatic for the participants, but there was not a lot of variation between groups based on the total number of traumatic events experienced. Reviewing the trauma history between the two groups reveals that one of the differentiating factors between the HRS and the LRS groups may be that the HRS groups tend to communicate more openly about their prior trauma experiences, which may help them in adjusting and relating to one another's experience resulting in more positive relational satisfaction. Also, enduring multiple traumas may have strengthened the relationship by making each spouse stronger and more skilled at coping and surviving traumatic events. In the next section, the group comparison of communication will be discussed to provide possible explanations of why the HRS has higher levels of relational satisfaction than the LRS group.

**Communication.** As part of the interview, one of the questions asked the participants to describe their communication with their spouse. Not surprisingly, the participants in the high relational satisfaction group reported having good communication, while the participants in the low relational satisfaction group reported having poor communication. When the interviewer asked Participant 1M about his ability to communicate with his spouse about the deployment, he shared, "*She knows everything that happened... I was calling her every time I got a chance and telling her what was going on.*" Another participant shared, "*It's fairly good, I've got to say that we talk* (3F, HRS)." Participant 5M (HRS) shared his hesitation:

*When I got home I wouldn't talk to her the first couple of weeks about it. I would not, but ever since then, when I first went to see [Chaplain] with her, I told her everything that happened with the soldier dying and everything with a counselor there so she could understand how I felt about the deployment...how she worried because when a soldier dies is when she starts stressing out even more because we weren't allowed to call home for about five days. (5M, HRS)*

He also shared the differences that he noticed in his communication with his wife by sharing,

*We didn't talk that much before the deployment because she would ask me how my day was and I was like "You don't want to know," or just "same old same old." Now she'll ask me how my day was and I'll tell her everything that happened throughout the day. (5M)*

These statements reveal the participants' ability to communicate about their traumatic experiences with their spouses, which affords high levels of relational satisfaction in their marriages.

When the interviewer asked the question, "How would you rate your partner's ability to listen when you talk about the deployment and/or traumatic events," the participants in the high relational satisfaction group all reported being willing to listen to their spouses when sharing about their traumatic experiences, even if they did not understand it enough to discuss it with their spouses. Conversely, the participants in the low relational satisfaction group reported being willing to listen, but at lower rates than the high relational satisfaction group. For example, Participant 6F (LRS) shared:

*Interviewer: How would you rate your ability to talk with your husband about the deployment or your events that happened to you? On a scale of one to ten, with ten being excellent and one being poor.*

*Participant 6F: Two... neither one of us really want to talk about the same things...{Interviewer: How would you rate your husband's ability to listen when you do talk about things in your past or his deployment?} Two. (LRS)*

Another participant answered the same questions:

*I think I'd say two because he doesn't want to speak of anything over there. Um, as towards how we handle deployment as a whole very easy to talk to him, I'd say nine, but when it comes to the events of [Iraq], we only speak of them. {Interviewer: Okay, even with you having had a past deployment yourself?} Yeah, he'll say I don't understand, I was not there and I can agree with him, you know, I wasn't there, I don't know what happened or what went on. (2F, LRS)*

According to the data, two out of three of the female partners and two out of three of the male soldiers in the low relational satisfaction group rated themselves with low rates (2 on a Likert scale of 1 to 10) for their ability to communicate about their deployment or traumatic events. One of the males (2M) in the low relationship satisfaction group does not talk about his deployment, and his spouse shared:

*I mean he doesn't talk of it. I think honestly if he doesn't speak of it then it doesn't really affect him. I think the more he talks about it, the more it would affect him. Uh, we got in an argument once and he said, "don't ever question what I did over there." So I believe that you know he has his, a knowing of what he did and what had to happen, but he'd prefer not to talk about it. But, I don't think it was traumatizing in that sense, I just think*

*he knows what he did and had to do and it's just a way of life, I guess. For us, anyway.*

*(2F, LRS)*

Two of the three female participants of the LRS group also reported a low rate (2 on a Likert scale of 1 to 10) when describing their male spouses' ability to listen when they discussed their own traumatic experiences. In contrast, two out of three of the male participants in the low relational satisfaction group rated their spouses with high rates (9 on a Likert scale of 1 to 10) for their spouses' ability to listen when they shared about their deployment or traumatic events.

Not only was trauma history helpful in comparing the HRS and LRS groups to explore what may affect higher relational satisfaction in the HRS group, each participant indicated having high levels of trauma, but the theme of secrecy, as a coping mechanism, may explain what contributes to the HRS having high relational satisfaction and LRS having low relational satisfaction. Related to communication, there are some interesting comparisons with secrecy among the participants. All six couples reported having some level of secrecy about their personal traumatic experiences, mainly the war traumatic experiences of the soldiers. Participant 1M (HRS) reported sharing most of his traumatic war experiences during and after the war, but he did describe some level of secrecy when stating that he did not share everything with his spouse. He explained that there are some things (i.e., like a grenade going off 10 feet from him) that he will never tell his spouse. Couple 4 (LRS) described having no secrecy about the soldier's war trauma, but the female spouse did report that her husband does not want to communicate about her traumatic experience of being raped while he was deployed because he "*does not know what to say,*" which fits this present study's description of secrecy as an effort to protect the spouse or oneself. An interesting finding with the traumatic experiences of the spouses is that all six soldiers reported knowing about the spouses' trauma from their spouse, yet all of the soldiers

had some level of secrecy in sharing their own traumatic war experiences with their spouses. Only one participant (3M) would not share about his spouse's traumatic experience due to not wanting to breach her confidentiality; thus, he only reported that she did experience a traumatic event (a victim of childhood sexual abuse), but did not describe it further during his interview.

Couple 5 (HRS) reported not sharing for a short period of time upon the soldier's return home, but began to share more with his spouse. Thus, what appears to be occurring with these couples is the low relational satisfaction couples seem to be more private about their traumatic experiences. The three couples of the low relational satisfaction group (2, 4, & 6) reported some level of resistance and/or hesitancy about divulging their traumatic experience; therefore, it can be concluded that the couples who were in the low relational satisfaction group appeared to disclose less information about their traumatic experience than the high relational satisfaction group couples. Hence, the couples who reported higher relationship satisfaction indicated less secrecy and more communication about the traumatic experiences of the couple, particularly war-related experiences.

The soldiers reported knowing about their spouses' rapes and previous sexual abuse, but some did not want to discuss with their spouses or the interviewer. For example, Participant 6F (LRS) stated that her spouse "won't talk about" her traumatic experience of being raped. Participant 6M (LRS) shared that he knew his spouse's history, but that they do not discuss it much anymore even though it still affects her. He shared:

*Well, the first two years we were together we talked about everything. When we were dating and everything, she'd tell me this happened to her and I'd say, "Well, anything I can do about it to help you?" "No." "You want me to tell you to talk to your brother about it?" Say no it happened 15, 20 years ago, nothing we can do about it, but she's lived with*

*it every day in her life. But she, she talked to me about it the first couple years we were together. I tell her now does she want to talk about it. But like I say, communication is not there so... so it's kind of hard to talk about those things. I'd say she's hiding a lot (6M, LRS).*

Overall, the soldiers appeared more reserved in sharing information about their traumatic experiences, particularly their war deployment, while the spouses were more open to sharing about their traumatic experiences. In both groups, the female participants seemed more eager to share their trauma histories with their spouse than the male participants; thus, a possible difference between the HRS and LRS groups is communication, which has been revealed to have an effect on the relational satisfaction. The HRS couples seem to have the ability to be more open in their sharing and processing their trauma than the LRS group, which may have nourished the relational dynamics needed to sustain any traumatic events, particularly war deployment. Therefore, communication is a key component of relationships where trauma is present and can make a difference in the spouses' relationship satisfaction.

**Insider/Outsider to their partner's trauma.** In wanting to examine any differences and compare the HRS and the LRS groups, the researcher included a question to possibly identify if the participants, who all reported their own trauma history, were knowledgeable or understanding of or if they could relate to their spouse's traumatic experiences. Gathering this information would assist in understanding how the couple was able to relate or connect with each other's trauma. Knowing this information may help to understand why half of the sample reported high relational satisfaction and half reported low relational satisfaction.

Depending on the participants' ability to communicate about their traumatic experiences, some participants may consider their spouse to be an "insider" or "outsider" to their traumatic

experience. In the current study, an insider was described as someone who has an understanding or has knowledge of particular facts or information about an event or experience of their spouse. For example, the interviewer asked Participant 5F (HRS) if she saw herself as an insider or as an outsider to her husband's deployment:

*Insider. The beginning of the deployment I was an outsider. When I got into my FRG I started learning a lot more. I started dealing with a lot more of the military. And that's when I became the insider. So now my husband goes again which he will be going at the end of November. I will have his foot out the door. I'm ready, I'm not ready for the bad parts, but I'm ready. I'm a lot more intuitive.*

An outsider was described as someone who does not have an understanding or knowledge of particular facts or information about an event or experience of their spouse. For example Participant 2F (LRS) described herself as an outsider:

*I would say I'm kind of more of an outsider due to the fact that I don't know anything about what went on. I mean he'd speak of little things here and there but can I say, "oh, you know he did this and this and that?" No, I can't. He doesn't include me in that. (2F)*

Each participant was asked questions about if she considers himself/herself as "insiders" or "outsiders" to their soldiers'/spouses' traumatic experience by asking questions such as, "Do you think that he/she views you as an insider or an outsider or would he/she identify himself/herself as an insider or outsider to what you have experienced?" Participant 1M stated that he sees his spouse as an insider to his deployment because he said that she was "*there with me every minute,*" referring to their on-going communication while deployed. Participant 1F shared that she saw her husband as both an insider because he has been deployed and an outsider because he has not been raped or sexually abused. Couple 1 was in the high relational satisfaction

group, and the soldiers in the high relational satisfaction group (1M, 3M, & 5M) mostly described their spouses as “insiders” to their deployment experiences. In contrast, the soldiers in the low relational satisfaction group (2M, 4M, & 6M) perceived their spouse as an “outsider” to their deployment experience, but an insider to any other traumatic experience, such as child abuse, serious accidents, or death of a family member. It appears that couples who communicate about the deployment and other traumatic events and reported high levels of relational satisfaction were more likely to see their spouse as an “insider,” while the couples that did not share much, if any, about their deployment or other traumatic events and reported lower relational satisfaction were more likely to view their spouse as an “outsider.” While being an insider or an outsider may be some indication of how satisfied the couples were and how the couples were affected systemically, the next two sections will describe other factors to compare differences between the HRS and LRS groups.

**Anger.** While the spouses reported signs of PTSD, anger may be another contributing theme distinguishing between the HRS and LRS groups. As mentioned earlier in the *Spouses’ Secondary Traumatic Stress* section, two of the three LRS female spouses shared about the anger they experienced at some point during the deployment. For example,

*I was angry at first... I guess I was mostly just worried... I think just the whole traumatic experience, my husband’s at war, he could be coming home to me in a body bag. I think that things were so overwhelming that it makes you stress and worry and then it makes you never sleep, you’re not hungry, you have absolutely no appetite whatsoever...But because of my actions of me not caring or worrying about myself because all my worries and stress was with them, and with my husband, that’s where it all was. And anger, I had a lot of anger built up (4F, LRS).*

The spouses' anger may contribute to the low relational satisfaction. The remaining spouse of the LRS group did not report having any anger. Anger and angry outbursts may reveal that there is more emotional dysregulation in the LRS group with more emotional reactions to the deployment than in the HRS group. The anger experienced by these spouses occurred at some point during the deployment. This anger may have hindered the couples' relationship both during and upon return from the deployment resulting in the inability to transition back into the home and the relationship positively. As participant 4F expressed her fear and worry, she became angry at the circumstances of war. There was minimal support for the subtheme of anger, yet this type of expressions related to anger were not shared by the HRS group, thus providing us with another possible factor that differentiates the LRS and HRS groups. As previously mentioned, the increased responsibilities and duties may have contributed to some of the anger. Therefore, increased responsibilities and duties will be reviewed in the next section.

**Increased responsibilities and duties.** Increased responsibilities and duties (i.e., fulfilling parenting roles, fulfilling household chores, and managing finances alone) was a common theme among all participants, but may have contributed to more dissatisfaction for the LRS group. This theme was previously described as a negative impact of deployment on couple relationships and appears to have contributed to the lower relational satisfaction scores. The female spouses reported having increased responsibilities and duties during their soldiers' deployment resulting in increased stress for some, while others seemed to gain a sense of achievement due to acquiring new roles and becoming independent. The initial readjustments to the new roles and transition upon their soldiers' return home could present difficulty resulting in a lower level of relational satisfaction. This is just a possible implication of how the HRS group has higher levels of relational satisfaction than the LRS group. Even though all participants

reported that the increased responsibilities and duties had a negative impact on their relationship, the LRS seemed to have been affected more negatively.

## **Conclusion**

The comparisons present the similarities and differences of this sample. The comparisons included examining the subthemes of demographics, trauma histories, TEQ scores, secrecy, communication, insider/outsider, anger, and increased responsibilities and duties to explore how these factors may contribute to the HRS group having higher levels of relational satisfaction than the LRS group. According to these comparisons, the results revealed that demographically, age could be a defining difference between the HRS and LRS groups with maturity being a key element in distinguishing a higher level of relational satisfaction in the current study. Also, the race demographic revealed that the HRS group was more diverse than LRS group, which was another key finding. As for the comparison of trauma histories, it was discovered that the personal experiences of enduring high levels of trauma for all participants (both war deployment and non-deployment related) may contribute to high relational satisfaction in the three couples (HRS group) that rated higher in their relational satisfaction. In addition to the trauma histories, the TEQ scores were examined and there were minimal differences between the HRS and the LRS groups, but this finding confirmed that all participants experienced multiple traumas. After reviewing the trauma histories and TEQ scores, the subtheme of secrecy was compared and concluded that secrecy seemed to be a way to cope with personal traumatic experiences by which the LRS group reported disclosing less information about their trauma histories than the HRS group. This conclusion suggested the idea that communication may be a differentiating factor between the groups. The comparison revealed that the HRS group communicated about their war deployments and traumatic experiences more than the LRS group. Overall, the female

participants in both groups seemed more open to sharing than the male participants in both groups. As for the insider/outsider subtheme, the HRS group seemed to communicate more, thus considering their spouses as “insiders,” while the LRS group seemed to communicate less and considered their spouses to be “outsiders”. As for the anger, it was experienced during deployment and was mentioned only by spouses (2) of the LRS group, and may be a distinguishing factor between the LRS and HRS groups. Lastly, the increased responsibilities and duties were compared for both groups and concluded that the LRS group reported less relational satisfaction due to the increased responsibilities and duties, unlike the HRS group. The HRS group seemed to have less negative relational impact from having increased responsibilities and duties. These comparisons helped to examine any differences between groups in this study. Each factor supported the goal of this study, which is to understand how military war deployment affects couple relationships.

In conclusion, the present study included narratives of six couples (12 individual participants), in which at least one partner had been deployed. The participants of the sample provided information about the effects of the war deployment, both individually and relationally; descriptions of how trauma is recognized; the ways in which spouses experience trauma; and how couples use secrecy as a form of protection with trauma. Hence, four thematic categories emerged from the analysis of the interviews with description of comparisons of the high and low relational satisfaction groups. The research data of this current study revealed the manifestation of secondary traumatic stress and presented verbatim descriptions to promote understanding of the effects of war deployment trauma in couple relationships.

## **CHAPTER V**

### **DISCUSSION**

Researchers have studied war-related trauma and PTSD to determine its impact on intimate (couple) relationships (Maloney, 1988; Nelson & Wright, 1996; Rohall, Segal, & Segal, 1999; Solomon, Waysman, Levy, et al., 1992). However, most studies (Brown, 1984; Hoge et al., 2004; Hoge et al., 2006; Hunt & Robbins, 2001; Iowa Persian Gulf Study Group, 1997) seem to focus on the symptoms of the primary trauma survivors (the deployed soldier), while overlooking the impact of the traumatic events on those close to the primary survivor, such as a spouse/partner. Traumatic events not only affect the individual who experienced the trauma, but also the people who have significant relationships with the traumatized individual (e.g., spouses/partners and children), and the literature supports that war-related stress and trauma may be experienced individually, as well as systemically (Dekel, Goldblatt, Keidar, Solomon & Polliack, 2005; Rohall et al., 1999; Solomon, Waysman, Belkin, et al., 1992).

The purpose of this study was to determine the impact of trauma and post-traumatic stress on the couple relational system by exploring the intrapersonal and interpersonal dynamics. Expanding the view of trauma, in the field of Marriage and Family Therapy (MFT), to include those close to a trauma survivor is referred to as a systemic view of trauma. Much has been done to identify the need for clinical treatment and other services for the primary trauma survivors. However, spouses/partners, children, and others close to the trauma survivor are often overlooked and do not receive the help they need to cope with the problems they may experience. The goal of this study was to gain an in-depth understanding of the systemic effects of trauma in military couples after being deployed to Iraq and Afghanistan. The study provided

verbatim explanations of the systemic effects of trauma as it specifically impacts couple relational systems.

The present study included narratives of six couples (12 individual participants) from a sample of Army couples in which the male participants had been deployed to Iraq. The six couples included in the current study were selected based on their report of high trauma symptoms by the male soldiers and either high relational satisfaction (3 couples) or low relational satisfaction (3 couples). The participants provided information about the effects of the war deployment, both individually and relationally; descriptions of how trauma is recognized; the ways in which spouses experience trauma; and how couples cope with trauma. The results of the current study revealed the manifestation of secondary traumatic stress and presented an understanding of the effects of war deployment trauma in couple relationships. In the following section, the theoretical explanations of the research themes will be presented, along with a discussion of the models for secondary traumatic stress, the strengths and limitations of the study, future research suggestions, and implications for clinical practice.

### **Summary of the Results**

The current qualitative study investigated how war deployment affects couple relationships. The open-ended interviews allowed for themes to emerge to begin the investigation of how trauma effects couple relational systems. The rich verbatim data allowed the researcher to conceptualize the lived experiences of military couples that experienced deployment. Many participants shared that they basically restarted their relationship upon redeployment due to the separation. The spouses generally felt as if their “space” was invaded, while many male soldiers expressed feeling like a “stranger” in their own home during the initial two to three weeks after returning home post-deployment. Several female spouses shared the

common worry whether their husband would return home alive, while a common worry for the male soldiers seemed to be their concern about the many life events (i.e., child birth or baby's first steps, etc.) that were missed during deployment and worry about the safety and health of their spouse. Some participants described feeling closer to their spouse due to the deployment separation. They explained that the simple things of life and of marriage (i.e., spending time together and showing affection) are often taken for granted and the deployment provided time and space to realize this occurrence, bringing some couples closer.

Returning from deployment was described as an adjustment and each participant described their deployment-related experiences. The deployment was described as traumatic by some and stressful by others. However, whether the traumatic experience was the result of war deployment or non-deployment trauma, the couples' lives and relationships were affected. Interestingly, the sample revealed that couples with high levels of trauma can maintain high levels of relational satisfaction with acknowledgement and understanding of each other's trauma history and open, on-going communication, while some couples with high levels of trauma may struggle more due to the lack of knowledge of each other's trauma history and limited communication. Communication, which can be a form of support, is crucial for positive, healthy couple relationships and high levels of relational satisfaction, especially when enduring military war deployment.

### **Evaluation of Research and Theoretical Application**

Secondary traumatic stress and the impact of trauma were confirmed within this sample, in which there was notable evidence of its impact individually and relationally. The thematic categories included: *positive impact of deployment on the couple relationship, negative impact of deployment on the couple relationship, soldier's war-related trauma, and issues of secrecy.*

Overall, it is important to provide a more thorough, empirically-based theory of the systemic effects of trauma, to include individual effects on the trauma survivors, secondary trauma effects on partners, and the systemic effects on the couple relationship. The reciprocal relationship between the individual level and couple functioning level of the primary and secondary trauma survivors was demonstrated in the current study through describing systemic key variables, such as relational satisfaction, communication, and roles.

**Positive impact of deployment on the couple relationship.** Any means of support, communication, and positive role shifts were viewed by the participants as a positive impact of the deployment. All participant indicated areas where they identified a positive impact from their war deployment experiences. Several female spouses mentioned that their husbands supported them during the deployment, primarily through communicating in various forms (internet, phone, and mail). The spouses shared that these communications were comforting and reassured the safety of the soldiers while at war. The male soldiers also shared their appreciation for the support their wives offered throughout the deployment and upon return. In general, support and open communication are characteristic and necessary for a healthy, positive relationship. Within this current sample, considering all participants reported a history of trauma histories, war-related and non-war-related, several participants shared their realization that communication during and post-deployment was necessary, the low relational satisfaction group did not report communication as a tool to emotionally connect them as a couple as they readjusted. For the high relational satisfaction couples that did utilize communication as a tool, regardless of their report of the severity of their trauma histories, they each increased their own ability to support and understand each other affording them to see the deployment as having a positive impact on their relationships, which resulted in less relational dissatisfaction. This finding is supported by the

work of Nelson Goff et al. (2006), which found that open, clear communication about past traumatic experiences within couple relationships resulted in increased understanding, increased support, an increased connection within the relationship, thus having an overall positive impact on their relational functioning.

Several soldiers mentioned that the deployment allowed them the opportunity to evaluate their role in the marriage, which resulted in positive readjustment. The female spouses shared several positive transformations of their husbands as a result of the deployment, including increased display of affection upon returning home, increased care and concern, and having a more positive temperament. Spouses seemed to be shocked at these positive temperaments and transformations of their soldiers; the female participants shared their expectations that were quite the opposite of how their soldier returned. The changes may be attributed to the deployment separation itself, which may have allowed the soldier the opportunity to examine his role in his family from a distance over time. Generally, when people evaluate their roles in life, they are very seldom taken away from the system for a significant period of time to thoroughly evaluate their behaviors. Also, it may be the first time for the soldiers to experience not physically fulfilling their role in the family because they are not present, which allows them the opportunity to analyze their role from the outside by being removed, the soldiers may have been able to experience personal growth through the separation and implement positive changes post-deployment.

All of the female spouses reported assuming more roles and responsibilities and reported enjoying the independence they experienced. While the newly acquired independence was enjoyable, it was difficult for them to transform their roles and share responsibilities again when their husbands returned home. Whereas the adjustment to the initial deployment separation was

reported by the spouses of this sample as difficult, it was also thought to have a positive effect by some spouses. McCubbin and Patterson (1982) suggested that families who identify the stressor event as positive (often done by reframing the event) cope and adjust better by clarifying the issues and implementing problem-solving strategies, decreasing the emotional stress related to the stressor event, and encouraging each member to support one another while continuing their daily lives. Thus, positive relational satisfaction was possible for couples that acknowledged the positive gains due to the deployment.

Another interesting finding and positive impact of the deployment was that the soldiers who were able to communicate while deployed were more likely to return home and be open to sharing more details about their deployment. Three couples with high levels of trauma symptoms also reported high relational satisfaction scores. Other research has found that high trauma symptoms are negatively related to relationship satisfaction (Blalock-Henry et al., in press; Cook et al., 2004; Jordan et al., 1992; Mikulincer, Florian, & Solomon, 1995; Nelson Goff et al., 2007; Solomon et al., 1992). The current study revealed that some couples with a partner experiencing high trauma symptoms may experience high relational satisfaction. Possible explanations for this may be age (maturity levels) of the females within the sample, the females' high levels of trauma which provided a personal level of understanding of their soldiers' traumatic experiences, and the soldiers' and spouses' ability to communicate openly about their previous traumatic experiences.

Overall, the results of this study revealed that although war deployment is a stressful time for couples, the communication, role transformations, and gaining independence are contributing factors to the positive impact of deployment on couple's relationships, similar to what other research has found (Bell & Schumm, 1998; Blount et al., 1992; Figley, 1993; Hobfoll et al.,

1991; Kelly et al., 1994; Laufer & Gallops, 1985; Solomon, Waysman, Levy, et al., 1992). This provides support for these results in revealing that the stressful event of war deployment can indeed positively affect both the soldiers and their spouses. Each of the previously identified theories and models of systemic traumatic stress contributed to understanding the results of the current study. Particularly, Family Systems Theory seems to conceptualize how the couples processed, responded, and positively coped with war deployment and traumatic experiences that disrupted their daily functioning and attempts to return to homeostasis. Family System Theory provides an understanding of how the deployment impacted the system (the couple) and how that impact resulted in a response or reaction from the system (the couple); in this case, the response or reaction was positive. However, this study also revealed the negative impact deployment can have, which will be described next.

**Negative impact of the deployment on the couple relationship.** All of the participants in the current study also described the negative impact of the war deployment on their relationship. The female participants explained that the deployment created increased responsibilities and duties due to the soldier being deployed, which created stress related to the loss of emotional support, fulfilling parenting roles, fulfilling household chores and related task, and managing all finances alone. This theme was described in the literature by several authors (Albano, 1994; Ford et al., 1993; Kelley, 1994). As mentioned by Laufer and Gallops (1985), adjustment and readjustment can have a negative effect, which may not be reversed upon the soldier's return. Incidences such as this may disrupt the marriage and/or cause relational problems and result in negative relational satisfaction.

As the female participants discussed the stress related to the absence of their partners, the male participants in this study commonly reported similar negative effects of the deployment,

such as missing special events in the lives of the family members, changes in their roles upon returning home, and the difficulty of the transition back into the family and home environment. The notable difference in reviewing the negative impact of deployment in this study was that it seemed to be two varying styles of communication among the male participants upon returning home from war. One style of communication can be described as soldiers sharing much information about their war deployment experience and the other style of communication involved being limited in sharing about their war experiences, which corresponds with the literature. Solomon et al. (2008) and Ruscio et al. (2002) both stated that veterans may avoid discussing emotional subjects and sharing their thoughts about their traumatic experiences. This “constricted responsiveness” may lead to relational problems (Carroll et al., 1985).

In the current study, the soldiers who communicated less were the soldiers who were least likely to transition back into the families and into their roles without difficulty. Perhaps communication is what the couples needed most to be able to transition and resume their roles and responsibilities to avoid any negative impact. Being able to communicate about resuming their roles and responsibilities would provide a much smoother transition and increase problem-solving skills for these couples who have endured stress and trauma. If either partner has specific needs, wants, or desires for post-deployment, the way to make sure it is known is to verbalize it. Five of the six male participants eventually shared details about their war deployment, while one male participant’s spouse (2F, LRS) shared that her husband would not share any information. Other soldiers were guarded during the initial weeks at home, but later began to share information/details. Being guarded after enduring war, which involved times of fear, uncertainty, and hypervigilance, is expected. However, prolonging sharing about the traumatic events is likely to induce negative effects on the couple relationship because the couple has yet to share

the unspoken details of the experience, which could foster continued relational distress. Similarly, as some soldiers described not being open in communicating their war-related experiences with their spouses, some spouses expressed being overwhelmed by not knowing what to say or how to react to their soldiers' war-deployment experiences. Oftentimes, this is due to the spouses' lack of trust and difficulty knowing how to help the soldiers readjust (Shehan, 1987), not realizing that they too are traumatized (Hutchinson & Banks-Williams, 2006). Being apprehensive is a reasonable expectation when communication about the traumatic events has been limited or non-existent. Unfortunately, the couples' communication system becomes more defensive than supportive (Shehan, 1987), because the spouses feel as though they do not know how to help the soldiers readjust.

**Soldiers' war-related trauma experiences.** The soldiers' war-related trauma experiences was identified as a major theme in the study by all participants. The assessments revealed that the soldiers' war-related trauma were connected to the individual symptoms in both soldiers (primary trauma) and spouses (secondary trauma). The soldiers' traumatic stress symptoms and spouses' secondary traumatic stress were identified as the subthemes related to the soldiers' deployment experiences. Two primary areas of post-traumatic stress symptoms were described in interviews: re-experiencing and arousal. As in previous wars, the intensity of the psychological aftermath has increased and has had a lasting effect (Dobbs & Wilson, 1960; Iowa Persian Gulf Study Group, 1997; Jamil et al., 2004; Kulka et al., 1990; Verbosky & Ryan, 1988; Barret et al., 2002) with the exception of Operation Desert Storm according to Scurfield (1992). Thus, this current sample included soldiers of OEF/OIF who may be at risk for problems like post-traumatic stress symptoms, substance abuse, and depression (Sammons & Batten,

2008). Hence, the individual trauma symptoms reported in today's generation of soldiers/veterans needs to be more thoroughly researched and understood.

The study did not seek to identify trauma symptoms within the soldiers, but it sought to review how trauma-related symptoms and traumatic experiences may impact the couple relationship. Therefore, re-experiencing (i.e., flashbacks and intrusive memories) and arousal (i.e., visual and auditory triggers and being easily startled) symptoms of these soldiers also were reported by their spouses, but many spouses shared their observations, use of caution, feeling helpless, and being hypervigilant with their soldier upon their redeployment home. Also, five of the six spouses shared the effects that these symptoms had on them, which supports the idea of secondary traumatization (Figley, 1983; Nelson Goff & Smith, 2005). However, the Secondary Traumatic Stress Theory and the Couple Adaptation to Traumatic Stress Model seem to explain this theme best. As Figley (1983) stated, "We, too, become 'victims,' because of our emotional connection with the victimized family member" (p. 12). According to Figley (1983), the underlying principle of secondary traumatic stress theory is that traumatic experiences adversely affect those close to a trauma survivor. As for the current study, the soldier returns from war deployment, followed by an onset of individual symptoms (primary trauma) which affected the spouse (secondary trauma) and result in impacting the couples' relational satisfaction/functioning, as described in the CATS Model (Nelson Goff & Smith, 2005). The CATS Model explains how the primary survivor's trauma symptoms can initiate a systemic response in the secondary partner affecting the functioning of the couple relationship. The model has a couple functioning component that specifically addresses the qualities, such as relational satisfaction and communication, which were identified as important factors in this study. The data and findings from this study supports the CATS model.

The spouses in this study particularly described the continuous fear and worry about their soldiers, in addition to describing their own secondary traumatic stress symptoms of sleep disturbance, anger, hypervigilance, anxiety, appetite disturbance, and other problems. These findings support much of the literature that has been published on secondary trauma in spouses in veterans/soldiers (Shehan, 1987; Solomon, 1988; Solomon, 1991; Solomon, Waysman, Belkin, et al., 1992; Solomon, Waysman, Levy, et al., 1992; Verbosky & Ryan, 1988). Williams (1980) noted that wives of veterans with PTSD are inclined to find themselves entrapped due to their compassion they develop when sacrificing much of themselves and their needs for their family. Williams' (1980) assertion helps to explain the secondary traumatic stress symptoms of the spouses of this study. These wives reported being affected by anything that affected their husbands. For example, as mentioned, Participant 2F (LRS) stated:

*Whatever affects him affects me. You know if he's emotionally distraught or angry or stressed, that reflects on me and I get angry or stressed out.*

Many spouses in the sample shared similar experiences; however, the difference between experiencing stress and experiencing secondary traumatic stress is that these spouses' reported symptoms that occurred secondarily as a result of their soldier being deployed. Nelson Goff and colleagues (2009) questioned what makes the OIF/OEF deployment traumatic versus merely stressful for the partners of the veterans; thus, the current study may have answered that question in revealing that the spouses reported their own secondary traumatic stress symptoms as a result of the deployment of their soldiers to the wars in Iraq. For example, in the current study the wives reported having their own primary trauma and stress related to the deployment. Although the wives in this study reported having their own traumatic experiences (and were asked about individual and relational effects of those experiences as well), in the interviews, the wives

discussed more of what they have witnessed and heard from their husbands and how they have been affected by their husbands' war deployment experience and trauma symptoms during and post-deployment. Reports, such as these, from military wives are common and help to reveal the effects on the spouses and their relational system. Hence, the CATS Model (Nelson Goff & Smith, 2005) and Secondary Traumatic Stress Theory (Figley, 1983) help to explain these findings.

**Secrecy.** Described by four of the six soldiers and one out of six spouses, secrecy may shed some light on how traumatic experiences affect the couple relationship. In the current study, the participants withheld or provided limited information about their trauma histories with their spouse, particularly soldiers. Interestingly, more spouses discussed the PTSD symptoms of their soldiers than the soldiers did themselves. Because of this "secrecy," the couple relationship may suffer. Several reasons have been provided previously in the *negative impact of deployment on the couple relationship* section that may provide explanation for the secrecy issues among military couples. However, the theme of secrecy seemed to have such a considerable impact on the participants within the study, that it was necessary to explain the results of this thematic category. Symbolic interactionism can be applied when reviewing the data that described the theme of secrecy. Symbolic interactionism was helpful in examining the meanings of the participants' interpretations of their traumatic experience(s), and it was helpful in understanding how the participants perceived that their trauma affected their couple relationship. As Blumer (1986) noted, interpretations are not made due to the actions of others, but by the meanings that one attaches to such actions. Thus, the symbolic meanings that the participants attached generated behavior. In this case, it was to withhold all or parts of information related to the deployment experience.

Withholding information regarding a traumatic experience seemed to be a coping mechanism by all of the participants within the study. As participants mentioned being fearful that their soldier/spouse would not be able to relate or understand and being fearful of the emotional reaction to hearing the details, it may be that trauma survivors (primary or secondary) cope by maintaining control over the only foreseen part of the traumatic experience that they can, which is to divulge or to not divulge the details of their trauma experiences. The trauma survivors may attempt to control all logistics of divulging their “secret,” due to the sense of “control” that a trauma survivor may have not had during the actual traumatic experiences. The need for secrecy may also be due to the feelings of guilt and shame due to trauma. This secrecy then may result in a form of control and protection. Some soldiers mentioned wanting to “protect” their spouse or the spouses mentioned “walking on egg shells” to protect the soldiers and themselves from additional emotional reactions. However, secrecy does not allow the couple to connect and may add to problems in a relationship that is already vulnerable. This idea may assist in explaining why *secrecy* continued to be an apparent theme in this study and how trauma, even if it is not directly discussed in couple relationships, will likely have a systemic impact. Likewise, symbolic interactionism recognizes that individuals identify their own meanings, which dictate their behavior, thus leading some trauma survivors to create control over their experiences by withholding information based on their defined meanings of their traumatic events.

Several authors (Johnson & Williams-Keeler, 1998; Nelson Goff et al., 2009; Nelson Goff et al., 2006) have discussed trauma survivors being avoidant versus being able to confide and connect emotionally due to the feeling of threat, endangerment, or retraumatization. As Johnson and Williams-Keeler (1998) stated, “Situations where one feels vulnerable become

studiously avoided” (p. 26). Avoidance seems to be reinforced by the shame that trauma survivors feel due to feeling unworthy of love and care (Johnson & Williams-Keeler, 1998); thus, avoidance through secrecy helps to mask the shame and fear that may be felt. The female participants in the current study who indicated issues of secrecy about being raped or about their history of sexual abuse may have used secrecy to avoid feelings of shame and fear. Likewise, the soldiers may have avoided discussing their deployment experiences for the same reason. Similarly, Nelson, Wangsgaard, Yorgason, Kessler, and Carter-Vassol (2002) discovered the theme of secrecy with single and dual trauma couples. These authors proposed similar ideas about secrecy based on their findings, such as avoidance due to fear, shame, denial, not realizing the importance of sharing about their traumatic events, and maintaining the tradition of the family in keeping secrets. Avoidance fuels the secrecy that may result in poor relational adjustment (Solomon et al., 2008).

### **Group Comparison**

The group comparison assisted in better understanding any similarities or differences between the two groups in the current study. Several areas were analyzed to provide explanations of why the high relational satisfaction group indicated more relationship satisfaction than the low relational satisfaction group. Particularly in this study, some of the effects of war deployment on relationships and the manifestation of secondary traumatic stress have been reviewed and discussed; however, the descriptions of the effects of war deployment, in addition to each couple having high levels of trauma and varying levels of relational satisfaction, is what makes this study unique. This study utilized purposive and criterion sampling method to select an information-rich sample from the original pool of participants in order to select soldiers that rated high levels of trauma symptoms to yield new information in this research area. Previous

research on the relational effects of trauma have been described as negative or distressed (Jordan et al., 1992; Nelson Goff et al., 2007; Riggs et al., 1998; Solomon et al., 1992; Lev-Wiesel & Amir, 2001). While the current study supported that finding, it also revealed that it should not be assumed as the only outcome, as some couples in this study with high levels of trauma after war deployment also reported high levels of relational satisfaction.

Although each subtheme contributed to understanding the differences among the high relational satisfaction and low relational satisfaction groups, the overall defining factor from the results of this study suggested that the participants' trauma history and ability to communicate may be the main distinguishing factors of the groups within the current study. Additionally, the participants' trauma history and ability to communicate may not only explain how the groups differ, but it may increase researchers' and clinicians' level of understanding of how war deployment affects couple relationships. Other subthemes, including insider/outsider, anger, and increased responsibilities and duties, will also be discussed.

In the group comparison section, the analysis of the trauma history of both partners and in both groups revealed that the participants of the sample survived a variety of traumatic events, including several non-deployment related traumas. The section revealed that spouses who have their own traumatic experiences, particularly high levels of traumatic experiences, and have knowledge of their soldiers' trauma histories may have a personal level of understanding of their soldier's trauma and the ability to relate and connect with each other better than those who have not endured high levels of traumatic experiences of their own. Reprocessing trauma within the couple relationship can help to create a bond between the partners to promote healing; the bond can be used as a protective shield against any future trauma or re-traumatization (Johnson & Williams-Keeler, 1998). When each partner is aware of the trauma history and they begin to

reprocess it together strengthening their bond, they have become part of the solution, instead of remaining a part of the problem (Johnson, 2002). Therefore, having knowledge of the soldiers' trauma history, in addition to having their own traumatic experiences may contribute to higher levels of relational satisfaction in couples, thus providing "common experiences" shared by both partners.

Communication is one way couples are informed of each others' traumatic experiences. Blalock-Henry et al. (2010) described a similar theme of "coping mechanisms," in which participants explained how communication was found to be instrumental in coping with trauma in relationships. Communication helps the couples to not only be informed, but it helps them to cope (Schwerdtfeger et al., 2008), as many participants described in the current study. The group comparison section of the results revealed that the high relational satisfaction group communicated more with their spouses about their war deployment and their non-deployment related traumatic experiences than the low relational satisfaction group. Seemingly, disclosing their trauma history may have provided the interpersonal connection needed to maintain a high level of relational satisfaction. Having a high level of trauma exposure and being knowledgeable about the trauma history, in both partners because it was communicated openly within the couple relationship, may be related to higher levels of relational satisfaction. Thus, the analysis of trauma histories and communication may explain the major factors that differentiate the high relational satisfaction and low relational satisfaction groups. As previously mentioned, the current study had two extremes of communication reported among soldiers and spouses about the soldiers' war deployment. One extreme was open communication providing much information/detail and the other extreme was limited communication about the war experiences. Negative, limited, poor, or a lack of communication may lead to negative dyadic adjustment as it

did in the low relational satisfaction couples in the current study. Hence, consistent with other studies (Carroll et al., 1985; Dekel, Enoch, & Solomon, 2008; Nelson Goff et al., 2007) impaired communication may inhibit or reduce relational satisfaction. However, it is important to also recognize that poor relational satisfaction may impair communication.

In addition to the finding that limited communication was related to the levels of relational satisfaction in some of the military couples of this sample, the current study also found that communication affected the participants' view of their spouse being considered as an insider or an outsider to their traumatic experiences. The results suggested that couples who communicate about the deployment and other traumatic events had higher levels of relational satisfaction and were more likely to view their spouse as an "insider," while the couples who were limited in their sharing and had lower relational satisfaction were likely to view their spouse as an "outsider." The insider/outsider subtheme was a distinguishing factor between the high and low relational satisfaction groups. Once again, the couple system can be as supportive and considered an insider when each partner can share and reprocess their traumas to create the closeness and understanding needed to heal and have high levels of relational satisfaction. Being considered an outsider confirms that one of the partners may not understand and is not able to assist in the survivor's healing process, which confirms that the primary trauma survivor is alone (Johnson, 2002). Therefore, the insider/outsider subtheme helped the researcher to understand why the high relational satisfaction group had higher levels of relational satisfaction; these couples may realize that the struggle to recover from trauma is easier with the help of their spouses.

Anger was another subtheme that was identified in the study to help explain why some couples in the sample had lower levels of relational satisfaction. Typically, anger is a symptom

described by soldiers (Kulka et al., 1990; Laufer et al., 1981), but was expressed by the female spouses in the current study. Anger suggests that there is emotional dysregulation in the female spouses of the low relational satisfaction group. Anger was reported by the female participants to be related to the fear and worry about their husbands being deployed to the war in the current study. Solomon (1988) found female spouses to be angry about their husbands leaving them due to war. Anger is a common emotional response, especially in primary and secondary trauma survivors (Schwerdtfeger et al., 2008; Solomon, Waysman, Levy, et al., 1992). Couples should pay close attention to their own and their spouse's emotional reaction, as they could trigger one another to re-experience trauma resulting in being hypervigilant and emotionally reactive. The level of emotional reactivity could negatively impact the relational satisfaction (Hamilton, Nelson Goff, Crow, & Reisbig, 2009) and in fewer close relationships (Mills & Turnbull, 2004).

Although increased responsibilities and duties were reported by all participants, the couples in the low relational satisfaction group seemed to have been affected most, which also differentiates the high relational satisfaction group from the low relational satisfaction group. Female spouses in another study reported less ability to nurture, to be effective parents, and to maintain family closeness due to their increased responsibilities and duties during war deployment (Kelley, 1994). The female spouses' reactions and increased roles may result in initial frustration and anger that later build resentment and feelings of guilt (Solomon, 1988). The anger is a mixed emotional response of the female spouses having to assume all responsibilities because of their husband's war deployment, which may decrease the relational satisfaction within in the couple relationship.

For years the troubled soldier/veteran has been the focus of most research, while the spouses who suffer, in some cases the same emotional distress, are overlooked. This study

revealed that, not only do the soldiers suffer similar symptoms of distress, the spouses suffer also. The spouses can be vital in fostering recovery from traumatic events for their soldiers, just as the soldiers can be vital in fostering the recovery of their spouses from their traumatic events, whether secondary trauma or previous direct trauma. All of the couples in the current study shared their lived experiences to help others understand the impact of trauma, both primary and secondary, and its effect on couple relationships. The results provided rich detail of couples who reported having high levels and low levels of relational satisfaction regardless of the severity of their trauma symptoms.

### **Strengths and Limitations of the Study**

**Strengths.** This qualitative study investigated how war deployment affects couple relationships, specifically investigating the individual trauma symptoms, levels of relationship satisfaction, and other variables related to the impact of trauma on each individual and on the couple relational system in explaining the intrapersonal and interpersonal dynamics. The researchers conducted individual interviews with each participant. The interviews provided individual descriptions of the participants' trauma histories; therefore providing the trauma history of both partners, which is a strength of the study. The interviews were conducted individually with each partner versus jointly as a couple to provide each participant's opinion confidentially and objectively; this is seen as a strength, but also may be a limitation of the study. The researchers analyzed in-depth, verbatim transcripts from the interviews of both spouses in six couples and provided insight not only about how war deployment affects the couple relationship, but it revealed some factors (i.e., analysis of each other's trauma history and communication) that indicate how deployment trauma may exacerbate previous trauma experiences in couples individually and how those factors may affect the relationship.

Consequently, the participants highlighted several factors that explain why some couples report high levels of trauma and high relational satisfaction and some couples report high levels of trauma and low relational satisfaction. The in-depth, verbatim transcripts were a strength of this study in providing the information-rich data that could be used in further analyses to continue to explain the systemic effects of war deployment and trauma, since it has become a very common occurrence in the military families of the United States; further analyses would produce increased levels of understanding to help today's military couples facing deployments.

**Limitations.** The study required a small, homogeneous sample to maintain consistency and identify themes within the data. Although a qualitative design was ideal for gathering in-depth recounts of the participants' experiences, broad generalizations of the findings cannot be drawn due to the small sample size and the homogeneity of the participants. For example, all recently deployed soldiers were males affiliated with the Army Posts or Army Guard and Reserve units in the state of Kansas. Also, all couples were married for fewer than six years and the participants were predominantly European-American (white).

Another limitation of this study is that all participants volunteered by contacting the TRECK team to participate in the study versus being randomly selected. For example, couples that are eager to share the details of their war deployment experiences may provide the researcher with information similar to what already exists, whereas the couples that are not volunteering for research may have the information that is currently not being shared and is missing in the field of research. Likewise, accurate details of the participants' experience were needed, but it is possible that the data may be inaccurate due to the participants misunderstanding the standardized interview questions, anxiety, having personal bias about the war(s), and/or re-experiencing symptoms of their traumatic event(s) while participating in the interview, which

could hinder the accuracy of the results. Also, the data were self-reported, and may have included personal bias possibly due to openly sharing about the interpersonal dynamics of their relationship. Conducting separate individual interviews versus joint couple interviews may be a limitation, as joint interviews may have provided more systemic, detailed information about the couple relationship.

Finally, the researcher as the measurement tool may be a limitation. As the measurement tool, I have a limited amount of experience in conducting or analyzing qualitative data. Also, as the researcher, I have the dual role of being the researcher and an analyst. It is possible that these facts could influence the results. However, in qualitative research, the same data may reveal similar, yet different themes with a different researcher.

### **Research Implications**

As the limitations of the study suggested that the small, homogeneous sample affects the external validity, future studies could enhance this area of research by enlarging the sample size and diversity among several characteristics (i.e., sex, age, length of marriage, and geographic location). Like most existing research, the sample consists of male soldiers/veterans and their wives. The current research included some dual military couples, but none that were currently both active at the time of the interview or deployment. It would be interesting to utilize the same methodology for couples who are both active military. The findings about the impact of trauma on each partner may vary from the findings of the current sample. It would be of interest to the researcher to examine the emerging themes and the couples' view of their war deployment.

Another important area of focus could be on the children of these couples. Surely, the children are affected if the soldiers and spouses are affected. Future research may want to include more soldiers/veterans who are female. This type of study involving female soldiers/veterans

may help us to learn if there are any similarities or differences in how male and female soldiers/veterans are impacted by war deployment, and if the male spouses react differently than female spouses due to their soldiers'/veterans' deployment experiences. Also, the current study included soldiers who recently returned from combat deployment and all soldiers had only been deployed to OIF/OEF once. Even though interviewing recently returned soldiers and their spouses was the interest of the researcher in the current study, waiting a few years post-deployment or conducting longitudinal research on veterans of current military combat deployments may offer more explanation in this area of research. Additionally, perhaps a developmental perspective is needed in future research to analyze how the family life cycle issues, such as military couples with children at different ages, adjust with the onset of PTSD symptoms in the couple relationship.

This study poses questions for future research studies to employ larger samples to explore how the soldiers' job duties and area of work might result in specific deployment duties that may endure more traumatic experience. Also, research exploring what prevention and support programs are in place pre and post deployment for the soldier, the partner/spouse, and the couple as a unit. Other variables found in this study could offer many research study ideas in understanding the effects of trauma, both military related and non-military trauma, in couple relationships.

Finally, it is important to remain mindful of the veterans and their families that have successfully maintained their healthy family relationships. Thus, prevention and treatment efforts should be focused on to moderate the distress and promote resilience in military families. Continued research and clinical treatment can expand the view of traumatic stress and resilience.

## **Clinical Implications**

The psychotherapy field has recognized through clinical experience, the current study, and other research studies that traumatic events affect the individual who experienced the trauma, as well as others who have significant relationships with the traumatized individual. However, because others, such as spouses/partners, children, and others close to the trauma survivor are often overlooked, they oftentimes do not receive the help they need to cope with their trauma symptoms. The themes that emerged in this study will provide therapists with insight of the specific areas that couples may present with in therapy. Clinical implications are discussed below.

Marital therapy has been identified to be a necessary component of treatment and recovery for the treatment of trauma in couple relationships (Carroll et al., 1985; Reid, Wampler, & Taylor, 1996), but is not meant to be presented as the only effective treatment for trauma in couple relationships. A highly recommended and empirically supported form of marital therapy found to be effective in treating trauma survivors is emotionally focused couples therapy (EFT). EFT consists of nine steps (three stages) that focus on reprocessing the emotional responses to aid the partners in changing their interaction patterns to provide a more secure attachment. Johnson and Williams-Keeler (1998) suggest that attachment should be the focus of marital therapy with trauma survivors in agreement with the work of van der Kolk, Perry, and Herman (1991; as cited in Johnson & Williams-Keeler, 1998) who proposed that human beings receive comfort from other human beings and that the symptoms are more likely to improve if others are available. Having a supportive relationship will also aid trauma survivors in regulating negative symptoms of trauma, such as the re-experiencing, withdrawal, and avoidance. Johnson and Williams-Keeler (1998) noted that the attachment process of connecting, supporting, and caring

for each other in the couple system is choreographed in marital therapy, which results in new behavior for the trauma survivor(s) diminishing the effects of trauma, while providing an emotional response that is counteractive to the initial post-trauma emotional response. This idea suggests that once the couple connects and forms an attachment that remains secure after reprocessing their traumatic experiences, safe connections between the couple are likely to result in positive recovery in therapy.

In this study, marital therapy, particularly EFT, would be beneficial and appropriate in assisting couples who have experienced traumatic events in repairing their lives and their marriage. The participants in this study struggled in various areas resulting in the emerged themes. The themes can be considered as red flags for the therapist, and addressing these themes or issues of secrecy, anger, increased responsibilities/duties, and trauma histories can be discussed in marital therapy. Realizing that couples who have endured trauma may have presenting problems such as these will help the clients and therapist to identify possible areas of concern or difficulty early in therapy.

As previously mentioned, communication and support strengthens the road to recovery and was found in the study to be the missing element in the low relationship satisfaction couple relationships. Communication was a major form of support described by the participants in this study. Some participants reported having support from their partners, while some reported not having support. Consequently, some couples suffered individually and relationally with symptoms of re-experiencing, withdrawal, and avoidance. Therapists should assess communication in the beginning of therapy, explaining the importance of open lines of communication and the various forms of communication (verbal and nonverbal). With trauma being an experience that can easily be re-experienced or triggered, nonverbal communication

should definitely be reviewed, as it could unintentionally contribute to the trauma symptoms experienced. Therapy often offers the secure, safe environment for couples to communicate and discuss any struggles, secrets, anger, increased responsibilities/duties, and trauma histories.

EFT works to build a secure foundation for couples to communicate about these issues in order for healing to take place. EFT involves three stages, including a period of stabilization, building the self and the relationship, and integrating the self and the relationship (Johnson & Williams-Keeler, 1998), and with these three stage and nine steps, a couple will likely begin to communicate about their secrets, anger, responsibilities, and trauma histories. The couples in this study who had difficulty in these areas reported being unable to communicate about these areas, which inhibited their process of healing, resulting in low relational satisfaction and may have exacerbated their trauma symptoms. Therapists would need to help the couple to identify the negative interaction cycles in their relationships. Therapists would need to discuss and validate each partner's emotions, and help them to describe their experiences in a way that each can understand and have empathy versus rejection, anger, or fear.

The therapist may want to help the couple establish rules and boundaries to promote safety and for each to know what is expected. Many couples may have problems with boundaries within their relationships. Establishing boundaries will help to ensure safety and the couple will have a sense of what to expect from each other in regards to the individual limits for each partner. Setting boundaries will also help the couple to discuss the increased responsibilities/duties that the spouse acquired during the deployment and develop how the responsibilities/duties will be transitioned or changed within the relationship. These discussions will help the partners to form a bond with each other. The therapist can help the couple cope with

the trauma(s) by creating a bond of trust and closeness, versus not creating a bond due to withdrawal by one or both partners.

Additionally, the therapist can assist the couple in discussing the secrets that were likely due to a lack of communication. Secrets may help to destroy any bonds that were present or block any bonds that could be formed. Some participants' secrets seemed to persist due to fear, shame, and not knowing if their spouse would understand. Consequently, it seems as if these secrets led the partners to have fear, feel rejected, withdrawn, and confused because they did not understand. Therefore, the therapist can help the couple create a bond that will allow them to engage and process the traumatic experiences for continued integration.

In addition to marital therapy, another important aspect of treatment is psychoeducation. Several authors warn that psychoeducation must be included in marital therapy to explain the nature of trauma and its symptoms (Rosenheck & Thomson, 1986), as well as to assess for violence and substance abuse (Matsakis, 1994; as cited in Johnson & Williams-Keeler, 1998). Psychoeducation would help to educate the soldiers/veterans and their spouses, not only on the nature of trauma and its symptoms, but it would teach them about the effects of trauma on others close to the trauma survivor, such as family members, and it would teach them ways to cope with the trauma. Assessing for violence will help the therapist to determine if the client is in danger. If the client is being violent or is the recipient of violence, a Marriage and Family Therapist will generally conduct individual therapy versus conjoint therapy to ensure safety and to avoid aggravating the trauma symptoms or increasing the likelihood of continued violence. Assessing for substance abuse is generally a sign of negative coping and will require the person to cease the substance abuse or seek treatment for the substance abuse first in order to effectively process the effects of trauma.

Lastly, individual and group therapy are also recommended. Different modalities may be helpful in dealing with different aspects of survivors' problems (Johnson, 2002). Individual therapy will often be the prerequisite to marital or couples therapy, in order for trauma symptoms to be appropriately treated. Individual therapy will usually involve several different kinds of interventions to work on various trauma issues. Johnson (2002) noted that two popular, basic goals identified by therapists for individual therapy include regulating the affect, which is most often related to fear and anger, and creating new meanings of the trauma. The success is based on the client's ability to connect and to trust another person with their pain. It is recommended that individual therapy is needed to provide desensitization of the trauma memories, while couples and group therapy is needed to learn how to reconnect in relationships (Herman, 1997). However, couples therapy is considered the main context for learning to reconnect.

The findings of this study provided some specific themes and factors that can be useful for the therapists as they help their clients recover from their trauma. It is the researcher's hope that the findings of the study will assist therapist in educating, normalizing, and empowering clients in healing from trauma.

### **Concluding Remarks**

Understanding traumatic events can be difficult for both the primary survivor and family members. Military war trauma can have a lasting effect. Growing up in a home where my father struggled with symptoms of PTSD, later increased my curiosity to understand not only his illness, but to learn more about the effects of war on others close to the trauma survivors, particularly couples and families. In my early education, I was always interested in learning more about psychology because I was experiencing my father's mood instability and hearing about his nightmares, among other things that I knew were related to his psychological well-being and the

effects from the Vietnam War. By the time I went to college, he was diagnosed with PTSD, and I was studying psychology. At this point, I realized that his illness affected me and my family. Pursuing this area of research was one another way for me to increase my understanding of the lived experiences of others who have endured the war and trauma. Because of my life experiences, in addition to what I have learned from conducting this study, I firmly agree that treatment should include spouses/partners, family members, and others close to the trauma survivor. The psychotherapy field has recognized the impact of war deployment trauma on family systems and the need of treatment for primary and secondary survivors. It is my hope that much more work will be done to prepare and strengthen relationships to endure war-related trauma through continued research and therapy by bridging the gap of primary and secondary traumatic stress in the helping professions.

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## APPENDIX A

### QUALITATIVE INTERVIEW QUESTIONS

#### **Soldier Version**

##### *General Relationship Questions:*

1. In general, how would you describe your relationship?  
-3 characteristics that best describe your relationship
2. How would you describe your communication with your partner?
3. Who expresses emotions more freely in your relationship? Explain.
4. How would you describe your “role” or “position” in the relationship?
5. How satisfied are you with your current “role”?
6. How do you and your partner resolve conflict in your relationship?

##### Intrapersonal Questions

(NOTE: Refer back to any symptoms indicated on the PPTSD-R or TSC-40 and probe for examples)

7. How has your recent deployment to Iraq/Afghanistan/Other most affected you personally?
  - Do you consider that experience “traumatic?”
  - What differences do you see in yourself before the deployment compared to after the deployment?
8. When has that experience had the most negative effect on you personally? Explain
9. Have there been any positive outcomes or anything positive that you gained from that experience?  
Explain

**\*\*Note:** If there are other events indicated on the Traumatic Events Questionnaire in the Quantitative Questionnaire, repeat the above questions for those events.

10. Are there any other events or experiences that you consider particularly significant? (Describe and explain the effects)

### Interpersonal Questions

11. How would you rate your ability to talk to your partner about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)

12. How would you rate your partner's ability to listen when you talk about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)

13. In general, how do you feel about the deployment? How does your partner feel about the deployment?

14. How did your partner support you in your deployment or other trauma experience?

➤ Prompt specifically for emotional support

15. Does your partner identify him/herself as an insider or outsider to what you experienced? (if questions, ask "Does your partner consider him/herself to be a part of what you experienced?") Prompt for specific example.

16. Do you see your partner as an insider or outsider to what you experienced? (if questions, ask "Do you consider your partner to be a part of what you experienced?") Prompt for specific example.

Partner:

17. Has your partner ever experienced any traumatic events? (what are those experiences? Did they occur prior to or during your relationship?)

➤ Does your partner consider those experiences traumatic?

➤ Do you consider his/her experiences traumatic?

18. How did you learn about your partner's trauma? What was the experience of learning about his/her trauma like?

19. How is your partner most affected by his/her past trauma experiences?

20. How are you affected by your partner's trauma?

*Relational:*

21. How is your relationship most affected by:

-your deployment (or other past trauma)?

-your partner's (past trauma)?

22. How do issues related to your deployment (or other trauma) arise in your relationship?

-How often does that occur?

23. How do issues related to your partner's trauma come up in your relationship?

-How often does that occur?

24. When has your deployment (or other trauma) had the most negative effect on your relationship?

Explain

25. When has (your partner's experience) had the most negative effect on your relationship? Explain

26. Have there been any positive effects from (that experience) on your relationship? Explain

Reunion/Redeployment

27. What has the transition home been like for you?

➤ Specific positive aspects?

➤ Specific areas of difficulty?

28. How does the deployment affect your relationship (ask specifically for impact Pre-deployment and Post-deployment)?

29. What were your expectations of your partner before you returned home?

➤ Did he/she meet your expectations? Please describe.

30. What differences did you notice about your partner after you returned home?

### Recovery

31. What has been beneficial in coping with your deployment or other past trauma experience(s)?  
(techniques, people, etc?)

32. Have you been in therapy to deal with the effects of the deployment or trauma?

-Did you go alone or with your partner?

-What was that experience (those experiences) like?

-What aspects were helpful/not helpful?

33. How has your partner helped you recover from the effects of the trauma? How have you helped your partner recover from the effects of his/her trauma?

34. Is there anything else that you feel is important for us to know?

## Partner Version

### *General Relationship Questions:*

1. In general, how would you describe your relationship?
  - 3 characteristics that best describe your relationship
2. How would you describe your communication with your partner?
3. Who expresses emotions more freely in your relationship? Explain.
4. How would you describe your “role” or “position” in the relationship?
5. How satisfied are you with your current “role”?
6. How do you and your partner resolve conflict in your relationship?

### Intrapersonal Questions

7. How has your (husband/wife)’s recent deployment to Iraq/Afghanistan/Other most affected you personally?
  - Do you consider that experience to be “traumatic” to you? To your spouse?
    - a. When has that experience had the most negative effect on you? Explain
    - b. Have there been any positive outcomes or anything positive that you gained from that experience? Explain
8. If they have other events from the TEQ marked “Yes,” ask about those:

You indicated that you also have experienced \_\_\_\_\_ (from Traumatic Events Questionnaire in the quantitative questionnaire). How has that experience(s) most affected you personally?

- Do you consider what you experienced “traumatic?”
  - a. When has that experience had the most negative effect on you? Explain
  - b. Have there been any positive outcomes or anything positive that you gained from that experience? Explain

## Interpersonal Questions

9. How would you rate your ability to talk to your partner about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)
  
10. How would you rate your partner's ability to listen when you talk about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)
  
11. How did your partner support you during his/her deployment or in your other trauma experience?
  
12. Do you identify yourself as an insider or outsider to your partner's deployment experiences? How does your partner view you? If questions, ask "Do you consider yourself to be a part of what your partner experienced?)" Prompt for specific example.

Does your partner identify him/herself as an insider or outsider to what you experienced? Do you see your partner as an insider or outside to what you experienced?

## Partner:

13. How is your partner most affected by the deployment?
  - Does your partner consider those experiences traumatic?
  - Do you consider his/her experiences traumatic?
  - In general, how does your partner feel about the deployment?
  - How do you feel about the deployment itself?
  
14. How did you learn about your partner's deployment? What was the experience of learning about his/her experiences while deployed like?
  
15. How are you most affected by your partner's deployment? (*NOTE: Refer back to any symptoms indicated on the PPTSD-R or TSC-40 and probe for examples*)

16. Has your partner ever experienced any other traumatic events (refer back to the TEQ) besides the deployment? (what are those experiences? Did they occur prior to or during your relationship?)—If “yes,” repeat the above questions.

*Relational:*

17. How is your relationship most affected by the deployment?
18. How do issues related to the deployment arise in your relationship? How often does that occur?
19. When has the deployment (or your partner’s other trauma experiences) had the most negative effect on your relationship? Explain
20. *If participant or partner had other traumas:*
- How is your relationship most affected by your/your partner’s (other traumas)?
  - How do issues related to your/your partner’s (other traumas) arise in your relationship?
    - How often does that occur?
  - When has your/your partner’s (other traumas) had the most negative effect on your relationship? Explain
21. Have there been any positive effects from (the deployment/other trauma) on your relationship? Explain

**Reunion/Redeployment**

22. What has the transition to home been like for you?
- Specific positive aspects?
  - Specific areas of difficulty?
23. How does the deployment affect your relationship (ask specifically for impact Pre-deployment and Post-deployment)?
24. What were your expectations of your partner before he/she returned home?
- Did he/she meet your expectations? Please describe.

25. What differences did you notice about your partner after he/she returned home?

### Recovery

26. What has been beneficial in coping with the deployment or other past trauma experience(s)?  
(techniques, people, etc?)

27. Have you been in therapy to deal with the effects of the deployment or trauma?

-Did you go alone or with your partner?

-What was that experience (those experiences) like?

-What aspects were helpful/not helpful?

28. How has your partner helped you recover from the effects of the trauma? How have you helped your partner recover from the effects of the deployment or other trauma?

29. Is there anything else that you feel is important for us to know?