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Living with the Invisibly Wounded: How Female Partners of Male OEF/OIF/OND Veterans with PTSD Understand their Experiences

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Living with the Invisibly Wounded: How Female Partners of Male OEF/OIF/OND Veterans with PTSD Understand their Experiences

by

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Dedication

To the many military partners whose lives have been shaped by the wars in Iraq and Afghanistan and whose sacrifices too often go unrecognized

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Living with the Invisibly Wounded: How Female Partners of Male OEF/OIF/OND Veterans with PTSD Understand their Experiences

by

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This study builds on the literature demonstrating systemic effects of PTSD on spouses of military veterans. An interpretive phenomenological approach was utilized for interviewing and analyzing data from twelve female partners of veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn who have PTSD. Half of these women had begun their relationships prior to the veterans' deployments and half had met their partners after their military service. Seven themes emerged from the analysis of participants' narratives that captured the confusion, uncertainty, and emotional distress often central to women's experiences and highlighted their sense of responsibility to their partners, the challenges with trust and intimacy in their relationships, shifts in their identities, and the strategies they used to cope. Noteworthy was the fact that women's descriptions of listening to veterans' trauma disclosures did not support the construct of vicarious traumatization as a primary mechanism to explain participants' distress. Women's narratives did lend support to the relevance of the theories of ambiguous loss, caregiver burden, and appraisal theory to understanding the heightened psychological distress and relationship distress in this population.

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Chapter One: Introduction

> "You do not need to put on a pair of boots and patrol outside the wire to suffer the effects of war."
>
> -Deborah Mullen, wife of Navy Admiral Michael Mullen
> Speaking at the 2011 Military Health System Annual Conference

In the past decade, the United States military has deployed over 2.4 million troops to serve in Operation Enduring Freedom in Afghanistan (OEF), and Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) in Iraq (Spelman, Hunt, Seal, & Burgo-Black, 2012). Several factors have contributed to the toll that engagement in these extended conflicts has taken on the physical and mental health of US troops. Insurgent warfare, the extended and frequent deployments, and the greater number of troops surviving severe physical wounds have all been cited as factors that relate to the difficulties some individuals are experiencing in recovering from combat service (Marx, 2009).

Research has revealed that military personnel face significant risks for developing a range of mental health issues such as depression, substance abuse problems, general anxiety, and posttraumatic stress disorder (Tanielian & Jaycox, 2008). The phrase *invisible wounds* has become a popular descriptor for these psychological injuries because "unlike the physical wounds of war, these conditions are often invisible to the eye, remaining invisible to other service members, family members, and society in general"; they "affect mood, thoughts, and behavior; yet, these wounds often go

unrecognized and unacknowledged." (Tanielian et al., 2008, p.iii). A review of recent studies suggests that 13% to 20% of OEF/OIF/OND service members and veterans develop PTSD (IOM, 2012). There are fewer estimates of prevalence rates for sub-threshold PTSD, but research on past cohorts of veterans indicate that another 20% of OEF/OIF/OND veterans will likely have trauma related symptoms that lead to significant impairment (Grubaugh et al., 2005).

PTSD is a condition that not only impacts a person's intrapersonal functioning via symptoms such as intrusive memories or, paradoxically, difficulty remembering the trauma, it also significantly shapes the quality of an individual's interpersonal functioning. The disorder is characterized by four clusters of symptoms: 1) intrusion, 2) avoidance, 3) negative alterations in cognitions and mood, and 4) alterations in arousal and reactivity. These symptoms have been linked in studies with previous military cohorts to veterans' relationship distress, physical aggression, and problems with physical and emotional intimacy (Fredman, Monson, & Adair, 2011). Research has begun to emerge that documents a similar association between PTSD symptoms and the quality of intimate relationship functioning among OIF/OEF veterans (Nelson-Goff, Crow, Reisbig, & Hamilton, 2007). Furthermore, relationship difficulties in combat veterans with PTSD have been linked to numerous negative outcomes, including lower engagement in treatment (Meis, Barry, Kehle, Erbes, & Polusny, 2010), poorer treatment response (Evans, Cowlishaw, & Hopwood, 2009), and elevated risk for suicide (Cox et al., 2011).

As a result of this diminished interpersonal functioning, PTSD may have systemic effects on those who are close to veterans. Approximately 58% of individuals serving in the US military are married; consequently, many OIF/OEF veterans with PTSD symptoms do not struggle with this condition on their own (Miles, 2002). The 2014 report *Hidden Heroes: America's Military Caregivers*, based on a large-scale Rand Corporation study, points to some of the potential risks associated with being the spouse of a veteran with PTSD. Individuals caring for post-9/11 veterans with medical and/or mental health problems that create some level of disability were compared to caregivers of pre-9/11 veterans, caregivers of civilians, and non-caregivers. Among other factors, caring for a post 9/11 veteran, being female, being the spouse or partner of the recipient of care, and caring for someone with a psychological or neurological disorder that may result in behavioral issues (such as PTSD, TBI, or substance use disorders) were each independently associated with higher odds of mental health problems such as probable major depressive disorder and anxiety (Ramchand et al., 2014). Research on previous cohorts of US veterans and their families, along with clinical observation based on work with this population, has laid a foundation for understanding these women's struggles. The large scale National Vietnam Veteran's Readjustment Study revealed that spouses of veterans with PTSD were more likely to report significantly lower levels of happiness than spouses of veterans without PTSD, and were much more likely to report having felt as though they were going to have a nervous breakdown (Jordan et al., 1992).

The term "secondary traumatic stress" (STS) has been used in both specific and general ways to describe such effects on veterans' partners. There is some disagreement in the literature over the use of this term. Some argue that STS implies a reaction to detailed knowledge of another's trauma that mimics PTSD in that it involves the same clusters of symptoms (Renshaw et al., 2011). Others have used STS to describe a reaction of more general psychological distress as a result of exposure to a family member's PTSD (Dekel & Solomon, 2006). Despite this theoretical dispute, there is widespread agreement among researchers that female partners of men with combat related PTSD experience more general distress, relationship distress, and a range of other psychiatric symptoms (see reviews by Monson, Taft, & Fredman, 2009; Galovski & Lyons, 2004; Dekel & Solomon, 2006). One emerging line of research has focused on determining the predictors of this distress. Several studies have demonstrated the correlation between the severity of a husband's PTSD and the level of distress that his wife reports (Renshaw & Cambell, 2011; Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005; Dekel & Solomon, 2006). Other studies have found that the husband's symptoms related to emotional numbing are most strongly associated with women's adjustment problems (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Galovski & Lyons, 2004; Riggs et al., 1998).

In her book *Vietnam Wives* (1988), Veterans Affairs Psychologist Aphrodite Matsakis drew attention to some of the common ways that the lives of the women she worked with were shaped by their husbands' PTSD. She documented women's descriptions of their husbands as "ice men" who were either completely numb or who

vacillated between being emotionally present and "walling out" others. She also noted their reports of physical and emotional abuse, juggling the demands of their multiple roles, and feeling overwhelmed and isolated due to their husbands' symptoms. These narratives clearly illustrate the toxic effect that their husbands' reactions to combat trauma had on them and offer a powerful depiction of this experience. Myriad contextual factors have changed since the Vietnam War, including: the nature of the combat experience, the frequency and length of deployments, cultural expectations around gender roles, and awareness and recognition of PTSD. As such changes were anticipated to be associated with corresponding shifts in the meaning of the experience of being the partner of a veteran with PTSD, the current research project was undertaken in order to illuminate the experiences of OEF/OIF/OND spouses within this larger context.

Research that provides a vivid account of the experiences of female partners of male veterans with military-related PTSD is of particular value to clinicians working with this population. Little is known about the prevalence of such individuals seeking mental health treatment outside of Veterans Affairs (VA), but a significant number will see a clinician at a VA facility as a member of a couple in couples' treatment. VA clinicians have access to a great deal of research focused on the experience of OEF/OIF/OND veterans with PTSD, but the relative lack of research on partners' experiences may result in clinicians being at a disadvantage when it comes to understanding partners' perspectives. In his book *The Self in the System* psychologist Michael Nichols makes a compelling case for the importance of recognizing the individual needs of each treatment

seeking family member (1987). He argues that even when working with a system the therapist "must reach out and motivate individuals", and that individuals are more motivated when they feel understood (p.38). Research that captures how the military partners of veterans with PTSD experience their situations is therefore valuable in providing clinicians with information that may help them deepen their understanding of these women. Given the critical role of healthy social support in recovery from PTSD, better treatment for partners of combat veterans with PTSD can also contribute to the enhanced mental health of veterans themselves.

Increased recognition that traumatic stress can affect veterans' spouses has led to a call for more research on this population. In an effort to address this need, this study built upon previous work on systemic effects of trauma in military couples and investigated the lived experiences of female partners of OEF/OIF/OND veterans with PTSD. I conducted a series of in-depth phenomenological interviews with 12 women followed by a detailed analysis of these interviews with the goal of uncovering how these women experience their partners' condition and how this may influence their feelings about themselves and their relationships. Previous research with women from different countries and different eras has pointed to the complicated nature of these women's situations (Matsakis, 1988; Dekel et al., 2005). Phenomenological methods are well suited for investigating this topic because they allow the researcher to "tap into the ambiguity and contradictions inherent in experience in order to capture layers of complexity" (Finlay, 2011, p. 18).

Chapter Two: Literature Review

Introduction

The integrative analysis will begin with a brief introduction to research on military couples, and in particular, information regarding dynamics that may be pertinent to the experience of spouses of veterans with PTSD. This will be followed by an overview of posttraumatic stress disorder (PTSD), including a summary of the diagnosis, the most common manifestation of symptoms amongst combat veterans, frequently occurring comorbid conditions, and implications for veterans' interpersonal functioning.

Turning to the population of interest, female spouses of veterans with PTSD, a review of the research will begin with a summary of qualitative work that initially drew attention to the circumstances of these women's lives in the post-Vietnam era. These richly descriptive studies pointed to the link between marriage to a veteran with PTSD and heightened distress. Subsequent quantitative research on spouses of veterans with PTSD has primarily focused on confirming and clarifying the nature of this association.

An overview of these investigations will seek to elucidate what conclusions can be drawn from this literature and what questions remain to be answered. Researchers have considered multiple mechanisms to explain psychological distress in this population, some related to the veteran's behavior and other's related to the partner's perceptions and behaviors. The concepts of secondary traumatic stress, caregiver burden,

and appraisal theory will be presented and research pertinent to these constructs and others will be examined.

Relationships in the Military Context

A framework for conceptualizing the experience of partners of veterans should take into consideration the broader context within which these relationships often develop: the military. The culture of the military is far from monolithic. Many aspects of an individual's experience in the armed services will vary depending on factors such as branch of service, rank, occupational specialization, and area of deployment. However, there are some features common to the military experience that have implications for not only service members' lifestyle, but that of their partners as well (Devries, Hughes, Watson, & Moore, 2012). These include the assignment of lengthy deployments, the formal hierarchy, and the practice of frequent relocation.

Deployment of service members to locations in and out of combat zones is an experience central to the military identity that has significant implications for military couples. The service member's extended absence from home and family has long been recognized as a strain on all parties involved, and OEF/OIF/OND service members and their families have faced more frequent and longer deployments with shorter intervals between tours of duty than during previous wars (Marx, 2009). Although it was not focused on a sample of veterans with PTSD, the results of a recent phenomenological investigation of the deployment experience for both male service members and female

partners point to the challenges that all military couples must navigate during both the separation and reunion phases (Baptist et al., 2011). Data collected from in-depth interviews led researchers to summarize that "while open and frequent communication was important in the adaptation process, communication was not synonymous with transparency. Unshared stories created a void that prevented couples from confiding in and supporting their partners." (Baptist et al., 2011, p. 199).

Descriptions of dynamics confronted in military relationships often include an emphasis on the influence of the hierarchical structure (Hall, 2012). The military is an organization in which rank is a very salient piece of identity. The importance of one's rank is tied to the emphasis on chain of command, the idea that service members should follow the orders of superiors without question (Devries et al., 2012). The utility of this hierarchical system is easily recognized in the context of a war zone where order and clarity are necessities and decisions must be made swiftly. However, service members' experiences within this authoritarian structure often lead them to carry these values into the home and into relationships with civilian partners, shaping the dynamics around the sharing of power and decision-making. *Boundary ambiguity,* a state of confusion about who plays what role or has what responsibility within the family, has been linked to a confluence of the concern over structure that comes with the authoritarian military environment and the necessity of spouses taking on new roles during service members' deployments (Hall, 2012). Hall argues that in relationships in which the service member

identifies as the "head of household", his deployment and return home can lead boundaries to "become ambiguous for both members of the couple" (2012, p. 141).

Such dynamics were noted by researchers who interviewed reservists and their partners multiple times over the course of the year following service members return from Iraq (Faber, Willerton, Clymer, MacDermid & Weiss, 2008). They framed their analyses of the data in Boss' *theory of ambiguous loss* which is based on the idea that when a loss remains unclear or is surrounded by uncertainty it freezes the grief process, prevents cognition and coping (Faber et al., 2008). Faber and colleagues noted that all of the partners reported some experience of "ambiguous absence" during deployment; the service member was physically absent but psychologically present. This experience resulted in challenges for the partners at home, who had to fulfill service members' responsibilities themselves, often while feeling uncertain about how their spouses would do so. Renegotiation of these roles upon the reservist's return was complicated for many of the participants by the experience of "ambiguous presence" during which partners reported feeling that the service member was physically present but psychologically absent. Faber and colleagues note that, "family members felt hesitant about asking their reservist to resume certain roles, as they felt unsure of whether the reservist was ready to take back some of his or her roles or of exactly how much more time the reservist needed. Reservists also wondered about how to take up roles without interfering with the family members' new routine and how exactly to fit back into the family" (Faber et al., 2008, p. 226).

One of the most commonly recognized aspects of military life to exert an influence on military couples is frequent relocation. On average, families of active duty military personnel relocate within the US or overseas every two to three years (Park, 2011). The popularly used shorthand for a child from a military family, "military brat", is a term which in particular references this pattern of repeated moves due to a parent's reassignment. While no such label exists for the military spouse, the impact of frequent moves on partners appears to also be significant. For example, spouses that must relocate every few years may face challenges with maintaining meaningful employment and accessing social support networks (Hall, 2012; Karney & Crown, 2007).

This pattern of mobility is one aspect of the military lifestyle that clinicians have highlighted as creating attachment issues for couples. Attachment theory proposes that the quality of the relationship a child develops with a primary caregiver is central to her ability to explore her environment and manage her distress, and recent research has demonstrated that these concepts continue to figure prominently in adult relationships as well (Basham, 2007, p. 84). Hall notes that the prolonged separation of deployment may be especially difficult if one or both partners struggle with issues around trust and maintaining closeness (2012). The mobility of the military lifestyle can also compound issues with connection with one another as couples must repeatedly rupture and form new social bonds (Hall, 2012). In addition to exposure to combat, some troops return from battle reporting betrayal from commanding officers, disillusionment with the military establishment, and discrimination by other troops, all of which may be experienced as

relational traumas. Such experiences may shatter, "one's sense of self and trust in others" and have implications for interpersonal relationships when a warrior returns (Hall, 2012, p.144).

Overview of PTSD

A wide range of reactions to the experience of trauma have been documented. Many individuals respond with only acute symptoms that fade relatively quickly or with no stress-related symptoms at all (Marshall et al. 2006). However, following a traumatic incident some people experience a disturbance in their behavior and mood that seriously interferes with their social, occupational, or personal functioning. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, PTSD is "the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death" or witnessing or learning of such an event happening to a loved one (DSM-IV-TR; APA, 2000).

Among those that develop PTSD after exposure to trauma, presentation of the condition is somewhat heterogeneous, but the disorder has traditionally been conceptualized as including persistent symptoms that are present for at least one month and can be organized in to the following three clusters: re-experiencing of the traumatic event in one or more ways, avoidance of stimuli associated with the trauma and numbing of general responsiveness, and increased arousal. In the DSM-V, the criteria have been

changed slightly to reflect research that has revealed a four-factor model of this condition better fits the symptoms that individuals most commonly report (APA, 2013; Meis et al., 2011). The four symptom groups overlap considerably with those mentioned above: re-experiencing and avoidance are included, hyperarousal in now subsumed under alterations in arousal and reactivity, and emotional numbing has been moved into the broader category negative cognitions and mood. Re-experiencing symptoms are characterized by intrusive memories, nightmares, flashbacks, and physiological and psychological reactivity that occur when confronted with trauma cues. Avoidance symptoms include avoidance of memories, feelings, and thoughts associated with the trauma as well as external reminders. Hyperarousal symptoms consist of sleep disturbance, hypervigilance, and aggressive, reckless or self-destructive behavior. Negative cognitions and mood represents a variety of feelings, "from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event" (APA, 2013).

PTSD and Veterans

After PTSD was officially added to the American Psychiatric Association's manual in 1980, the large-scale National Vietnam Veteran's Readjustment Study (NVVRS) of the following decade revealed that 15.2% of Vietnam veterans met full criteria for PTSD many years after exposure to combat (Schlenger, Kulka, Fairbank, &

Hough, 1992). Recent studies have found troops who have served in OEF/OIF/OND to endorse similar rates of PTSD (Tanelien & Jaycox, 2008). Drawing upon years of experience working with Vietnam veterans at a VA outpatient clinic, psychiatrist Jonathan Shay has summarized how PTSD symptoms are commonly manifested in combat veterans. He notes the persistent "mobilization of the body and the mind for lethal danger, with the potential for explosive violence", "activation of combat survival skills in civilian life", "expectation of betrayal and exploitation", and "suicidality, despair, isolation, and meaninglessness" as particularly destructive sequelae of wartime trauma exposure (Shay, 1994, P. xx).

Common comorbidities.

Unfortunately veterans who develop PTSD after exposure to combat trauma are also at heightened risk for other conditions. Research has consistently found high comorbidity among PTSD and substance use disorders, with alcohol use disorders (AUDs) being the most common problem among veterans. According to Stewart and colleagues review of studies on Vietnam veterans with PTSD, a reported 64–84% had a comorbid lifetime diagnosis of AUD (1998). In a 2010 study of alcohol misuse among veterans seeking post-deployment VA healthcare, veterans who screened positive for PTSD or depression were two times more likely to report alcohol misuse relative to veterans who did not screen positively for these conditions (Jakupcak et al., 2010). In the most comprehensive data on prevalence of AUDs among the OEF/OIF sample, Seal and

colleagues found that the 63% of those diagnosed with AUD, also had a diagnosis of PTSD (2011). Studies on individuals with comorbid AUD and PTSD provide evidence of poorer functioning, worse treatment outcomes, and less social support in this group (Riggs, Rukstalis, Volpicelli, Kalmanson, & Foa, 2003; Ouimette, Brown, & Najavits, 1998; Ouimette, Ahrens, Moos, & Finney, 1998).

Research suggests that 2-14% of all OEF/OIF/OND veterans have a depressive disorder, however, the rates of depression are much greater among veterans with PTSD (Tanielian & Jaycox, 2008). Recent data collected on randomly sampled group of depressed OEF/OIF/OND veterans with at least one VA primary care visit in the previous 12 months revealed that 36% screened positive for PTSD and these patients reported more severe depression, less social support, and more suicidal ideation (Campbell, et al., 2007). A large-scale RAND study of OEF/OIF veterans found approximately twice as many vets (9.1%) had both PTSD and depression as had either condition alone (Tanielian & Jaycox, 2008).

Along with PTSD, the other condition that has become one of the "signature wounds" of the most recent military conflicts is traumatic brain injury (TBI) (Tanielian & Jaycox, 2008). Insurgent warfare in Iraq and Afghanistan relies heavily on improvised explosive devices and the detonation of these bombs has been responsible for the majority of casualties in these conflicts. Some estimates suggest that "at least 30 percent of troops engaged in active combat in Afghanistan and Iraq for four months or more" are

likely to have suffered a mild TBI as a result of an IED explosion (Tanielian & Jaycox, 2008). Research on the effects of these concussive head injuries is being pursued but the long-term consequences are still unclear. Currently it appears that many symptoms of TBI overlap with PTSD, complicating diagnosis and treatment for veterans. A recent study of medical records of 340 OIF/OEF veterans presenting to a VA polytrauma center highlight this overlap. They found the frequency of veterans reporting PTSD, chronic pain, and concussive head injuries in isolation "was significantly lower than the frequency at which they were present in combination with one another, with 42.1% of the sample being diagnosed with all three conditions simultaneously" (Lew et al., 2009).

Given the prevalence of PTSD co-occurring with issues of depression, substance misuse, mild TBIs, and chronic pain, many veterans struggling with the effects of combat are struggling with complex groups of symptoms that have mental and physical manifestations.

Effects on relational functioning.

The symptoms noted above have direct and typically negative consequences for Veterans' ability to connect with intimate partners (Dekel & Monson, 2010). The NVVRS provided initial evidence of the interpersonal consequences of this condition; veterans with PTSD were twice as likely to have been divorced and more than three times as likely to have experienced multiple divorces (Riggs et al., 1998). *Sex and Intimacy after Combat*, a collaboration between Veterans Administration clinician Dr. Sharon

Wills and OEF/OIF/OND veteran Matthew King, helps to explain the problem at the root of these dire statistics (2012). They outline numerous ways that combat trauma disrupts individuals' basic psychological needs, consequently compromising veterans' abilities to be connected to their partners. According to King and Wills, these issues are commonly manifested in symptoms such as "difficulty experiencing strong emotions and appearing uncaring and unreachable", "seeing things as black or white, with little tolerance of the 'gray areas'", and "difficulty giving or receiving compliments and validation of or by others" (2012, p. 216).

Evidence from research with a wide diversity of veteran groups supports the association between PTSD and relationship distress. In their study of Vietnam veterans from New Zealand, Macdonald, Chamberlin, Long and Flett found PTSD severity correlated with severity of general interpersonal difficulties, which was associated with decreased family functioning and dyadic adjustment (1999). In their study of former WWII prisoners of war, Cook, Thompson, Riggs, Coyne, and Sheikh (2004) found a significantly higher percentage of POWs with PTSD reported problems in their marital relationship when compared with those without PTSD. In addition, the emotional numbing of the veterans was significantly associated with their relationship difficulties, independent of the severity of PTSD or other symptoms.

Recent research with OEF/OIF/OND veterans has demonstrated that the connection between PTSD symptoms and interpersonal problems extends to the current

generation of veterans. Results of a 2007 study that included 45 male Army personnel and their intimate partners demonstrated that both veterans with PTSD symptoms and their partners were significantly less satisfied with their relationships than veterans without PTSD or their partners (Nelson-Goff, et al.). More recently, researchers have used longitudinal study designs in order to gain a better understanding of how these variables are related over time. A sample of 313 National Guard troops completed assessments measuring PTSD symptoms and relationship adjustment at two time points, shortly after returning from Iraq and one year later (Erbes, Meis, Polusny, & Compton, 2011). While each of the four symptom clusters was correlated with relationship satisfaction at time 1, researchers found that when they controlled for the effects of the other variables, dysphoria (which overlaps significantly with the DSM-V category negative cognitions and mood) was the most important predictor of a veteran's relationship satisfaction cross-sectionally and the only symptom group that had an indirect effect on later relationship adjustment after controlling for prior relationship adjustment (Erbes et al., 2011).

Spouses of Veterans with PTSD

The systemic costs of PTSD were first demonstrated in research on families of Holocaust survivors. Multiple studies on this population revealed the transgenerational effects of trauma, with children of survivors exhibiting a range of pathological reactions that included depression, emotional numbing, aggression, and isolation (Jordan et al.,

1992). Following the Vietnam War, clinicians began to note similar patterns in the families of veterans with PTSD.

The first significant work on spouses of veterans with PTSD was a descriptive account of the struggles of women who supported their husbands in their battles with this chronic condition. After working with veterans and their partners for nearly 15 years in various VA settings and polling counselors at 189 Vietnam Veterans Outreach Centers, psychologist Aphrodite Matsakis wrote a book about the effects of Vietnam veterans' PTSD on their partners' physical and emotional health. She begins her book, *Vietnam Wives* (1988), with an excerpt from the anonymous poem *Goodbye: To My Viet Nam Veteran Lover*: "I am powerless over you/Not all my love/Nor all my sweetness/Nor all my desire/To kiss your wounds/And give you/More and more/ Of me/ Can pierce your fears/Your basic mistrust/Of everyone". The poem illustrates themes that are present in many of the women's narratives that she includes in her text: women's wish to fix their husbands, their sacrificing themselves towards this end, and their inability to penetrate their husbands' emotional numbing. In a chapter on these women's multiple roles, the wife of one combat veteran shares, "I wish I could socialize and do more for myself, but I don't have the time….I have to be around as much as possible in case he has a problem" (Matsakis, 1988, pg. 84). The woman appears to feel she does not have the resources to fulfill her own needs and support her husband, and her concern for her husbands' wellbeing results in her social needs going unmet.

In another early examination of this population's experiences, Verbosky and Ryan (1988) analyzed the weekly content and process notes from a significant others' therapy group conducted with 23 female partners of Vietnam veterans at an outreach center in Florida. They identified ways that veterans' PTSD symptoms interacted with the women's mental health. The veterans' experiences of guilt (for surviving or not being able to save others) correlated with guilt in the women who expressed feelings of worthlessness about being unable to help their partners. Veterans' emotional numbing and restricted expression was related to the women's asserting control in the relationship, in order to "take care" of their partners' needs. Other patterns concerned the cycle of passivity, aggression, guilt, and dependency that played out repeatedly between the partners as they struggled to each have their needs met. Almost all of the women expressed feeling overwhelmed and helpless in the face of their partners' symptoms.

The rich data captured in these early qualitative and mixed method studies shed light on some of the complex dynamics within these relationships as well as the tremendous pain and frustration many partners were experiencing. The emphasis on the multiple roles they played suggested the level of strain that women in this group were often under, influencing later research that connected this experience with the concept of caregiver burden (Beckham, Lytle, & Feldman, 1996). Although there are indications that the experiences of partners of veterans from OEF/OIF/OND fit these descriptions in significant ways, there are also important contextual differences and because such differences have the potential to shift the meaning partners ascribe to elements of their

experience the current qualitative project attempts to attend to these changes, for example, in the accessibility and dissemination of information on PTSD, the visibility of veterans' mental health problems, and the existence of more formal and informal (often online) social support around these issues.

Recent quantitative research has also demonstrated that military veterans' PTSD may be particularly damaging for their partners. A 2005 study examining transmission of trauma symptoms among 708 partners and 332 parents of Dutch peacekeepers who had participated in military action found significantly different effects for these groups (Dirkzwager et al., 2005). Participants were classified by the level of PTSD symptoms present in their child or partner, resulting in four groups that were compared on posttraumatic stress, health problems, the quality of the marital relationship, and social support. Parents of peacekeepers with varying degrees of posttraumatic stress were not found to differ significantly on the examined variables. Partners, however, were found to be significantly impacted by the presence of any PTSD symptoms in their spouses, even when the level of PTSD was below the threshold for a diagnosis. Specifically, these partners reported having more symptoms of posttraumatic stress, more somatic complaints, more sleeping problems, and more negative social support during the preceding week. Their husbands' level of PTSD was also correlated with their own marital satisfaction, such that the higher the level of PTSD, the lower the wife's level of relationship satisfaction. The authors suggest that the "intimate nature of the marital relationship and the fact that the partner is usually the main source of support" leave

partners more susceptible to developing distress in response to veterans' traumatic stress than cohabitating members of the extended family (Dirkzwager et al., 2005, p. 223).

Multiple studies have made similar comparisons between couples in which a military veteran exhibits some level of PTSD symptoms and those in which the veteran does not. Results have consistently pointed to an association between posttraumatic psychopathology and problems with family functioning, while exposure to combat trauma alone, without subsequent PTSD symptoms, has not been significantly associated with family issues (Dekel & Solomon, 2006; Monson et al., 2009). In a recent longitudinal study that included both male and female Gulf War I veterans, Taft, Schumm, Panuzio, and Proctor (2008) demonstrated that the relationship between combat exposure and family adjustment problems was completely mediated by PTSD symptom grouping for male veterans. In contrast, PTSD symptoms only partially mediated the relationship for female veterans. There was evidence of direct effects of combat exposure on problems in these women's families in addition to those mediated by PTSD, suggesting the possibility of gender differences in the systemic effects of combat service. With the rapidly increasing number of female military personnel, gaining a better understanding of the effects of combat duty and PTSD on female veterans' families is crucial. However, given the possibility that the mechanisms at work are different for male veterans and female veterans, the current study will be limited to female partners of male service members.

Effects on spouses.

Research has found wives of veteran's with PTSD to be at risk for a variety of mental health issues. Results from the NVVRS, the national epidemiological study on the impacts of PTSD on Vietnam era veterans and their families, indicated that spouses and partners of veterans who met criteria for PTSD reported significantly lower levels of happiness and life satisfaction and had significantly higher nonspecific distress score, when compared with wives of Vietnam veterans that did not have PTSD (Jordan et al., 1992). They also reported more marital problems and more family violence. A 1992 study of 205 wives of Israeli combat veterans of the 1982 Lebanon War revealed that wives of veterans with PTSD had significantly higher levels of somatization, depression, obsessive-compulsiveness, anxiety, paranoid ideation, interpersonal sensitivity, and hostility than those whose husbands did not have PTSD (Solomon et al., 1992). In addition, they described themselves as significantly lonelier and less satisfied with their social support. Although these studies use multiple outcome measures, they all provide evidence of the link between veteran's combat related PTSD and military spouses' psychological distress.

Predictors associated with spouses' distress.

With the link between combat related PTSD and military wives' distress well established in the literature, some researchers have turned their attention to identifying the variables associated with spouses' heightened distress. Variables that have been

included in these investigations include those pertaining to the veteran and those related to the spouse (Dekel & Solomon, 2006).

Predictors related to the veteran.

Symptoms of withdrawal and numbing.

Multiple studies have linked the severity of a veteran's PTSD to the severity of his partner's distress (Beckham, Lytle & Feldman, 1996; Dirkzwager et al, 2005; Calhoun et al., 2002). Building on this somewhat intuitive relationship, researchers have attempted to tease apart the relative contributions of PTSD symptom clusters. Most researchers have drawn on the DSM-IV three symptom cluster conceptualization of PTSD and repeatedly found the withdrawal/emotional numbing symptoms to make the greatest impact on both partners' estimations of relationship distress and the wife's psychological distress. In a 2011 study of 206 service members from the National Guard, Renshaw and Cambell found that when examining PTSD symptoms at the cluster level, only the numbing/withdrawal cluster was significantly associated with the partner's distress. The crucial role of the expression of positive emotions in maintaining close marital relationships has been cited as one explanation for the particularly damaging effects of the veteran's emotional constriction (Dekel & Solomon, 2006). Rosenheck and Thompson (1986) highlighted confusion that surrounds the veteran's role within the family after returning from combat and how the numbing symptoms that may follow re-experiencing and hyperarousal symptoms can take a toll on family members. For

example, when a veteran withdraws after episodes of aggression or flashbacks, he may create further barriers in the family's attempts to assimilate and understand his behavior.

In an attempt to better understand how veterans' numbing/withdrawal symptoms lead to distress in couples, Campbell and Renshaw examined the correlations between PTSD symptoms, relationship satisfaction, and perceptions of emotional disclosure in a sample of OIF/OEF-era National Guard service members and their romantic partners (2013). Path analyses of the data collected from 83 service members and 91 partners at two time points four to six months apart revealed that female partners' reports of service members' emotional disclosure were significantly positively correlated with both partners' ratings of relationship satisfaction at the second time point (Campbell & Renshaw, 2013). These results provide another explanation for the negative impact of the emotional withdrawal characteristic of PTSD on veterans' partners.

Intimate partner violence.

As would be expected from research with the general public, higher rates of intimate partner violence have also been associated with poorer psychological adjustment for veterans' spouses (Calhoun et al., 2002). Past studies have documented a higher rate of physical aggression perpetrated by Vietnam era veterans with PTSD than those without PTSD (Beckham, Moore, and Reynolds, 2000). Byrne and Riggs found that 34% of their sample, 50 combat veterans with significant PTSD symptoms, reported perpetrating at least one act of violence toward their partners in the past year (2006). In a

study focused on Israeli prisoners of war and their wives, presence of PTSD and husband's aggression were significantly linked to the partner's psychological adjustment and marital satisfaction 30 years after their release from captivity. (Dekel & Solomon, 2006). Calhoun, Beckham, and Bosworth also found that among a sample of combat veterans and their spouses, veteran perpetrated interpersonal violence was strongly and significantly correlated with the partner's psychological distress (2002).

Secondary traumatic stress: Veteran's disclosure of trauma.

One of the terms most commonly used to describe distress among partners of veterans is secondary traumatic stress, however this may not always be an accurate description of what is occurring. Figley first used the phrase "secondary traumatization" to refer to findings that those who were in close proximity of someone suffering from the effects of trauma could become traumatized themselves (Figley, 1995). A similar phenomenon was noted by McCann and Pearlman to occur in therapists working with victims of trauma (1990). They coined the term *vicarious traumatization* to describe the transformation in cognitive schemas that result from empathic engagement with a client's traumatic experiences. Their clinical work revealed a pattern of therapists developing symptoms mirroring those of their traumatized clients. Research has since demonstrated the risk of similar reactions in caregivers working in child welfare, domestic violence, and healthcare among other fields (Schauben & Frazier, 1995; Bride & Figley, 2009). In 1995, Figley drew upon this work in conceptualizing *secondary traumatic stress* and

secondary traumatic stress disorder (STS/STSD) as "the natural and consequent behaviors and emotions resulting from knowing about a traumatic event experienced by a significant other- the stress from helping or wanting to help a traumatized or suffering person" (p.7). He has also used the term *compassion fatigue* to describe this phenomenon and argued that, not only do symptoms mimic those of primary traumatization, but that in extreme cases of STS a diagnosis of PTSD may be warranted.

The term *secondary traumatization* has been applied to work with military families in both a narrow and broad way. It has been used as a synonym for vicarious traumatization to specifically refer to the transmission of trauma symptoms (nightmares, flashbacks, intrusive thoughts) from a veteran that directly experiences trauma to a close friend or family member who learns of the trauma indirectly (Galovski & Lyons 2004). More generally, the term has been used to refer to any systemic transmission of distress from a veteran who has directly experienced trauma to those around him or her, not only symptoms that mimic PTSD.

However, some researchers have argued that using the term *secondary traumatic stress* to describe all distress experienced by spouses of service members with PTSD symptoms is misleading. Renshaw and colleagues recently conducted a study examining the composition of spouses' distress in order to clarify whether their experiences reflected secondary traumatic stress or general psychological distress (2011). They used a PTSD measure commonly utilized in the study of STSD, and asked participants whether they

attributed the symptoms they endorsed to the traumatic events their husbands had experienced during their military service, or to events in their own lives (which could include interactions with their husbands.) Of the 170 civilian wives of military personnel that reported symptoms of distress, 30.5% endorsed enough symptoms to warrant a diagnosis of PTSD. Of these women, 62.4% indicated their responses were unrelated to their husbands' service, 24.7% indicated that their distress resulted from both their husbands' experiences and their own, and only 12.9% reported that their symptoms were due solely to their husbands' experiences. Although there were indications that some participants may be suffering from STS, the researchers concluded that the majority of spouses were experiencing distress that did not fit the STS model, and cautioned against the loose use of the term to "connote the full gamut of symptoms and mechanisms specified within this framework", given that treatment needs for people experiencing STS/STSD may be different from those experiencing more general psychological distress (Renshaw et al., 2011, p. 467). Based on this recommendation, the broader term *psychological distress* will be used throughout this proposal to refer to partners' reactions to veterans' combat related PTSD and secondary traumatic stress will only be used to reference the STS model.

Despite the prominence of the STS model in the literature on this population, very few studies have focused on the impact of a veteran's disclosure of traumatic material to his partner. Recent research based on data from the National Vietnam Veterans Readjustment Study drew from material collected from 465 combat veterans and their

spouses during the Family Interview Component to examine this connection (Campbell & Renshaw, 2012). They created a "communication about Vietnam" composite variable by combining spouses' responses on three items measuring the frequency of the veterans' talking about, the partners' listening to, and the partners' understanding of the veterans experiences. Results indicated that deployment-related communication about Vietnam was not significantly correlated with partner distress overall, however, "communication about Vietnam was increasingly and positively associated with partners' psychological distress as veteran's symptoms of PTSD rose into the clinical range" and in fact was "nonsignificantly and negatively associated with such distress as PTSD symptoms decreased below this level" (2012, p. 18). The authors suggest that these findings may point to the potential for the overlap of the disclosure of traumatic material with evidence of the veterans' symptoms to be a source of psychological distress for the partner.

Predictors related to the spouse.

Although the literature suggests that being married to someone with combat related PTSD has pathogenic effects, there is also evidence of a considerable amount of variance in women's psychological adjustment to this situation. For example, Jordan et al. (1992) found that a significant portion of the wives of veterans with PTSD described themselves as happy and satisfied with their lives. In unraveling what accounts for these different reactions, factors related to a partner's perception of her husband's behavior and how his condition affects her may play an important role.

Partner's perceptions of deployment experiences.

Renshaw and colleagues have completed multiple studies that suggest military spouses' understanding of and attributions for their husbands' PTSD symptoms may be involved in their distress (Renshaw & Campbell, 2011). Research with relatives of individuals who have a mental illness has suggested that "symptoms that are seen as out of a person's control should be less distressing to family members" (2011, p. 1). In a 2008 study, they found that among a sample of 50 wives of service members who had served in Iraq, husbands' PTSD symptoms were significantly associated with wives' marital satisfaction, with higher levels of symptoms predicting less satisfaction. However, this association was significantly moderated by wives' perceptions of their husbands' combat experiences. When women perceived their partners' levels of combat to be higher, the association became nonsignificant (Renshaw & Campbell, 2008).

In a 2011 study with a sample of 206 National Guard service members deployed in OIF/OEF, the same researchers found that the overall association between PTSD symptom severity and the partner's distress was not moderated by partner's perceptions of how much combat exposure their husband had experienced (as they had found in 2008), but when examined at the symptom cluster level, the association between numbing/withdrawal symptoms and partner distress was moderated by partners' perceptions (Renshaw & Campbell, 2011). When partners reported believing that their husbands had experienced high levels of traumatic experiences while deployed, the link

between their husbands' numbing symptoms and their distress diminished significantly. Most recently, Renshaw and Caska replicated these findings in a study involving two large samples, one of partners of OEF/OIF/OND veterans, the other using previously collected data of partners of Vietnam veterans (2012). They found similar results in both samples: "when examined simultaneously, partners' perceptions of withdrawal/numbing symptoms were associated with greater distress, but perceptions of re-experiencing symptoms were unrelated to psychological distress and significantly associated with lower levels of relationship distress" (Renshaw & Caska, 2012, p. 416). They argued that because re-experiencing symptoms are much more obviously linked to trauma, this pattern of results supports the theory that partners report less distress about symptoms that can be clearly linked to an uncontrollable mental illness.

A 2014 study attempted to directly test this hypothesis by having 483 civilian females married to active duty Army soldiers rate their husbands' levels of PTSD and combat exposure (Renshaw, Allen, Carter, Markman, & Stanley). Those that reported significant levels of PTSD symptoms were then asked how much they perceived these issues to be related to internal factors ("the type of person he is" and "an aspect of his personality") or external factors ("situations your spouse has experienced" and "things that have happened to your spouse") (Renshaw et al., 2014). As anticipated, external attributions were positively correlated with perceptions of combat exposure and re-experiencing symptoms while internal attributions were

positively associated with perceptions of numbing/withdrawal symptoms. The negative association between PTSD symptoms and relationship satisfaction grew stronger as internal attributions for husbands' symptoms increased; the more women linked their husbands' symptoms to their combat and other experiences, the more satisfied they were with their relationships (Renshaw et al., 2014).

Caregiver burden.

One variable that has been repeatedly associated with spouses' distress in this population is caregiver burden. This construct has been operationalized as the perception that one's life is adversely affected by caring for a family member (Zarit, Todd, & Zarit, 1986). Spouses are the main providers of nonprofessional care for US veterans, and 80% of spouses play a large or very large role in helping veterans manage their PTSD symptoms (Lyons & Root, 2001). Spouses may feel strained by the financial demands that often accompany issues with unemployment or underemployment, the emotional demands of coping with unpredictable mood and behavior, or the social isolation that can result from reduced time and energy for interacting with others (Dekel & Solomon, 2006). Clinicians working with families affected by a spouse with PTSD have noted that in such families "the traumatized individual's ability to function within the marriage is perceived as 'inadequate' while the spouse's is seen as 'overadequate'. Over-functioning and being a full-time caretaker for the entire family can create feelings of resentment and of being overburdened" (Harkness & Zador, 2001, p. 344).

Caregiver burden was first investigated among caregivers of older adults and those with chronic medical conditions such as Alzheimer's disease and dementia; findings linked perception of burden to poorer psychological and health outcomes (Beckham et al, 1996). Recognizing the systemic burden that psychiatric conditions could create, Noh and Avison conducted research on couples in which one spouse had been previously hospitalized with a psychiatric condition (1988). They found that a significant number of spouses reported feeling burdened by their family members' condition.

Beckham, Lytle, and Feldman were the first to first to apply this construct to the experience of spouses of veterans with PTSD (1996). In their study of Vietnam War veterans and their spouses, participants completed measures at two time points, an average of 8 months apart. Cross-sectional analyses indicated a significant correlation between PTSD symptom severity in veterans and their partners' perceptions of burden. At both time points, partners' burden was associated with partners' adjustment (psychological distress, dysphoria, anxiety) and was a better predictor of these outcomes than veterans' PTSD symptom severity. Additionally, change scores in individuals' reported burden positively predicted changes in all of the measures related to partners' distress. Calhoun, Beckham and Bosworth (2002) sought to cross-validate this work and also found a strong relationship between caregiver burden and spouse's psychological adjustment. Although they examined other variables thought to contribute to a spouse's burden (measures of a veteran's depression, hostility and health issues), only

interpersonal violence and veteran's PTSD symptom severity independently contributed to the spouse's burden and distress.

Studies with the spouses of Israeli veterans have found caregiver burden to be a significant predictor of partners' adjustment as well. Ben Arzi, Solomon, and Dekel compared spouses of veterans with PTSD and post-concussion syndrome to spouses of a control group of veterans, and found higher levels of burden and distress in both research groups (2000). Dekel, Solomon, and Bleich (2005) examined the contributions of both the veteran's level of impairment and the spouse's sense of burden to the spouse's emotional distress and marital adjustment in a sample of over 200 couples in which the male veterans had been diagnosed with PTSD. They found that spouse's level of distress was higher than that in the general population and that this distress was more closely associated with the perceived caregiver burden than with the husband's level of impairment.

Some of the themes which emerged from a 2004 phenomenological study of Israeli spouses of veterans with PTSD, illustrate their findings regarding the spouses' experience of burden (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005). The researchers held a semi-structured in-depth focus group with nine wives of Israeli veterans that had previously been diagnosed with PTSD by the Israeli Ministry of Defense. Five themes emerged in the women's discussion: the large degree to which PTSD shaped their physical and emotional lives, the struggle to maintain control of their

personal space, the loneliness of being with a partner who is physically present but psychologically absent, the reasons that separation and divorce were not options they felt open to explore, and the benefits of the marital relationship. In the women's discussion of how their husbands' PTSD shaped their experiences, they highlighted the loss of personal time and space as one of the most prominent hardships. Women spoke of how their fears about their husbands' wellbeing or their husbands' demands for their attention made it difficult for them to concentrate on activities outside of the home. In particular, the blurring of boundaries between the women and their husbands and the development of symptoms that mirrored those of their partners was apparent. Women spoke of being sensitive to loud noises and having their mental and physical worlds reduced. One wife, an artist, admitted, "If I sculpt, I only sculpt about the subject of PTSD…. Once I was very active. For years I haven't gone to an art event. I simply bury myself at home.... Today I am connected only to PTSD" (p.28). The theme relating to their struggles for control of personal space was illustrated by comments on the difficulty of retaining a sense of separateness from their husbands. They spoke of resisting the pressure to allow their husbands to become dependent on them, and in some cases, their reluctant acquiescing to this role.

Only one study has investigated caregiver burden among spouses of OEF/OIF/OND veterans with PTSD symptoms. Caska and Renshaw's (2011) findings replicated previous studies that found veterans' PTSD symptoms and partners' burden associated with partners' psychological distress. As in other studies, partners' perception

of burden fully mediated the relationship between veterans' PTSD symptoms and partners' distress. The relationship between veterans' symptoms and partners' burden was not moderated by difference in severity (clinical versus subsyndromal), thus their findings were consistent with Dekel et al.'s (2005) results that subthreshold PTSD is similarly associated with partners' burden. In two separate bivariate regressions they found that veterans' symptoms of depression and anxiety contributed to partners' distress as well, and that these relationships were also completely mediated by burden.

Summarizing Findings

A recent meta-analysis suggests one way of framing the research that has begun to accumulate on the impact of PTSD on intimate partners. The authors examined two primary associations: the correlation between PTSD symptoms and partner's relationship satisfaction and between PTSD symptoms and partner's psychological distress (Lambert, Engh, Hasbun, & Holzer, 2012). For the first, the authors identified 22 appropriate studies and the results indicated an effect size in the small to moderate range ($r = -.24$, $p < .001$). Military status and gender of the trauma survivor were both significant moderators, indicating that larger effect sizes had been found in military samples and among female partners of male veterans. The authors also collapsed data across 25 studies that examined the relationship between an individual's level of PTSD and his or her partners' distress (Lambert, Engh, Hasbun, & Holzer, 2012). Distress was an umbrella category that included STS, caregiver burden, and general measures of anxiety,

perceived stress, and depressed mood. The analyses revealed a moderate association with an effect size of r=.30 (p<.001). Again, military status was determined to be a significant moderator of this relationship, such that the effect was stronger for studies with military samples. The work of Lambert and colleagues conceptually differentiates between two broad types of distress that partners may be experiencing: distress related to their relationships versus personal, psychological distress (2012). Their results provide evidence that each type of distress does appear to be significantly linked to the situation of the partner and underline the importance of examining the experience of females married to veterans with PTSD.

PTSD effects a significant portion of the veterans that have served in the wars in Iraq and Afghanistan and a large amount of resources have been devoted to better understanding and treating this population. Yet, despite strong evidence of the systemic effects of PTSD, relatively little research has been devoted to this cohort of partners of veterans. Such research is valuable on multiple levels. This population has been found to be at increased risk for psychological distress and relationship distress and better understanding their experiences is an important step toward ensuring their clinical needs are met. In addition, veterans' partners play a crucial role in providing support to veterans and research has repeatedly demonstrated the connection between positive social support and improvement in PTSD. Providing better care for veterans' partners is therefore also a neglected strategy in improving care for veterans. The small, but growing body of research that has focused on partners of OEF/OIF/OND veterans builds on findings from

studies done in other countries or on previous eras of veterans but includes limited qualitative studies. There is a need for in-depth research with this population that attends to the context of the current era of US military couples and allows women to use their own words to capture a more rich and complex understanding of the meaning that they attach to their experiences.

Chapter Three: Methodology

> "In phenomenological research the emphasis is always on the meaning of lived experience. The point of phenomenological research is to 'borrow' other people's experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience" (van Manen, 1990, p. 62)

Proposed Study and Research Questions

The current study seeks to contribute to the literature on the systemic effects of PTSD on partners of veterans with military trauma. As the large majority of individuals in this situation are female civilians in relationships with male veterans, the present study will build upon previous research focusing on this group. A small but growing body of literature has examined variables associated with distress amongst this population, but few studies have used in-depth methods to examine the experience of being in a relationship with an OEF/OIF/OND veteran with military-related PTSD. The qualitative studies done with previous eras of military partners were invaluable in illuminating some of the struggles women in this population were facing. However, there are many contextual differences for partners of post-9/11 veterans, and there is a need for research on this specific group that provides this type of rich understanding of their experiences. Given this need, I employed qualitative methods, more specifically a hermeneutic phenomenological methodology, to illuminate the lived experience of female partners of

OEF/OIF/OND veterans with PTSD. In particular, the study explores how partners experience and understand PTSD symptoms and how these symptoms may influence their feelings about the relationship with the veteran and about themselves.

In describing the strengths of qualitative approaches to inquiry, Maxwell highlights intellectual goals that are particularly well suited for qualitative research designs, including those that seek to understand "the *meaning,* for participants in the study, of the events, situations, experiences, and actions" in which they are involved or engaged (2005, p. 22). In the context of women married to veterans with PTSD, research has indicated that partners' appraisals of factors related to their husbands' experiences and symptoms (such as level of combat exposure and type of symptoms) are related to their distress, but little is known about how these factors are experienced or interpreted by women. This additional information is important if we are to understand how veterans' symptoms affect their wellbeing. By focusing on how women experience life as the partner of someone in significant distress, connections between veterans' behavior and their partners' distress can be better understood from the partners' perspectives.

Positioning the Research Endeavor

Of the diverse qualitative strategies used in psychological research, I chose methods rooted in hermeneutic phenomenology to investigate the experiences of partners of veterans with PTSD. At its core, such research can be described as "concerned with unveiling hidden meanings of lived experience" (Finlay, 2011, p.112). The

phenomenological approach is appropriate for this study because it incorporates many of the strengths of qualitative inquiry; it is discovery oriented and the results are based on the collection of rich, idiographic data captured in the participants' own language rather than an external frame of reference (van Manen, 1990).

Most of the psychological research that has involved partners of veterans with PTSD has relied solely on quantitative methods. Exclusive use of quantitative methods often signals that research is grounded in either the positivist or post-positivist paradigm. Educational researcher Egon Guba describes the positivist philosophy of science as rooted in a realist ontology, the work of the researcher aims to uncover the reality of a phenomenon or discover the Truth about a topic (1990). This goal restricts the researcher to an objectivist epistemology; the inquirer must remain without bias so as to accurately observe and record this truth. Working in this framework, such a goal can only be achieved through approximating rigorous empirical experimentalism as closely as possible (Guba, 1990). Researchers working from the post-positivist paradigm, a revised philosophy that accepts the impossibility of fully knowing reality or completely divorcing oneself from bias, also maintain the importance of striving toward objectivity and using methods that approximate empirical experimental research in order to move as close to the Truth as possible (Guba, 1990).

Within the field of psychology, as within other human and social sciences, the last thirty years have brought increased recognition of the value of drawing from diverse

perspectives when designing research (Creswell, 2003). Many contemporary psychological researchers espouse a philosophy of science that embraces the complexity involved in seeking and interpreting knowledge. The increased acceptance of constructivist epistemological positions within the psychological research community has been accompanied by a proliferation of research methods that reflect this shift, and these methods have replaced the goal of revealing the singular truth about a subject with the goal of uncovering individuals' truths, personal constructions with social and experiential bases (Guba, 1990). Many of these methods rely on the analysis of qualitative data. One benefit of collecting qualitative data is that research participants are able to describe their experiences in their own words rather than attempting to fit them into preconceived, and perhaps ill-fitting, categories. The majority of past research on female partners of veterans with PTSD has attempted to apply concepts grounded in work with other groups to fit this population. For example, the theory of secondary traumatic stress is rooted in research with therapists and their clients and the model of caregiver burden grew out of research with those caring for older adults with chronic health problems (Figley, 1995; Beckham et al., 1996). Collecting data using open-ended questions, rather than quantitative measures developed with other populations, safeguards against data being squeezed into frameworks that reduce or distort the experience being captured.

Due to the nature of quantitative research, data collected using such methods often reflects the choice to emphasize precision over richness (Guba, 1990). This imbalance is tied to a particular view of science as pursuing the goal of prediction. The

focus on cause and effect relationships is linked to the tendency to describe phenomena numerically and use quantitative approaches to better understand patterns and relationships (Creswell, 2003). Although these endeavors have value, much is lost when numbers completely replace language because language is what allows our participants to describe the context and texture of the issues being explored and allows for the possibility of extended or novel understandings. The heavy reliance on nomothetic approaches, concerned with patterns of large groups, has resulted in an almost complete disregard for idiographic data despite the power it often holds to illustrate the essence of an important experience (Smith, Flowers, & Larkin, 2009). My choice to adopt a qualitative method for the present study, which allowed for in-depth collection of data from a relatively small sample of women, was an attempt to address this imbalance. This approach enabled participants to share richer material and therefore lessens the risk of missing nuances that are central to understanding this complex phenomenon.

An additional benefit of employing a qualitative design in psychological research is that such designs fit research goals aimed at discovery rather than verification. Quantitative research designs require well-formulated hypotheses and findings are often questioned if researchers are reported to have been "mining the data" to determine what relationships exist between variables. Qualitative methods, on the other hand, are considered a good match for exploratory studies (Creswell, 2003). Many approaches to qualitative research allow for, and even emphasize, the use of inductive rather than deductive strategies for conceptualizing a study's data (Miles & Huberman, 1994).

Although there have been recent quantitative studies that have looked at OIF/OEF couples in which the veteran spouse has PTSD, they have primarily sought to verify existing theory, rather than explore dynamics that may be different than those in couples from previous eras or different countries. The possibility that female partners may understand their experiences in ways that have not yet been labeled or described provides further incentive to pursue the present study using a qualitative method.

Phenomenology's philosophical grounding.

The phenomenological tradition of research within the social sciences can be traced back to Edmund Husserl (1859-1938), a European philosopher and mathematician. Husserl first outlined his version of phenomenology at the beginning of the 20th century as a specific manner of investigating consciousness (Smith et al., 2009). Recognizing the limitations of applying the methods developed for studying the material world to humans, he devoted himself to devising more appropriate methods for this purpose (Wertz et al., 2011). He was concerned in particular with how to understand peoples' lived experiences, coining the term *Lebenswelt* (translated as *lifeworld*) to capture the idea of the "the natural attitude of everyday life" which he described as "the original, pre-reflective, pre-theoretical attitude" (van Manen, 1990, p. 7). His studies led him to outline a rigorous way of shedding biasing assumptions and identifying the essential nature of "the things themselves" (Dowling, 2007, p.132).

Husserl's method, transcendental phenomenology, includes three basic steps. The first which is often called the "phenomenological reduction", prepares one to approach the investigation of an object by assuming an unprejudiced view so that it can be "precisely described and understood" (Dowling, 2007, pg. 132). This is accomplished by *bracketing,* or setting aside*,* one's preconceptions based on theory or previous experience in order to approach the object with "disciplined naiveté" (Giorgi & Giorgi, 2003, p. 249). The second step, *free imaginative variation,* is a process of systematically imagining the object with elements changed or removed in order to determine which dimensions are integral to the essence of the object. The third and final step is to describe the essence of the object based on the results of these procedures (Giorgi & Giorgi, 2003). Husserl promoted this method as an important tool for understanding humans and understanding the philosophy of science (Wertz et al, 2011). His students continued to use his methods and to promote his ideas, leading phenomenology to become an influential philosophical movement throughout Europe that branched into several different disciplines.

In the first half of the twentieth century, Husserl's assistant, German philosopher Martin Heidegger (1889-1976), expanded his ideas in ways that had significant implications for many fields, phenomenological inquiry in particular (Smith et al., 2009). Heidegger continued to grapple with epistemological questions, but argued that the goal of simply describing phenomena is made impossible by the fact that description always involves an interpretive element. He emphasized the role that *historicality*, a person's

background, culture, and history, plays in shaping the way he understands the world (Laverty, 2003). Heidegger believed that it is not possible to explicitly identify and detach oneself from the influences that shape interpretation of the *lifeworld*. His revised approach, hermeneutic phenomenology, centered on the nature of "being in the world" and was more explicitly concerned with illuminating the meaning of phenomena rather than just the essential structure (Dowling, 2007).

As the philosophy of phenomenology was evolving in Europe, psychologists and psychiatrists in the United States of America were looking to phenomenology as an alternative framework for understanding human experience. In the 1960's Amedeo Giorgi, an experimental psychologist that had grown disillusioned with the methods of research he had practiced in the laboratory, set out in search of an alternative approach (Wertz et al., 2011). His quest led him to the work of Husserl, and he designed a systematic approach to research based on Husserl's concepts. The work of Giorgi and his colleagues in the psychology department at Duquesne University paved the way for wider acceptance of phenomenological research and recognition of the importance of different methods for "human science"(Wertz et al., 2011).

Within the last decades phenomenological research methods have been embraced more widely by psychologists, as well as researchers within education and health care, because of the need for flexible, distinctive, and comprehensive tools suited for engaging questions about human experiences. Topics that have been investigated with this

approach range from how individuals with AIDS understand their illness (Anderson & Spencer, 2002) to the meaning of cutting behaviors among dissociative females (Robinson, 1998) to experiences of marriage in midlife (Appleton & Bohm, 2001). However, while these and many other studies fall under the umbrella term phenomenological, they have actually been completed using a variety of methods, some of which share similar principles and some of which diverge significantly.

Hermeneutic phenomenology as methodology.

The present study was undertaken using hermeneutic phenomenological methods. Far from a prescriptive formula for inquiry, hermeneutic phenomenology is a flexible framework that allows for the selection of complimentary procedures (van Manen, 1990). Many variations of this approach to research have been articulated. The method of research I employed in this study was based on the overlapping conceptualizations of Canadian phenomenologist Max van Manen's lived experience approach and British psychologist Jonathan Smith's Interpretive Phenomenological Analysis (IPA) and incorporated research strategies from educational researcher Irving Seidman's phenomenological interviewing method (Finaly, 2011; Seidman, 2013).

This methodology shares much with other phenomenological approaches to human science research, including: an explicit focus on lived experience, the centrality of rich and layered description, and attunement to phenomenological themes (Finlay, 2011, p. 16). The focus on lived experience can be traced back to Husserl's concept of the

lifeworld. While often there is an interest in research that places people in artificial contexts, phenomenology is concerned with an individual's natural way of being in the world. Phenomenological accounts are powerful not only because of their connection to everyday life, but also because of the quality of their descriptions of experience. Finlay writes that "Phenomenological accounts seek to describe experience systematically in all its density, poignancy, richness, and paradox." (2011, p. 18). A third common principal across phenomenological research is the importance of "reflecting on the essential themes which characterize the phenomenon" (van Manen, 1990, p.30). van Manen illustrates the seemingly paradoxical simplicity and complexity of such a task using the experience of time:

> What could be more easily grasped than time? We regulate our lives by time. We carry the time around on our wrist. We divide the day into morning, afternoon, evening, and night time…. And yet when someone asks us "what is time anyway?" we are quickly at our wit's end to describe it. What is it that goes by fast or slowly when we say that time is elapsing? So there is a difference in our pre-reflective lived understanding of the meaning of time and our reflective grasp of the phenomenological structure of the lived meaning of time. (1990, p.77).

In order to describe the latter, the phenomenological researcher must thoughtfully attend to the themes that arise in the data. Van Manen argues another way of thinking about themes is as "structures of experience" that provide a way of "seeing" meaning (1990, p.79).

Hermeneutic phenomenology can be distinguished from other forms of phenomenological study by its emphasis on interpretation in addition to description.

Giorgi and his colleagues from the Duquesne school developed research methods (rooted purely in Husserl's philosophy) that serve the goal of illuminating the essential structure of a phenomenon through description. In contrast, researchers working from a hermeneutic phenomenological perspective begin with the concept of a person "as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns" based on the contributions of Heidegger, Merleau-Ponty, and Sartre to the phenomenological project (Smith, 2009, chapter 2, section 1 summary). This broader framework has led hermeneutic phenomenologists to embrace an expanded understanding of *experience* as "a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationship to the world" (Smith, 2009, chapter 2, section 1 summary). Recognition of the dynamic and complex nature of experiential phenomena is at the heart of viewing phenomenological research as a necessarily interpretive task.

Another defining research activity central to the hermeneutic phenomenological approach is the researcher's active reflection on her relationship with the topic of inquiry. Personal perceptions and experience of a research subject may provide both clues to understanding it and biases that shape his interpretation of it (Finlay, 2011; van Manen, 1990). Van Manen disputes the possibility of *bracketing* preconceptions the way Husserl described because he argues that it is ineffective to try to ignore or forget what one already knows. Instead, he suggests the researcher should make explicit their beliefs, theories, biases and assumptions about a particular topic in order to hold those in

awareness throughout the research process (1990). Drawing on Heideger's reinterpretation of *bracketing*, Smith emphasizes that it is not always possible in the early stages of a project to completely recognize one's biases, but that the researcher should approach reflexivity as a cyclical process (2009). He also references the work of Gadamer, a phenomenologist who wrote about the dynamic process of hermeneutics, summarizing, "Sometimes we can identify our preconceptions in advance; sometimes they will emerge during the process… Either way, this requires a spirit of openness" (2009, Chapter 2, Gadamer section, para. 6).

One benefit of incorporating Interpretive Phenomenological Analysis into the current methodology is the idiographic sensibility of this approach. Smith et al. emphasize the value of capturing the meaning of an experience for a *particular* person and exploring the similarities and differences between a small number of cases, in addition to making more general claims about an experience (Smith et al., 2009). This is demonstrated in the attention given to the participant's context and the depth of the "micro-level" analysis of each case (Finlay, 2011, p. 140). In this regard, IPA shares the strengths of other approaches that involve the detailed analysis and comparison of a small number of cases. In his 1988 article *A Theory of Multiple-Case Research,* Rosenwald persuasively argues for the power of research designs that allow for both the in-depth exploration of individual lives and the identification of shared meanings as cases are "brought into 'conversation' with one another" (p. 239). He illustrates how researchers' preoccupation with focusing on what is unique about one person's experience and the

misconception that individual differences render this research irrelevant to a larger audience pushed the field of psychology away from multiple-case investigations. Rosenwald challenges the idea that designs that focus on the *general*, reporting only significant trends across large groups, may enrich social knowledge more than those concerned with the *particular*, detailed elaboration of a few cases. Rather than "standardize or seal off individuals", the model he outlines "seeks to understand them both singly and together, by recognizing them in complementary and problematic engagement" (p. 256). Similarly, the in-depth analysis of cases central to the IPA approach offers the opportunity to speak to a collective experience without losing sight of the individual.

In addition to the framework provided by IPA and van Manen's lived experience approach, the present study utilized research strategies based on the work of Irving Siedman, an educational researcher who has developed a method for qualitative research based upon phenomenological interviewing. In-depth interviewing was chosen for the present study because engaging the questions driving the research necessitates a format that allows participants to share rich material. Seidman writes that, "At the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they make of that experience." (1998, p.3). He emphasizes the importance of multiple meetings with each participant in order to place their experiences in context and outlines a structure for research based on a series of three interviews. In the first, the researcher asks open-ended questions that encourage the participant to share as much as

possible about her life up to the present as it relates to the topic (Seidman, 2013). In the next interview the participant is asked to reconstruct concrete details related to the topic being investigated. Then the third and final interview focuses on questions that probe the meaning of the participant's position in relation to the topic being explored. According to Seidman, "The combination of exploring the past to clarify events that led [participants] to where they are now, and describing the concrete details of their current experience, establishes conditions for reflecting upon what they are doing now in their lives." (2013, p.22).

Researcher's position.

Choosing to approach this study from a hermeneutic phenomenological stance meant challenging myself to recognize what I was bringing into the interview encounters and how this might shape the data being generated in these spaces as well as my later interpretations of the material. My ideas about what the experience of women in relationships with veterans with PTSD might be like began to develop the moment that I first was drawn to this topic. In 2010, I had the opportunity to be involved in a research project examining combat veterans' personal narratives and one afternoon engaged in a conversation with a participant after his interview. This Vietnam veteran shared that he had just recently sought treatment for PTSD and was becoming aware of all the ways the symptoms of this disorder had affected his life. He expressed that he felt much gratitude towards his wife in particular for remaining with him despite his emotional detachment

over the previous 40 years. His comments stayed with me, and I found myself wondering what it would be like to share a life with someone who was often as distant as he had described. I assumed that this would be very difficult and as a recently married person myself, I questioned whether I could sustain a relationship in such a context. My curiosity about this topic led me to look into the literature on the subject and to begin to pursue this research interest with a sense of admiration and empathy for individuals in this position.

By the time I was working on my proposal for the current study I had gained clinical experience with veterans working as a student therapist in a VA clinic focused on PTSD treatment. In that setting, I witnessed firsthand veterans' anxiety, irritability, depression, and suicidality and felt concern, frustration, responsibility, and fear in response to their suffering. I often felt drained after therapy sessions. These experiences prompted me to think more about how individuals who are so deeply connected to these veterans would be affected by their distress. I also heard stories from veterans of failed relationships and relationship problems and found myself again imagining that it would be a very challenging situation for a partner.

Prior to beginning my interviews and asking each participant to share with me their associations to the military, I realized I needed to examine my own. Besides a distant cousin who had deployed during the Gulf War, I grew up knowing no one that was in the military. I had been taught by my mother to have great respect for veterans, however, this was more of a hypothetical value since I knew and interacted with so few

people that fit this description. I met my husband the year the US invaded Iraq and quickly became more aware of the sacrifice involved in military service as three of his siblings went to Iraq or Afghanistan and his family managed all that came with these deployments. My appreciation for the service of the entire military family has deepened over the years as I have seen the ways in which life was upended by frequent moves and uncertain futures, and I witnessed the support and flexibility required of military spouses and children.

As I have worked on this project I have tried to remain aware of these preconceptions as well as those rooted in my review of the literature on this topic. I have tried to be open to recognizing biases that had an impact upon what I was able to *see* in the experiences that participants shared, and to suspend all of these assumptions while engaged in interviewing and the initial phases of data analysis. Completely removing the influence of prior knowledge and experience on the research process is an impossible task. However, I hope that by striving to be reflexive about my influence on the process and transparent about my position in regard to this topic, I have been able to describe and interpret these women's stories in a way that does "justice to the fullness and ambiguity of the experience." (van Manen,1990, p. 131).

Participants

Recruitment for the present study targeted female participants over the age of 18 who were married to, or in committed relationships and cohabitating with, male veterans

of the OEF/OIF/OND wars whom had either received a diagnosis of PTSD from a professional caregiver or displayed significant symptoms of the disorder to their partners. 12 women who fit these criteria participated in the study. Initially recruitment was limited to women who were in committed relationships with their partners previous to the veterans' deployment to OIF/OEF/OND, however this criteria was dropped in order to include a wider sample of all partners who been in their relationships for at least a year. Given the prevalence of comorbid psychiatric diagnoses and neurological diagnoses among veterans with PTSD, women whose husbands had additional diagnoses such as major depressive disorder, substance abuse disorders, or TBI were not excluded. IPA studies typically utilize a small sample because of the focus on detailed analysis of individual cases and the centrality of idiographic principles in this approach. Smith suggests that the sample should provide enough cases that the researcher is able to draw meaningful comparisons between the participants without losing sight of analytic priorities due to becoming overwhelmed by a large amount of data (2009).

Recruitment methods were purposive and relied primarily on informal networking. Organizations that serve military families were contacted and asked to disseminate recruitment materials, flyers were posted on social networking pages devoted to this population and websites such as *Craig's List*, and other individuals learned of the study through word of mouth. Individuals who contacted me to express interest in participating were asked screening questions over the phone or email to confirm that they met the inclusion criteria. Women were provided informed consent materials describing

the nature and purpose of the interviews, policies on confidentiality, and possible uses of the research results, either in person or via email and had the opportunity to ask questions about the study. All women who participated were also provided information about pertinent non-profit organizations, mental health services, and resources for individuals who have experienced domestic violence. In an effort to recruit additional participants, an amendment to the study protocol was approved by the IRB over the summer of 2015, and a $25 gift card was offered as an incentive for participants recruited after this date.

Approval by Human Subjects Committee

The proposed study was approved by the Institutional Review Board for the Protection of Human Subjects at the University of Texas at Austin and conducted in compliance with their guidelines as well as the ethical standards set forth by the American Psychological Association.

Data Generation

Participants were asked to engage in a series of semi-structured interviews lasting approximately 60- 90 minutes each. In structuring the interviews, I drew from Siedman's approach to phenomenological interviewing in which participants meet with the researcher multiple times and each meeting has a different emphasis (2013). Although Seidman describes a three-interview series as the ideal structure for collecting information on these topics, he recognizes that this is not always possible and that the structure should be adjusted to accommodate the needs of the study (1998, p. 15). Due to

early observations that participants were very busy juggling household demands, caregiving responsibilities for their families, and in many cases work and school schedules, women were asked to participate in two interviews rather than three and time was managed to cover each of the areas discussed above. In two cases, women were interviewed on just one occasion for a slightly longer amount of time. In the first case, this was due to the distance required to travel to meet with the participant. In the second case, the participant spoke rapidly and moved through the material at a relatively quick pace.

6 of the 12 participants were interviewed in person. These women were asked to choose a location they preferred that provided privacy and quiet to meet. These interviews were conducted in participants' homes, their offices, outdoor spaces, or other locations. The remaining 6 women lived outside of the region and were interviewed over the computer using an online videoconferencing platform. Meeting times were arranged over the phone or email and participants simply clicked on a link sent via email in order to begin the video call. These women chose locations where they were comfortable to meet, and most opted to call in from their homes. Interviews of all participants were scheduled approximately 1 to 2 weeks apart, however, in one case scheduling conflicts resulted in interviews being spaced 4 months apart.

Interviews followed a general format, however, the details each participant shared informed the formulation of additional open-ended questions. During the first interview

the participant was encouraged to share information about her background and any familiarity she had with military culture prior to her current relationship. She was then asked to recount the story of her relationship from how it developed to the present day, including her experiences during deployment(s) if she was with her partner while he served in the military. She was also asked about her knowledge and thoughts about PTSD prior to her partner's diagnosis. During the second interview the participant was asked to reconstruct details of interactions with her husband and her thoughts and feelings during such events. Follow-up questions covered what types of things participants did to manage their reactions to these experiences. The final portion of the interview was devoted to exploring how the participant saw her partner's PTSD impacting her feelings about herself and her relationship and, what the roles she played in her relationship meant to her. These questions provided participants a clear opportunity to share the connections they drew between their experiences and to express how they understood them.

I approached and conducted the interviews with an understanding that "knowledge is in fact dialogical, and that it is co/re-created in the course of the interview interaction" (Noy, 2007). In an effort to bring to lights what I was contributing to the data through the interactional space of interviewing, I engaged in reflective writing throughout this phase of the project. I recorded my observations about each interview and the associations I had to the participants and the material they shared as a method of highlighting my conceptions of the phenomenon and how they influenced the research.

Transcription

Each interview was recorded using a small digital recording device or directly onto a secure, password protected hard drive. I transcribed the content of each interview giving special attention to capturing verbal and nonverbal material accurately (Seidman, 2013).

Data Analysis

The data from all of the interviews was analyzed following hermeneutic phenomenological principles. Van Manen (1990) and Seidman (2013) provide general guidelines which are consistent with the basic analytic strategies of IPA (Smith et al., 2009). In addition, Smith and colleagues (2009) offer more detailed recommendations in the form of a structured yet flexible method that was utilized for this portion of the study.

There are multiple principles shared by hermeneutic phenomenologists that informed the analytic phase of the present study. I strove throughout data analysis to be guided by an open attitude rather than deductive hypotheses. Seidman recognizes that while the researcher cannot enter analysis without preconception, she should work to "come to the transcript prepared to let the interview breathe and speak for itself" (2013, p.120). Similarly, researchers working from an IPA perspective describe the process of data analysis as "inductive, fluid and emergent" (Finlay, 2011).

The identification of themes in the description of an experience is also central to this approach to analysis. van Manen compares phenomenological themes to "knots in the webs of our experiences, around which certain lived experience are spun and thus lived through as meaningful wholes" (1990, p. 90). This metaphor captures an important quality of phenomenological themes; they are directly connected to the experience being examined. Beginning with the themes that were initially noted, I attempted to root them directly in the experiences women reported, rather than external or separate ideas. Because the "Meaning or essence of a phenomenon is never simple or one-dimensional", I also attended to the multi-dimensionality of women's feelings and experiences in each stage of the analysis (van Manen, 1990, p. 78).

The final shared principle of hermeneutic phenomenology that shaped this stage of the study, addressed this complexity: the hermeneutic circle. Heidegger coined this term to describe the process of uncovering a work's meaning through moving back and forth between part and whole (Dowling, 2007). What is considered "part" and what is considered "whole" shifted throughout this phase of research. For example, the meaning of a small section of a transcript was reflected on in the context of the full interview just as themes across different participants' interviews were related back to passages from a particular individual's interview.

Although none of these models include a prescriptive procedure for data analysis, IPA offers the most guidance for researchers. Smith et al. acknowledge that although the

analytic process is dynamic and multi-directional, it can initially be helpful to follow a structured approach that includes several steps (2009). Following their recommendations, I began data analysis with immersion in the interview content from a single case. This started during the transcription process as I listened again to the original recording of the first interview and created a complete record of the exchange. The resulting transcript was read and re-read with the goal of focusing the analysis on understanding the participant's experience. The second step was noting my initial reactions to the text, an open-ended process which involved writing detailed notes in the margins of the transcripts (Smith et al., 2009) These notes included descriptive comments about the content of the text, linguistic comments about language use, as well as some conceptual comments that were slightly more interpretive. After a thorough annotation of the transcript, I moved to the third step of analysis, identifying themes in the data. Smith and colleagues explain that during this step "the task of managing the data changes as the analyst simultaneously attempts to reduce the volume of detail (the transcript and initial notes) whilst maintaining complexity, in terms of mapping the interrelationships, connections and patterns between exploratory notes" (2009, Chapter 5 step 3 section, para. 2).

After both interviews from the first participant were analyzed in this way, I moved to the next case (Smith et al., 2009). Smith et al. acknowledge the inevitable influence of findings from previous cases, but nonetheless encourage making an effort to bracket this information when working with subsequent material (2009). Following

detailed analysis of interviews from all 12 participants, I began to look for patterns across all of the cases. (Smith et al., 2009). I first created tables that captured the emerging themes for each participant. With the goal of illuminating the relationships between elements of the experience for different participants. I deconstructed the tables and organized the themes into groups that seemed to illustrate these patterns (Smith et al., 2009). Several strategies were used to map out relationships between these themes and included noting when one theme subsumed a group of related themes. Through this process larger, super-ordinate themes were identified that captured a relationship between groups of emergent themes. Once these were identified, I returned to the participants' transcripts and collected examples that illustrated each theme into documents that provided references for the writing phase. Throughout the analysis, when responding to the transcript or looking for patterns across interviews, I attempted to stay close to the text, seeking to make interpretations that were an "*amplification* or *illumination* of meaning…cued or sparked by a close engagement with the data" rather than imposing completely external interpretations (Smith et al., Chapter 13, para. 5).

Theme	Participant	Example/pg
Concern for suicide	Diana	6, friends that have died by suicide, but the person will find a way of doing it
Planning for crash	Diana	6, the time of year when he is wounded is coming . He will crash again. He always do.
Fears for baby	Diana	6, Imagine with a baby as well, lack of sleep, baby crying all that, everyone's tired
Phase to endure	Diana	7, If I can be strong and I can pass through this
Trapped	Diana	7, This marriage must work
Little knowledge of PTSD	Diana	7, There is nothing good in my mind.- Don't worry about that. You know I couldn't believe. I didn't have any idea what PTSD is.
Prayer	Diana	7, Went back there and talked to him. I was praying a lot.
Husband feels unreachable	Diana	8, He close himself in such a way sometimes, no one can reach him.
Suicide concerns	Diana	8, he was scared about that window that he could jump
Role of her identity	Diana	9, my personality is more like problem solver

Table 1. Emerging Theme Table

The final phase of the analysis was writing up the results that follow with the goal of clearly presenting the primary themes and conceptualizations that emerged from the data. The discussion section then frames these results in the context of the existing

research, noting ways in which the participants' experiences illustrate the literature, pointing to issues that may not yet have been addressed, or in some cases critiquing the existing research with examples of experiences that point in directions not accounted for in the literature.

Chapter Four: Results and Integrated Discussion

In this chapter I will present the results of my analysis organized into the following seven super-ordinate themes that reflect key dimensions of the experiences women shared: the struggle to understand, emotional rollercoaster, an uncertain path, responsibility to support, impaired trust and intimacy, moving forward, and shifting identities. These each represent a group of themes that emerged across interviews of the 12 participants as they discussed the significant effects of veterans' PTSD on their own lives. After presenting and describing the results that relate to one super-ordinate theme, I will discuss the ideas that have been raised in the context of the existing literature on this topic. I will then proceed to the next super-ordinate theme and discussion. The table that follows includes a list of the participants, their partners, and some additional biographical data.

Participant (Veteran)	**Age**	**Employment**	**Race/ Ethnicity**	**Region of US where living**	**Years together**	**Type of union, before/after deployments**	**Children**	**Branch of service**
Elizabeth (Joe)	29	Financial Services	White, White	South	9	Married, Before	1 daughter	Army
Robin (Andy)	31	Social Work, part time	White, White	South	15	Married, Before	2 sons	Army
Sonia (Mike)	38	Law Enforcement	White & Latina, White	South	13	Married, Before	2 daughters, 2 sons	Army
Amanda (Samuel)	31	Medical Field, not working outside home	White & Irish, African-American	South	5	Married, After	2 daughters	Army
Lucy (Chuck)	29	Former student, not working outside home	White, White	West	9	Married, After	1 son, 1 daughter	Army
Allison (Tim)	42	Graduate Student, College Instructor	White, White	Midwest	15	Married, Before	2 sons, 2 daughters	Army
Jill (Jesse)	39	Legal, Investigations	White, White	Northeast	2	Not married, After	Veteran has 1 daughter	Army
Cathy (Paul)	38	Student	White, White	Midwest	22	Married, Before	1 daughter, 1 son	Navy

Table 2. Participant Data

Participant (Veteran)	Age	Employment	Race/ Ethnicity	Region of US where living	Years together	Type of union, before/after deployments	Children	Branch of service
Shannon (Jeremy)	32	Graduate student, youth pastor	White, White	South	7	Married, After	No children	Marines
Diana (Alex)	36	Former business manager, not working outside home	White & Latina, White	South	1	Married, After	2 sons	Marines
Kendra (Carl)	36	Business manager	White, White	South	1	Not married, After	None	Marines
Briana (Chris)	42	Emergency Services	White & Latina, White	South	11	Married, Before	1 son, 1 daughter	Marines

Table 2. Participant Data Cont.

The Struggle to Understand

Being in a relationship and living everyday with a veteran who has PTSD was at times a very confusing experience for all of the women interviewed. They described themselves as caught up in an ongoing struggle to understand what was unfolding in their lives with their partners. The onset or intensification of symptoms was particularly perplexing for the participants as they observed their partners behaving in uncharacteristic ways and frequently found themselves wondering: What's going on? Why is he doing this? Who is this person? Attempting to answer these questions in the

context of tumultuous life histories and relatively little sharing about military experiences was especially challenging, but some described experiencing moments of insight in their ongoing work to put together pieces in a large and complex puzzle.

Who is this person?

Most women reported knowing relatively little about PTSD before their partners' symptoms emerged and even some who had experience with PTSD in their professional lives or with a family member did not feel that they really understood all the ways that combat-related PTSD could influence someone's behavior. For many women, this meant that their partner's initial manifestations of this disorder prompted confusion and a strong desire to understand what they were witnessing and experiencing.

Allison's husband joined the Army for a second time after they met, had their first son, and were married. He deployed to Iraq 10 years ago and after returning he exhibited emotional numbing and outbursts of anger that would sometimes result in him punching holes in their walls. Although his behavior could be distressing, Allison reported that for years she "blamed it on other things." However as her husband's symptoms began to intensify, Allison grew more concerned and more confused by the increase in what she called "black outs", sleep disturbances that resulted in him walking around, appearing awake but talking nonsensically as if he were drunk. She shares the thoughts she had about these incidents in the following excerpt:

> A lot of it was "What are you taking? Are you on some sort of medication I don't know about?" You know, "What are you doing?" I knew we didn't keep alcohol in the house and if we did it wasn't a lot. More just, wanting to know where this is coming from and why? Well what do you mean, you kept saying you were playing a game. Where does that come from? What does that mean? And he just didn't have the answers.

These episodes her husband is experiencing provoke many questions for Allison. She feels compelled to try to understand and, in particular, determine the cause of his strange behavior but is frustrated by Tim's lack of any satisfying answers. She becomes so desperate to identify an explanation that she seeks out medical testing as she explains below:

> He was taking UA's because I accused him of being on drugs. I'm like my husband is on drugs and they did all kinds of urine analysis. I mean he submitted to everything. I thought maybe he was diabetic and his blood sugar was dropping. Like I tried so hard to find a medical reason. Something more than just from- but it seems like it would be when he would go to sleep and these things would …he would be a different person.

Allison was one of two women in the sample who mentioned that they resorted to drug testing their spouses because of the presence of unexplained and upsetting behavior. In both cases, the negative results seemed to provide little reassurance as they were left wondering what was happening with their husbands. Like Allison, many of the women interviewed still struggled to explain their partners' symptoms even though they now had the framework of PTSD through which to make sense of them. Thus the time before they had connected the veterans' behavior to this condition was described as especially confusing.

Half of the women in the sample met their partners after they had returned from their deployments, however, most of these women described an initial "honeymoon" period of the relationship during which veterans appeared relatively symptom free. When problems then did emerge they were also likely to question what was happening. Lucy is a 29 year-old mother of two who was working as a security guard when she met her husband Chuck at her workplace just over nine years ago. She noticed that he took his job more seriously that the other guards and that despite being the same age, he had an air of maturity that was appealing to her. She speculated that his deployments to Iraq at the beginning of the war had contributed to his demeanor. They were soon engaged, and she described the first six months of their relationship free from significant signs of trouble. She discusses one of her first indications of more serious combat-related issues below:

> I mean I did something silly like, I went and I- and he was sitting on the bed getting ready for work and I walked in the room and I jumped on his back just to be cute. I found myself very quickly very flat on my back and pinned down. Because I scared him. And a lot of people would have been angry. A lot of people would have been hurt. For me, it was a "Why?" Which I think is what got me through a lot of the first couple years, was wanting to know why. It was the, "It's not me. This isn't- the look on his face, the look in his eyes, it's not him. It's not the person I fell in love with. What's going on?"

The contrast between Lucy's playful gesture, intended to express affection, and her partner's violent response, born of fear, is striking. With the knowledge she currently has about her partner's condition, she now describes her movement towards him as "silly", but without that context his reaction is very disorienting. Her lack of anger seems to be rooted in her instinctual awareness that his actions are not the result of his feelings

for her or an intention to harm her. After ruling out these possibilities she then moves to the question that was frequently on the minds of most of the participants of the study, why? For Lucy, the quest to find an answer is characterized as a sustaining process when she says it is "what got me through a lot of the first couple years". The fact she does not even recognize her partner in the person that is pinning her against the ground contributes to her assuredness that there is something wrong that she must try to understand.

Not unlike Allison's characterization of her husband as "a different person" during his black outs, Lucy uses the expression "not him" to describe her partner during this episode. This language was echoed repeatedly throughout women's accounts of their experiences. The perception of the partner as someone else was sometimes described as a temporary occurrence coinciding with bouts of intense symptoms, while for others it was as if this other person who was "not him" had come to inhabit their partners during their deployments and had remained since that time. In both cases it was described as distressing and confusing to suddenly feel the partner was a stranger to them.

Briana and her husband Chris met 10 years ago through their work at the same urban fire department. Chris served in the Marine Force Reserve and nine months into their relationship he proposed after receiving orders to deploy to Iraq. A few years later he deployed a second time, and when he returned he was distant, irritable, and constantly pursuing work that took him away from home. Briana described her reaction to this change in her husband in the following excerpt:

> I mean there was the "what to look for" from the family readiness a little bit, but it was more so, "You're not my husband. You may look like him, but there's something going on wrong, or going on that I can't fix. You know, I'm here and I'm going to support you. I'll give you what you need, but I don't know what that is…." I even told him, my biggest fear with him coming back, I'm married to somebody and I don't even know who the hell it is. But I knew who he was when he left and he came back and he was the same guy kind of, but he turned into somebody else and he became more of that kind of irritable guy that, "Ah! I don't know what to do for you!"

Briana explains that because she had been through two deployments, she had received information on warning signs of PTSD from the military. She suggests, however, that it was the recurring thought "You're not my husband" more than anything else that alerted her to the fact that something was wrong. She emphasizes that she still felt committed to support her husband, but because she did not know what was going on she did not know what might be helpful. She described the loss of her familiarity with her partner as her biggest fear about deployment and her alarm over her situation comes through in the statement, "I'm married to somebody, and I don't even know who the hell it is." As she continues to try to explain the him/not him duality of her partner following his deployment, the confusion of the experience is apparent, as is her frustration over not knowing what to do to bring her known husband back.

Recognizing the problem.

As women struggled to understand what was going on with their partners and why they were not acting like themselves, they described having moments of insight about their experience in which they were able to put together pieces and see things more

clearly. For some, this was when they matched their husbands' behavior with the label of PTSD, while others described their awareness of PTSD as an explanation for changes in their partner's behavior as gradually developing over time. A third of the women in the sample described a specific moment of insight that shifted their perspectives on their experiences entirely.

Elizabeth has been with her husband Joe since she was 20 and he was 33. He proposed before he was deployed for the first time, about eight months into their relationship. He began to struggle with symptoms of PTSD and possible TBI after he was injured in an IED explosion and had to return early from the deployment. About 5 years into their relationship, he was given orders to deploy again. Elizabeth clearly remembered a moment immediately prior to his departure for this second deployment when she fit the pieces together about what was driving his distress:

> He was standing outside and he was smoking a cigarette and I go to rub his back and he's just like, "Go away! Leave me alone." And I was very, very upset. And I was like, "You're pushing me away? We're not going to start this again. No! Come on we have to discuss this. We're gonna get through this again." He goes, "What if I don't make it back?" And he goes, "What if something happens again." He goes, "You don't know what it's like to have your friends slaughtered in front of you and their blood all over you." And I started realizing that the whole problem is he's got PTSD. That it's not been me. I've done all these things in my life for him to keep us together and it wasn't me. It was him the whole time.

Elizabeth's memory of her husband's dramatic disclosure on the eve of his return to the war appears to completely change the way she views what is unfolding in her relationship. Elizabeth's father is a veteran that exhibited signs of PTSD throughout her

childhood. She was just 19 when her first marriage to her high school boyfriend ended after he became verbally abusive and she engaged in infidelity during his deployment to Iraq. When her current husband, Joe, came home the first time and began acting more irritable, distant and disengaged from the family, she considered that it might be PTSD related, but then dismissed this theory. She decided to focus on doing whatever it took to keep him happy in the relationship, as she was intent on not going through a second divorce. In the passage above, learning for the first time Joe's feelings about what he endured in his previous deployment opens her eyes to his suffering. In stating, "I've done all these things in my life for him to keep us together and it wasn't me," she seems to admit that she had been going to great lengths to keep her marriage intact because she felt that she was somehow to blame for the problems they were experiencing. With the recognition that another man in her life had been deeply affected by his wartime experience, comes the relief of no longer shouldering so much responsibility for his discontent.

Cathy's experience of connecting her husband's behavior to PTSD stands in contrast to most of the women in the sample. For her, the moment she learned of her husband's condition was the beginning of her struggle to make sense of things. She recounts the night she first learned of his diagnosis in the following passage:

> But when we got to California, one day he came home and he looked different, his eyes looked different. And I had made dinner and I sat down to talk to him and he said he was at a Chief meeting and he just started bawling, crying. And I never- I maybe once or twice had seen my husband cry, but never had I seen

> emotionally bawling crying, and he just started emotionally bawling and crying. And I didn't know what to do, I- My response was, I'm like, "What's wrong?" (cheery tone) And I kind of like laughed about it. I'm like, "What's going on?" (cheery tone) And that really upset him and that was the beginning of him showing me his emotions. But we had talked about it and he told me he had been seeing a psychologist and a psychiatrist and that he had PTSD.

Cathy's shock at seeing her husband behave in a way that is completely unfamiliar to her is understandable given their long history together. Cathy and her husband Paul met in a high school biology class. As she describes it, she was the "smart girl" and he was the "trouble maker" who came to sit next to her one day in order to get the answers on a test. When he decided to join the Navy shortly after graduation, Cathy was excited because she saw it as a choice that would provide security for their future. They were married in his first year of service, and it was 15 years later, in 2011, that Paul completed two separate seven-month deployments to Iraq in a span of 19 months. It was approximately a year after his return that they moved to California and he shared with her his diagnosis. In this exchange with her husband she responds to his crying with the appropriate questions, but her upbeat tone seems completely mismatched to his outpouring of emotion. Her laughter serves as a clue to the discomfort she is experiencing at seeing this unknown side of her husband and only serves to further upset Paul. In most accounts women spoke of noticing and questioning their partners' behaviors over time and trying to determine if they fit into the category of PTSD, but Cathy's husband had successfully concealed his distress from her until this point and she seems completely caught off guard by this revelation.

Cathy went on in the interview to explain her internal reaction to the news she had just received:

> Uh… I thought we were a statistic. I was like, "Oh! Now we're a statistic!" I…(sigh) I don't know. I don't know. I mean I didn't know how to deal with any of it. I didn't know what it was, I mean they talk about it, but I just didn't think we were going to be that family that had to deal with PTSD. I didn't know what it meant. And then I thought maybe he was kidding himself. That he didn't have PTSD. That just all these guys are talking about PTSD so he thinks he has it.

Cathy's immediate thought of being "a statistic" and her emphasis on all the things she did not know at the time suggest just how disorienting the experience of learning of her husband's diagnosis was for her. Her view of PTSD as something that other people in other families have to contend with hints at the stigma she associates with this label, but her description of her internal reaction suggests that the term does not have real meaning for her otherwise. Her shock seems to quickly fade into denial as she admits her hope that he might just be "kidding himself." Although some women were eager to have a label for the problems they noted with their significant others, a few women mentioned a similar impulse toward denial of the possibility of their partners suffering from PTSD. Although they did not specify their reasons for this response, concerns about stigma, along with the chronicity or impairment associated with this condition likely contribute to difficulty accepting this diagnosis.

Is this PTSD?

Once women knew that their partner was suffering from PTSD, either because they had come to be convinced for themselves or their partners had received the diagnosis

from a professional, their struggle to understand continued. For the majority of women whose relationships began after their partners' deployments, the question "Is this PTSD related?" was recurrent in their narratives. Behaviors that were most often associated with this uncertainty were those that were less obviously linked to trauma or associated triggers, including irritability and angry outbursts. In the following passage Jill recounts what followed her first experience with her partner's explosive anger:

> Um…I don't even know (starts crying) it was horrible. I went home. I was home for like two to three days. He called. He apologized. You know, I love you. I'm sorry. I'll do whatever we have to do. Um, you know and I told him, (still crying) I understand that there are certain things that you can't control. And I will be there and I will support you and I will help you. But that cannot happen. Um, and I struggled at times because we had we had a tough summer, for a reason that I will explain in a minute, but I struggled sometimes, because it's like is this PTSD or is this just violence. You know? And I don't. I don't believe for one minute that he just wants to be a jerk.

On beginning to remember what she referred to as their "first big blow out," Jill begins to cry for the first time in the interview. While her partner Jesse had been open about his diagnosis and she had noticed some behaviors that she thought might be related to PTSD, she was completely unprepared when a few months into their relationship what she saw as a minor argument erupted into him screaming at her and calling her names. Her response to his apology captures her desire to stand by him in his struggle yet set a limit on what she will accept by acknowledging that some behaviors are out of his control, but also barring behavior like he exhibited. However, as she reflects on this and their tumultuous summer, she is unsure of whether his outbursts are related to his PTSD or are "just violence". The question seems to imply that if these are symptoms of a

disorder, then perhaps he cannot control them, whereas the latter option suggests more culpability. However, immediately after she asks the question, she seems to lean in the direction of an answer when she states emphatically that she does not believe that he desires to behave in this way. Jill returns to this question in her second interview when she is describing her reticence to let her friends and family in on what she is going through:

> I think a lot of people are like, "You don't deserve this. It's not okay. Walk away." You know. And it's not okay and that's the hard part. Is he being a jerk? Is there a better way that he can handle this and he's not? Is this all PTSD related?

While Jill, like many of the women in the sample, avoids telling others about what's happening in her relationship because she does not want to be advised to leave her partner, she also agrees that the way he treats her is not acceptable. This leads her to wonder aloud again how to think about his behavior. Her series of questions suggest a possible continuum of options with a "jerk" who is in control of his behavior on one end and someone who is completely at the mercy of his PTSD is at the other.

The question of whether veterans' behavior is due to PTSD seems to be central to many of the women's thoughts about their relationships because it has important implications for how women respond to hurtful behaviors. After Diana states, "I don't know where is his personality and where is PTSD?" she goes on to explain why the question is important by drawing a comparison to another more common medical condition that couples may face:

> And you don't really know what- like the person has diabetes, okay, for example, and he's having a good diet, taking care and everything you're supposed to do, but sometimes doesn't feel well. You forgive this person. You take care of the person, right? So, if instead of diabetes you say PTSD, he's doing everything he's supposed to do but sometimes things don't go well and I have to forgive, because not his fault, you know? But sometimes I'm not sure if it's PTSD or if it's just selfish or his temper.

As discussed elsewhere, many women referenced the classification of PTSD as an illness when discussing their duty to stand by their partners and care for them. Here Diana draws on a medical comparison as well, and she makes clear her belief that when someone is doing what he can to manage his condition, the partner should recognize that and be forgiving in response. In her first interview Diana clearly outlined the things that someone with PTSD should be willing to agree to in order to maintain a relationship, including regularly attending therapy, taking medications as prescribed, and pursuing a positive outlet to reduce anxious energy. Her husband Alex has been compliant with his regimen of individual and couples therapy, medication, and Tae Kwon Do. She has noted improvement in his condition since he began treatment, however, there are still often times that his behavior hurts her feelings. She is bothered by not knowing whether these issues are directly linked to the illness of PTSD, and would therefore deserve forgiveness, or are just part of who he is, and consequently do not qualify for this benefit.

Another reason that women may be troubled by this question is illustrated by Kendra's confusion over where her partner's PTSD symptoms end and relationship variables begin. She shared that the most difficult aspect of her relationship has been "not knowing what's going on in his head and not knowing what's related to the issues he has

versus this situation itself. And is it me, or is it PTSD?" In the following excerpt from her interview she elaborates on what this question means to her:

> Um... It's just, I'm sure that I'm not the only one who feels this way, but just about everything I'm always kind of wondering, "Is this just how he is as a result of what he's been through in his life or is it because I'm not good enough, or he doesn't love me enough, or I'm not pretty enough or I'm not making enough money, or I'm not doing the right thing?" And that's been- it put's a lot of stress because you don't know how he really feels. I have no idea how he really feels about me. I know what he says he feels about me but his actions, I have no idea. I have no idea. And again, I cannot tell you if it's the relationship or if it's him. I have no clue.

Kendra describes a number of challenges in her relationship with Carl, but characterizes her confusion about the reasons for his behavior as the most difficult for her to manage. Her central question, "Is it me or is it PTSD?" highlights her concern that she may be the real reason for his lack of affection and attention. Throughout her narrative, Kendra expresses a great deal of empathy for what Carl has been through, which includes a history of childhood abandonment and abuse prior to his entry to the military, a significant amount of combat trauma, and a betrayal by a longtime girlfriend after returning from multiple deployments. She is aware that all of these factors have likely made an impact on him and contributed to his current struggles with excessive drinking and withdrawal from others. Yet, her string of questions outlining all the ways that she might not measure up to his standards is a reflection of the insecurity that she has developed within the relationship. This uncertainty about where she stands with her partner makes it difficult for her to trust that the behavior that she can logically connect to his PTSD is not actually a product of their troubled relationship.

Lack of sharing about military experiences.

Another theme related to women's struggle to understand what was going on with their partners, was the infrequency with which veterans shared information about their combat experiences. Although the level of communication about wartime experiences varied by couple, nearly every participant brought up the fact that veterans guarded this information closely and women's opportunities to hear veterans' war stories were relatively limited.

Jill's partner Jesse was typical of the partners of the women who were interviewed in that he very rarely shared any details about his wartime experiences with her. He had described the pain of accompanying his best friend's body home after he was killed in action, and when she encouraged him to explain to his daughter the reason that Memorial day was so difficult for him, she heard him say that four of his friends did not come back from the war. She reflects on the challenge of not knowing more about his experiences below.

> And obviously, I know he was in a leadership position, I don't know besides those four. You know, he was in for 11 years. I'm sure that it was more than those four so I don't know who didn't come back. I don't know what calls were better than others. I can't even- I've never been to war I can't even imagine. I can call a fitness class. I mean come on now. So I, you know, I think for me it would be easier, and this is unfortunately using Hollywood, in *American Sniper* where the guy shot the kid, I think it would be easier for me knowing that he shot a bunch of children. That way I could process and understand, this is what is on his mind 24-7. You know? I could actually accept that. I could accept that he had to kill all these people or that he had to strangle them or he had to do whatever he had to do,

> but it would be so much easier for me actually knowing that whereas I don't think that he could actually EVER tell me and feel comfortable about himself.

At the beginning of this passage Jill emphasizes how little information she has concerning what difficulties her partner encountered while overseas. Her hesitance to even speculate about these matters comes through when she says "I can't even imagine." She continues, "I can call a fitness class. I mean come on now," implying that her side work as a fitness instructor is the toughest thing she has had to endure. She repeated this idea of the war experience as beyond her comprehension multiple times in the interview and it often seemed to be linked to a sense of respect for her partner. Yet, despite her belief that the circumstances of his experience are unimaginable to her, she also craves knowledge about what he went through, even if this information includes disturbing details such as the killing of children. She views knowing the traumas as a key for her to be able to "process and understand" what is constantly in his thoughts and consequently influencing his behavior. She also believes however, that the one thing she feels would be most helpful to her is impossible for him to provide because of Jesse's shame and guilt.

Veterans' avoidance of disclosure extended, in some cases, to a reluctance to discuss PTSD symptoms. Amanda was a participant that had been married to another veteran with PTSD prior to her current husband Samuel. Her first marriage ended due to her ex-husband's physical abuse and refusal to seek treatment. He had deployed to Iraq in 2004, a few years after they began their relationship and less than a year into their

marriage. She noticed signs of problems immediately after his return and had a vivid memory of when she first attempted to broach the topic:

> He shut completely down. It was right after he came back and he had had a real bad outburst. I was like, you know, "Do you want to talk to me? Whatever's bothering you, do you want to talk to me about it? Is there something- Are you having flashbacks or something? What's going on with you because you're sweating, you're having nightmares? You know, talk to me." I wasn't quite at that point, quite ready to give up on my husband or on my marriage. And he just looked at me and I can't explain it. It was like his eyes were soulless and he just shut completely down. He said, "Don't ever ask me that again." And I never...I mean, I can't begin to explain... his eyes looked dead to me after I asked him that. After I asked him, you know, "What's going on with you? Is there something that happened? Do you need to talk about it?" He just completely shut off. It was like a switch.

Like Elizabeth, Amanda reported that she had grown up with PTSD. At the age of 2, her paternal grandmother and her husband, a Vietnam-era veteran with PTSD, adopted her. Because of this childhood experience, Amanda quickly recognized evidence of trauma-related problems in her husband. When she inquires about her observations, her ex-husband sends her a clear message through both his words and his appearance: this topic is off limits. Her statement about not being "ready to give up on" her marriage, reveals that at this point she had maintained hope that figuring out what was driving her husband's problems might salvage their relationship. The description of the change in the look of his eyes when she begins questioning him about these signals of his distress is similar to an account Elizabeth gave of her husband suddenly having "crazy eyes" when she approached him about his symptoms. Many women noted these type of dramatic changes in their partners' appearance when they would become triggered by something.

Several other women mentioned that asking something as basic as "What's wrong?" could appear to heighten veterans' anxiety and therefore any information gathering had to be approached gingerly. In this situation, Amanda learns that asking about the problem can itself be an overwhelming trigger for the veteran and should therefore be avoided.

When just a question itself can result in such an intense response women are understandably left in a precarious situation as they grapple with the many unknowns of this experience. Most of the participants clearly respected the sacredness of their partners' war narratives, but were also curious about the connection between what happened to them and their current struggles. In figuring out how to navigate communication about the difficult topics surrounding her husband's military experiences and current struggles, Shannon began by talking about how avoidant her own mother is of difficult topics:

> And I want to make sure that I don't fall into that role either. But I also don't want to be in the role of asking so many questions that I somehow help to open a wound that is healing or bring up something or ask something in a way that is not helpful, in way that is not helpful for him either. So I feel like I'm kind of walking that tight rope of saying or asking too much and building a wall where we can't talk about it. So there's that, I feel like that's where I am.

Shannon met her husband Jeremy while on vacation, shortly after he returned from his last deployment doing personnel retrieval in Afghanistan. The cousin of a close friend, they immediately hit it off though she knew little about the military and was disturbed to see a gun in his car that weekend. A few years later, after a long distance friendship developed into a romantic relationship, they were married. It was at this time

that his problems with sleep became much worse. Weeks of 2-3 hours of sleep a night would leave him acting strangely and she struggled to make sense of what was going on. In the passage above, Shannon reveals her concern that communication about these topics carries the risk of harm for her husband. Her reference to the tightrope walker clearly illustrates the feeling that she must step delicately in order to avoid causing him injury with her inquiries or allowing unshared experiences to form a barrier in their relationship as she had sometimes witnessed in her own family.

When there was not an exchange of information between partners about what was occurring, women were often left to fill in the blanks in their partners' stories themselves. This dynamic was particularly apparent in Sonia's narrative. She and her husband Mike met through his brother, a coworker at the jail where she was employed. She was a 26 year-old single mother of two young girls who were quickly taken with Mike, a 21 year-old soldier stationed at a nearby Army base. The couple met in late 2002 and were married in early 2003. Mike deployed to Iraq later that year when Sonia was pregnant with their twin sons. After Mike returned he quickly began to exhibit anxiety, emotional volatility, and aggression and would drink to "calm down." When drunk he would repeatedly raise the topic of the horror that he had experienced, but would not want to discuss it further. Sonia describes her response below:

> I would ask him, "Okay, you keep talking about we don't know what you've been through. We don't know what you've seen. What was it that was so bad that happened over there that you are mad at the world and mad at everybody?" And I'm wondering if it had something to do, because he did a lot of convoys and they

> say you don't stop for anybody. And there's been some mention about kids forced to stand out in the middle of the road with bombs strapped. And sometimes they couldn't tell if they were strapped or not. They just tell them, run through them. Don't stop. And I'm wondering maybe because it hit home, he's got kids, you know he loves my daughters to death. And he'd bring up the kids and stuff and start crying so I'm thinking is that maybe what's eating him up so bad. I mean...But still, why does that have to turn to anger and then he'd then turn around and take it out on me. It's like it's because of me that he's over there, which he was in the military before I got there, so I don't understand why. Maybe it's just cause I'm the closest to him, somebody that, he's always with me, and he's like I'll just focus all my anger and hate on her. Like I said, I just don't know. And I've tried to kind of like talk to him about it, but it's just like, he's like, "You just don't know." And I'm like "Okay." And he's like, "I don't want to talk about it."

Sonia's struggle to comprehend what could have been so upsetting to her husband seems to be made all the more confusing by his frequently reminding her how little knowledge she has of his experience. In the absence of any additional details from him, she is forced to construct her own possible narrative that would be horrible enough to explain his abusive behavior towards her. She pulls from what she has learned about the conflict in the media and what she has observed about her husband's emotional responses to their children to piece together a tragic story that involves harm to children. Yet, this answer does not satisfy her desperate wish to know why she has become the target of his outrage. Her frustration is apparent as she explains that her efforts to gather any more information are always unsuccessful. Most women in the sample expressed that they only knew a portion of their partners' war stories. Those, like Sonia, who were unclear on what exactly was at the root of their partners' distress reported looking for clues that might help them to understand odd or problematic behavior. Several women brought up

their theories on things like why a veteran slept in a sleeping bag on top of his bed, was always watching war movies, or would become upset by children's cries.

Most of the women in the sample could recall at least one occasion when their partners had opened up to them about an upsetting combat experience or spoken with someone else about such an event in their presence, but these moments stood out in their minds because of their infrequency. However, a couple of participants reported that conversations about what happened overseas were not unusual in their homes. Lucy, in particular, was able to speak of her husband's deployments in an unusual amount of detail. She explained it this way:

> I'm- I can count myself among the lucky. I know a lot about my husband's deployments. I know most of his traumas. I know probably more details than I would ever want to know…. It's one of those that, the knowledge that I have of his deployments helps me understand what I need to do or what he needs, more than it does anything else. Because I am able to stop and rewind and go, "Okay, this is why this is upsetting him." For example, I never understood why the smell of bleach bothered him so much. Knew it pissed him off and I knew it put him in a mood, but until I stopped and listened to all of the details he gave me of one of the events out there, I'd never paid attention to the part of the story where he told me that what they cleaned the vehicles out with, was bleach. When you lost somebody in a vehicle, vehicle's gotten blown up, there were body parts all over the place, inside the vehicle, blood, everything. It was bleach and water that they poured inside those vehicles to wash it out. And when I realized that, I went, "Oh, well shit. Okay." So for me it is a database of knowledge.

Lucy's characterization of herself as "lucky" indicates that she is well aware that her husband's level of disclosure about his deployment experiences is unusual. She seems to feel honored that he has shared the knowledge of "his traumas" with her, but also alludes to the emotional weight of hearing such stories when she admits to probably

knowing “more details than I would ever want to know.” Lucy later elaborates on this by explaining that there is pain associated with knowing about certain traumatic events that caused her husband pain because she “can’t fix” them, but as she makes clear in the passage above, overall this knowledge is a great resource. In the example she provides of her husband’s response to the smell of bleach, it is easy to imagine that without this information the simple task of cleaning the kitchen might result in a confusing mood swing in her partner, and in the absence of an explanation for such behavior might be taken personally or lead to an argument. However, Lucy explained that because of her knowledge of what her husband experienced she is usually able to connect his behavior to external triggers or attend to indications of upsetting internal experiences. She consequently recognizes that his responses to these have little to do with her. Information about his combat experiences has also led her to modify her behaviors, for example, simply buying a cleaning product with a different odor has enabled her to avoid the trigger of the smell of bleach.

Complicating matters.

Within the narratives of over half the participants, the struggle to fathom what was going on with their partners and with their relationships was complicated by factors relating to their personal histories as well as events unfolding around them in what were sometimes described as chaotic environments.

Robin's narrative highlights the way that other traumatic experiences unfolding in the lives of military couples can add layers of complexity to the task of discerning the catalyst for changes in veteran behavior. Robin and her husband Andy met in high school and had been married for three years when he deployed to Iraq. When he left, she and her toddler son moved from the base where they were stationed back to her hometown in order to avoid the culture of excessive drinking, drugs, and promiscuity that she reported wives commonly participated in when the troops were deployed. She had attended high school with her husband's younger brother and in the passage that follows she explains what occurred when he contacted her after she arrived back in town.

> And so, he's like, "Well, you're turning 21-" He had just gotten out of prison actually. He's like, "Well, you're turning 21 so let me take you out, I'm Andy's brother so I should be able to do that." You know those sorts of things. So I went out with him and he ended up getting me really drunk and molesting me while I was passed out. Yeah, great guy! And then after that he would come over at like 2 or 3 in the morning demanding to be let in. And so, I um talked to his parents who didn't believe me. And I talked to Andy and I was like I don't feel safe. Like this guy will not leave me alone. He's your brother, like we need to do something. And so he ended up talking to his parents and getting them to keep an eye on him.

Rather than providing a more stable environment for her and her son, Robin's move back to her hometown results in a series of significant violations. Robin describes experiencing multiple betrayals. She is not only molested while intoxicated, this act is perpetrated by her own brother-in-law after he uses their familial relationship as a means to gain access to her while her husband is gone. His harassing behavior continues to the point that she feels she must reach out for assistance, but the response of her husband's parents is an additional betrayal when they do nothing to protect her and even question

her honesty. Although she had not wanted to involve her husband, she finally reaches out to him in order to ensure her safety. When Andy returns at the end of his deployment and Robin senses that he has changed in some fundamental way, these events weighs heavily on her mind:

> We went to the field to go pick him up and he looked awful. He had like no soul in his eyes. It was, it was really, really weird to see him again after a year and knowing, you know, knowing what he looked like before. Knowing what he- just the things that he had been saying, just the person that he was, all the characteristics of the person that he was. Like I could tell that there was something wrong when I went to go pick him up. And I thought it was me, I thought that it had to do with me and his brother. So I took a lot of that personally and um took a lot of the blame I guess for it.

As many other women did in their interviews, Robin notes that a change in her husband's eyes alerts her that her husband is not well. Gone is all trace of the person that she knew who had been sending her loving correspondence during his absence. However her interpretation of this change is rooted in her own deployment experiences. She had already worried that her decision to tell her husband about what happened with his brother was "not a good wife thing to do" given the pressure within military culture to avoid sharing information that could be stressful to military personnel during their deployments. Seeing his diminished state convinces her of the toll that her divulgence has taken on him. When her husband, who had previously avoided alcohol because of the damage it did to his family, soon begins to drink excessively this provides her with further evidence that she is to blame for his distress. It is not until over two years later

that she looks up a list of symptoms of PTSD and realizes that the story is more complicated that she initially believed.

Military couples are not dealing with the effects of combat trauma in a vacuum and this portion of Robin and Andy's story illustrates the impossible task that women face when they are trying to disentangle the causes of distress. A few women mentioned how challenging it was to determine how their partners' distress was related to PTSD versus other issues in their lives currently. Others wondered how historical factors might play a role. Nearly half the women alluded to their own histories of childhood trauma. Jill explained the influence of her background on the way that she interprets her partner's verbal aggression. "Um, Keeping in mind I was abused. Childhood. (big sigh) I start thinking, "Why am I dealing with this. Why is he treating me this way and why am I letting it happen?"

In addition to the many other questions prompted by their relationships, at times some women seemed to be speculating about what besides combat might have contributed to their partners PTSD. A third of the women in the study brought up their partners' difficult childhoods in their narratives. Sonia described her husband's early childhood as very abusive and this factored into one of the theories she developed to explain her husband's current behavior:

> I think that's why some people maybe some people have that because it probably depends on what kind of background they had before they came into the military. Maybe that contributes to it, but I mean like this last guy that I talked to, he came

> from a good upbringing and everything. There's no abuse or anything in the family, went to the military, got deployed six times, and he came back with no problems…. But I think it's more, it's worse off on those that come from abusive households, in that they get deployed and come back and they see more than what they were used to seeing at home, like seeing the dead body, or having to shoot someone. I think it probably contributes to it and just elevates it to where they can't control their emotions anymore. I don't know. That's just my guess.

In this excerpt Sonia references a man she had recently spoken with about how combat effects people. The fact that this individual went on an unusually high number of deployments, yet does not display the destructive behavior that her husband does is baffling to her until she considers the role that someone's history of abuse may play. As a survivor of childhood abuse and domestic violence she is likely particularly sensitive to the ways that early experiences can leave someone vulnerable to further harm. No other women in the sample articulated their hypotheses so directly, but others also emphasized their partners' difficult backgrounds suggesting that women in relationships with individuals who have pre-military trauma histories may be curious how the potential for a cumulative effect of trauma exposure may play a role in their significant others' behavior.

The Struggle to Understand in Context

This theme highlights confusion as a primary feature of the experiences of women in the study. This sense of not understanding what was going on related to many different aspects of their partners' behavior and their lives with their partners. Women consistently commented on the mysterious or changed identity of their partners following the development of PTSD, with statements such as "he was a different person" or "it was not

him". The feeling that the partner that they have loved is somehow missing while he is in fact present, is consistent with Faber and colleagues finding that families of reservists reported experiences of the *ambiguous presence* of service members following their return from deployment to Iraq. This construct is rooted in Boss' theory of *ambiguous loss*, "a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present" (1999). In the case of returning military reservists, families felt that their family members were physically present, but psychologically absent (Faber, 2008). However, Faber et al. did not focus on veterans with PTSD and their findings suggested that the sense of uncertainty around veterans' presence typically dissipated in six weeks as families readjusted to their lives together. Across interviews, women's narratives demonstrated that the experience of the veterans no longer being the person that they were prior to the development of PTSD extended much longer and in some cases, indefinitely. Additionally, the onset of this sense of the veteran's transformation did not always coincide with his return from overseas, as some veterans did not display significant symptoms of PTSD right away. No published studies have examined how this construct applies to partners of OEF/OIF/OND veterans with PTSD, but Boss' theory of ambiguous loss was connected to themes that emerged in Israeli wives discussion of living with veterans with PTSD and appears to be a useful lens through which to view aspects of this experience and some of its consequences (Dekel et al., 2005). For example, the strong desire to have a clear explanation for her husband's behavior, even if it is drug abuse, leads Allison to ask her husband to submit to urine analysis. In this case

it seems that Allison is so distressed by the not knowing why her husband is a "different person," that she would prefer to find out that he is using drugs than have no explanation. Boss argues that the constant stress of living without answers may create psychological distress and block effective stress management (2004).

Another aspect of women's struggle to make sense of their experiences in their relationships was their active engagement in trying to piece together what has happened to their partners with little information. Most women shared that although they knew something about PTSD, they did not really understand how these "invisible wounds" might be expressed in combat veterans. Their confusion about what they were witnessing was not aided by veterans' avoidance of discussing stressful military experiences, in particular those related to trauma. The reluctance of these veterans to disclose to their partners fits with previous findings that, amongst trauma survivors, certain types of communication about trauma are associated with higher severity of posttraumatic symptoms, including not wanting to reveal thoughts and feelings about what they had experienced (Mueller, Moergeli, & Maercker, 2008).

Because women did not want to "push" and questions about symptoms were viewed as triggering, they were often left to create their own hypotheses about the causes of the changes they were viewing in veterans. Their discussion of these issues lends support to the developing literature on the role that spouses' perceptions of veterans' symptoms play in their distress. This body of research has suggested that women's

understanding of and explanations for veterans' symptoms play a role in their distress (Renshaw & Cambell, 2011). For example, Jill's statement, "I think it would be easier for me knowing that he had shot a bunch of children. That way I could process and understand this is what is on his mind 24-7" illustrates how women's perceptions of veterans' level of combat exposure can moderate the relationship between veterans' PTSD symptoms and women's distress (Renshaw & Cambell, 2011). Knowing this information would seemingly make it easier for Jill because Jesse's behavior would then be a natural consequence of this terrible experience, and not something that he could control. Further evidence to support the attributional theory, that family members of someone with a mental illness are less distressed by symptoms that appear to be out of their control, was provided by the prominence of questions about whether veterans behaviors were PTSD related for some of the women in the sample. Diana is clearly bothered by her uncertainty about whether some of her husband's behaviors are related to "his personality" or his PTSD and indicates that she feels more inclined to forgive things that she believes are connected to her husband's illness.

Women's statements also supported previous research suggesting that symptoms that are not obviously connected to trauma are more distressing for veterans' partners (Renshaw & Caska, 2012). Kendra's question, "Is it me or is it PTSD?" seems to be particularly prompted by her partner's withdrawal and distance. She explains that she has difficult trusting Carl's verbal expressions of love because they do not seem to be reflected in his actions. Since his distant demeanor is not obviously linked to his military

history, and could also be explained by a lack of affection for her, it makes her "insecure" and increases her anxiety. Women also expressed distress about symptoms such as sleep disturbances, but this distress seemed to be more acute when they did not understand the cause. Once veterans were known to be struggling with PTSD, some women reported feeling less afraid of such symptoms and what they might mean for the veteran.

The results of the current study highlight the potential importance of the timing of the relationship in understanding the concerns that are most prominent for female partners of veterans with PTSD. Women whose relationships began prior to the veteran's development of PTSD seemed to be most bothered by confusion around the present/not present dynamic that is described in the literature on ambiguous loss. However, the majority of women whose relationships began after veterans had developed PTSD, and who did not have as much of a baseline to which they could compare their partners' behavior seemed to be more distressed by questions relating to the level of control their partner exerted over certain behaviors. These differences have not previously been investigated in the literature and may have important treatment implications.

Another aspect of women's confusion that emerged in women's narratives relates to the complexity of teasing apart the various contributions to their distress. Many women reported that they and/or their partners had tumultuous backgrounds that included abuse or interpersonal betrayals. Several also mentioned the presence of other psychosocial stressors in their lives. A significant amount of literature supports the

possibility of a cumulative effect of trauma (Agorastos et al., 2014). In addition, psychosocial stressors are known to exacerbate PTSD symptoms (Gehrman, Harb, Cook, Barilla, & Ross, 2015). These women's narratives provide a compelling case for taking context into consideration when determining treatment needs for military couples affected by PTSD. In the case of a few of the participants, events that unfolded at home during veterans deployments may have interacted with PTSD's characteristic disruption in cognition to result in the veterans' persistent distorted beliefs around the cause of their suffering. The blame that was placed on Robin for example certainly contributed to her distress and her confusion about what was happening in her relationship.

My own experiences during participant interviews of noting the frequent questions that arose in my mind of what was truly connected to the experience of military traumas versus myriad other stressors that the couple faced, also provided me insight into women's urge to constantly question the etiology of the veterans' behaviors. Research has demonstrated that many people enter the military with histories of abuse and that, as Sonia theorizes, this may make them more vulnerable to developing PTSD (Agorastos et al., 2014). Although pulling apart the influence of different experiences may not be possible or particularly helpful, these results suggest the importance of recognizing this complexity in treatment and engaging it rather than ignoring it.

The Emotional Rollercoaster: Women's Responses to Veterans' PTSD-Related Behavior

> I don't know like…it's kind of a rollercoaster of emotions. It's anger and hatred for the way I'm being treated. It's shame for not being able to cut it off before it happens. Or you know, did I do enough? Why can't I do something that can help this situation….There seems to be this, "Okay, I'm done. I've done all I can do and I can't do anything more." That's the frustrating part.
>
> – Jill

Living with someone displaying extreme emotions, frequent mood shifts, and at times the violent behavioral outbursts that are symptomatic of PTSD, was described as an emotionally intense experience by women in the study. As women spoke about their relationships with their partners, they often highlighted veteran behavior that had been particularly upsetting to them and the emotions such behavior provoked in them. Most women described their partners as engaging in a wide range of types of upsetting behavior, from completely avoiding interacting with them and their children to yelling at them and punching walls, and described themselves as experiencing a variety of emotions in response. Women most frequently described feelings of fear and anxiety about their partners' behavior, but experiences of frustration and anger, and sorrow and depression were also commonly mentioned in their narratives. Women reported their responses to their partners shifted at times and were often related to variables such as their own mood or sense of stability.

Living in fear & struggling with anxiety.

One of the most prominent themes that emerged from women's narratives was the experience of fear. Women reported being fearful for their partners, their children, and themselves. Fear for partners' wellbeing was often related to concerns about the potential for them to injure or kill themselves through suicide, reckless behavior, or substance and medication misuse. Fear for their children's wellbeing was rooted in women's concerns about how their partners' behavior put their children at risk of physical or emotional harm. Concerns for their own safety was discussed in connection with veterans' potential to become physically violent and abusive during angry outbursts.

Central to Robin's narrative about her relationship since her husband's deployment are the experiences of fear and anxiety. Andy's struggles with PTSD, depression, and alcoholism steadily intensified after he returned in 2006 until early 2015. She summed up her feelings about this time by explaining "I was always afraid that Andy was in danger. Or that Andy was putting himself in danger or putting my kids in danger. Making bad decisions, cheating on me, hurting himself really was more what it was." This fear began to take hold after Robin's husband was fired from his job a few years ago because of issues with alcohol, and he became suicidal. He eventually confided in her that he was concerned about his thoughts, and she took him to various treatment providers. She describes the continued decline of his mental health below:

> Um, as he got on medication, still drinking, still drinking. And then, I mean he just kept getting worse. Kept sleeping more. He started- it almost looked bipolar is what it looked like almost cause he wouldn't be able to sleep for 2 or 3 days. And I thought maybe he was doing meth. So I drug tested him and he wasn't doing meth (laughs) so he would get manic and he would want to kill himself and then he would be okay for a couple of days and then he would be down and he couldn't do anything but play video games or watch TV. He wouldn't go out in public. And those had always been problems you know. All of the drinking, the crowds, the going out in public, the angry outbursts, like all those things had always been there, you know since he got back from Iraq, but they got so much worse. So much worse during this time period. And I mean I…I … hid guns, I moved guns, I put blanks in guns.

Each woman described her partner's constellation of PTSD symptoms slightly differently, but Robin's description of the progression of her husband's condition touches on several of the types of behaviors that were repeatedly associated with women's fear for the wellbeing of their partners. Excessive alcohol use was a cause of significant concern for about half of the women in the sample, most of whom were particularly fearful about the danger of drinking while on medications. Veteran's erratic sleep patterns and the behavioral consequences of not getting adequate sleep for long periods of time were also noted by many women in the sample and some expressed concern about how lack of sleep may impair veteran's judgment in dangerous ways. Robin's concern about the potential for Andy to try to hurt himself was not unusual either. Almost half of the sample expressed serious concerns about their partners committing suicide. Some of their partners had made suicidal threats or gestures and others had made past attempts. In the excerpt above, Robin's fear escalates to the point that she feels she must try to prevent him from gaining access to the weapons that he prizes.

Andy's health continued to decline steadily as his depressive symptoms worsened and he stopped leaving the house, bathing, or eating, but continued drinking excessively. Robin describes this period below:

> And um, for me during this time was really scary because I didn't know- When I was getting my masters I'd be gone from 6-9 at night, and when I came home I wouldn't know if the kids had eaten, if they were alive, if the kids had bathed yet, if our little one would be out running around in the street because nobody was watching him. I had- but if I tried to talk to him about these things then I was blaming him, I was talking down to him, I was insulting him, I was disrespecting him, you know. Just it was this constant battle of survival slash just trying to make it work I guess.

Robin's fear for her children's safety is easily understandable given her partner's state of mind at this point in time. He is not able to care for himself, and therefore his lack of attention to the safety and wellbeing of the children is perhaps not surprising. Yet Robin's schedule keeps her away in the evening and she seems to feel stuck. Her attempts to address these issues with him result in the projection of his feelings of worthlessness and further conflict between them. Several women highlighted their concerns for their children as being one of the most distressing aspects of their husband's behavior. In addition to not providing adequate supervision, in the case of veterans who were drinking or using drugs, there was also the concern that the veterans would drive children places while they were intoxicated. Also raised was the fear that children could be harmed if exposed to the veteran during episodes of anger or during flashbacks or upset by veterans' hard to understand behavior.

Robin's narrative is a particularly good illustration of how women's fear for their partners and families can be associated with negative consequences for their own emotional functioning. As Andy's condition continued to worsen, Robin began to experience significant symptoms of anxiety herself. She described how her symptoms presented below:

> So, oh, but I started having trouble sleeping. I started having panic attacks actually. I went to a doctor and I was diagnosed with depression, which yeah sure, but its probably more like a little bit of PTSD in there as well cause I started taking on his characteristics. Like the secondary PTSD stuff, the research is coming out on that, and I'm all for that because I started having trouble in crowds, I started having panic attacks, I started you know, I became lethargic unless I had to go to work, I started showing the same sorts of symptoms that he showed.

Robin acknowledges that she may have been depressed, but more pronounced for her were the symptoms of anxiety that so closely resembled some of those she had witnessed her husband battling. She goes on to include nightmares and paranoid thinking in the list of problems that she had never previously experienced, but began to emerge around this time. While her husband's symptoms are predominately rooted in his combat experiences, the symptoms that Robin describes as "secondary PTSD" appear to be related to her own experiences of living in an environment that feels unpredictable and dangerous for the people that she loves. Years of worry and fear about her husband's behavior take a significant toll on her emotional health and result in these symptoms of anxiety and depression that mimic some of Andy's struggles. Robin's anxiety was more prominent than most of the other women interviewed, but many endorsed some of these

same symptoms. The most common manifestations were persistent worry, tension, physiological upset, and hypervigilance. A few women also mentioned avoiding crowded places themselves. Kendra described her physical symptoms of anxiety this way, "My chest feels tight. My stomach's in knots, I'm twirled up. I get a little bit light headed if I'm under this anxiety for a long time."

For Cathy the most prominent symptom of anxiety was worry. When asked to sum up the experience of being in her relationship, she said, "It's worrying. It's like *always* worrying. And there's always something to worry about with it. I don't wish it on anybody." In addition to concerns for her husband's safety and wellbeing, concern about her family's security was a prominent feature of her worry:

> It's scary because he's the only one that has a job right now and if he loses his job, my son doesn't get his medical care and he's in therapy every week for 2 hours in speech and occupational therapy, my daughter she loses her post-GI bill money to go to college with, that's gone. My medical care is gone. I can't finish school. We'll lose our house. You know, I worry about him, but I worry about our stability as a family too.

During her husband's second deployment, Cathy noticed that her son, who was less than a year old, did not appear to be reaching his developmental milestones. After taking her son through a great deal of testing while her husband was serving overseas, her medical team determined that he had moderate mental retardation. Cathy has consistently had her son engaged in multiple forms of therapy since that time and thus medical insurance is crucial for his care. In the excerpt above she also highlights several other necessities tied to her husband's continued employment with the Navy. The potential for her husband's

condition to result in his being dismissed from his job prior to him reaching 20 years of service next year and qualifying for retirement clearly weighs heavily on her as she sees that it would have many negative consequences for their entire family.

In addition to feeling fear *for* their partners and families, about a third of the women in the sample reported that they experienced fear *of* their partners at times. In some cases this was more related to not understanding their partners' symptoms than it was a direct threat against them. Allison provides such an example below:

> When he came back, I would notice he would almost like zone out. There was one night he really scared me because it was like he wasn't there. I was like talking to him and it was like he was on drugs or something and he was just zoned out and I called one of his platoon sergeants to come over. And I was like, you've got to take him away because he's scaring me, and I don't want him around the kids.

At the time Allison references above, she has not yet connected her husband's symptoms to PTSD. She finds these "zone outs" to be disturbing and therefore fears her husband during these episodes. In this case she calls one of his military connections to remove him from the home so that their children will be protected from this unexplained behavior. When veterans were perceived to be a threat, women reported that they often called on either a military contact or a law enforcement officer to aide them. A third of the women reported that they had done this at least once at times of great fear, though they were hesitant to involve others and their partners were angry about them doing so.

In other cases, women's fears of their partners were connected to an act of violence or a threat that was directed at them. Sonia recounted a particularly terrifying experience she had with her partner, shortly before he began to physically abuse her:

> I do know that it got to the point that then he started, after breaking things, he started to target me for it. And there was one point in time, I don't know if he was drunk or he'd just been depressed or what. I'm thinking he argued with me over something stupid. He actually scared me. He scared me crazy. He went, and this was leading up the assault deal, he went and took his gun and said, "I can't take this anymore." And he started crying like crazy, uncontrollably. He put it in his mouth and said, "I'm just gonna end it all!" And then uh, I said, "What are you doing?" And I didn't know it wasn't loaded. And he was going to pull the trigger and then he takes it out, he backs me up into the walk-in closet. He says, "It's all your damn fault!" and he points it at me, at my head and he was like you know what this is all your fault. And I was like, "What did I ever do to you? What did I ever do to you?" And he could not answer me. Well, then he throws the gun down. He sits there and he starts crying. And I said, "What is it that's…What's bothering you? Tell me what it is. I can help you if you just let me." And he just said, "I'm sorry. I didn't mean to do that, to scare you or whatever."

Sonia's experience of being backed into a corner at gunpoint is a dramatic example of how the volatility of emotions and aggression that are symptomatic of PTSD can combine into situations that are frightening and confusing for a partner. At first her husband Mike seems overwhelmed with sorrow and desperate enough for relief from his pain that he is considering suicide. However her shock and concern for him are quickly replaced with fear for her own safety when he turns the gun in her direction and verbalizes his belief that she is responsible for his suffering. She is so determined to understand Mike's alarming behavior that even in what she believes is a life-threatening moment, Sonia asks her partner, as she has many times, what crime she committed

against him. The rage that Mike feels toward Sonia seems to dissipate as quickly as it appeared, but it would not be long before it returns and he faces criminal charges for assaulting her. Amanda also reported that her ex-husband had begun physically abusing her after returning from combat; however, the majority of the women in the sample had not experienced this type of physical abuse at the hands of their partners. There were other physical injuries reported, for example, Cathy ended up in the emergency room for stitches after being hit in the head by a wooden box that her husband had thrown in a rage. A larger portion of the sample described times when their partners threatened them and mentioned that veterans' access to and familiarity with weapons contributed to their fear.

Frustration and anger.

Experiences of frustration and anger were also recurrent in women's discussion of their responses to their partners. Women described these feelings as ranging from mild frustration about veterans' avoidant or rigid behavior to intense feelings of anger over the effects that veterans' choices have had on their lives. Some women also voiced that they felt guilty about their anger.

Elizabeth was one of two women in the study who associated her partner's frequently shifting interests and impulsive spending patterns with his traumatic experiences. Joe had been home for less than a year when he suddenly approached her about beginning to compete in dirt track racing. On a very limited budget and with a new

baby, she was not as enthusiastic about this prospect but reluctantly agreed. Elizabeth explained what happened next:

> And we bought a racecar ourselves, and we didn't get it quite off the ground before he decided to sell it. And then he wanted to get into horses. And so I was like, "I don't want horses" and he was like, "But we need a horse." He was like, "Look at Mary! Look at how happy she is!" And by now, she's about a year, a year and a half old. And I was like, "No!" And he's like, "Yeah, let's get a horse." And so he just turns around to the guy and he's, "We'll take her." And I'm like, "Where is this money gonna come from?" And he said, "Don't worry about it! Let me worry about it!" And I was like, "You don't even do the bills. You don't even know how much is in the account. How dare you do this! How dare you spend money and not even know if we have it!" So we pulled the money out of our butt and got the horse. Found a place to put the horse. One horse turned into four horses and four horses turned into, "I don't want horses anymore, I want a boat, let's buy a boat."

Like many young military families, Elizabeth and Joe were on a tight budget once Elizabeth was no longer working. As the person responsible for managing her family's finances, Elizabeth appears to be concerned about spending money on Joe's recreational interests when money is so scarce. Throughout her narrative she talks about how hard she tried to accommodate her husband once he was home and she had the sense that he was not happy. In this excerpt she portrays herself as initially trying to be open minded about Joe's new interests, but her anger is clear once he disregards her concerns and proceeds with the purchase of the horse without her approval.

Briana provided another example of being provoked to anger by a spouse. In the account that follows she describes what happened the last time she sat in on one of her

husband Chris's therapy sessions and gave him feedback on a recent interaction they had engaged in about feeding the cat.

> I was talking about him talking to me like I was a five year old and getting off on his freaking box, his soap box, because the fucking cat didn't get fed that evening. And I'm home, our daughter was home, and he was home too damn it. But the cat didn't get fed. These animals need to be fed twice a day and he went on and on and on about it. It's not like you're not here either, whoever's here feeds the freaking goddamn animals. I don't want her in the house anyway. And he just kept going on and on. I mean over and over. It's like okay. How many times or how many different ways are you going to say it? And it wouldn't stop. And I'm like what response do you want to shut the front door. Because enough. I'm not five!

Briana states multiple times over the course of her two interviews that she is not fond of expressing her emotions, especially verbally. She has on occasion written her husband a letter to let him know when something bothered her, but prior to her husband's second deployment and the onset of his PTSD, he was always the one in the relationship that would "pry out of her" what she was feeling. With the distance and irritability that accompanied his return, their communication has suffered. Like many of the partners in the study, Chris was described as frequently getting angry over small things and the therapy session referenced above was Briana's chance to vent about the way that her husband spoke to her on one such occasion. Although she described herself generally as "not sweating the small stuff" and not confronting her husband about his symptoms, the passage above illustrates that frustration has clearly been building about the way that he addresses her at times. She went on to explain that she is more understanding of his

bossiness with her about safety-related issues because she could see the connection between that and PTSD:

> But when he goes off on this retarded thing about the animal being fed twice a day. And I try to put the OK where's the hazard, where's the harm, where's that danger here? Cause I don't see it. You're being retarded right now. Go to the bar. Go somewhere cause I got it. We're done talking about it, I'm not 5.

Briana explains her frustration about feeling scolded by her partner with the fact that his behavior does not seem to be related to any PTSD triggers. Without that explanation, she views his rigidity about this chore as ridiculous and his tone with her as unacceptable. Many women mentioned that not only were symptoms such as hypervigilance and exaggerated startle responses that were clearly linked to trauma easier to understand, it was also easier to manage their own responses to their partners' behavior in these situations. When partners became irritable or withdrawn in response to "unknown triggers", women were more likely to have a negative emotional response whether that be sadness, fear, or anger as Briana's example demonstrates.

Cathy was the woman in the sample who was most open in discussing her current feelings of anger toward her spouse:

> And even though I don't like it, I have a lot of resentment and I'm really upset about everything. And I think he's pretty selfish with how he thinks and I've got to realize that that's the PTSD you know he's not able to put himself in my shoes, and I'm really not able to put myself in his shoes. But I'm trying to be empathetic to what he's going through, and I don't feel like he's empathetic to what I'm going through because I am raising our two kids by myself. I'm you know taking care of his bills and I got him a house you know I did all of this by myself and I

> don't think he thinks. Something goes wrong with the house I take care of it. Either I fix it or I have to find somebody to fix it and then we'll fight about that. So it's mainly just arguing now but any time you start arguing with him he'll break down in tears and he'll start crying and then it's…you know, you really don't have an argument left so you have to deal with him crying. And then I get mad and I tell him to stop bawling about it because it's not going to solve anything, and I get angry.

Shortly after Cathy learned of her husband's diagnosis, he explained to her that he could not continue to serve in the military much longer because of his anger about the way that younger troops were treated. He told her he wanted to get out as soon as he met his 20-year requirement, and they adjusted their plans accordingly. His PTSD and substance abuse seemed to worsen and a few months later he told Cathy he felt she should move back to their home state in order to secure a home for them while they still had access to military loans and give him a goal to focus on, finishing his service and reuniting with his family. Cathy followed through with their plans over a year ago, but as she discusses above, she does not feel that he appreciates the stresses she faces alone. This section of interview captures her struggle to come to terms with his condition and determine in what ways she can hold him accountable and what she has to forgive because of his illness. She expresses anger about his "selfish" thinking, but then scolds herself when she says, "I've got to realize that's the PTSD." Yet, her sense of frustration overrides this apprehension about blaming him for things that are out of his control as she goes on to list the stresses she faces and describe the anger that his emotional displays provoke in her. A few women used language that was similar to Cathy's when they began to express their anger towards their partners. For some, recognition of PTSD as an illness seemed to

be linked with a sense that it's "not right" for them to feel frustrated by their partners symptoms or angry about the slow speed of their recoveries.

Sorrow and depression.

A third category of reactions that women discussed experiencing in response to their partners included those of sorrow and depression. A few women mentioned that they developed significant symptoms of depression after the onset of their partners' symptoms, while most others spoke more generally about sadness over experiences of loss, having "the blues", or being "hurt" by their partner's behavior at times.

The combination of TBI and PTSD has led Lucy's husband Chuck to struggle with significant cognitive issues on top of those types of PTSD symptoms already discussed. After recognizing that he needed treatment and beginning to seek services from the VA, his symptoms continued to progress over the next two years and he attempted suicide after a four month long struggle with a migraine. He was hospitalized 5 times for PTSD treatment in less than 3 years for a total of nearly a year in the hospital and continues to struggle with significant cognitive impairment and psychogenic nonepileptic seizures that his neurologist links to the PTSD. As Lucy has been supporting her husband over the last several years she has become involved with different military serving organizations and met many other spouses of wounded veterans. She explained the pain she experiences about her husband's illness by comparing it to another wife's experience:

> I have one particular spouse that- I love her dearly, I've known her for years, who very much wants to recreate the husband she had before deployment. She wants to get him better enough that he's just like that again. She is yet to let go of the fact that that's not going to happen. It's, it's a grieving process. And it's a continuous grieving process. Um, one of the biggest things that I've battled with because of the way that Chuck's conditions have progressed, is it's almost daily for me. There are days where- almost every day I am losing some part of him. I very rarely see the man I married. It's very much learning to stop holding on so tightly to what I had and find the little moments that I can be happy about, kind of thing.

Although Lucy met her husband after his deployment, she has seen such a dramatic decline in his health over the last several years that she mourns the loss of the man that she married. The gradual nature of his decline leaves her feeling that he is slipping away from her each day, and thus the process of grieving is always beginning again. She has tried to change her thinking about this, to be less like the friend whose attachment to an image of her former spouse prevents her from facing reality, in order to open herself up to the opportunity to find moments of joy and connection with her husband now. But as she describes in the passage below, sometimes her sadness over his conditions is overwhelming:

> There are times where, prior to my marriage I had a back injury, and so I will have times when my back will flare up and I'll end up on medication. And I can't say it's not a temptation to take a little bit more than I should, just to feel numb. It's, its not far-fetched to look at the bottle of wine and go I bet you I can find a glass big enough to hold all of you. Because it's just, it's tiring. And, more than anything it's lonely. Cause you're in a world where your kids may have memories, but you're the only one that holds the memories. He doesn't. There have been times where we've had to sit down and look at pictures of our wedding because he doesn't remember it.

Lucy is honest about the urge she sometimes experiences to numb herself from her pain. She and her husband are still in their late twenties and have young children. When she married her partner less than a decade ago, she never could have imagined that in such a short time she would be trying to help him remember this important event or that she would regularly be helping him to clean himself because he loses control of his bladder during seizures. She shared that the difficulties of their struggles have contributed to her development of depression for which she is now in treatment.

In the years since he has returned from deployment, there have been a few periods in which Sonia's husband has been unfaithful to her and left her for other women. She describes below how her insecurities about her relationship spread to other areas of her life:

> Then I started thinking about my kids. That I was probably sucking at being a mother too. That I couldn't do for them. If I suck at being a wife, I'm gonna suck at being a mother. And then I was working all the time too. So it was just like I started to feel like, "I'm the wife. I'm the mother. I'm supposed to be able to keep my family together. If I can't keep my husband you know happy and he has to go somewhere else, and I can't hold my family together..." So… I got depressed, really, really depressed.

Because her husband has blamed her for his problems since returning from overseas, Sonia perceives his infidelity to be evidence that she has not been able to help him enough with his problems, and thus he had no choice but to turn to other women. Since she has judged her worth as a wife as low, she then begins to question her ability to fulfill her other roles successfully. These negative thoughts contribute to her experience of

depression, which Sonia associates with this difficult time. Several women in the sample described having low periods in which they had noted feelings of worthlessness in the contexts of their relationships. A few women reported that not being able to help their husbands improve left them questioning their worth. For others it was the sense that they had "failed" as wives because their husbands did not open up to them and share their pain. These types of self-critical thoughts were experienced as painful and debilitating.

A few women indicated that their feelings of sadness would sometimes be expressed as anger. Shannon explained her response to her husband Jeremy's sudden avoidance of sex this way:

> I really did internalize the rejection. And, and I remember thinking in general, it's turned in- like we've now shifted in marriage to where it's less passionate and more of a friendship and that was, that was sad and I think that I, I did, I would pick arguments. Like there were times that I was really, I was pissed. I was really angry and I would pick arguments with him about it or not about that, but about other things. It was almost like that showed up-I knew that I couldn't get mad at him for not having sex with me, like that's not something that you could really pick a fight over. It didn't feel like that to me at least. But there were other things that I knew that I could somehow be frustrated with him on and I know that we had arguments about stupid things because this was the source of it.

As will be discussed in relationship to women's struggles with intimacy, many women confronted changes in their sexual relationships that they associated with PTSD. When those changes resulted in decreased sexual intercourse, women often reported feeling hurt by their partners' perceived lack of sexual interest in them. Shannon experiences sadness over the loss of this aspect of their relationship, however, she does not feel she has an

avenue to express this sorrow. This hurt develops into anger at her husband for rejecting her and is released in a variety of indirect ways.

Complex interactions.

The idea that women were at times better able to manage their responses to their partners symptoms and at times struggled to not feel reactive to them was something that was echoed by many women in the study. Diana spoke about how changes in her hormone levels during her pregnancy had made it much harder for her not to "see red" during arguments with her husband. She provided a recent example of how this played out for the couple:

> He's sometimes it's very difficult for him to show emotions. Not sometimes, almost alwa- all the time. But I kind of know him and I know the way he shows emotions. But now that I'm pregnant so much hormones, and you know the whole situation is so difficult for me. I need him more than before and he cannot give me more. And we have a lot of arguments about this. And this weekend we argued because he was planning to do a lot of stuff and I wasn't included in his plans you know. Like all the week I'm alone, and on the weekend he's gonna do something else?

The argument that developed from Diana's hurt feelings about not being included in her husband's plans became very heated and eventually resulted in her breaking his laptop and him threatening to beat her. She recognized that her responses to him had escalated the situation, but felt that she was so swept up in the emotion of their interaction, that she was unable to respond differently when he refused to give her the space she requested in order to calm down. The couple met less than two years ago when

Alex came to live and study Jiu-Jitsu in Diana's home country of Brazil. He rented an apartment from Diana's cousin, but made plans to return to the US soon after arriving because of difficulty adjusting. Diana's cousin asked her to look in on him and help him transition to life in Brazil, and they quickly developed a relationship. After she became pregnant and his symptoms worsened, Diana agreed to accompany Alex back to the United States so that he could receive specialized PTSD treatment. Consequently, in addition to being newly married and nearly 9 months pregnant, Diana is transitioning to a new country and does not have access to the support system of her family or even activities that she would normally do to focus her mind on other things. Without a job or a driver's license, her husband is the primary source of human interaction and she is aware that she is quite reliant on him at the moment to meet her emotional needs. This dynamic has challenged her ability to not be hurt by his lack of attention and resulted in more frequent and intense arguments.

Kendra spoke about how the negative emotions that she had already struggled with surrounding a health problem interacted with her feelings about her partner's behavior:

> I have endometriosis and that's already a difficult thing to deal with, but for some reason because he's so withdrawn and I'm so insecure with how he feels about me it kind of intensifies and magnifies every other negative emotion that I already have when trying to deal with my own health issues. My anxiety is through the roof. I start acting crazy!

Kendra shared that because of her health problems she has struggled with fertility and weight issues for some time, but that she was better able to manage some of the painful feelings related to these problems prior to her current relationship. She views her insecurity as the direct result of her partner's detachment and the anxiety she feels as a result of this dynamic challenges her ability to positively cope with her health. As she notes, these feelings then have an impact upon her behavior and she acts in a manner that is unfamiliar to her.

Women who had struggled with diagnoses of anxiety, depression, or other mental health problems prior to their relationships were particularly aware of how their mood influenced the way they responded to their partners' behaviors or how those behaviors might trigger symptoms related to their conditions. Amanda has been aware of her diagnosis of bipolar disorder for many years. When explaining how her partner's symptoms affected her, she emphasized how much her responses to her partner depended on her own mood. For example, in the passage below she begins by explaining how her husband's "apathy", the flat affect and withdrawn quality that she said is a common part of his presentation, effected her when she was recently in a depressive cycle:

> I curled up on the couch and cried for two straight days about it. Because I couldn't figure out you know, "Why doesn't my husband want to sleep with me? Why doesn't...Why doesn't he want to drag his ass out of the freakin bed and come spend time with us?" You know I stayed curled up on the couch for two days. If I'm in a manic cycle, it's gonna piss me off and, I'm gonna be in that man's face about it. "Get off your ass, be a man, be a husband, be a father." And when I'm stable it's, "Okay, his PTSD must be bothering him today." You know

> like I've been doing. I'll just get up and go check on him. “Honey, do you need anything? Is everything okay? Do you need me to do anything?” You know, “What do you need?” So, like I said, how I react to any given situation is really gonna depend on where I am at, you know, cyclically.

The wide range of Amanda’s reactions to the same behavior from her husband highlights the role a woman’s mental health can play in interpreting her husband’s behavior. When she feels stable, Amanda is easily able to make sense of her husband’s disconnection from the family in the context of his PTSD and respond in a supportive manner. When she is depressed, she struggles to understand his symptoms, interprets them as a reflection of his feelings for her, and is deeply distressed by them. As she explains, an upswing in mood corresponds to greater feelings of being wronged by her husband and a confrontational approach to dealing with the situation.

Jill’s narrative provides another illustration of the way women’s pre-existing mental health concerns can influence their response to their partners’ behavior. Throughout her interviews Jill was open about her history of childhood abuse and how she felt that played a role in different aspects of their relationship. When asked about how her life is affected by her partner’s PTSD symptoms, she responded,

> That’s a loaded gun! (laughs) You don’t know what to expect. I think for me in particular, stability and security is very important. Um… especially with my childhood abuse and all of this back and forth, and “I want you today, I don’t want you tomorrow”, and then “I am going to act like everything is completely normal and nothing changed or nothing happened” is incredibly difficult.

Jill is aware that her background has contributed to her preference for environments that are predictable. For this reason, the inconsistency of her partner's affection and mood are especially emotionally difficult for her to navigate. Jill shared that she had struggled with depression off and on through most of her life. She has had this condition well-managed with medication for the last few years, but explained she experienced an increase in her symptoms around the holidays last year:

> In general I haven't had any suicidal ideation for a long time except for Christmas. And Christmas was absolutely ruined. I spent the day by myself crying. That was probably the only time that I've been like I just want to die. I'm done. I just want to die. I've never tried it. So I mean, I have a pretty good grasp on it. I'm not going to say that these explosive arguments help at all, but they haven't dragged me underwater up to this point.

For Jill, the acute onset of suicidal ideation on Christmas was directly related to feeling "unappreciated" by her partner. She elaborated that when her partner "went off on her" twice on Christmas Eve, once for singing while his daughter was on the phone and once for preparing fried rice when he does not like eggs, she was extremely hurt and reached an all time low. Although this was an isolated incident and she has remained stable since that time, it reveals a potentially dangerous vulnerability to becoming overwhelmed by her partner's irritable behavior. Her initial response, that the question of how her partner's PTSD affects her is a "loaded gun", takes on another meaning in the context of this event, as some of his symptoms may at times be particularly dangerous for her.

The Emotional Rollercoaster in Context

This theme captures the variety and intensity of women's emotional responses to behavior that they perceived to be related to their partner's PTSD. The significant amount of negative emotion that women reported experiencing adds additional support to previous findings that this population is at elevated risk for both personal, psychological distress and relationship distress (Lambert, Engh, Hasburn, & Holzer, 2012).

Women's feelings of fear and anxiety were particularly prominent in their narratives. One line of research has suggested that such experiences could be characterized as *secondary traumatic stress*. In it's more narrow application, this term has been used to describe the transmission of distress from someone who directly experienced trauma to a family member or someone else who develops symptoms that mimic PTSD after indirectly learning of the trauma (Galovski & Lyons, 2004). Participants' accounts do not fit with this model however, as women did not report significant distress related to learning about the traumas that their partners experienced. In fact, as the discussion of their struggle to understand suggested, not fully knowing about what had caused their partners' pain was described as a much more distressing. Lucy, who reported knowing a significant amount of detail about her husband's traumatic experiences, explained how this information was an important tool she could use to help her husband. While a couple of women reported symptoms that mirrored their partners' (such as Robin's panic attacks and nightmares) these appear to be best accounted for by

the events unfolding in their own lives with their partners, rather than by knowledge of their husbands' experiences. For example, Robin's persistent fear for the safety of her loved ones due to her husband's substance use.

A substantial proportion of the women in the study also reported fear in relation to experiences of physical violence, threats or other psychological aggression perpetrated by their partners. These forms of intimate partner violence (IPV) have been found to be more frequent in veteran samples than the general population and especially among veterans with PTSD (Beckham, Moore, Reynolds, 2000, Byrne & Riggs, 2006). Although only a few studies have examined the frequency of IPV among Iraq and Afghanistan veterans, results from these studies have also suggested elevated rates of IPV perpetration among this group (Teten et al., 2009). Women's accounts of being threatened, injured, or attacked verbally, at least on occasion to the point of feeling they needed to call a third party to assist them, are consistent with aggression being a significant problem in this population and these results underline the importance of attending to safety concerns in clinical work with military couples that include a veteran with PTSD.

Several of the women's narratives point to the potential for experiences of compounded stress when veterans struggle with substance use in addition to PTSD. Despite the prevalence of substance use issues among veterans with PTSD, little research has examined how this comorbidity affects veterans' partners. For both Cheryl and Robin

their husbands' substance misuse contributed significantly to their fear of leaving their children at home with their fathers while they attended classes and their concerns about their husbands' safety due to driving while intoxicated. Much of Kendra's distress about her relationship was connected to Carl's behavior when he was drinking and she noted her resentment about the fact that he would wake up every day not remembering the cruel things he had said, while these hurtful statements were impossible for her to forget. For women with partners that misused substances, issues around the partner's use played a significant role in their personal and relationship distress suggesting that additional research is needed that specifically seeks to better understand how a veteran's problematic use of alcohol or drugs to cope with PTSD is understood and experienced by partners.

Women reported experiencing a wide range of emotions beyond fear, including significant anger and frustration with their partners at times. There has been little research on experiences of anger among women married to veterans with PTSD, however a recent article examining the possibility of increased cardiovascular risk for Iraq and Afghanistan veterans with PTSD, points to the importance of expanding this literature (Caska et al., 2014). Two groups of couples, those that included a male veteran with PTSD and those that did not, were asked to complete a conflict discussion task while there blood pressure was monitored. Compared to controls, couples that included a veteran with PTSD displayed greater increases in anger and blood pressure during the task, and unexpectedly, female partners' responses were similar if not greater than veterans'

responses, suggesting they may also be at increased risk for cardiovascular problems (Caska et al., 2014).

In her book *Vietnam Wives*, Matsakis writes that while most of the wives she encountered in her work at a Vet Center were angry with their spouses, they also had ambivalence about their anger. She states, "On the one hand, they feel their anger is a legitimate response to being mistreated, unloved, and overburdened; on the other hand, since their partners suffered through various hardships in Vietnam, they "should" be more "understanding" and "patient" (Matsakis, 1988, p. 123). Cathy's discussion of her resentment towards her husband illustrates how quickly women can move back and forth between feeling justified in their anger and questioning it. While much of the previous research has focused generally on women's distress, or on symptoms that mimic anxiety, results of this study suggest that women's feelings of anger are a prominent feature of their experience, deserving of more attention.

While women's experiences of sorrow and depression appeared to be linked to a variety of mechanisms, Lucy's account of the grief surrounding her partner's diminished cognitive capacity provides further evidence of the relevance of Boss' ambiguous loss theory to this population, and in particular, those families struggling with TBI and PTSD in combination. As Lucy explains so eloquently, she feels that she is "losing some part" of her husband every day due to his progressively worsening condition, and therefore cannot fully grieve one loss before moving on to the next.

Uncertain Footing

> All my life right now could be on a floor that suddenly disappears. You know you're walking and suddenly there is no floor anymore. So if he doesn't really love me, what the hell am I doing here?
>
> - Diana

As many of the women spoke about their interactions with their partners, their daily lives, and their hopes for the future, the uncertainty with which they were grappling became apparent; it extended from what they might expect from the day to what they could envision for their futures. The ambiguous nature of PTSD also left them questioning their abilities to respond appropriately and where to turn for help.

Unpredictable paths.

One persistent theme across many of the women's narratives was the unpredictable nature of PTSD. Different symptoms of the disorder can manifest at different times and, as the following passage from Shannon illustrates, they are not always the times that one would expect:

> Yes, I knew that PTSD was there and I knew that it affected people in many different ways. But I guess that the biggest thing I was ignorant about and didn't expect was delayed onset, well delayed effects, symptoms coming up at different times. I didn't expect that. And I didn't expect symptoms to come out at some of the most happy, comfortable times. You know, it's like 2 or 3 weeks after we're married and we're like, "Ah! Okay, great. This is over. This is wonderful." We'd gone through that stressful time of getting married and planning everything. And we'd moved in the same period of time. I started seminary in the same period of time. It was this massive... And he had joined the Navy reserve over the summer and was gone for 8 weeks while wedding planning. But anyways, all of this had

> subsided and that was when the strongest bout of all of the symptoms came. It started like 2 or 3 weeks into our marriage. And I did not expect that. I didn't... I always felt like, like with other things. That there are other things that bring that out and bring it to the surface or that it's something you get over. And once you've experienced it, you're done. Um, and that was wrong. (Laughing) That was very wrong.

Shannon's account of the unanticipated arrival of significant PTSD symptoms to her home as a newlywed demonstrates a common experience of women in the sample, feeling caught off guard when their partner's symptoms of PTSD seemed to come from nowhere. PTSD symptoms can often intensify in stressful times, and some women shared that they noticed this to be the case for their partners. However, sometimes triggers for symptoms are not clear or can be related to internal experiences rather than external factors that can be observed. Shannon had known her husband for some time prior to their wedding, first as a friend for two years and then as a boyfriend and roommate for another year. She was aware that he had experienced some symptoms of PTSD, and since she knew they could be triggered by stress she may have even prepared for an onset of symptoms while they navigated so many transitions the summer before their wedding. Her exclamation, "Ah! Okay, great. This is over. This is wonderful." captures the relief she seems to feel when she perceives that she and her husband have just come through a stressful period and made it to the other side unscathed. Just as she is beginning to settle into a routine with the man she has committed to for life, her world is disrupted by symptoms of anxiety that she had never seen in her husband. The challenge of coping with his behavior seems to be made more painful by the unmet expectations

that the beginning of their lives as a married couple would be a particularly happy and exciting time. Her laughter in the last line of the passage seems to emphasize how inaccurate her former beliefs about PTSD now seem to her. The notion that this condition could be either predicted or cured is now ridiculous.

Another aspect of the unpredictable nature of living with someone with PTSD relates to the symptom of irritability associated with little or no provocation. Many veterans struggle with variability in mood over the course of the day in addition to variability in symptoms over longer periods of time. All of the women in the sample reported their partners faced challenges in their relationships with others related to being "grumpy", "mean", or "edgy" about small matters. For some of the women, this was a more prominent feature of their partners' presentations, as it was for Elizabeth. She had been drawn to her second husband in part because of how different he seemed from her first husband, a veteran that she married in her senior year of high school and divorced after he was verbally abusive and physically aggressive while on leave from Iraq. Her second husband Joe is 12 years older than her, and during their courtship he was always kind and well mannered. After a combat injury that resulted in a TBI, Joe had to return to the United States, and it was not long before she noticed herself working hard to avoid making him upset:

> It was stressful but at the same time I kept telling myself as long as I keep everything perfect, it's fine. As long as he comes home and he's happy everything's good. You never know who you're waking up next to. It's like spinning a huge wheel. Somedays we're good and other days we're bad.

This excerpt captures a paradox that is inherent in both PTSD and systemic responses to this disorder, the human instinct for order seems to drive us to try to control what can't be controlled and predict what can't be predicted. Traumas are by their nature typically unexpected and/or uncontrollable events. Individuals with PTSD are often driven to try to control their environments in an attempt to prevent another such occurrence. Elizabeth's description of her response to her husband's irritability mirrors this. She is trying to control her husband's mood, yet the metaphor she chooses to describe her situation captures the futility of this pursuit. Her strategies are relatively useless in this game of chance and her efforts result in additional stress.

Several women shared similar stories of efforts to adapt their behavior to accommodate their partners' mood swings. They used phrases like "walking on eggshells" and "poking the sleeping tiger" to explain how their lack of certainty about what to expect from their partners resulted in them striving to tread carefully. As it was in Elizabeth's case, this was usually associated with tension and anxiety. It can be also be difficult to let go of trying to prepare for the worst, as Elizabeth describes below:

> I'm always curious to see how his day is when he comes home. If he gets off the bike or out of the truck and he tells me, "Oh, it was such a bad day." I'm like oh no, here we go. I automatically start thinking he's gonna throw a fit, he's not gonna talk, everything's just gonna go crazy and chaotic again, and sometimes you know I have to remind myself, no, I can't always think that it's gonna be bad just because that's how it used to be. Sometimes I have to watch what I say to him still, because if I say something wrong he takes it wrong.

Elizabeth has seen a great deal of improvement in Joe's behavior since he began a new job and has a larger support system. While his mood still fluctuates more extremely than it did prior to his deployments, he is able to recover more quickly and avoid some of the behavior that was so hurtful to her in the past. She is aware though that she is still very attuned to his mood and often catches herself expecting the worst from her spouse if there is any indication of negativity. She describes making a conscious effort to balance her thinking, but then notes that she does still need to be on guard at times so that she won't say the wrong thing and provoke a problem. This last line is particularly telling as it seems to indicate there is still an unpredictable element to his mood that she should be careful not to trigger, even while she is making the argument that she should be more optimistic about the situation.

How can I help?

Another theme related to women's overall sense of uncertainty was the lack of confidence some women expressed in their knowledge of how to best help their partners' manage PTSD. For some women this was specifically related to how they should respond to certain symptoms and for others it was a more general sense of not knowing how to support them in recovering from this condition. Sonia was particularly bothered by not having clarity on what she should be doing to help her husband Mike. She shared that she was very frightened after being knocked to the floor and put in an arm bar one night when she attempted to kiss him on the forehead. While she was still on the floor, she proceeded to try to talk to him about it:

> Like even when he had me down I said, “Are you okay? Is everything alright? I didn't mean to scare you.” And he was like. “I'm sorry. Just don't ever do that to me again.” And I was like, “Well I wasn't intentionally trying to hurt you I was just trying to lean over and give you a kiss. Like I always do.” He was like, “Oh, I'm sorry. I'm sorry.” I said, “Well, why did you think that I was going to attack you?” And he was like, "Nothing. You know. Nothing." I said, “You sure you don't want to talk about it?” And he's like, “No, I'm alright.” He said, “I'm just kinda worried you know we live off of the highway.” And I was like, “You know that we been living off the highway for like 6 or 7 years now and you never really acted like this before.” He said, “No, I'm okay.” I said, “Well, if you want to talk about it I'm here.” And he said, “No, I'm good.” And he went back to sleep. And it just drove me insane. I would sleep with my eyes open, I would stay awake and I would be looking at the ceiling and thinking. I don't even know how to help this guy. I was like, “I want to help him. He's my husband. I care about him. I love him a lot. But how can I go about it without him getting upset and thinking that I'm just trying to pry when I’m not.” I just wanted to help him. I just didn't know. I didn't have the tools. There's nobody that I felt was out there that maybe went through the same thing that I went through that helped with their loved one. There was nobody around me that I could talk to see if maybe they could give me tips or pointers to help him out. I just felt that I was stuck.

Sonia’s memory of this exchange with her husband is rather vivid, perhaps due to the fear she experienced when he attacked her. Standing in contrast to the intensity of what’s just occurred is the gentle style of questions she recounts using to nudge him toward revealing what is propelling these sudden changes in behavior. She has a strong desire to help Mike, but since he has not been responsive to her questions she feels “stuck”.

Several elements of Sonia’s experience were shared by other women in the sample. Her fear of provoking an argument with further questioning is another example of the previously discussed tension that surrounds the sharing of the deployment

experience. Sonia's feeling of not having the tools she needs to help her husband was also recurrent in the narratives of several women who felt "ill-equipped" or "unprepared" when it came to knowing how to respond to certain symptoms or just generally helping their partners to improve. As she describes losing sleep over questions of what to do, the anxiety Sonia feels about her situation is palpable. Anxiety is a common consequence of uncertainty and again, was something that many women voiced as being associated with their lack of confidence about how they should proceed. The isolation that Sonia experienced was not unique. She knows no one in a similar situation who she can turn to for advice. While some of the women in the sample had connected with other women in relationships with veterans with PTSD via online communities, the majority had not previously known anyone in this situation and were hesitant to talk to others about their concerns for reasons that are discussed elsewhere.

One situation that a few women expressed uncertainty about was how to respond to trauma disclosures. Cathy's story was unlike many in that she had not been aware of the problems her husband was experiencing until after he had already sought out treatment and begun counseling. When he finally opened up to her about what was going on she was overwhelmed by his display of emotion and by the news that he had PTSD. She shared that she had little idea of what her husband had done during deployments and had liked to imagine that he had always been on base in his office. Her sense of uncertainty about how to respond comes through clearly in the following rich description of her experience of hearing about her husband's combat traumas for the first time:

> It was, I just, I didn't know what to say to him, I was like- the words wouldn't even come to my mind. I didn't know when he was talking about body parts and picking them up off the road, and not knowing who was who, it was like, "Ah!" I didn't even know what to say to him. I just took a step back and then I tried to rationalize it. It was like, he was telling me a story and I was making a movie in my head. You know? "We drove up. There's body parts. We're picking them up." And a whole movie was just playing out in my head. So I guess I was trying to kind of see what he was seeing. But it was just, it was too much. And I just- I didn't know what to say to him. I didn't know how to help him deal with it. I don't know what makes somebody better.

Central to Cathy's memory of this experience is the sense of being overwhelmed, as her exclamation "Ah!" seems to indicate. This appears to be in part due to the graphic nature of the images that Paul is sharing with her, but also in part due to a sense of helplessness rooted in her not knowing how to respond. The repetition of the phrase "I didn't know" five times in this short excerpt conveys how much that experience of uncertainty was paralyzing to her. The last two lines of the passage indicate that she believes that there would be responses that could help him deal with the memory and therefore make him better, which may explain the intensity of her reaction to not knowing what these responses are.

Facing an uncertain future.

The weight of the unknown also shaped many women's narratives in the way they discussed their thoughts about the future. Some women had seen treatment gains and expressed hope for their partners' continued improvement, others whose husbands had seemed to slowly get worse over time expressed concern that this pattern would continue. Either way, one belief that was shared by most was that PTSD would in some way

continue to exert influence on their husbands and thus on their lives, making it difficult for them to feel secure about what their futures may hold.

The severity of Robin's husband's symptoms have made his battle with PTSD a central feature of her life for the last nine years. Approximately five months prior to our interviews he completed a peer-run residential treatment program that targeted both his PTSD and substance use and since returning he has maintained his sobriety. While she was happy to report that he had been exhibiting more signs of "his old self", she was also aware of another emotional reaction to his improvement that she discusses below:

> His patience has come back. And for me it's kind of scary in a way because I'm like, "Whoa! When is he going to lose it again?" He's been losing it for so long. He'll be fine for a little bit and then lose it again that it's just I know that I'm kind of stuck in this pattern of…survival basically…and being prepared to get through those moments when he's not doing well. It's almost like I'm planning on him to fail. And I know that that's not, not super helpful for him to know that his wife is planning on him to fail (laughs).

Robin's life has been dominated by her husband's illness for so long that his recent improvements are still difficult for her to trust. Like Elizabeth, she seems to be trying to manage an unpredictable situation by mentally preparing for the worst, in this case planning for him to "lose it". What she is referring to as "it", is not completely clear. She may be referring to his newly returned patience, one of the features that attracted her to him when they first met and he was teaching her martial arts, or "it" may be his overall stability. Both have been extremely variable for the last several years and a mechanism

she has come to rely on to protect herself from the instability has been to expect the unexpected. As she makes clear, Robin is aware of this process and that communicating such a negative outlook on the future is likely not beneficial to her husband's recovery.

Robin is also struggling to feel more confident about her long-term future as is illustrated in this portion of her response to how she feels about her role in her relationship.

> It depends on the day. So (laughs)…Sometimes I feel like this is exactly where I'm supposed to be. This is what I'm supposed to be doing. That I did the right thing by sticking it out. And then there are other days that I'm like I gave up my career. I gave up traveling. I gave up …money…to be with someone that I don't know if he's ever gonna get better. You just don't know if he's ever gonna be fully functional. I don't have any idea if he will ever be able to be an adult who takes care of himself. And that's pretty taxing some days because I want to have a healthy family, a healthy relationship, and I want …you know I want all the things that most people want: security, happy, safety, um…but those are things that I am not afforded in my position.

Robin's reflection on these conflicting feelings about her relationship begins with the expression of the confidence she feels at times about her decision to stand by her husband and take on a larger role in supporting him. But she also expresses that there are other times when she is acutely aware of the sacrifices that have accompanied this decision. She seems to suggest that it would be easier to make sense of those losses if she had more certainty about his recovery, but then emphasizes how little confidence she has in that prospect with the three sentences that follow and begin "I don't know", "You just

don't know", "I don't have any idea". This not knowing takes a toll on her because she still has a desire for a stable future, but sees it as something outside of her reach.

Several women referenced the idea that their images of their futures had become less clear due to the strain that PTSD exerted on their relationships. For example, women who did not yet have children with their partner speculated about whether PTSD would mean their dreams of a stable family life and shared parenting responsibilities would not be fulfilled. While the majority of the women did not express any serious consideration of leaving their partners, four women shared their concerns about whether they would be able to continue to handle being in their relationships. Cathy expressed that she sometimes wondered, "Why don't I just leave him?" When asked how she answers that question she stated:

> I don't know. I don't- I've been really close. I'm just like, how much. I don't understand how you put a timeline on this stuff. You know you wait for somebody to get better, but you're like one year…two years…like three years…I don't know. I guess when I'm, when it's done, when my heart is done then I guess it will be done and I'll just know. But I don't know. I keep hoping. I keep hoping. And I'm feeling like I've seen stuff starting to get better, so it can only go up from here. I feel like we've hit the lowest point so, things are getting better so, I trust in him that things are going to get better, but I don't know maybe if we hadn't been married for twenty years it'd be a lot different. Cause you don't put 20 years into something to walk away, you're supposed to stay and fight. I don't know.

Cathy struggles to answer the question others have asked her and that she has begun to ponder herself, why doesn't she just walk away from her partner? Throughout her interviews she seems to be arguing with herself about this point. She touches on the

importance of commitment and the unfairness of leaving someone when they are ill, but also talks about how she no longer judges women who do decide to pursue divorce, understanding their decision because, "It's hell." She acknowledges here that, given the nature of the disorder, expecting someone to recover according to a certain schedule does not make sense, but she talks elsewhere about how long three years feels and that she craves the knowledge of an endpoint to her family's distress. She seems to settle into the idea that if the end of her relationship is in her future, it will come at a time she will feel more certain about being "done". She then returns, however, to arguing both sides of this question again as she discusses first the gains her husband has made, and then the idea that if it were not for the time she has already invested, she might be more willing to walk away. She ends her response the way she began it, with a succinct summary of why not to leave, "I don't know".

Uncertainty in Context

The psychological consequences of women's view of their lives with veterans with PTSD as unpredictable has not received much attention in work on the current era of military couples, but it has been acknowledged in previous qualitative research. In Vietnam Wives, Matsakis describes the stress that accompanies many husbands' unpredictable fluctuations "between being emotionally present and 'walling out' their families with what one woman aptly calls 'an invisible sheet of ice'" (1988, p. 33). She ties this aspect of veterans' presentations to the emotional numbing that occurs naturally as a part of survival response in traumatic situations and will periodically be reactivated.

She also documented the experience of a woman who reports she "walks on eggs" in order to prevent her husband's unanticipated angry outbursts (Matsakis, 1988, p. 125)

In the current study, women echoed such efforts to prevent veterans from becoming distressed. This pattern provides support for the concept of *partner accommodation*, a construct that has just recently begun to be explored in relation to couples that include someone with PTSD. Accommodation refers to the ways in which partners change their behavior in response to significant others' PTSD symptoms. An exploratory study on 46 treatment seeking veteran couples utilizing a newly developed instrument for this construct has demonstrated that accommodation is negatively correlated with relationship satisfaction for both veterans and partners, and positively correlated with partners' depressive symptoms and state anger (Fredman, Vorstenbosch, Wagner, Macdonald, & Monson, 2014). Lucy's description of changing cleaning products in order to avoid triggering Chuck, and Cathy's description of not approaching Paul about financial or childcare responsibilities because of not wanting to upset him are both examples of this accommodation. Researchers drew from literature on families of individuals of with OCD, partners' enabling of individuals with substance use problems, and excessive self-sacrifice by family members of individuals with mood disorders in conceptualizing this construct which they have suggested "may be a well-intentioned effort to adapt to living with a loved one with PTSD but which, like caregiver burden, may carry with it negative implications for partner well-being in the form of greater distress" (Fredman et al., 2014, p. 380).

The study's authors have recommended future research examine women's motivations for altering their behavior, for example whether accommodations are made in order to be supportive or whether they are made out of a feeling of obligation, as this may predict differential results for perceptions of support in the veteran (Fredman et al, 2014). The results of the current study suggest that women do accommodate veteran behavior for a variety of reasons. Lucy's deciding to abstain from using bleach in her house in order to avoid the smell triggering her husband was described as an easy change that prevented distress for both she and her partner, whereas Elizabeth described her efforts to prevent her husband's outbursts as being very taxing, saying, "the stress of having to feel like you have to make someone happy 24/7, you know made me feel like I was about to crumble." These very different examples suggest that some types of partner accommodation may be more damaging to relationship satisfaction than others, and that clinicians may want to take this into consideration when discussing partner accommodation with couples.

Another topic related to women's uncertainty about the future of their relationships is the perception of the possibility for veterans' recovery. Past research has demonstrated that family members often express doubt about the potential for veterans to achieve symptom improvement, which can negatively impact veterans (Sherman et al., 2008). Most of the women in the current sample also described PTSD as something that would be in their lives forever and expressed a mixture of doubt and hopefulness about the extent to which improvement in PTSD symptoms was a realistic goal. While they

wanted to believe in the possibility of continued growth for their significant others, Lucy described recovery as an "unfair expectation" and Diana shared her feelings that one must "never forget" the PTSD, because it can be a threat to a partner when it is disregarded. Given the chronicity of PTSD for many veterans the avoidance of having expectations for recovery appears to be a defense against disappointment for partners. Clinicians seeking to instill hope in veterans and their families may want to approach this issue with an understanding that partners' attitudes are not just a result of negativity.

Responsibility to Support

One of the themes present in each of the participants' narratives was the sense of duty to help her partner in his struggles with PTSD. Women connected that responsibility to the commitments they had made to their partners and their love for them. The type of support that women described providing varied based on factors such as the types of symptoms that the veteran experienced and the level of their functioning. Despite the differences in the types of help women gave their husbands, there was significant overlap in the strategies of support they described using and in some of the challenges they faced in their efforts to do so.

A sense of duty.

> He did his time in combat. He did his time fighting for what he thought was right. And now he can't fight anymore and that's my job. He went there and he had his battle buddies there and they either made it back or didn't, aren't around, whatever may be the case. I'm the single- I'm the single battle buddy that's left, that's got to make sure that the wolves stay at bay kind of thing. And it's something that for the most part, I have found comfort in knowing that I have

> found a way to do my duty, it's to find a way to do my part in a lot of it. And I think that's the one reason that I've never fallen all the way down the rabbit hole with the depression, is I know that him and the kids can't do it without me. Does it mean it hasn't crossed my mind, no. Does it mean that it's probably the only thing that pulls me back most of the time? Yeah. I know that he could not function and he could not survive without somebody like me there all the time. Basically working right there next to him and being willing to take that bullet for him and being willing to step in front of that person that is coming after him and saying, "No! Enough is enough!"
>
> -Lucy

As the granddaughter of two World War II veterans, the daughter of an Air Force Veteran, and the wife of an OIF veteran, Lucy is very aware of the significance of the term she chooses to describe the role she plays in her husband's life. Within military culture a battle buddy is someone with whom a deep bond is shared, a connection that is rooted in the knowledge that this person is willing to risk it all for the good of the other. Lucy's uses the words "duty" and "job" to capture her sense of responsibility to her husband. In this excerpt she is particularly focused on the protective aspect of being his partner, referencing her willingness to go up against "wolves", "take a bullet" and "step in front of that person coming after him." She also indicates that the role that she plays in caring for her husband and children is not only vital to them, it brings her a sense of meaning and purpose. Recognizing their need for her has helped her to continue on despite her battle with depression and at times been the primary factor protecting her from "falling all the way down the rabbit hole."

Once they began dating, Lucy and Chuck's courtship was quick and intense. He proposed after only four days, but because he was still in the midst of divorce proceedings, it was not until two years later, a year after the birth of their son, that they celebrated their marriage with an intimate wedding. Although Lucy saw some signs of potential problems early on in their lives together, they were relatively minor issues. Over time however, symptoms of PTSD and TBI such as intense startle reactions, flashbacks, and cognitive issues, progressed to the point that he recognized he needed to seek treatment in the fall of 2009, three years into their relationship. She described her thoughts about the time this way:

> And we'd been through a lot of episodes, and a lot of, I mean, there were times when he would black out and check out and remember nothing. And I had to realize. I had a choice. I could either bolt and basically abandon him at that point in time. Or I could try and stand there by him and walk through it with him. And for me, I very much took my vows seriously. I, there was no reason for me to walk away. I wasn't in danger. There were frightening times, I won't deny them. But I was always able to think my way out of them.

While the first excerpt from Lucy highlights her sense of responsibility to her husband in calling it her "job", this passage makes it clear that she is also aware that this is a position that she could walk away from. She recognizes her freedom to choose whether to honor her vows by standing by her partner or to leave him to face these problems alone. Because she takes the promise she made to heart, she believes that she has a responsibility to him and the only legitimate reason for leaving would be the clear

presence of danger. Although she does admit to feeling scared at times in her relationship, she sees herself as resourceful enough to avoid harm.

This idea that supporting one's spouse through his experience of PTSD is both a responsibility and a choice was echoed by many of the women in the study. They felt that it would be wrong to leave their husbands when they were in a time of need, but they were also aware that many women did make the decision to leave and thus recognized that this was an option. Several women expressed pride in the fact that they were weathering the storms with their partners- another indication that, even if they did not explicitly state it, they knew continuing in their relationships was not the only option. A few women did speak about having thoughts of leaving their partners, but they were all still hopeful that their situations would improve enough that this step would not be necessary. Drawing a line at being in danger was also a perspective shared by many participants. A few women explicitly stated that physical abuse was not something they felt anyone should endure, and one woman reported having left a previous spouse who was a veteran with PTSD due to the level of physical violence. Women's narratives reflected both their sense of duty to stand by their partners in their battles with PTSD and the recognition of their agency to choose something different.

Another participant, Shannon, described her feelings about being the partner of someone with PTSD in this way:

> It's part of my husband. (Begins to tear up) And I love my husband dearly. And that's part of, it's part of what I have to accept no matter what that means from here on out. And its a, so there's a certain sense, odd sense of duty on that, but there's also just, it's just part of who he is and that's part of what I committed to. And I think that part of what you commit to in marriage is not...it's you do through good times and bad when you're going through daily situations. I think, and I recommit to that. Like that's a, I know that every day I am recommitting myself to him and this life that we're building together and this is part of the framework and structure of that life. As shitty as it is, as much as I feel like I was in denial about what it was and all that, it is part of his life and what he has, has been through is part of what makes him who he is, and ...that's just...that's life.

Along with her sense of duty to her husband, what comes through clearly in this passage is Shannon's view of PTSD as a part of him rather than something separate. Because she loves her husband so much, she believes she must accept him as a whole person, including this difficult piece rooted in his past experiences. By the time they were newlyweds she knew that he was experiencing occasional panic attacks and had witnessed some of his problems with sleep, but these issues seemed to be relatively under control until shortly after the wedding. At that point his sleep issues intensified and she became aware of patterns of rigidity and irritability as well. In the passage above, Shannon admits to initially being in "denial" about what PTSD really was and consequently what it would mean for her life with Jeremy. Like Lucy, Shannon references the importance of her marriage vows, "in good times and bad", in explaining the responsibility she feels to her spouse. She describes an active engagement with her commitment to him as they move forward in a shared life, the shape of which is inevitably influenced by his struggles with posttraumatic stress. She does not attempt to

paint this aspect of Jeremy in a positive light, acknowledging that it is “shitty”, but suggests that just as his history can’t be erased, this part of him can’t be removed, and therefore must be accepted.

Although Shannon situates the struggles of PTSD in her husband, rather than apart from him, there is still a protective element of her responsibility to him that bares some resemblance to the tasks required of the role of the battle buddy Lucy describes.

> I continue to feel this responsibility. I continue to feel this, I've got to fix it, got to help it, gotta somehow swoop in. And this feeling of, I've got to make sure that I prevent that or that I'm somehow there to fix that when it happens. It was an anticipatory responsibility that had its own weight of that responsibility that I felt. Which sounds REALLY controlling, and I don't want to be controlling, but there's that you know- I want to fix it. I want to solve it.

Shannon feels her responsibility to her partner extends beyond standing by him through his internal struggles to somehow solving these struggles. It is described as an “anticipatory responsibility” suggesting that she experiences a particular pressure to prevent problems related to his condition. This pressure to be ready at any time to “swoop in” weighs on her and even as she describes it she steps back and worries that it is leading her to act in a way that conflicts with her values. Many women spoke of their roles as partners similarly, emphasizing their responsibility to not only stay with their partners as they experienced problems related to PTSD, but to be a part of the solution to these problems. For some, like Shannon, this meant at times trying to intercede through vigilance to the environment, avoidance of stressors, and close observation of their partner’s mood before issues developed. Several of the women reported that if some type

of potential trigger was detected or their partner's mood began to sour they would then attempt to intervene, sometimes relying on one of the strategies of support discussed in the next section.

Strategies of support.

The uncertainty that women sometimes faced about how to best help their partners did not prevent them from making significant efforts to assist them with their trauma-related symptoms. All of the women in the sample mentioned strategies that they have used to support their partners when they were experiencing trauma-related symptoms. Six primary methods of helping veterans manage these issues were reported: listening, soothing, encouraging, mediating, and advocating. The extent to which the women employed these strategies depended to a large extent on their perceptions of their partners' levels of functioning. There were women within the sample whose partners were described as fairly highly functioning and, despite struggles with PTSD, were employed and able to navigate most situations without serious impairment. There were other women whose husbands were described as having greater difficulty successfully functioning in an independent manner. The veteran's level of functioning often appeared to be tied to either the severity of his PTSD symptoms or the presence of comorbid conditions such as TBI, substance use disorders, or Major Depressive Disorder.

Deciding when veterans needed support and what approaches to try to use to help them was often based on women's keen observations of their partners. Many described

becoming completely focused on their partners if they became aware of exposure to a known trigger, such as a person dressed in Middle Eastern clothing or a combat scene in a film. When it came to less obvious triggers, many women noted that a change in their partners' appearance, was an initial warning sign. For example, a "stone cold" face, being "completely tensed up" and "turning bright red" were among the visual cues that women stated were signals their partners were distressed.

Support through listening.

Listening to their partners' stories of their military experiences was reported to be an important way that women chose to help them. Although most veterans did not often talk about their specific combat traumas, when they did or when they were sharing other memories of their military experiences, most women saw attentive listening as the most helpful way of supporting them. In the passage that follows Kendra reconstructs how she responds when her boyfriend Carl talks about his combat experience:

> He was telling the story, he's got a couple, but in this instance I believe he was telling the story about somebody had come up and they had bombs attached to them and it blew up and the man's head and scalp was like hanging off of a wire and he had to go take it down and started telling stories like that. Um, I'm quiet about it because that's kind of what I read in the books. I'm quiet about it and I just nod like I'm listening to you. I'm hearing you. And I kind of touch his arm and I don't say anything. You know. And uh, that's about it. And you know I let him tell his story and I let him say what he needs to say and he knows that I'm there and he knows that I'm listening. And I have told him flat out before, I am here for you always and if you need to tell a story and you need me to just shut up and listen to it, tell me and I'm happy to do that. Or if you want me to tell you how I feel about it, I'll do that too. But you just let me know what you need.

> Basically. So when he does tell a story I usually just shut up and nod and touch his arm and rub his back, stuff like that.

Although Kendra reports saying very little during this interaction with her partner, she works to communicate several messages via her listening. Through her focus, her gestures, and her touch she tries to express that she is really hearing the story that he is sharing with her, and that she is present for him if he needs her. Several women reported that they naturally were drawn to touch their partners while listening to them share their difficult memories. Sometimes that came in the form of placing a hand on their bodies, other times it was cradling them in their arms as they talked. Kendra mentions that her approach is based on what she has learned from reading about the topic, however most women reported that they were just naturally inclined to be relatively quiet during trauma disclosures, perhaps trying to offer a few supportive words. Some women seemed confident about this approach while others voiced more uncertainty about whether they were responding appropriately to what was often graphic and disturbing content.

Support through soothing.

Another of the most commonly reported ways that women in the sample offer their partners support is by trying to soothe them when they become upset. Women shared stories of trying to calm their partners in the context of exposure to trauma cues and just when daily stressors seemed to trigger anxiety or a change in mood. Women described using techniques to ground their partners in the moment such as having them focus on them, squeezing their hands, and modeling slow breath.

Allison explained that she recently stopped trying to sweep what was going on "under the carpet" and confronted the fact that the problems he had been struggling with might be symptoms of PTSD. She gave multiple examples of moments that she has helped to calm her husband down when he became angry or anxious such as when a police officer showed up at their house unexpectedly to inquire about a camera that had been found:

> I had to like hold his hand the whole time and squeeze his hand, you know, "It's ok." Cause he was about ready to flip out on the police officer, like, "Why is he in my house? What's he want? What's he doing?"

She elaborated on how she thinks this helps him by explaining:

> One thing is like the holding of his hand or rubbing his hand, you know soothing, "It's ok. We've got this. No big deal. It's going to be over in a couple minutes." Kind of like, almost like going through a doctor's procedure with a small child getting a shot, you're like trying to comfort them. We actually have some key words that we use that are made up words or they're odd words that are just between me and him, you know when I say those words he knows to reel it in.

While describing the experience of soothing her husband when he is upset, Allison suddenly recognizes how this role parallels one she plays in a different setting, her children's doctor's office. As a mother of four, Allison has likely spent a fair amount of time taking her children to get shots and knows that while an adult is aware that the procedure of getting a shot does not represent a real threat, a child's fear of the needle may overwhelm him and lead to distress. PTSD often leads individuals to have trouble distinguishing what are real sources of danger. Just as she would with a child, her responsibility to her husband is to reassure him that despite whatever has triggered him,

he is not at risk of real harm and help him to endure the situation. With her husband she communicates these messages indirectly with her soothing touch and sometimes more directly by using words they have devised to signal that he does not need to continue to escalate his response, as he would if there was a real threat, and that can let her handle the situation.

Although many women described using touch effectively to calm their partners, a few mentioned that touch could also be a trigger that intensified symptoms at times. Jill learned this lesson early into her relationship with her partner Jesse when she attempted to use touch to calm him down during an argument:

> I'm not into yelling. I'm not into fighting. I want to resolve whatever is on the table. Um, and I know that I went, to me when I argue with somebody I want to touch them and ground the situation, like look at me and calm down. And really the reason that it ended that night is because I went to do that and again his face was just like stone cold. And he's like, "I'm going to the bathroom." And then he went to the bathroom and he came back out and he's like, "I would never hurt you on purpose, I would never put my hands on you on purpose. You cannot charge me that way. He's like, if you charge me that way, I can't tell you what how I'll respond." I mean honestly I hadn't even thought about that concept.

Jesse's reaction was shocking to Jill because a gesture she had always employed in seeking peace was interpreted as an act of aggression. This interaction serves as a type of introduction to the battle mindset that is associated with combat related PTSD. When someone is attempting to survive in a threatening environment, any intrusion into private space can be seen as a danger, and Jesse indicates that despite not having an intention to cause harm to Jill, such a gesture could have unanticipated and dangerous consequences.

Support through encouragement.

A third strategy that came up in most women's accounts was their efforts to encourage their partners. In a few cases women described trying to get their partners to engage more outside of the home by encouraging job seeking and recreational activities, a couple mentioned trying to encourage a veteran to stick with an activity rather than give up on it when they became anxious or overwhelmed. However, this strategy was most often discussed in the context of treatment. The majority of partners of women in the sample had been treated at some point for PTSD, but in many cases symptoms had been problematic for veterans for some time prior to their seeking treatment in the form of counseling or medication. Some women expressed a great deal of concern about pushing too hard for treatment and making veterans angry or strengthening their resistance.

Briana was like many participants in that she was hesitant to "pry" or "create an argument" by bringing up her concerns about her husband's distance and irritability. When she found out last year that the fire department where they worked was beginning a therapy group for employees with PTSD she seized the opportunity to finally broach the subject:

> And they were ready to kick off the group PTSD to see who fell into those categories and to see if it was going to be something that the department could carry on, and I just told him I said, I think you need to go to this and check it out. I didn't accuse him of anything, like, "Hey, you're kind of being short" or "Hey, you're being a real asshole." You know. I never called him out on it, but I just made the suggestion that I really think you need to check this out. They're looking for folks to be a part of this group and maybe you are, maybe you're not.

> Check it out! And he did, cause it was something I suggested and he was like, "Holy shit! I didn't know how bad I was."

Briana embraced a low-pressure style in discussing the possibility of treatment with her husband and in her description of this conversation she emphasizes her non-confrontational approach. Elsewhere in her narrative she expressed pride about the fact her encouragement led him to seek treatment and credited her decision to make it a "suggestion" rather than an argument as one reason it was effective. She shares that she has seen significant changes in his behavior since beginning treatment and expresses relief and happiness at this turn of events. Yet, at points in her interview she seems to be questioning whether perhaps she should have brought up her concerns sooner and whether that might have changed things for her family in these last few years. Her continued uncertainty about whether she chose the best approach illustrates the difficulty women face in balancing their desires to help their partners through encouragement with pushing them away by pushing too hard.

Support through advocacy.

A fourth way that a few of the women in the sample reported providing support to their partners was through advocacy. The women who brought up advocating on their partners behalf were all married and all suggested that ensuring that their husbands received adequate medical care and benefits was an important part of their role as spouses. Advocacy in this context primarily included significant involvement with application for VA benefit claims and communication with the veteran's medical team.

This might be as simple as accompanying their husbands to appointments in order to help the veteran communicate his needs. For other women, whose husbands' war-related injuries were more medically complex, this work could absorb a significant amount of their time. Many of the women in the sample referenced the VA's reputation for bureaucracy as Amanda did when she described her feelings about supporting her husband Samuel through this advocacy:

> That's where I'm so lucky I have a lifetime of experience harassing the VA. I know how to harass the VA and get my husband what he needs and I'm willing to do that, because if it means spending an extra 15 or 20 minutes on the phone telling somebody else how to do their job to make sure my husband gets the care that he needs and deserves, that's not a problem for me. I like a good fight anyway, I'm Irish. So it doesn't wear down on me, fighting for my husband. Fighting with my husband, yeah, that's what wears me down. Cause I tend to feel like, if I'm fighting with my husband there's no purpose to this, but when I'm fighting for my husband you know, whether its harassing the VA or finding resources, he had a problem with a civilian employer last year, you know finding the resources to help my husband get where he needs to be. There's a purpose.

Amanda is the daughter of a Vietnam veteran with PTSD and was married for several years to an OIF veteran that exhibited many symptoms of PTSD prior to her current marriage to Samuel. Amanda was trained as a nurse and has put her experience navigating the complex system of the VA to use seeking proper medical care and benefits for Samuel's service-connected injuries of PTSD and TBI. She makes it clear that she is not afraid to confront individuals who stand in the way of these goals and is not intimidated by the bureaucracy of this government agency. She describes this work as giving her a sense of purpose that seems to energize her. Her feelings related to

advocating for her husband stand in contrasts to those evoked by conflicts she engages in with her husband that are unproductive and therefore draining.

Holding it together: Increased demands for women.

Another theme that emerged in almost all of the women's narratives was their tendency to take on additional responsibilities in their relationships when their partners' PTSD symptoms became more intense. Sometimes this was described as being out of necessity to compensate for their partners lower functioning or absence from the home, other times it was described as a way to try to keep the veteran from getting triggered by the inevitable stressors of daily life.

After the shock of learning that her husband was in treatment for PTSD and had been drinking heavily since returning from overseas, Cathy watched as his mental health steadily declined. She had already considered herself to be in charge of much of their family life, but as her husband's condition worsened she found herself taking on even more of the responsibility for managing their family of four. She characterizes this aspect of her role below:

> It's a family thing, but somebody's got to hold the household together while the sailor, marine, soldier is falling apart. Somebody's got to hang in there and be the glue and hold it together so he can get better…. But I don't think everybody realizes everything that the spouse or whatever, they have to deal with because the person suffering from the PTSD is upset, or they're medicating themselves with pills, or their taking risks, and they can't be upset or bothered by stuff. So we have to deal with that, all that and all the worries, worry about their job, worry about them, and then we have to deal with family responsibilities and kids

> responsibilities, and house stuff and money stuff and we can't bother them with it because you don't want to set them off because they're actually doing OK now. Let's not make it worse for them. So, it's like from all directions.

Cathy argues that people are unaware of the behind the scenes work involved in supporting a veteran with PTSD and encouraging his recovery. Her lengthy list of all the duties that a spouse in her situation must tend to communicates the volume of duties for which she is currently responsible and her sense of it being nearly never-ending. Cathy also mentions that an avenue of support that would typically be open to someone, sharing stress with the partner, is closed to her because of the perception that any stress could "set him off" or jeopardize his recovery. Present in this passage are hints of feelings that surfaced throughout her interviews, a sense of being overwhelmed by all of the tasks on her plate and some resentment towards her husband for putting her in this stressful position. A few women used very similar language to describe the pressure they felt to be the person that "holds everything together" in the context of PTSD. These descriptions often resembled the accounts of some women's deployment experiences, when they were responsible for keeping things running smoothly in the absence of their partners. Thus doing it all was a familiar experience for a couple of women who were with their partners prior to their illness.

One of the domains in which Cathy reports having more responsibility because of her husband's condition is in the care of her children. Almost all of the women who reported additional demands on their time were mothers and parenting was one of the most frequently cited areas to be affected by their spouses' PTSD. A number of factors

were associated with veterans reducing their involvement in childrearing. Women cited issues with anger, substance abuse, rigid thinking, and emotional distance as PTSD-related problems that impaired their partners' parenting skills and sometimes motivated them to keep their partners and children separated.

Robin and her husband Andy met when they were in high school and had their first child, Rob, before Andy joined the Army a few years later. Their second child, Drew, was born after her husband had returned from his deployment to Iraq and was exhibiting significant symptoms of PTSD. She contrasted these experiences below:

> When Drew was a baby, because he was born afterwards, the crying for [Andy] was really not good. When Jimmy was a baby we would switch off getting up to go take care of the baby. There would even be nights where he'd say, "You know what just sleep. I'll go get him. You need your sleep, I'm going to take care of him tonight. I'll just- I'll go sleep with him or whatever." But when Drew was born, the crying made him angry. Like, he was just MAD. Like he couldn't handle it. He didn't have a lot of alone time with Drew because he couldn't handle the crying. And Drew didn't cry a lot. I mean he wasn't colicky or anything. He was like a normal, actually he was probably a better behaved baby than most babies. Rarely did he ever cry. He only cried if he was hungry or needed a diaper or something like that and um, he couldn't bring himself to fix it. He couldn't go make a bottle. He couldn't go change the diaper because the screams were too much. I mean he would sit in bed with a pillow over his head or he would scream at me. "Get out of bed! Take care of that! Make him stop! Stop the crying!" The crying was a big deal.

About half of the women in the sample mentioned that children's cries or screams were a trigger for their partners. Some knew that their partners had experienced traumas that involved children while deployed while others speculated that this was the case. Of

these women, a few had observed their partners struggle to manage their anxiety in response to their children's cries including one participant, Sonia, who had resorted to sleeping in a walk-in closet with her twin newborns because of how much the babies' cries were upsetting her husband. Two other women who were pregnant or pursuing pregnancy expressed concerns about how their partners may respond to their babies in the future. As Robin's account illustrates, the demands for the mother are significantly greater when her partner is unable to assist her with basic childcare because of trauma-related symptoms.

Now that Robin's children have grown older, their father's PTSD has affected their parenting in other ways. Their oldest son Jimmy is now 13 and had witnessed his dad struggle with severe PTSD, depression, and alcohol abuse for years before Andy recently sought counseling and began to improve. Robin reflects on one of the consequences of her husband's mental health problems in the passage below:

> So, it is unfortunate in a way because our oldest son has really kind of gotten to a point where if dad is saying something, it's probably bullshit (laughs). He just- he takes everything that his dad says with a grain of salt and he comes back to me with everything. Um…and that, that is unfortunate, but I'm glad in a way that he's been able to do that as well because there have been some crazy things that have come out of his mouth that are just not legit you know. (laughs) But now dealing with that, Andy is trying to be supportive and trying to be a good dad and…Jimmy is like, "Well dad said I was grounded because I didn't turn this paper in." And I was like, "Well, I guess you're grounded then." Like, "That's not my fault, that's your fault. You didn't turn it in. Consequences man!" He's like, "Ahh! That sucks. Mom said I was grounded." (laughs)

Robin's feelings about her husband's loss of credibility in the eyes of their son are complicated. She knows that Jimmy's lack of trust in Andy is an obstacle to the process of rebuilding the relationship, but she also recognizes that her son's skepticism of his father has been protective in the past. At times, Andy has been emotionally abusive and said cruel things about her to their son. During his lowest points he was suicidal, homicidal, and exhibited signs of psychosis. Her laughter during her explanation of this dynamic seems to be in part a way of distancing herself from the pain of these memories. Whichever view she takes of Jimmy's choice to disregard his father's word, the consequences for her are the same: increased parenting responsibility that leaves her to play the role of both parents.

Mothering their partners: Boundary challenges.

Another theme that surfaced in women's characterizations of their efforts to support their husbands through their struggles with PTSD was the difficulty of maintaining traditional boundaries within the relationship. About half of the women in the sample referenced the mother/child relationship when characterizing aspects of the role they played in their partners' lives. These women expressed a range of viewpoints about the inevitability of this shift in roles and emotional responses to having that level of responsibility for their partner's wellbeing.

Amanda was particularly descriptive in her explanation of the dynamic that often exists between she and her spouse:

> Sometimes I like to tell people that I have 4 kids. And then they say, “Oh really. What do you have?” “2 boys and 2 girls.” “How old are they?” “42, 15, 5 and 6 months.” “You look really young!” And I'm 31. With him sometimes when you're dealing with the PTSD and the TBI, it really can, it can be like having another kid. He has a lot of the-He's very focused, rather he has tunnel vision and if he's not in that tunnel vision situation it's not so much that he's unfocused, it's just it goes kind of along with that apathy. You know where he's very unmotivated so I have to kind of lead him through it. You know? Remind him, “Honey”-Like he just lost his job, so I have to wake up and remind him, “Honey, you need to call back on some of these jobs.” You know. I mean he's 42 years old and I have to tell him how to get a job. 42 years old and I have to tell him, it's not enough to just send these companies your resume you have to write down who you send your resume to and call them back. And I have to remind him of these things multiple times. A lot of that's the, part of that's the TBI, cause like I said, he's also dealing with TBI or memory loss. It is like having another kid sometimes

Amanda is very straightforward in her description of the amount of caretaking she feels she must provide for her partner. She makes a joke of their situation with others, but her frustration about this dynamic is clear. She repeatedly uses the phrase “have to” to indicate that the support she provides her husbands with tasks such as searching for new employment is not something she opts to do, rather it is a necessity. She also points out that veterans who struggle with TBI in addition to PTSD may have more issues with cognitive functioning and that the additional assistance that they may need may make it even easier for partners to fall into the role of parenting their partners.

Diana and her husband Alex have also run into conflict around what role she should play in his life. When they first met in Brazil a relationship quickly developed as Diana saw how much Alex needed her support during a time that marked a difficult anniversary related to his service. However now that they are living as a married couple

and she is preparing for the birth of their son she is resistant to provide some of the support that he requests as illustrated by her response to the question of what role she plays in managing his health and well-being:

> Like a mother. But I have told him a thousand times I don't want to be your mother. He tells me, "Remind me to take this medicine." But he has agenda. He has alarms on his phone. He can remind himself! I tell him I don't want to treat you special. If you want to have a normal life, you have to act normal!"

Diana begins her response by comparing her role in maintaining her husband's health to that of a mother, but quickly goes on to protest being asked to play that role by her husband. Whereas Amanda appears to accept, albeit with frustration, that this dynamic is a natural consequence of her husband's injuries, Diana voices distress over the implications of treating Alex like her child. She views him as capable of solving the issue of forgetting medication by using resources that he has available to him rather than relying on her. She also connects this relatively small example of assisting with medication reminders to Alex's prospects for reaching his goal of a "normal life" by implying her help with such things is abnormal, and therefore an obstacle in his path.

Robin also addressed the challenge of maintaining healthy boundaries when she described her search for a middle path between doing for her husband and leaving him on his own.

> I'm really trying to help him function and be his own person, but it's a very, very fine line to walk between being somebody's nagging mom and being a caregiver. You know there's a really fine line between encouraging someone and doing it for them. And those are the kinds of things that I'm really having to figure out instead

> of being completely hands off, but not being completely hands on at the same time either. Because if he does something well, I want him to know that he can do it well without thinking to himself, "Oh, the only reason that I'm able to do that is because my wife's here." You know?

As a counselor, Robin is likely familiar with the traditional wisdom about the importance of healthy boundaries in relationships. This passage reflects her thoughtful engagement with this idea as she discusses reducing the level of support she is providing her husband now that his mental health is improving. However, even with her experience in the mental health field, the challenge of determining where the line is between helping too little and helping too much is significant. In the final sentence she articulates her motivation for continuing to wrestle with this complicated issue when she expresses her fear that not doing so, and continuing to treat him more as a son than a spouse, will undermine his sense of self-efficacy.

Costs of support.

For most of the women in the sample, accepting a sense of responsibility for their partners' health was accompanied by a cost of some sort. Just as women's roles in supporting their husbands differed, the negative consequences they reported experiencing were varied but had the potential to affect both their physical and mental health.

Throughout these women's narratives, the role of a supportive partner was associated with being patient, understanding and forgiving, The pressure to live up to this image left women vulnerable to negative emotional consequences when their behavior

did not match this idealized standard. Most women recognized that just as their partners' behavior influenced them in countless ways, they exerted an influence on their husbands that had the potential to be negative. Some women expressed that they felt guilty or frustrated with themselves about times when they were impatient, lost their tempers, or reacted poorly to their partners. Jill described experiencing anger at herself for not being able to stop arguments from escalating. Shannon shared that since she was the person without PTSD in the relationship she felt the need to always be strong and respond appropriately to her partner's symptoms, and felt guilty about times when she had not.

These negative feelings were particularly strong for Kendra. Carl was one of her customers with whom she occasionally interacted over the phone. Shortly after she was sent by her industrial parts company to manage a new warehouse in the state where Carl lived, they began speaking frequently outside of work and a relationship developed. When he came across the state for a visit so that they could finally meet in person, he decided to stay and move in with her. Over the phone Carl had indirectly indicated to Kendra that he had PTSD, but as the passage that follows indicates, Kendra was not overly concerned about how this would affect the relationship:

> I mean I knew he had a little bit of the PTSD but my suspicion was that it's not very serious and we're going to get through it together and my goal and what I wanted was to be there for him. I really wanted to be a source of hope and support because I don't feel like he's ever had that before.

Kendra's minimization of the potential effects of PTSD is similar to that described by Shannon. Even women who were aware of their partners' conditions could not really know what this would come to mean for them. The first couple of months went really well for the Kendra and Carl, but the stress of simultaneously navigating transitions to a new state, new job, and new relationship without the support network she left behind weighed on her. One day after becoming upset at work she impulsively quit her job. This unexpected change of circumstance completely shifted the tone of the couple's interactions. Carl became distant and began drinking heavily every night. She describes her feelings about the situation below:

> But I'm really let down in myself because I feel like I've created more stress for him just with quitting that job and the whole financial situation. So I feel really bad that that has not worked out. And also what I'm finding is that he makes me so incredibly insecure, that I'm having to work really hard on myself to be strong and supportive and I'm not doing as good of a job as I thought, because he's affecting me a lot, so my reactions to things are off the wall. I'm not able to be just calm and in control of things. You know when he's drunk and he starts going in to some hissy fit about something. Instead of just being calm about it, now I'm throwing things, now I'm slamming doors, now I'm screaming and yelling and sleeping on the couch. So it's been very hard not to react to the things that he does.

Kendra's disappointment in herself for falling short of her goal of providing Carl unconditional support is a theme that surfaces repeatedly in her narrative. Although she was able to secure another position within a few weeks, she still connects the "stupid" decision she made to leave her other job to all of the problematic behaviors that Carl has exhibited in the year since. She recognizes that as much as she would like to be immune

to his harsh words and hurtful behaviors, these things affect her significantly and leave her insecure about the relationship. From this place of vulnerability it is difficult for her to find the strength required to live out the role she had fantasized she would be playing in Carl's life. Rather than dismissing Carl's behavior and remaining a calm presence in the storm, she finds herself responding in kind to his outbursts and perpetuating a destructive cycle. This failure to live up to her own expectations adds a layer of pain to the hurt she is currently experiencing in her relationship.

Taking on additional tasks in order to hold everything together was also associated with some negative consequences for women. The word "exhausted" was used repeatedly to describe how women felt while juggling the demands of being the primary caregiver for children, completing the majority of household duties, and managing many aspects of their partners' lives. Amanda shared that the phrase "I don't have time for the nervous breakdown I so richly deserve" is a favorite among a group she belongs to of military spouses. A couple of women explicitly connected this pattern of functioning to negative consequences for their physical health. Robin shared that after living "minute to minute" for years, she was told by her primary care doctor that she had "run [her] endocrine system into the ground". Lucy reported often skipping meals due to the stress of her responsibilities, getting little sleep due to her husband's sleep disturbances, and referred to the Rockstar energy drink she consumed throughout our first interview as her "friend". In describing a pattern she connects to prioritizing the health of her husband and

children before her own, she stated, " I can run on fumes for a really long time, but when it finally putters out, I'm down for days at a time which doesn't work. It doesn't fly."

The combination of playing the role of mother to a partner and being solely responsible for much of a family's care can leave a spouse feeling she does not have the space or time to process her own feelings. The recent loss of a parent highlighted this imbalance for Amanda:

> So much of our lives will rotate around his, yeah *his* moods and how *he* feels. You know what I mean? And you get to, and let's face it, it's where it does kind of make you feel like you're off by the wayside a little bit. Like when is it, I've told him before you know, sometimes I feel like, "When is it my turn?" When is it- my dad died February 11th, when is it my turn to curl up in a little ball and say, "I miss my daddy?" I don't have time for that. I have three kids to take care of and I have a husband to do for. But I do, even I-I have those moments where I say, "When is it my turn? When do I get to say, you know, I miss my daddy?" Or, "When do I get to say, you know, what am I supposed to do? When is somebody going to take care of me for once?" And then I suck it up and move on. (laughs)

After suffering a major loss in her life, Amanda yearns for the opportunity to grieve and to be comforted. The demands on her time are one obstacle to having the space that she needs to process her loss, but just as significant an impediment is her feeling of being the only "parent" in her family. This role brings with it the pressure to stay strong and continue caring for others even when struggling to process her own significant loss. The sudden shift in emotion as she speaks reflects this pattern, as she only briefly allows herself to register the sadness of what she is saying before she laughs and states that she must "suck it up and move on."

Responsibility to Support in Context

While there is much attention given to the importance of social support for veterans with PTSD, there has been little attention in the research given to the types of support veterans receive from their partners or partners' experiences providing this support. This study therefore adds to the literature by providing a richer description of the types of tasks that women do for their partners in an attempt to support them and the meaning these tasks hold for women.

The concept of secondary traumatic stress via vicarious traumatization is often mentioned in this literature, yet there have been no studies directly examining the partner's experience of listening to veterans share traumatic material related to their combat experiences. The only indirect evidence supporting this model of transmission of distress in couples comes from Campbell and Renshaw's 2012 study of the association between spouses' perceptions of veterans' communication about their Vietnam experiences and spouses' distress. While the results indicated a connection between communication about Vietnam and wives' distress, among couples that included a veteran with clinically significant levels of PTSD, the authors acknowledged that the use of composite variables to gauge discussions about trauma was less than ideal. As was mentioned previously, in the current study women's descriptions of their experiences listening to their partners' memories did not fit with these models of secondary traumatic stress. Most women framed these moments as opportunities to provide support and though they did share that they could be emotionally arousing, most women described

their attention as focused on meeting the needs of veterans during these exchanges rather than on their own reactions to the material being presented. When they described experiencing anxiety in these moments, it was typically related to their uncertainty about how to respond "correctly". The possibility remains that hearing details of veterans' traumatic experiences may be a significant source of distress for some partners, or a certain level of repetition of these memories may be disturbing to some women; however, the descriptions provided by women in the study would suggest that these are less typical responses.

Some attention has been given to the associations between veterans' disclosure of traumatic memories to loved ones, reduced severity of posttraumatic symptoms, and higher likelihood of posttraumatic growth (Currier, Lisman, Harris, Tait, & Erbes, 2013). Research has also indicated that the quality of support a veteran receives after the disclosure of trauma, is an important factor in whether disclosure is beneficial in processing and reappraising distorted cognitions about the event (Belsher, Ruzek, Bongar, & Cordova, 2011). Little research has examined the quality of the support provided by spouses and partners in this regard, however, the results from this study suggest that women's responses were generally helpful, with a focus on listening rather than providing their own thoughts on the events and communicating acceptance nonverbally through touch.

Given the fact that women's reactions to veterans' memories were not described as traumatizing, that supportive responses to disclosures have been found to be a benefit to veterans, and the quality of responses women described providing to veterans was typically good, more emphasis should be placed on promoting the healthy sharing of material related to veterans' military experiences. In my own experience delivering evidence based treatments for PTSD at VA medical centers, I have observed an attitude that traumatic material is to be guarded and shared only in the special context of the therapeutic encounter. Clinicians who are aware of veterans' hypervigilance for signs of judgment may be concerned that receiving the wrong reaction from loved ones will be damaging to the veteran. While this possibility exists, modeling an overly protective attitude to this material may reinforce veterans feelings that most others cannot understand their experiences and be a disservice to their relationships. Partners are an underappreciated resource in this regard that appear to be interested in learning skills that would ensure they are able to respond to veterans in a helpful manner.

The perception that women's lives were negatively affected by the care that they were providing for their significant others was also apparent in women's narratives, providing additional evidence for the continued relevance of caregiver burden for this era of partners. The sense of burden was much more prominent in the narratives of women that had children in the home as partners' reduced involvement with childcare was described as contributing considerably to women's level of responsibility for the family. Financial responsibilities were also frequently mentioned as contributing to the burden

that some women described. Cathy's statement about feeling that no one realizes the pressure on the spouse to "be the glue" while dealing with stresses and worries "from all directions" illustrates the pressure and sense of feeling overwhelmed that plays into the concept of burden. Her response to her husband's withdrawing from the family is to take on more responsibility, resulting in an overfunctioning/ underfunctioning dynamic that is noted by systems theorists to be problematic. This pattern was explained in research on a psychoeducational program for Israeli couples that included a veteran with PTSD (Rabin & Nardi, 1991). The authors described veterans' passive avoidance of the family, related to guilt about aggressive outbursts, as leading to women's doing more in avoidance of further conflict with her spouse. Rabin and Nardi noted that this often led the women to feel frustrated, and eventually respond with their own aggression (1991). They describe this cycle by saying, "overfunctioning in the wife may reinforce underfunctioning in the husband, which increases overfunctioning in the wife" (Rabin & Nardi, 1991, p. 212). This dynamic overlaps with the concept of partner accommodation and both appear to relate to the woman's perception of burden. In Cathy's case, she feels she must not bother Paul with these responsibilities, but then she feels unappreciated in her efforts and worries about all that she has to do.

The blurring of boundaries in their relationships with their significant others also contributes to women's overfunctioning and sense of burden. Women's descriptions of boundary diffusion in their relationships with their partners were very similar to those of women in a 2005 study of Israeli spouses of veterans with PTSD (Dekel, Goldblatt,

Keidar, Solomon, & Polliack). Many of the women in that focus group reported that they struggled with the pressure to care for their spouses, and that although they did not want their spouses to be dependent on them they were often unsuccessful in preventing this. Amanda's description of her husband as her fourth child clearly demonstrates that this phenomenon continues to be a challenge for the partners of OIF/OEF/OND veterans, whom often feel they have no choice but to care for their spouses.

In *Vietnam Wives*, the spouses that were profiled had predominately been born in the mid-twentieth century and Matsakis discusses how conformity with traditional gender norms played a role in many women's sense of pressure to care for their husbands (1988). The cultural landscape for this generation of veterans' spouses has changed considerably. All of the women in the current sample had attended higher education or worked in jobs outside of the home and referenced their professional identities. Many of the women were also mothers and appeared to place a high value on the role of nurturing their families, and their opinions about division of labor and childcare appeared to vary considerably. No studies were identified that examine how women's identification with more traditional or more modern norms play a role in perception of caregiving burden. In the current study, women's narratives suggested that despite variance in the group on this dimension, women felt a responsibility to provide care and support. In those couples in which veterans were described as more avoidant of participating in family life and household tasks, all women appeared to be drained by their level of responsibility and able to identify some negative consequences.

Impaired Trust & Intimacy

Among the destructive consequences of PTSD that women outlined, problems with trust and intimacy in their relationships were two frequently repeated and closely related themes. These problems appeared to be associated both with veteran's PTSD-related behavior and women's perceptions of and responses to their partners. A number of challenges to both emotional and sexual closeness were described by women including: veterans' limited communication, women's withholding of emotions, men's reduced sexual interest or dysfunction, pornography use, and infidelity.

Challenges to emotional intimacy.

Several aspects of women's experiences as partners of OEF/OIF/OND veterans with PTSD appeared to be connected to their struggles with trusting and feeling close to their partners. Some of these elements were highlighted in Robin's description of how PTSD has affected her relationship:

> I would describe PTSD as like this huge like bigfoot, black, scary monster, that stands in between Andy and I and just claws at me. It's,…I'm usually pretty good at detaching his symptoms from him as a person, and I would say that it's killed a lot of the trust that was there, and it killed it a long time ago, it killed it years ago. I would say that it…it definitely destroyed a lot of intimacy, our ability to communicate with each other, and that's stuff that we're having to rebuild.

The metaphor Robin uses to describe the damage her partner's PTSD has caused her relationship captures her experience of this condition as an overpowering and hostile force that divides them. Her statement "it's killed a lot of the trust that was there" communicates her belief that some of the destruction it has caused to their relationship is

irreversible. That trust is the first on the list of casualties is also an indication of the high cost of this particular loss. She goes on to explain:

> He knows that something's wrong and he knows that he is not the same person. He remembers how he used to feel and so that puts a lot of pressure and guilt on him and the way that he reacts to guilt and pressure like that is to medicate more and so the trust and the safety issue that I should feel with my husband is not there. I mean I don't trust him to take care of himself at all. And, with that too, that kind of cuts out some of the respect that you should have for your husband. And I'm sure he can feel it. You know? He used to tell me, like before he wanted help, he used to tell me that I was acting like his mother. Now I'm always mothering him. So it became this parent child relationship because he wouldn't take care of himself and I wasn't willing to give up yet. So…it changed the intimacy and just the level of trust that we had in each other because he didn't want to be married to a mom and I didn't want to be married to a child. I mean it changed everything.

Robin connects several specific aspects of her experience with her husband to the loss of trust and intimacy in their relationship. She notes that the way her husband has medicated himself through alcohol has further reduced her ability to feel safe with him. Women whose partners struggled with substance use issues in addition to PTSD voiced their fear about their partners' judgment and such concerns are an obstacle to connection. Some of the other elements of women's experiences with their partners are also damaging to the emotional safety that is integral to nurturing intimacy in a relationship, including themes discussed elsewhere such as the unpredictable nature of PTSD symptoms and women's experiences of fear associated with veteran's anger and aggression. Robin also views the more maternal role she has been playing in her relationship as having a cost in this regard, suggesting women who find themselves

relating to veterans more as they would children than they would adult partners may experience difficulty sustaining romantic intimacy.

In addition to these previously discussed aspects of their experiences, two additional patterns emerged in women's narratives that related to challenges with emotional intimacy. One was that veterans' lack of communication diminished women's trust in the veteran and the relationship. Veterans' avoidance of discussing upsetting military experiences has already been discussed, but there was also a less extreme but noteworthy avoidance of talking about other emotionally laden topics that came through in women's descriptions of their relationships. Cathy was clear about how communication had changed in her relationship:

> We're kind of like best friends. I mean, I feel like I can tell him anything and before all this happened I know he would tell me about everything. But since the incident, I mean I don't really trust him a whole lot because I know he lies about stuff and covers stuff up and hides stuff.

The "incident" that Cathy is referring to is her husband's disclosure of his PTSD. Since that time she has not only discovered that he has lied to her about his substance misuse, but also suspected that he has not been open with her about his feelings and progress in treatment. She admitted to wondering on occasion if he's just telling her what he thinks she want to hear, something she did not expect from her "best friend."

An unexpected turn of events occurred a year into Shannon's marriage, and Jeremy's lack of disclosure effected their ability to come together at that time. Jeremy

had joined the Navy Reserve after their marriage and was anticipating another deployment when someone in the military doing a record review noted that the VA had prescribed him a medication for treatment of his PTSD symptoms that was not allowed to be taken by active duty personnel. This discovery cost him his position and he was very upset. Shannon wanted to support her spouse but as she describes below, he was not open about what was going on:

> And that was really awful during that period of time it was even, he would because he was defensive about it, because I think he wanted to make sure I didn't think he was doing anything wrong, he was really giving less information. It was real fuzzy.….And it's almost like the vagueness is this veil that he puts over it. The vagueness and the um, the not telling all of it. And telling me this story in twenty different parts that I have to piece together. Like that seems to be this veil that keeps me and others from seeing what's actually going on and maybe him too.

Shannon's comparison of her husband's style of communication to a veil, illuminates the way that it serves to keep him from truly being seen by his wife. This strategy may feel protective at this moment when he feels his trust has been breached by his healthcare team and as Shannon suggests it may even be a way for him to avoid having to confront this unpleasant situation himself, but this reduced communication also keeps him from being vulnerable in a way that is integral to emotional intimacy.

Jill moved in with her partner Jesse after they had been dating for about a year, but has maintained her own apartment as well because of her partner's tendency to kick her out of his apartment when he gets upset. This had occurred again the week of Jill's

first interview and she talked about Jesse's response when she attempted to address this issue:

> And I'm like, "I can't continue to go back and forth and back and forth and back and forth, and be kicked out, and be treated like this. There has to be some realization that this is not okay and we need to talk about this. You know? And figure out." I presented it and said, "It's not about criticizing you. It's about figuring out how we handle this issue to move forward together." I don't know that he takes it that way cause he's like completely avoidant, completely wants to avoid the whole issue…. Like, literally will move on to another topic or conversation like he didn't hear it. Whether it's, "Oh, did you hear such and such happened on the news?", or "So, is she going to school tomorrow?"

Jesse's repeated refusal to engage Jill in discussing a pattern of behavior that has been extremely destructive to their relationship provides another example of veterans' avoidant communication. While she attempts to use language that will prevent him from feeling attacked, she still does not know his thoughts about the issue because he has not shared them. Jesse is urging Jill to move out of state with him, but his unwillingness to talk about this issue is a barrier to her making such a commitment and moving forward in their relationship. Whether through dishonesty, vagueness, or complete avoidance, the lack of open communication about issues central to their relationships was clear in many women's narratives, and this pattern was associated with problems trusting and feeling close to their partners.

Another issue restricting the level of intimacy in women's relationships appeared to be connected to their perceptions of their partners as lacking empathy for them. Diana provided a vivid example of not experiencing one's partner as empathetic. At nearly full

term, she was visibly uncomfortable during her second interview and shared that the previous evening she had experienced pains that she thought may be associated with labor. She describes her trip to the hospital with her partner in the passage below:

> Last night I was like I wish I was in Brazil and I had my family to take me to the hospital or even I could just take a taxi or anything easy you know. Cause here I find everything very difficult. So he took me there but he was in silence in the car. He put the radio very loud like rock and roll, and I was like, "Man, I'm having contractions here. I'm suffering. I'm scared. I'm…you know. I'm so worried about what's going to happen in the hospital, that we didn't take the bags to the hospital." I wasn't ready. I didn't feel I was ready to give birth. And he was with this bad mood, bad face. It was like it was something I did. It was my fault. Then I was like, "What's going on?" "I'm fine." He could not even look at me, you know? When he gets moody, and grumpos, and angry. He change his face. He's another look. He can be very lovely, but he can be very dry, dry and rude and say very nasty words. Fuck. Sometimes it just takes a little thing to change his mood. It's very easy to do it. And it makes me feel like it's my fault. I did something. But I know I didn't! And it's like, "Shit! I have to deal with this now? I have my own bullshit to deal with. I don't need to…It's not him that needs care now. It's me." You know? The attention should turn to me not to him. And then, I have to put him to his own way back, no? Like I take extra energy from me, to take care of him when I need help. And it's not the first or second time. It happens all the time.

In addition to illustrating women's attunement to and sense of responsibility for their partners' moods, Diana's story highlights her experience of her partner as so absorbed in his own experiences that he does not notice hers. During this car ride she is worried and experiencing considerable distress about what may be happening with her baby, however, she does not share these feelings with her partner. She observes his silence, his facial expressions, and his decision to turn up the radio as indications of his internal distress,

and just as his loud music fills the car, the volume of his emotions drowns hers out. She then finds herself focusing on soothing him when she feels she is the one that is in need of comfort, an experience that is familiar to them.

Diana's frustration with her partner is reminiscent of the resentment Cathy expressed about what she saw as her partner's inability to put himself in her shoes. Beyond anger, an additional consequence of women's experiences of their partners as lacking empathy was that it made them more hesitant to disclose their emotions and therefore limited their opportunities to connect. Several women reported experiences of feeling that their partners did not understand their feelings or failed to provide comfort to them in difficult times that may be linked, as it appears to be with Diana, to their eventually sharing less of themselves with their partners.

Challenges to sexual intimacy.

Nearly all of the women interviewed reported that they had experienced challenges in their relationships related to sexual intimacy, and they all suspected these issues were related to their partner's PTSD. These challenges varied, with some women reporting very little sexual activity between them and their spouses, others reporting their partners' sexual interest in them seemed to swing between extremes, and a few reporting patterns of what they perceived to be hypersexuality in their partners. In some cases this included frequent use of pornography and involvement with other women. These issues were confusing for women to understand and in most cases there appeared to be little or

no communication between women and their partners about these matters. These issues often led women to experience moments of insecurity and distress and negatively affected their sense of connectedness to their partners.

Periods of limited sexual activity were the most commonly reported problem related to women's sexual lives with their partners. Over half of the sample expressed that they were either currently struggling with these issues with their partners or had experienced distress over them in the past. Allison and her husband Tim are now communicating and working on improving this aspect of their relationship after facing challenges related to his sexual dysfunction. She explained how this began:

> He just would always say, "Oh, I'm too stressed. I'm not in the mood." And I just like started feeling insecure for a while there and then came to realize it wasn't that- it was more that it wasn't working. He didn't want to discuss it with a doctor because he was too proud. You know, then when he got the medication and it says it causes more problems, then that's when he finally went to the doctors and said, "Okay, I'm going to need something." So yeah, there were a good two years, like I said where I was like, "What's wrong with me?"

Allison's explanation of the decline in the sexual intimacy in her marriage touches on several points that were commonly mentioned by women in the sample. The first is that she initially is unclear on the cause and internalizes the problem, believing it to be related to his interest in her. Many women mentioned sudden worries about their physical attractiveness surfaced as a result of sexual intimacy issues with their partners. Tim's avoidance of the issue with her and with his doctor, highlights another recurrent aspect of the experience. Women reported their partners were reticent to discuss these issues in a

meaningful way and they sometimes felt uncertain how to broach the subject. Third, as was the case with Tim, medications commonly prescribed for PTSD can exacerbate or trigger the onset of sexual functioning problems. In this case, the knowledge that the medications could be responsible for sexual functioning problems seems to make Tim feel more comfortable seeking the medical consultation that he had avoided when there was not a clear cause.

Shannon classifies the infrequency of sexually intimate experiences with her husband Jeremy as "one of the biggest effects" of PTSD on their marriage. Despite some of the other PTSD-related challenges that Shannon and her husband Jeremy faced, they had always enjoyed a satisfying sexual relationship until about a year and a half into their marriage. In the midst of a stressful period discussed above in which he lost his position in the Marine Corp Reserve, Jeremy suddenly began avoiding sexual intercourse with his wife. As she explains below, his avoidance has persisted since that time:

> It's funny because I feel so much responsibility for it but I can't, you know I shouldn't feel responsibility for it. But yeah, it got to a point we... I mean I don't even count anymore. I don't know the last time we had sex, no idea. It sounds really bad. It hasn't been months and months, but it has been a significant amount of time. It's almost like, its not intimacy as far as cuddling or hugging or anything like that, but its as soon as this could shift over to "this could turn into sex", that he pulls away completely. It's like he can't go there.

Shannon begins by recognizing the responsibility she continues to feel about her husband's withdrawing from their sexual relationship, despite her awareness that she is not to blame. She seems somewhat embarrassed to admit that it is such an infrequent

activity that she cannot recall the last time they had sex. Unlike some of the women in the sample, who reported that all forms of physical affection seemed to decline simultaneously, Shannon explains that her husband is willing to express his feelings through touch, until they seem to be approaching the possibility of sexual intimacy.

Shannon went on to explain the typical way these issues play out as well as well as how she relates them to his PTSD:

> I'm sitting here making dinner with him and he's chopping up veggies and things, and we're just flirty and cute and, you know, young couple in the kitchen. And there was this certain point, it's almost like he knows, couples know this about each other, when a kiss turns into more than a kiss. And he's like, "Nope. I just can't." And like literally turns away. Like, "Nope." And I...I don't know what that is other than, there was something I was reading a while back that was linking-oh, it was Shinzen Young's um…*Science of Enlightenment* or something like that. And he says that we get to a point of, it's a certain emotional and physical full thing of awareness that is and that the only places that we get there are meditation, combat, and sex. That was a light bulb for me of like, "Oh, this is his mind saying, 'Oh hell no! We're not going back there.'" And that made it less, that helped me because I'm like, "What am I doing wrong?" I very much internalized that for a long time, and don't so much anymore.

Like Allison, Shannon explained that initially her husband's rejections of her sexual advances were hurtful and caused her to speculate about a myriad of causes such as 10 pounds of weight gain or having bad timing. However, coming across this resource that provided a possible explanation helped Shannon to let go of the self-blame. She reported that her efforts to discuss the problem with her husband often resulted in arguments and so she has stepped back and chosen to not push the subject for the time being. She has

worked through some of her anger with him as she has come to see him as "a victim in the mess" as well, but she does express frustration related to the obstacle this creates to their efforts to start a family. Shannon's sense of loss is also apparent when she talks about her current perspective on the issue, saying, "But its almost...I don't know. I feel like that part of our lives is gone in many ways. I don't know when it will get back. I don't know what that means."

Another pattern of sexual activity that a couple of women in the sample reported was veterans' swings between extremes of very low sexual interest and intense sexual interest. Lucy described the impact of these dramatic shifts on the sexual intimacy in her relationship:

> It is very much something that challenges us because there's the combination of the depression, which already effects the hormone levels in the body, and there also is the weight gain that has occurred from the medications he's been on. And there's a flux. There's a hypersexuality and a hyposexuality that occurs. Where he will go through fluxes of that's all he wants. And then he will go through fluxes where he wants nothing to do with it. And we went for so long without him wanting anything to do with it, that I now struggle wanting anything to do with it.

In this excerpt, Lucy notes a few of the factors associated with Chuck's combat injuries that have influenced his level of sexual desire. Weight gain and depression were also mentioned by another woman in the study seeking to explain her partner's sudden and dramatic change in sexual interest, as was pain from combat injuries. What Lucy also shares is that in the long absence of sexual relations with her husband her own desire decreases, making it difficult to accommodate him during his periods of intense desire. In

other parts of this interview, Lucy also considered how her caretaking for her husband in such a close way, for example cleaning him after his seizures, has made it difficult for her to feel sexually attracted to him. She expresses feeling guilt at the thought that she "shouldn't be depriving him of something because of something that's happening that he can't control." What stands out in Lucy's narrative is the unusual level of communication that she and her partner have about this topic. She reports that through open and honest conversations they have come to agreement on ways they can use things like "videos" to encourage physical intimacy or meet their own needs if the other partner is not interested.

A third theme that emerged in a few women's descriptions of their partners' sexual behavior was a pursuit of sexual activity as a form of high or a type of self-medication for their conditions. One of the activities that a few women mentioned in connection with this theme was their partner's frequent use of pornography.

> It's embarrassing to say but I think he has a serious porn obsession if not addiction because I found it all over his phone and everything like that and that's, I think he's using that as a lot of hiding from life and stress relief and everything like that and that bothers me ferociously, but I've never brought it up to him. But that really creeps me out to be honest with you it's very creepy to me.

In this excerpt, Kendra is clearly upset about her partner's use of pornography, yet she admits that she has not had a direct conversation with him about it. The only mention of the subject occurred one day when she voiced her displeasure after her partner, who had been anxious because she was spending time with a few male friends, demanded that she leave to come pick him up from work, only to ignore her, lock himself in the bathroom,

and watch pornographic videos on his phone. Such incidents left her seeing his use of pornography, as the other women in the study voiced, as a type of strategy for coping with stress that they had learned in the military. Although Lucy's perspective was different, the other few women who mentioned their partners' use of pornography were upset by it. They viewed it as a form of "cheating" on them, stated that it resulted in them feeling insecure about their bodies, and expressed concerns about how it might be negatively affect their partner's ability to emotionally connect during sex.

Sex played a particularly large role in Elizabeth's description of the challenges her relationship has faced over the course of their marriage. Shortly after her husband's early return from his first deployment due to a head injury, she noticed that he was spending a lot of time on the computer and realized he was watching live videos of girls over webcams. She was hurt and confronted him about his behavior, but he claimed it was not her business. She explains what happened next below:

> And even after we had this huge fight over it, it continued. And so in the back of my mind I thought, "Well, maybe if I give him more, maybe if I do more he'll stop doing that and he'll pay more attention to me. And he'll come back home where he needs to be and get off of the couch and get off of the computer." So I was like, "Why are you doing this? What are you wanting out of it?" He goes, "I don't know why I am doing it!" That was always his excuse, "I don't know! I don't know!"

Elizabeth's distress over her partner's explicit engagement with women online seems to be rooted in her feeling that it is taking him away from her. Elizabeth is still early in her marriage and pregnant with their daughter when her husband's online activity begins. Her

questions of him seem to be aimed at trying to understand his need so that she can recapture his interest and preserve her new marriage.

Elizabeth consulted a friend about her concerns and her desire to draw her husband's interest back to her. The friend suggested she bring another woman home, and her husband was receptive to this idea. They invite other women back to their home for sexual encounters on a few occasions, before her husband suggests inviting another man. She reported the idea was "creepy" to her, but she agreed:

> And so we invited a guy over and he was nice and one thing led to another, and the next thing I know it's other couples coming over. And I was like, I don't like this, but I keep it up because he's back home. I feel like he's actually part of the family again. He's not angry. He's a part of me and him again. He's starting to get more involved with Olivia as a baby. And then one day I told him, I was like, "I can't do this anymore, I'm done. I don't want to do this." And then we started fighting and arguing again. And the days went on and we argued and we fought and I kept thinking, "If I bring this back, everything's going to be okay." But deep down inside I always felt like it was wrong. But I knew if I did it again it would bring him closer to me. And it was the thrill for him. Being at war they get a thrill off of stuff, the adrenaline rush, and that's what it was for him. It was the adrenaline…. And so there for a while we kept the open marriage relationship and it was more him than it was me. I would always use the excuse, "Oh, I don't feel well" or "I'm on my period" every time we had people over or we went somewhere else so it prevented me from having to feel like I was doing it just to make him happy.

Elizabeth describes her enjoyment of having sex with people outside their relationship as fading rather quickly. However, she associates it with her husband's increased involvement with the family and that proves to be a substantial enough benefit that it outweighs her concerns about such behavior for a time. She views his desire for sex with

other people as one more result of his wartime experiences, a desire for a thrill more than a desire for sex. Yet, even in this context, she feels uncomfortable acting against her values in order to keep him satisfied. This internal conflict eventually led Elizabeth to request for a second time that they stop being involved sexually with other couples, and Joe agreed. She seemed to find confirmation in her adrenaline hypothesis when he began dirt track racing soon afterwards.

During Joe's second deployment he learned he was going to be released from the Army due to a knee injury. When he returned he was upset about the loss of his career 15 years into his service. He was soon unemployed, and spending most of his time at home. Elizabeth noticed him "pulling away" once more and soon discovered emails that he had exchanged with people on Craig's List soliciting sexual favors. She was very upset and approached him about his behavior:

> And I said, "What's going on? Why are you doing this?" And he was like, "I don't know, I just, I don't want to talk about it." And I was like, "No, what is wrong? Why are you doing this?" And it was a gradual answer. It took several days. It wasn't right away. His answer was because he felt that I wasn't...I was so independent with him being gone all the time that I didn't need him, for anything. And he wanted to feel needed by somebody, even if it was just for a little bit. He needed to feel that in control power. And he's like I need to feel just that rush of energy. And I was like, "Honey, they have paintball fields for that on post. That's why they have that now. For you guys when you're coming back and you're having these issues. It's because you're so used to being deployed and the army life, they have built these things to go out and do." And he goes yeah, but I don't want to do that. And I was like, this is what you are supposed to do, not this. And it was just, it was still quite an argument but that was the answer I got.

The struggle to understand what was driving Joe's behavior is apparent in Elizabeth's narrative. Central to the answer she receives from him is the suggestion that her efforts to keep him from becoming upset by taking on more responsibility have been interpreted as a signal that she does not need him. Her suggestion that Joe might find an alternative in paintball, indicates that even with his attempts to lay blame on her appearance of "independence," she frames his infidelities as more of a thrill-seeking behavior and is less focused on how some of the relationship dynamics at work between them may play a role.

A few of the women in the sample had partners that they knew had been unfaithful to them at some point in their relationships. A couple of other women expressed serious concerns about the potential for infidelity because they knew that their partners had previously cheated on other people. Elizabeth's hypothesis about the high of such sexual encounters was very similar to the explanation that Jesse gave Jill for the affair that ended his previous engagement. Sonia on the other hand, also connected her husband's affairs to his PTSD, but she understood them to be a consequence of her inability to adequately comfort Mike through his struggles. As discussed in relationship to the theme of depression, these thoughts about her failure to adequately comfort her husband were painful:

> It made me feel like I sucked at being a wife. I sucked at being his best friend. Like, that's why he went and sought you know another woman for his feelings or whatever, because I sucked at it, even though I was asking him and he wouldn't. I

> felt like I sucked, and it was all my fault. Because I don't know how to be there for him and this woman does. That hurt a lot. That really hurt a lot.

Sonia's perception that she is responsible for her husband's decision to be with other women seems to magnify the pain of her husband's betrayal. She appears to view infidelity, not as an indication of a shortfall in her husband, but as an indictment of her performance as a wife. Her thoughts also illustrate the inextricable nature of sexual and emotional intimacy. Sonia believes that because her husband was unable to confide in her, she could not "be there for him", and he was therefore forced to seek emotional and sexual comfort elsewhere. Her narrative illustrates how the damage to a partner's self-worth that results from infidelity may compound insecurities related to not being able to help a veteran with PTSD to get better.

Robin shared a recent nightmare that provides an example of how the effects of infidelity may interact with other experiences women have in their relationships to leave them feeling unsafe:

> Like last night, I had a nightmare and it had to do more with I think not feeling safe. I mean the content of it was my husband was allowing my 13 year-old son to drive 196 down the highway with me in the backseat trying to get my 6 year old to buckle his seat belt because I thought we were going to die. Then, you know, which has never actually happened before. Of course, it's never happened. But it was more of a safety, you know like just a very stressful safety kind of dream. And then the cops were chasing us and then I picked up my husband's phone and there were girls texting him on there. He was cheating on me. And that's when I woke up. I mean it was like (laughs) this very condensed "We're gonna die and you're cheating on me" moment.

Robin's dream communicates the danger she has come to associate with her relationship. As a passenger in the car Robin has little control over the situation and her efforts to try to reduce the risk, by putting a seat belt on her son when their car is traveling at such high speeds, seem relatively fruitless. This imagery suggests that infidelity can present a threat to a woman's sense of emotional safety, just as a veteran's PTSD-related behaviors can serve as a threat to the family's physical safety, and consequently further fracture a woman's sense of trust in a relationship.

Growth through challenge.

While there appeared to be much related to veterans' PTSD that created challenges to connection with their partners, a few women in the sample also mentioned that facing these issues together made them feel more connected to their partners. Allison explained this effect by saying, "In some ways it brought us closer, because I realize he's not just this big, bad soldier. He needs me sometimes. He needs more affection sometimes. In some ways it brought us closer together." Recognition of Tim's problems was initially frightening to Allison, but once she came to understand the causes of his behavior this fear dissipated. Tim has been open about asking for help with certain things and they have recently been communicating more about their issues around intimacy. As Allison has learned ways that she can effectively help him, she feels more needed by her partner and thus recognition of Tim's vulnerabilities has created the opportunity for a closer attachment.

A few women referenced the idea that the work they had put in to make it through some of the difficult periods with their partners was ultimately a benefit to their relationships. A couple of women specified that learning to talk about uncomfortable and difficult topics that can surround PTSD had made a significant difference in their relationship. Elizabeth also expressed that although there were ways that her husband's PTSD hurt her relationship, she believed that overall it had strengthened their bond:

> Because of it I don't think there's a whole lot of things that could come in our way now to separate us. Because in my mind that was the hardest thing I've ever had to go through with anyone. And if I can do it with him than there is no way we can't make it the rest of our lives with this. So I think it's made us stronger it just took a long time to get there. And I know there's still gonna be backfalls. I know there's still gonna be nightmares, but I know more how to handle it now then I did when we were first starting out, and I think that's a huge help.

Trust and Intimacy in Context

Relationship distress among both veterans with PTSD and their partners is well established in the literature, and results of recent research suggest that relationship problems continue to be a significant issue for OEF/OIF couples as well (Nelson-Goff, et al, 2007). Veterans' emotional detachment has long been cited as one explanation for difficulties in interpersonal relationships and the the results of the current study lend support to the recent finding that female partners' reports of service members' level of emotional disclosure were significantly positively correlated with both partners' ratings of relationship satisfaction (Campbell & Renshaw, 2013). Several women highlighted how veterans' lack of communication on emotion-laden topics ruptured trust and caused

problems in their relationships. While emotional detachment is a broader construct, emotional disclosure is a more specific behavior related to attachment that appears to present an important target for intervention.

While this mechanism appears to be one contributing factor to partners' concerns with their relationships, results from this study also suggest a relationship between women's perceptions of veterans' ability to feel empathy and women's own emotional disclosure. As women's experiences of not feeling comforted or understood by their partners seem to reduce their openness and increase distance in the couple, veterans' difficulties communicating empathy and challenges around emotional disclosure in both individuals appear to be important targets for intervention in clinical work with this population.

Attachment theory offers a useful framework for understanding these complex dynamics. Rooted in British psychoanalyst John Bowlby's (1969) observations of young children's reliance on certain innate behavior to maintain proximity to their primary caregivers, attachment theory characterizes the relationship between the primary caregiver and the child as a primary way for a young child to regulate his emotions. More recent theorists have concluded that the attachment system continues to exert influence over adults' interpersonal functioning, in particular in romantic relationships (Fraley & Shaver, 2000). Trauma can devastate any individual's sense of safety in the world as well as his ability to trust and be comforted by others and when people grow up in unstable

environments or experience traumatic events in childhood, military traumas may reinforce lessons learned at a young age about the danger of depending on others. Consequently, attachment insecurities have been conceptualized as both a possible risk factor for developing problems after trauma exposure and an outcome of such an experience (Currier, Holland, & Allen, 2012). Research has demonstrated a relationship between different types of attachment insecurities and PTSD in veteran samples (Renaud, 2008; Currier, Holland, & Allen, 2012). The complexity of teasing apart the influence of different events in veterans' lives has been discussed, but results of the current study highlight the contribution of the interaction between veterans and their partners' attachment-related behaviors to their relationship conflict. When Diana does not perceive her partner to be available to comfort her, her own attachment style influences her response, which in turn influences Alex's behavior. Research that takes into account both partners' attachment styles and behaviors is therefore important to better understand how these dynamics influence relationship distress in OEF/OIF/OND couples.

Women's narratives also point to the significant problems that PTSD creates in experiencing sexual intimacy with a partner. Nearly all of the participants reported some type of challenge related to sexual intimacy and the most frequently mentioned issue was veterans' sexual dysfunction. Although problems with sexual functioning among veterans with PTSD have not historically received much attention, a few recent studies have suggested that the scale of this issue is significant. In a retrospective cohort study of 405,275 male Iraq and Afghanistan veterans seeking care at VA facilities, individuals

diagnosed with PTSD were more likely than those with other mental health disorders to either have a sexual dysfunction diagnosis, be prescribed medication related to sexual dysfunction, or both (Breyer et al., 2014). When compared to those without a mental health diagnosis, the risk for sexual dysfunction diagnosis or treatment was more than threefold and veterans prescribed psychiatric medications were at the greatest risk (Breyer et al., 2014). Authors of another recent study providing evidence of PTSD as a significant risk factor for problems with sexual functioning among OEF/OIF/OND veterans, argue that sexual dysfunction is likely undercoded by physicians and therefore the scope of this comorbidity may be even larger than current research suggests (Hosain, Latini, Goltz, & Helmer, 2013).

Several women's narratives also included references to periods of what they perceived to be "hypersexuality" in their significant others. These were in some cases signaled by sharp increases in veteran-initiated sex as well use of pornography, online chatrooms, sexting, searching for prostitutes online, and having sex with other women. There has been very little research investigating the relationship between military-related PTSD and such patterns of sexual activity. Only two studies were found that explored this topic. The first, a case study of treatment with an OIF veteran who presented for addiction to pornography and combat-related PTSD, points to the use of pornography to avoid intrusive traumatic memories (Howard, 2007). The second, an investigation into the prevalence of compulsive sexual behavior among 258 service members that had served in Iraq and Afghanistan, found a higher incidence of engagement in compulsive

sexual behaviors than in the general public (16.7% compared to 3-6%) and that such behavior was strongly positively correlated with PTSD severity, and in particular, re-experiencing symptoms (Smith et al., 2014). There is clearly a need for additional investigations of this topic and as women's narratives suggest, veterans are not the only ones that are hurt by such behavior. Research on spouses of men meeting criteria for hypersexuality indicates increased marital distress and psychological distress (Reid, Carpenter, & Draper, 2011) and previous research has tied husbands' excessive pornography use to diminished sexual intimacy and relationship distress among partners (Manning, 2006). The results of this study also indicate that veterans' frequent pornography use may not only be problematic for relationships, but have negative consequences for their partners' self-worth.

Taken together these findings suggest that PTSD may have a variety of negative consequences for veterans' sexual lives that have the potential to damage their intimate relationships and negatively affect their partners. This aspect of veterans' health has not received adequate attention in research and additional studies that target veteran populations with PTSD would be helpful in clarifying the connection between veteran distress and use of sexual behaviors. While these articles point to a connection between sexual behaviors and the reexperiencing symptoms of PTSD, women in the study discussed veterans' admissions of feeling driven by the need for a "rush" or "high" as well as the use of pornography following relationship conflict as a self-soothing strategy. The current study highlights the importance of inquiring about issues related to sexual

behavior when working clinically with veterans and their partners, individually or in couples treatment, given the potential for significant effects on both partners.

Moving Forward: Coping with Distress

Women's efforts to cope with the distress related to living with a partner with PTSD emerged as a theme across interviews. There was a wide range in the level of distress women were currently experiencing at the time of the study with a fairly even distribution of participants across this spectrum. Some women's narratives included more discussion of the use of coping strategies to manage the feelings that were tied to their relationships, but all participants described the use of at least one of the methods included in this section to help them cope. Women also repeatedly brought up some of the obstacles or negative experiences related to their engagement with these strategies.

Seeking information.

Given the prominence of a struggle to understand confusing or upsetting behavior in the experience of living with a partner with PTSD, it was not surprising that the majority of women shared that educating themselves about the disorder had been one important way of managing their distress. A variety of methods of learning more about PTSD and about the recent wars were reported. For almost all of the women that included some use of the internet to gather information. Lucy shared that watching documentaries about the war had also aided her in better understanding her husband's fear. Kendra, like

some of the other women, had found books on the subject to be helpful, especially one on PTSD in OEF/OIF veterans:

> It was very, very specific. And what it helped me to do is, I can't say walk in their shoes, I'm never going to know how that feels, but it helped me to understand how it was. Um…for example, you don't know who your enemy is and who is not and it helped me to understand how, how that might feel. And it helped me to understand how would it feel if somebody had trusted me with a machine gun and I'm protecting my country and I'm a big hero and then I come home, and I'm nothing. And it helped me think about things like that that I wouldn't even have thought about because it's not what I've gone through. So it helped me to understand and be as empathetic as possible, not having gone through the situation.

Whether it was through reading books, going to websites, or watching movies, many women talked about how learning more about the OEF/OIF wars had given them a better sense of what their partners had dealt with overseas and were currently facing. As it did for Kendra, this knowledge decreased their confusion about their partners' behavior and increased their empathy for their partners.

Feeling overwhelmed by not understanding what was happening to her husband and feeling dissatisfied with the online resources she had come across, Shannon sought out a therapist that taught a course on PTSD at a local university:

> Um, and I told her that I was looking for two things. That I was looking to be educated on PTSD, because I felt like I didn't...I didn't understand and I really needed an education. And that I needed to figure out how to cope with how it was affecting me. And she was really good and respected that. And we had two sessions where she literally had a whiteboard out explaining PTSD and like going into reptilian brain and all of these different levels, and fight or flight and all these

> kind of things and this is what could be going on, which I really, I found that incredibly helpful. I could not tell you all of what that was at all. (laughs) I just remember going, "Oh, That's why this!" or, "Oh, that's why that!" and that was really helpful. But that was all me seeking out a person and saying, educate me. And not on a how to make him feel better kind of level, but like what in the hell is going on, like in his head, what's going on.

Although many women in the sample reported involvement in therapy, Shannon's seeking out of this type of formal education on PTSD was unique. She specifies that she also wanted to learn skills for how to cope with her feelings, but her description of the benefit of first receiving detailed information about PTSD, illustrates how the education itself was a type of coping strategy, providing an answer to some of the many questions that had been so troubling to her. Allison described the benefits of learning more about her husband's condition this way, "its not that I'm afraid of it anymore. I understand it more what's going on… so I think we are there for each other more emotionally and intimately than we were. " Allison clearly demonstrates the relationship between information and distress when she explains that more understanding of her partner's condition has resulted in experiencing less fear about his behavior and consequently more opportunity for connection.

Seeking professional support.

One of the other most commonly reported strategies that women in the sample used to manage their distress was counseling. Half of the women reported that they have sought individual counseling with the specific goal of helping them cope with the

systemic effects of their partner's PTSD, and two of these women had also participated in couples counseling. In addition, two women reported participating in therapy groups which were specifically run for women married to veterans with PTSD and two had attended retreats targeting this population. Although not focused on them, two women shared that they had been a part of some of their partner's individual therapy sessions in order to share their perspectives. Overall, women reported that their experiences with counseling were helpful and taught them new beneficial skills. In a few cases however, women reported that they discontinued treatment because they were not finding it effective.

Allison, who was initially hesitant to acknowledge her husband's condition, expressed how living with the effects of PTSD had shifted her perspective on certain things over time:

> And I guess some of it, that I might need some support too. At first I was completely against myself getting therapy and then I started seeing someone myself…to learn these things myself to deal with what I'm going through.

Allison was one of the women in the sample who was most open about the stigma she had associated with PTSD prior to her husband's diagnosis. She also expressed her fear that if people in her community knew she was in therapy, she might be judged negatively. However, as she states in this passage, she came to recognize that her husband was not the only one who needed to learn new coping skills and was glad that she had decided to seek professional support.

Lucy had been receiving free counseling over the phone through the nonprofit organization Give an Hour. She describes her experience with therapy below:

> So that has probably been the single most valuable thing I've found, just because it is, it truly comes down to me and taking care of where I'm at. It's been able to sort of validate and help me understand why other situations that are supposed to be helpful are not so helpful. I…I at one point did find the group setting very comforting, very relaxing. But the more that politics get involved in stuff like that and things like that, I deal with enough of that everyday. I don't need to go in twice a month for two hours and deal with more of it voluntarily. And so it became that moment in time of finding that which makes me feel better, that which makes me feel like I'm moving forward kind of thing.

Lucy sees her therapy hour as one of the few opportunities she has each week to focus on her own needs and, therefore, has found it to be an important part of caring for herself. Through her work she has also gained confidence in her ability to discern which activities and relationships are nurturing and which are draining. In the passage of above she contrasts her experience of individual therapy with her support group experience. She goes on to explain more about what led her to discontinue the group below:

> I have very little patience for being in a room with a group of women. I really do. I don't…I don't do the comparing notes kind of thing of whose situation is worse. Validate everybody for where they're at. Help them get through where they're at. And move on. Don't do the, "Oh, if you think that's bad, try this!" That doesn't work.

Lucy is open about her discomfort with the dynamics she associates with large groups of women. While a support group offers the unique opportunity to be surrounded by people that have a shared experience, she did not experience this group as a supportive

environment because she perceived participants as more focused on expressing their own pain than they were helping one another.

While Lucy found that individual therapy provided her the opportunity she needed to focus on herself, Diana's experience of counseling was just the opposite:

> So we started doing therapy. Couples therapy. And the counselor said we should do individual counseling as well. I said, "Okay. It will be good. Cause he has a lot of stuff to talk about. And I'm not the best person sometimes you know. And I have stuff as well, from my family, from my childhood." But then in the counseling hour I was never talking about myself, it was only about him.

Throughout her interview, Diana was quick to highlight the role that she played in influencing her partner's mood and behavior. She appears to be open and willing to engage in her own therapy, but quits after she notices it is just another space where she is focused on her partner rather than her own needs. While she has continued attending couples therapy she also expressed frustration about how that process began.

> It's always about him here. Even the couples therapy, the first session. When the guy asked so you have PTSD. Tell me more about it. It was 40 minutes about him. 5 minutes about me and something about the relationship. I'm like what the hell? Who am I here? Just a shadow or something?

Diana's life has changed dramatically since coming to the United States and after leaving her job, friends, and family behind, she feels much of her world centers on her partner. To have this dynamic play out again in the counseling room when she has a great deal to process related to her own history in addition to all of her recent transitions, is obviously

frustrating to her. She reports that it is what ultimately leads her to stop attending individual therapy during a period when support was particularly needed.

Sharing their struggles.

Another theme that emerged from the interviews and relates to women's efforts to cope with the complex feelings associated with their partners' PTSD was the value and challenge of sharing their struggle with others. A number of women expressed how important speaking about their experiences with friends, family, and online communities had been to them at times in their relationships. However, women's feelings about telling others what was happening in their homes were conflicted. They shared a number of concerns related to sharing this information and some reached out only in times of crisis, or not at all.

Robin's concerns about her husband's wellbeing were a constant companion once Andy left the military and his symptoms began to steadily increase in severity. She describes the isolation of this experience in the excerpt that follows:

> I felt very alone in those worries because I had one of two things happening, either the people in our lives at that point didn't think it was a big deal and that I was being controlling and manipulative. Or, they were wondering why I was still with him. "Why are you together?" There wasn't, there really wasn't a whole lot of support for me to help Andy or to stay in the marriage. It was either I'm crazy, or I'm not crazy but I'm crazy for staying. One or the other.

Robin's experience of feeling misunderstood by friends and family when she tried to share what was happening with her husband was echoed by many of the women in the

study. She is aware of being labeled as "crazy" by both those who feel she should leave her husband and those who see nothing wrong with Andy's pattern of excessive drinking and destructive behavior. Because of these critical messages that Robin receives from the people in her life, she feels unsupported in her choice to stand by her husband and try to honestly engage him about the problems she sees. Many women shared that they were certain that if they revealed to friends or family what happened behind closed doors, for example the holes in walls and cruel remarks, that they would be advised to leave their partners. Because none of these women were ready to make that decision, such advice was not perceived to be helpful. Criticism of their partners also put them in the challenging position of feeling the need to defend their partners at those times when they were most hurt by their behavior.

The one environment that provided the type of support that Robin felt she and her husband needed was their couples' bible study group. Here she explains what made the support of this group helpful to them:

> They would- nobody ever told me to leave him, divorce him, even after he had cheated on me, he walked out on us. They, they came over here, brought me food, helped clean my house, but not once did anyone ever put Andy down. They just said "Wow, he really needs some help." Which I mean that's what I was echoing. I mean they would say, "Andy is a wonderful man. He's so compassionate and he's such a good guy. I can't believe that these are the choices that he's made." And even our pastor, our pastor was like, "He's a great guy and he's gonna snap out of it. And you need to make sure you're safe.

Unlike the other people in her life, the members of her church community provided the validation that Robin had been seeking during this disorienting period. They actively pitched in with everyday responsibilities when she was overwhelmed by the stressors they were facing, but most importantly they did not judge Andy for his behavior or Robin for her decisions. They recognized that the couple was in need of help and supported her in prioritizing her safety without disparaging her husband. A few other women specified that the people they reached out to in times of distress were individuals who they felt comfortable talking to because they did not think they would hold the information against their partners. In a couple of cases women mentioned that they felt more open to sharing information about their relationships with others in the military, as they felt they would be more likely to understand.

Although Cathy reported that she had close relationships with her family, she provided a variety of reasons for her reticence to open up to them or other people in her life about what was happening in her relationship:

> I just- they're so far away there wasn't really anything they could do. So I didn't want to burden them with what was going on, and I didn't want to tell anybody that it was getting a little dangerous because I didn't want anyone to come in and take my kids away. And I didn't want to tell anybody in the military because I didn't want my husband to get in trouble and get you know kicked out of the military or get sent to NJP or take his money away because we need his money! We can't live without it. He's the only breadwinner, so…I didn't want to tell anybody. And I, I was embarrassed. I was embarrassed for our family. I didn't want…I didn't want to ruin the image of what our family was because a lot of people said we were like Norman Rockwell. We would do those types of things and I didn't want anybody to think that our marriage had faltered or was bad in

> any way. And I secretly hoped he was just going to get better right away, it was going to change real quick.

Cathy feels there is nowhere to turn when she is navigating one of the most difficult experiences of her life. She feels guilty at the prospect of putting that "burden" on family members and fears the negative consequences that might be associated with reaching out to someone in the military community. A few women voiced their concerns about telling other people in the military due to the potential for unforeseen and negative repercussions. Others mentioned that they felt it would be disrespectful of their partner's privacy and emphasized the importance of protecting their partners' images. Cathy's worry about tarnishing her family's image is an indication of the stigma she felt was associated with PTSD. Her minimization of the severity of her husband's condition also factors into her choice to limit what she shares about her struggles.

Despite her efforts to conceal the distress she is experiencing, there were times when Cathy did tell her family a portion of the story:

> The few times that I've shared stuff with my family is when things got so bad. They could tell by my face I was upset and then it just kind of bubbled out you know- we're having this issue. But there's been a lot of issues, so I just don't go to them with every issue. Because I just, I just, I don't want them. I don't know…validating- I don't want to have to validate my marriage to them because every week there's some kind of issue. You know, I'm just not gonna take every thing to them all the time. And it's stuff that me and my husband have to work out you know. We just have to work out on our own. But the few times that I've ever opened up to anybody is when it all got to be so much. It was such a bad thing that my husband was in a car accident and you know, it bubbled out.

This passage highlights Cathy's use of social support in times of crisis. Although she had no intention of sharing her upset, Cathy describes her distress as so intense in these moments that it was incapable of being contained. The reasons she provides for not going to her family at other times echo those of Robin and many of the other participants: she does not want to have to justify herself and her decisions. Unfortunately not having a more consistent release for her distress leaves Cathy vulnerable to becoming overwhelmed when new issues arise and having them "bubble out" once more.

Because of these concerns with stigma, feeling misunderstood, and protectiveness for the spouse, some women turned to online groups that are just open to women in the same situation as a way of finding support. Below, Allison explains the benefits of these groups:

> Just social support. That when something's going on I can go to this little group of women and say, "Hey, you know what has anyone else ever experienced this and what did you do?" Or, sometimes even just giving them feedback, and you know they're going through the same thing and it's like, "Hey, you know what, I can help her with this! I got this one! I've been there!" So that's been beneficial and like I said it really helps to know that I'm helping others and that they've got my back and they're not going to look at me like, what craziness does she put up with. Cause they're putting up with their own craziness.

For Allison, these groups provide the guidance on difficult questions she does not feel comfortable asking others. Even a few women who reported that they just looked at such web pages and did not typically post anything, expressed that reading about other families' struggles normalized their own experiences. Allison expressed elsewhere that

reading about veterans with more severe symptoms helps to put her husband's struggles in context and feel better about their situation. In the passage above, she also highlights how such forums provide the opportunity to help others in similar situations. About half the women interviewed reported that helping other military families is something that brings meaning to the pain they have experienced. This sometimes took the form of mentoring other women in the same situation, such as Robin reported doing with her sister-in-law, or more formal avenues like Amanda's political advocacy work on behalf of veterans seeking declassification of records or Kendra's volunteer work with a military serving non-profit organization.

Additional coping strategies.

Coping through prayer.

In addition to those methods discussed above, there were a few additional themes that arose in the women's discussion of what helped them manage their distress. A few women mentioned that they drew comfort and strength from their faith during stressful times. After Sonia reported that she had looked at her children as a way out of the deep depression she experienced in relation to her husband's infidelity, she explained it further this way:

> Faith. Church. A lot of prayer. That's what usually gets me through things like that. It will snap me back to reality. Like no, you've got kids, you 've got to keep it together for them because they're still young. Because they can't see you fall apart.

As she has in previous times of struggle, Sonia turns to religion at times when depression about the circumstances of her life with her husband is threatening to overwhelm her. Her faith serves to refocus her on her priorities, central of which are her responsibilities to her children. Her desire to present them with an image of strength is what allows her to not succumb to her stresses and "fall apart." Briana and Diana also specifically mentioned prayer as an important tool during distressing moments in their relationships.

Coping through writing.

Another coping strategy mentioned by a few women was writing about their experiences. One participant has a blog that she writes as a way of both releasing her own thoughts about what she is going through and sharing helpful information with other military spouses. Two women mentioned writing in personal journals had been helpful to them. Elizabeth explains why she prefers this practice to other strategies in the passage below:

> I think it gets my mind off it. Cause I just write down how it makes me feel and then I don't have anything else to say about it. I'm done with it, I don't have anyone staring at me, judging me, because it's just a book, it's just a piece of paper, it's a pencil. No one's turning around looking at me, going your weird, why do you stay with him? How do you put up with that? I don't have that. I just have me letting it all out in the open and then closing it back up when I'm done. And not having any judgment afterwards. I think that's why it feels so much better to do that than it does to talk to someone.

Journaling is a release for Elizabeth. Elsewhere in the interview she states that she recently burned a collection of journals that she had filled over the course of her marriage

because they were full of painful memories that she did not want to hold on to. She appears to process her feelings about her experiences through her writing, as she writes until she has nothing "else to say about it." While some women described accomplishing this through speaking with others about their struggles, Elizabeth was one of the women who reported that she no longer shared anything about her relationship with anyone because she had repeatedly felt rejected by people after she would describe what was happening in her marriage. She contrasts that experience with journaling because when she translates her experience into the written word she does not risk judgment.

Coping through externalizing the problem.

Another way that a few of the women in the study appeared to be coping with the systemic effects of PTSD was reflected in their language. These women conceptualized their partners' PTSD as something that was in some way separate from the spouse that they knew and loved. For example, Lucy shared a metaphor she had first heard at a retreat for spouses that had been very helpful to her in managing her own responses to challenging situations in her home.

> They were able to explain that there's a difference between the person you fell in love with and the person who has PTSD. They called it the shadow and it's like this shadow follows them back and sometimes you deal with the shadow, sometimes you deal with the person. That for me was huge in realizing when he has his meltdowns or he has his flashbacks, that anything said or done in those moments isn't personal. It is strictly within the bounds of what's happening to him. What he's re-experiencing, what he's thinking, what he's feeling and that most of the time it's not rational.

Beginning to view the effects of trauma as a shadow, a darkness that is attached to Chuck but still apart from him, resulted in a shift in Lucy's reactions to his behavioral disturbances. She explains that this way of thinking about his symptoms helps her to recognize that he is not choosing to act in this manner and therefore however he acts towards her it "isn't personal." Because this analogy describes symptoms such as flashbacks as something "happening to him", it also promotes empathy for his experience. Robin mentioned that she visualizes PTSD as a monster that comes between she and her spouse and Diana spoke about PTSD as a darkness that takes control of the "good" husband whom she loves so much. As Lucy explains, these ways of thinking and speaking about their partners' PTSD can translate into less distress about veterans' symptoms.

Moving Forward in Context

Women's discussion of their efforts to cope with their distress highlighted both their engagement with several helpful strategies and the obstacles that they faced, in particular in regards to accessing support from others. Most of the women in the sample were proactive about seeking out information related to PTSD or the recent wars. Online sources were a particularly popular way of gaining information, but some women did report feeling that online information was not pertinent to their situations or not helpful. Research has not been done examining partners' understanding of PTSD or the effectiveness of psychoeducational materials, and may be helpful in gauging where the

largest gaps in partners' knowledge exist. Given the prominence of women's confusion about how PTSD is manifested and the best ways to support partners, along with their frequent use of the internet, the development of more quality online resources that are geared specifically for this population may be warranted. For example, web-based psychoeducational interventions for cancer survivors and their caregivers were found to reduce dyadic distress and increase self-efficacy among caregivers (Northouse et al., 2014).

Overall, counseling was reported to be one of the most useful strategies for women managing distress. Women reported engagement in a variety of counseling services, including individual, couples, group therapy, and conjoint sessions with veterans. Little research has been done on the prevalence of partners receiving mental health services, but studies of veterans' attitudes towards including partners in PTSD treatment and of their beliefs about partners' desire to be included in care have indicated significant interest in expanding partner involvement. A recent study of 283 married or cohabitating veterans receiving treatment for PTSD in a VA medical center indicated that 78% expressed some interest in involving their partner in their treatment and 70% were open to couples therapy. Among just OEF/OIF veterans, the interest in couples therapy was even higher and 87% reported that they believed their partner would like to be more involved in their care (Meis et al., 2013).

One important finding of this study was that despite increased awareness of PTSD, less stigma associated with military involvement in the recent wars as compared to the Vietnam conflict, and the existence of online communities targeting this population, many women still expressed feeling isolated in their experiences. They reported either having experiences of feeling judged for their decisions to stay with their partners, being advised to leave their partners, or fearing such experiences to the point of not opening up to others. This isolation echoes findings from research on partners of Israeli veterans who were reported to be lonelier and less satisfied with their social support than women married to veterans without PTSD (Solomon et al., 1992). The perception of social support has been linked to better outcomes among individuals experiencing stressors (Haber, Cohen, Lucas, & Baltes, 2007) and therefore research that addresses ways of increasing women's perceptions of social support is needed. Such findings also emphasize the importance of continued efforts to reduce the stigma associated with combat PTSD and increase public awareness of the complexities that families face when managing this condition.

Although overall accessing online communities for partners of veterans did not erase women's sense of isolation, in some cases women did report that reading about other women's lives normalized their experiences and reduced their distress about their own relationships. Allison in particular had taken advantage of these communities to network with other women and consequently built relationships that she valued with people with whom she felt she could be honest about the challenges of her relationship.

Research examining peoples use of social networking features in online health-focused support groups suggests that users choose to use different features depending on their needs for informational versus emotional support and that the use of certain features is more associated with satisfying emotional support needs (Chung, 2014). This fits with the varying levels of engagement with these sites described by women in the study and the varying perception of the groups as helpful.

Shifting Identities

The many ways that women's experiences in their relationships influenced their identities emerged as a final theme. In some cases, women's experiences in their relationships seemed to reinforce aspects of their self-concepts in ways that they were proud to share. At other times, women's behavior in their relationships led them to question themselves as they struggled to recognize the people they became in their relationships. Some women also expressed that their connection to their partner had consequences for the way they saw themselves in relation to others, due to factors such as embarrassment over veteran behavior or perception of stigma. In a few cases, women's sense of purpose became so intertwined with care for the veteran, that women's individual identities were overshadowed and they expressed a sense of being lost or vulnerable to struggles with self-worth. A final pattern that emerged was women's recognizing new strengths through facing the challenges of their relationships.

That's not like me: Reinforcing and discrepant experiences.

References to the ways that their lives in their relationships either fit or did not fit with aspects of their identities were recurrent in women's narratives. When women connected their behavior to a central part of their personality, cultural identity, or history, it seemed to reinforce this aspect of their self-image. There were also times when women spoke of their behaviors in their relationships as surprising to them and discrepant from the ways that they perceived themselves. This seemed to lead women to a place of questioning themselves.

In describing what attracted them to their partners, the sorts of ways that they supported their partners, and their reasons for staying with their partners, many women spoke about how these things fit with key parts of their identities. These were more typically positive aspects of themselves that they highlighted through this process. Framing their experiences this way seemed to be a source of strength and to help them to make sense of their experiences. Like many of the women in the study, Diana reported that her relationship with her husband Alex had developed relatively quickly as they were married and expecting a baby within 10 months of meeting. She explained that she was attracted to his resilience and seriousness right away. She also appreciated the chance to help him through a difficult anniversary period and explained this by saying,

> I think it was this feeling of taking care of him and being good for him, that he was needing so much someone to take care of him. I like to take care of people you know. I'm like that.

This passage highlights how Diana's view of herself as a nurturing person matched well with the role she found herself playing early into her relationship. She was in her mid-thirties when she met her husband and the son that she had as a teenager was already off attending college. Alex was in his late twenties, far from home, and without any support. Seeing someone in need and with few responsibilities for others' care, she was drawn to help him. Initially this meant providing companionship and assisting him with small things like finding American foods so he could feel more comfortable. However, when he became very depressed and experienced intense suicidal ideation, she was able to see the importance of her care for him and this aspect of her identity was reinforced. Several women in the study mentioned that caring for others was an important element of their self-image and expressed pride in the help they provided their family members.

A few women connected aspects of their experiences in their relationship to their cultural identities. Briana drew on her identity as a Latina when discussing her commitment to her spouse:

> My culture, well my culture being a Hispanic, Latina, I mean I know I'm not going to be the one that says I want a divorce or anything like that. I'm you know, one and done. We said till death do us part so that's the way it's going to be. Just that embedded, I guess old school.

Briana's culturally influenced beliefs about the meaning of marriage are a way of helping her to organize her thinking about her experience. She was proud to share that both sets of her grandparents were married when they passed away and that her parents' marriage was still strong. Because of these deeply embedded values, she does not entertain the

option of divorce when her relationship with her partner is strained by his frequent absences from their home for training and deployment and his change in demeanor. She also connects the way that she manages her feelings about her relationship to this part of her identity:

> I guess too, my culture is to be there for him no matter what it is, so I just didn't really talk too much about things unless there was something that really irritated me.

She also ties the importance of supporting her husband through all circumstances to her culture, and this belief has implications for what parts of her experience she chooses to share with others. In general, Briana feels that what is occurring in her home is private, between she and her husband. Since she knows their relationship is permanent she feels like it is up to them to work things out. On the few occasions when she chose to speak to someone else about her relationship, she turned to her family with whom she is close. Thus Briana's cultural identity plays an important role in the way she navigates her experience and as she has seen improvements in her husband's health, her decisions to stand by him and utilize the support of her family have been reinforced.

An aspect of women's identities that was sometimes bolstered and sometimes damaged by their roles in their relationships was professional identity. Amanda was trained as a nurse and although she is not currently working outside of the home, her knowledge of the medical field is something that she draws on in the advocating that she does for her husband's medical care:

> I don't mind fighting for my husband. I don't. I happen to be blessed with an education and a skill set that means I know what the hell I'm talking about when I'm talking to these doctors. I know what tests I need to have them order. And it doesn't, it does not bother me. Like a lot of my friends, the endless calls to the VA and the endless trips to the VA, it wears them down, a lot of the other wives and caregivers that I've met through *Family of a Vet*, it does wear them down because it is endless….But for me, it doesn't, it doesn't wear me down because I feel like I have a sense of purpose when I'm harassing these people.

Amanda is confident about her knowledge of medicine and spoke about the many times she has utilized this information in assisting her husband sort through medication issues and other problems. Her sense of self-efficacy around such tasks may be one reason that she, unlike the other women she mentions, is not worn down by their frequent involvement with the VA healthcare system. While other women chose to leave jobs or school due to the demands of caregiving and consequently had less connection to this aspect of themselves, Amanda finds avenues through her advocacy to strengthen this part of her self-image.

Just as women highlighted some of the ways that their behavior in their relationships seemed to match their expectations for themselves, they also noted elements of their relationships that did not. The narratives of two women in particular, emphasized how little they seemed to recognize of themselves in their relationship. In Kendra's narrative, this began with the way that their relationship developed:

> What's a little bit crazy about it is that he was already in a relationship. So I hesitate to tell the story because it's not like me to do something like that and when I found out he was in the relationship I tried to stop talking to him, but I couldn't because I missed him and it turned into he came down to [Southern City]

> to visit me and never went home again. So we have a little bit of a weird, nontraditional story, kind of, I guess you could say.

Kendra's discomfort with revealing the fact that her partner was still in a relationship when they began dating is clear. She does not imagine herself to be the kind of person "to do something like that" and so, her failure to sever ties with her partner once she learns of his relationship status becomes one of the first ways that her self-concept is challenged by her behavior in this relationship.

As mentioned previously, Kendra reported a lot of disappointment in herself for the way she sometimes responds to her partner. In the excerpt below she shares a recent example of behavior that feels unfamiliar to her:

> So, for example, the other night I went out with friends and when we came back home we had dinner and I was going up to have seconds, and he's like, "You're eating again? We just ate." And I'm taking it the wrong way and thinking, "Well, he's calling me fat." So I'm throwing food across– so I took the sandwich and I like threw it on the counter. Just these outrage like these outrages because my nerves are so stressed and he gets on me. He was just getting on me the other night like, "You are always freaking out about something. Your feelings are always hurt or you're freaking out. You're this. You're that." And I'm not that type of person, well I never was until now that I'm dealing with him, but I'm not. I don't have that kind of reaction typically. And that's something that this whole experience has brought out in me.

Kendra's description of this scene emphasizes how little her actions resemble her typical behavior. She now sees her partner's comment in a different light and views her perspective at the time as the "wrong way" of looking at things. Her explanation for her reaction is the stress and anxiety she constantly feels with her partner, but understanding

the source of her edginess does not seem to diminish her concern about her behavior. When she states, "I'm not that type of person, well I never was until now that I'm dealing with him, but I'm not," her language reflects her uncertainty about whether she should accommodate her image of herself to account for this new pattern of behavior.

Jill also described a disconcerting distance between the way that she perceived herself to be in relationships and the way that she sometimes acted in her relationship. The behavior that was most upsetting to her occurred in the midst of their arguments:

> There are times where I feel so guilty that I have been triggered by his PTSD behavior and I've said stuff. I mean like I have argued with him in a way that I have not argued. I was married. I was in a relationship for 12 years. I am not a name-calling, throw down, kind of person. With what I do for work I have a lot of drama outside. I don't want the drama at home. And so, I think to some extent there's a lot of difficulty for me in, "Why can't we control this better?" or "Why can't I stop the argument before it gets to the point where he's throwing me out?" You know. And I know that there's personal responsibility on both sides. There's so many times I'm like, "What could I have done differently?" or "Why couldn't I just control my trigger so that none of this would have happened?"

In addition to providing another example of the tendency for women to feel guilty when they became involved in arguments with their partners, the passage above underlines how bothersome it is to Jill when she mirrors her partner's verbal aggression. Jill references her profession as a lawyer when she states her preference for avoiding conflict at home, and it feels like she is offering up evidence to prove that the way she has acted with Jesse is not an accurate reflection of who she is. Although, this pattern is disorienting to Jill, the use of the word "triggered" to describe her reaction to her partner reveals one of the

ways she has come to make sense of her reactions: through the lens of her own trauma history. Jill brings up the fact that she experienced childhood abuse several times during her interviews and repeatedly mentions that she experiences "fight or flight" when their arguments escalate and she is "triggered". This suggests that being a survivor of abuse is a salient aspect of her identity that may have been reinforced by the very behavior that has led her to question other aspects of herself.

The fact that two of the women who seemed to be the most bothered by thoughts about the atypical nature of their behavior in their relationships had two of the three shortest relationships with their partners and were the only two women in the sample that were not married is also interesting to note. Perhaps the prominence of this theme in their narratives is related to a more active engagement with the question of whether these relationships are a fit for them as individuals, whereas other women's identities have already shifted to incorporate this type of information about themselves.

He's mine and I'm his.

> I feel like in a marriage there's part of your, there's part of your identity that is with your spouse as well. Like in this partnership, it's, he's mine and I'm his. And so there's a connection there that part of your identity is wrapped up in that. And when you're embarrassed or frustrated, or just damn annoyed (laughs) that part of you and your identity, in that there's animosity and there's so much frustration.

Shannon's description of how her feelings about her husband's behavior have implications for her identity illustrates another theme that was present in women's interviews: the effect of women's relationships on their construction of their social

selves. Most of the women talked in some way about how veterans' behavior or conditions affected the way that they thought others saw them or that they saw themselves in relation to others. Women primarily reported that these effects were related to negative feelings about their partners' behavior or illness classification.

Shannon provided a few examples of times when she noticed that she was very aware of how others might be viewing Jeremy and felt concerned about what that would mean for the way that she was viewed as well. One of Jeremy's most disruptive PTSD symptoms was trouble sleeping. When he would go through long periods of time getting very little sleep, he would become very talkative, his thoughts would sometimes be confused, and he would seem to have trouble picking up on social cues. Shannon recalled what she was thinking the night she took him to a party to meet some of her old friends for the first time:

> I wanted to explain to everyone that this was not him. (laughs) I wanted to explain, "I don't know what's up. He got two hours of sleep last night. It's okay, like, he's not normally like this." I just wanted to… I wanted to give him...I wanted to excuse him. I wanted to make sure that he was excused from any type of judgment that might be going on I guess. And I knew if I was judging him, (laughs) I was like, "Are they? Are they judging him like I am at this point? And am I..." I felt like I wondered if they could see that I was frustrated with him and if that somehow concerned my friends that knew me. "Do they…What is their relationship like if she's frustrated?" (laughs) You know? I don't want to be the nagging wife. I *really, really* don't want to be the nagging wife. But there are many situations where I feel like I could slip into that very, very easily because of this.

Shannon sees Jeremy's behavior in the context of PTSD and connects his lack of social deftness to his sleep deprivation, but is still aware that there is a part of her that is "judging" him. Her concern about what other people may be thinking is not solely focused on their thoughts about him, but extends to what they may be thinking about her, illustrating her earlier statement about a portion of an individual's identity being connected to the behavior of the spouse. In Shannon's case, she very much wants to avoid the label of "the nagging wife." Ironically, her concerns about the way that her husband represents them in certain social environments lead her to act in a manner that is discordant with the way she sees herself as a spouse and she fears this may negatively effect how others view her as well. Shannon's desire to protect her husband from the judgment of others was shared by many women in the study. Several also specified, as Shannon does, that their concerns about others' perceptions were not limited to how the veteran was seen, but extended to how others viewed them. Whether these were worries about being seen as controlling or as "putting up with" too much, these types of thoughts about others' perspectives on them had the capacity to influence the way they see themselves.

Allison similarly voiced feeling embarrassed over her husband's behavior at times, and went on to explain how the context of the situation played a role in her reaction:

> If it's around people that, people we know but we don't know, as opposed to complete strangers in a store or medical staff, that I tend to get more frustrated

> when I'm like we're in- these people are all looking at us. You know. You're affecting- you know we have to deal with these people all of the time so I get more frustrated in those situations. I've really tried to do some working on myself with that. You know it's nice in this area because a lot of people do understand it, whereas, you know if we were somewhere not military affiliated people are going to be like, why is that nut doing that?

For Allison, the most acute embarrassment accompanies her husband's displays of irritability or anxiety in front of acquaintances with whom they interact frequently. These people they know, but do not know well, are probably not aware of her husband's condition and cannot interpret his behavior in that light. She does not finish the thought that begins "You're affecting", but one conclusion is that her husband is affecting her image as well as his own. She acknowledges that she does not like that she has these feelings of frustration with her husband, and that she is less likely to experience them when she is in a military community where people are more understanding of the effects of combat. A few women echoed this idea that those with more exposure to the military were more understanding of the issues that they confronted with their partners. This feeling may be another mechanism in which women's ideas about themselves shift as they choose to surround themselves with the families of other service members and identify more with their military family identity than with their former civilian self.

The stigma associated with PTSD is another factor that may influence women's sense of themselves in relation to others. Stigma came up in many interviews, and while a couple of women reported that they felt that the stigma of PTSD is decreasing as awareness of the condition grows, many women's narratives revealed that they continued

to feel that the diagnosis carries a negative connotation. Elizabeth reported that she had several negative experiences with reaching out to others that had left her feeling very isolated. When asked if she shared her experiences in her marriage with anyone, she stated,

> I tried to, but in the end I was always felt like I was crazy. I lost friends over it. So I quit talking to people. Period. About any of our issues. Because its like as soon as they would get in depth. You know and they're like, "Yeah, I'm there for you," that any time I needed help or needed someone to talk to I could call them, but then when I really started telling em what was going on, they were like, "No, I'm sorry. I don't want to be a part of that." And so you feel outcast. You feel like, that you're not a part of anything. That nobody wants to be around you because your husband has a disease.

Elizabeth's sense of being alone in her experience was especially strong. She describes her husband's diagnosis as something that alienates her from others. The rejection she faces when she is honest about their relationship, leads her to view herself as "crazy" and an "outcast", thereby damaging her self-esteem and her sense of belonging. While other women were less expressive about their own experience with stigma, two of the women who reported the most reluctance to recognize PTSD in their partners admitted to having their own bias against the idea of PTSD prior to their significant others developing this condition. The perception of PTSD as "a weakness" likely played a role in their difficulties accepting that their spouses were struggling with the consequences of trauma as this would then also have implications for their own identities.

Struggles with self-worth and loss of identity.

Women repeatedly used the term "insecure" to describe how they felt in the context of certain PTSD-related behavior. The link between symptoms such as emotional detachment and sexual dysfunction and women's tendency to question their worth as emotional and sexual partners was clear in several women's narratives and has been discussed in regards to intimacy and how it relates to women's depression.

Another way that women's involvement in their relationships left them vulnerable to questioning their worth was connected to their intense involvement with their partners' care. After Lucy's husband began to struggle with more significant symptoms that required one inpatient hospitalization after another, Lucy quit her job and began devoting herself full-time to caring for her husband and children. She applied and qualified for the VA caregiver program, which provides financial assistance and respite services to family members providing a significant level of veteran care. Lucy reported that this help offered substantial relief from the stresses of constant caregiving, but then, despite his worsening condition, they learned a year ago that they would no longer qualify for the program. Lucy has filed multiple appeals, but the assistance is yet to be reinstated and the "battle" to accomplish this has been a great drain on Lucy's time and wellbeing. This backdrop helps put into context the following passage on how her relationship with Chuck has influenced the way she thinks about herself:

> In a lot of ways I have begun to hinge my worth on whether I am successfully caring for him and the children. By all means that's my choice, per se, that's been something I have chosen to do. But it's still something that, with his conditions and with taking care of him, that's one of the reasons that I've battled the depression so badly for the last nine months, is because I can't seem to fix what's happening with our VA situation.

As Lucy's life has centered more and more on caring for her family, her ability to connect with other aspects of her identity has diminished. As a result her sense of her value is tightly intertwined with her role as caregiver. For Lucy, successful care is not just providing for her family's needs but seeing certain results. Watching her husband's condition worsen and being unable, despite significant effort, to have the VA recognize that his problems are connected to the injuries he sustained while in the military, has left Lucy questioning her worth and fighting significant depression.

Robin faced similar challenges in maintaining her sense of value as an individual, but in her case her professional identity was a complicating factor. She describes below how her thoughts about herself were influenced by her care for her partner:

> So, you know, for a long time it was like, "Well, I've put all of my energy and all of my effort into helping this person, into taking care of this person and they're not getting any better. They're getting worse." I'd think, "Nothing's changing." And so I really felt, for a long time, that I wasn't good enough and it was so frustrating because, especially while I was working I was doing really, really good work. I mean really good work. We monitored re-entry into the hospital. We monitored people up to a year later. And my patients were doing amazing. And then I come home and…(sigh) it's like at home, what I really wanted, the person I really wanted to help, was getting worse. So that hit me pretty, pretty hard.

The fact that Robin was a good clinician, whose work with clients was often successful, seems to compound the pressure she feels to help her husband get better. Unlike Amanda, whose confidence in her professional role appears to be reinforced by her involvement with her husband's care, Robin's involvement with her husband's care leads her to question her helping skills. As more of her time and energy are put into Andy's care, her appraisal of her worth comes to be more tied to her partner's health and she is left vulnerable to thoughts of worthlessness when his health worsens. The duty that many women felt to support their partners plays into these sorts of struggles, as the task of supporting a partner can be consuming. The cost to their sense of themselves as valuable individuals apart from the care they provided may have been especially high for Lucy and Robin. As their husbands' conditions became more severe and their risk for suicide higher, both women ultimately felt they must make caring for their partners their focus in order to keep these veterans alive, and sacrificed other aspects of their lives and their identities in their pursuit of that goal.

Recognizing strengths.

In their relationships with their partners, women's identities shifted as they confronted experiences that challenged and reinforced their ways of seeing themselves as individuals and in relation to others. Sometimes this process led them to recognize strengths of which they were previously unaware. Allison expressed that the experience of supporting her husband through his struggles with PTSD had given her self-esteem a boost.

> I think I've got a little bit more since I realized I *do* have a little more patience than I thought and…I think just the fact that I realize how much I do love this man. That I'm not walking away, I'm not leaving. Cause so many people through other outlets I've seen where they get divorced and wives walk away and husbands walk away. And I think it shows that I really love this man and I'm in it for the long haul.

Recognition of the fact that she is honoring her commitment to Tim despite the hard times they have experienced has made Allison more aware of the depth of her feelings for her husband. As her image of herself as a wife expands to account for this new information concerning her level of loyalty to and patience with her spouse, she reports she feels more positively about herself in general. Several women mentioned that their level of patience with their spouses had happily surprised them.

Allison's pride about her ability to stay the course of her relationship was also echoed by several women. However, a few women reported more complicated feelings about some of these same aspects of their relationships. Cathy explained her conflicting feelings about her decision to stay with her husband by saying,

> I'm not really proud of myself sometimes. I thought I was like this really strong woman. You know. All feminist and like if somebody breaks me or tries to break me, I'll just get up and walk away and that will be it. And I didn't do that. But then on the other hand, I'm kind of proud of myself for…you know for muddling through it and doing what I felt was right and trying to make it work.

The same decision, to remain with her husband as he continues to fight problems with PTSD and substance misuse, challenges some aspects of Cathy's identity and strengthens others. Many women discussed this idea that the same behavior had dual meanings and

their interpretation shifted back and forth over time. Cathy's process of examining these conflicting ideas about herself led her to make some changes:

> I think that doing all of this made me realize that I want, I need to do something about myself. I think I haven't been really happy with myself since I, since I just gave up everything and was a wife and a mom. And I knew, I always knew deep down I could do more and I think all of the testing and all of the stuff we went through made me realize I need to do something for myself. I need to be stronger. I need to be more independent. I need to show my kids that going to school is important and getting a career, and being independent and not relying on a guy is important. Even though we're married I want to show my daughter that I'm going to go out and get a career and it doesn't matter what I go through or how old I am. You know, if I want to be a nurse, I'm going to be a nurse. So in some sense it made me kind of disappointed in myself, but then the others you know it makes me proud. Because I did that! We went through like the worst of the worst and we did that. And sometimes I'm proud of our marriage and twenty years and sometimes I wonder how we got through it, how we're getting through it. In another way it makes me…it's just…I don't know. I guess it depends on what kind of day it is to how I feel about myself. (laughs) I'm proud of myself! I know I'm strong!

The challenges that Cathy faced, both related to her son's developmental disability and her partner's PTSD, led her to reflect on what she wanted for herself. She is now on a path that provides opportunities to strengthen her individual identity, but also complements her role as a mother as she is providing her children a positive model through her work to attain her educational goals. She speaks about her new pursuit of a career with pride and determination. While she still admits to the variability in her feelings about herself, recognizing the resiliency she has demonstrated in her relationship seems to bolster her confidence that she can accomplish whatever else she sets out to do.

Shifting Identities in Context

Women's narratives suggested that the influence of their relationships with their significant others on the way they viewed themselves was a complex process that had the potential to effect a woman's sense of identity in both negative and positive ways. Some of the challenges that such relationships present to retaining a sense of personal identity were documented in a focus group discussion of Israeli veterans' wives in which they emphasized that their constant caregiving demands created a pressure to become fused with their partners (Dekel et al., 2005). This was illustrated by statements from the spouse of a veteran who was an artist and whose sculptures had all come to focus on PTSD (Dekel et al., 2005). In the current study, the reduction in time and energy to devote to personal pursuits was particularly clear in the cases of Lucy and Robin, who had quit their jobs and studies in order to focus primarily on the pursuit of their partners' health and to care for their families. In both cases, the severity of their husbands' PTSD had first led to inpatient hospitalizations and after the release from treatment and continued issues with suicidal ideation among other things, they felt that their husbands' survival was dependent on them. These cases illustrate how the challenges to maintaining a sense of personal identity may become more intense as a veterans' PTSD becomes more severe. Previous research has linked the severity of a veteran's PTSD to the severity

of his partner's distress (Beckham, Lytle & Feldman, 1996; Dirkzwager et al., 2005; Calhoun et al., 2002). In this study, the women whose partners were described as having had more significant difficulties functioning (and who usually had PTSD and some combination of TBI, substance misuse, or depression) described themselves as having experienced more distress, supporting previous findings. In addition to the burden of care that such intense symptoms in veterans appear to require, women's loss of a sense of separate identity may also be a source of distress as it was described both by the participants in this sample and in work with wives of Israeli veterans.

Women's struggles with diminished self-worth as a consequence of watching their husbands' conditions worsen despite their dramatic efforts echoes a theme that was noted by Verbosky and Ryan as arising frequently in their analysis of process notes from a therapy group for female partners of Vietnam veterans (1988). They noted that the guilt of women for not being able to improve their husbands' condition was frequently discussed and related to guilt in men for returning home and not being able to save their friends who died in the war (Verbosky and Ryan, 1988). Many women in the current study referenced the guilt that their partners had expressed about events they had participated in during the war and the unfairness of returning home when others did not. Several women also mentioned that their partners struggled with issues of feeling worthless. These themes were particularly clear in Lucy and Robin's descriptions of their husband's struggles with significant suicidal ideation, and these two were also the women who most strongly emphasized their own struggles with self-worth in their narratives.

Verbosky and Ryan's work provides a lens for better understanding the relationship between the struggles of each partner in a couple, and there were indications in the results of this study of a link between veterans' struggles with guilt and worthlessness and their partners struggles to maintain a sense of self-worth.

In addition to the evidence that suggests being involved in a relationship with a veteran with PTSD can create disruptions in identity and have negative consequences for women's perceptions of worth, women's narratives also highlighted the potential for relationships to reinforce valued aspects of identity and lead to positive changes in women's self-image. One area that has recently received increased attention in the research on combat veterans is the potential for posttraumatic growth (PTG). This term refers to positive psychological changes that are the result of an individual's struggle to make sense of his or her traumatic experiences and their consequences (Tedeschi & Calhoun, 2004). Recent research with a clinical sample of 169 veterans of different eras that examined veterans' reports of enhanced perceptions of personal strength along with growth in the domains of recognition of new paths, appreciation of life, and spiritual change, found 69% of the sample endorsing growth in at least one of these areas (Hijazi, Keith & O'Brien, 2015). Israeli researchers have argued that given the level of distress experienced by women in relationships with veterans with PTSD, this same construct is useful in examining "secondary" traumatic growth in this population (Dekel, 2007; Greene, Lahav, Kanat-Maymon, & Solomon, 2015). They have conducted two studies among wives of former prisoners of war in Israel; in the first study, Dekel found a

positive correlation between the level of veterans' distress and both the wives' level of distress and the wives' level of growth (2007). This suggests that those women who report feeling most upset by veterans' behavior may also be presented with the most opportunity for positive change in their perceptions of themselves. Results of the second study provided additional evidence for the potential for overlap between the dimensions of PTS and PTG rather than them being mutually exclusive categories (Greene, Lahav, Kanat-Maymon, & Solomon, 2015). Cathy's explanation of her decision to return to school seems to illustrate these ideas. Her distress about not living up to the "feminist" aspect of her identity is still present, but as she struggles to make sense of the conflict in her values around being a strong woman and being a supportive wife and mother she recognizes new opportunities to embrace neglected aspects of her identity. Her decision to pursue education and employment as a nurse is then framed as reflecting both her image of herself as an independent woman and as a good mother who models self-sufficiency. In addition to personal growth, couples' struggles seemed to create opportunities for growth in their relationships as evidenced by Allison and Elizabeth's comments on the ways PTSD has strengthened their bonds with their husbands.

Concluding Remarks

The experiences of the women in the current sample differed in many ways. One woman had been in her relationship for just over a year, and another for over 20 years. A couple of women's partners had been in inpatient facilities for PTSD treatment numerous

times while others had never received any treatment. However, despite the many differences that shaped their particular stories, all of the participants described PTSD as influencing their lives and their relationships in profound ways. My experiences doing this research provided me with moments of insight into some of those ways.

As I began to meet with women for their interviews, I was given a quick introduction to the unpredictable nature of their situations. In the time between when we were first in contact and we had our first interview, Jill had moved back to her apartment due to suspicions about her boyfriend's infidelity. She was visibly upset in our first conversation as she considered the prospects for their future together, but by the second interview things had settled down and they had just returned from a family camping trip. After listening to Robin's story of her husband's gradual unraveling for over an hour, I noticed my own feelings of hopelessness about her situation emerging. Then as we were getting ready to end our conversation she explained to me that Andy had made significant improvements in the prior six months, was maintaining his sobriety, and she had just returned to working a few hours a week as a therapist in private practice. Listening to women recount their ups and downs, I was struck by the resilience these women had demonstrated in carrying on in the midst of so much uncertainty, often while shouldering immense responsibility for their families.

Another element that was immediately noteworthy was women's openness to sharing their narratives. Participants consistently walked me through some of the most

personal and painful moments in their histories. They were not shy to highlight the times that they stumbled as they made their way down this uncertain path and described these moments with tears and laughter and cursing, providing a glimpse of the many feelings they had experienced along the way. At times sitting with the pain that these women expressed was a challenge, but throughout the research process I felt a sense of honor to be entrusted with these stories, and recognized in my experience a parallel to their responses to listening to their partners' difficult combat experiences. These women had also been fighting battles, and like their partners, they had learned that people do not want to be confronted with the dark consequences of war. They determined they should just keep these things quiet or share them amongst themselves because others' capacities to understand are limited. It was their desire to help other women in similar situations, they explained, that led them to share such private and emotional material with me. Perhaps it was also the desire to be heard. For their willingness to share their stories, I continue to be extremely grateful.

Chapter Five: Conclusion

The Current Study

Although there has been an increase in appreciation for the ways that the experiences of returning veterans can impact their entire families, there has been little research that focuses on in-depth examinations of the lived experience of female partners of OEF/OIF/OND veterans with PTSD. Research with the spouses of Vietnam veterans and with military families in other countries has consistently demonstrated that sharing a life with a partner with combat-related PTSD is associated with significant distress. Phenomenological interviewing methods were employed with female partners of veterans of the Iraq and Afghanistan conflicts to determine how women in the current era experience life as the partner of a veteran with PTSD and to illuminate connections between veterans' behavior and their partners' distress. Despite shifting gender roles, advances in technology and communication, and differences in the nature of the military conflict, many of the primary elements of women's experiences in these relationships appear to be consistent across time and geography. As has been demonstrated in research on previous eras of military families, women described veterans' PTSD as exerting a great deal of influence of their lives and connected their partners symptoms with considerable distress.

Seven distinct themes emerged from women's narratives. These themes were closely connected as they captured women's cognitive and emotional responses to

different elements of their experiences in their relationships, including their efforts to make meaning from and cope with their distress.

The first theme discussed by participants was the struggle to understand PTSD and its influence on their partners and relationships. Women consistently reported confusion over their partners' behavior and how to interpret it, in particular in the early stages of living with PTSD. This confusion was often distressing to women who tried their best to make sense of their experiences of their partners' behavior, often in the absence of information from him. The context of chaotic environments and complex histories only compounded the challenges of this struggle for some women.

The second theme recurring throughout the sample was the "emotional rollercoaster" of living with PTSD. Women described experiencing a variety of intense emotions in response to their partners' PTSD-related behavior. Fear and anxiety were particularly prominent and often associated with women's concerns about the safety of their partners, their children, or themselves. Anger and frustration were frequently mentioned as well and most frequently related to veterans' disregard for the participants' thoughts and feelings. Women also described experiences of depression and sorrow that they tied to their sense of rejection from their spouse or the loss that PTSD symptoms represent. The way they managed these emotions and responded to their partners was related to their own sense of wellbeing.

The third theme that was apparent in women's discussion of their lives with their partners was a pervasive sense of uncertainty. Partner's unpredictable behavior made it difficult for them to know what to expect from a particular day or from the next year. This uncertainty also led women in the study to question whether they were supporting their partners in the best way and to wonder what their future with their spouse would look like.

A fourth theme that emerged in women's interviews was the sense of responsibility women felt to support their spouses. This was described as a duty that sustained them in their confrontation with challenge. They described a number of ways that they supported veterans in managing their symptoms including taking on additional duties in their homes and with their families, sometimes to the point of having difficulty resisting falling into a parental role with their partner. While they derived meaning from the support they provided, women's narratives also highlighted the costs of the roles they played in their relationships.

Impaired trust and intimacy was a fifth theme across women's interviews that had implications for women's sense of emotional and sexual connection with their partners. Most women described challenges with trust arising from problematic communication patterns with veterans, in particular the lack of emotional disclosure. Several women also indicated that they reduced their own level of emotional disclosure in response to veterans' deficiencies in expressing empathy. Sexual intimacy challenges were also very

common in the sample and were tied to veterans' sexual dysfunction, extreme swings in veterans' interest for sex, and secretive engagement in sexual behaviors such as use of pornography. Infidelity was also a concern in relationships that had negative consequences for both sexual and emotional intimacy.

A sixth theme that was present in women's narratives was their "moving forward" via the use of a variety of coping strategies. These included seeking information about PTSD, attending counseling alone or with partners, and sharing their struggles with confidants. A significant obstacle to communicating about their concerns with others was past negative experiences with feeling judged for their choices in their relationships.

The final theme that emerged in the participants' interviews was the way that their experiences led to shifts in their identity. Women discussed a dynamic process in which their images of themselves seemed to be influenced both by congruent and incongruent information about themselves based on their behavior in their relationship and their perceptions of how others viewed them. Intensive engagement with their partner represented a risk for their sense of a separate identity, but relationship challenges also provided opportunities for recognizing new strengths.

The current study contributes to our understanding of the experiences of women in relationships with OEF/OIF/OND veterans with PTSD and the meanings that they attach to these experiences in multiple ways. It is consistent with past literature indicating that living with a veteran with combat PTSD is associated with increased psychological

distress and relationship distress. Women's narratives also provided support for a recent line of research suggesting women's appraisals of veterans are one mechanism for explaining this distress. Women's concerns about determining whether behavior was PTSD-related provide evidence for the idea that women are more distressed by appraisals that behavior is linked to veterans' internal attributes than appraisals that it is a consequence of their experiences. Concerns about which aspects of veterans' behavior were related to PTSD and which were related to their personality were particularly salient for women who met their partners after their military service and therefore did not have a baseline to which to compare their behavior. This finding indicates that an aspect of couples lives that has not previously been addressed in the literature, the timeline of their relationships, may be one factor that influences partners' distress and the dynamics within the couple.

This study adds to the literature on partners of OEF/OIF/OND veterans with PTSD by demonstrating the relevance of ambiguous loss in understanding women's distress in their relationships. Women repeatedly noted the ambiguous presence of their partners through questioning the identity of their partners after the onset of PTSD rendered them unrecognizable at times. The invisibility of veterans' conditions and the intermittent intensification of symptoms seemed to contribute to their difficulties understanding and processing these losses. While Faber and colleagues noted that for families of military reservists returning from deployments the sense of ambiguous presence typically resolved within a couple of months following their return, the

confusion over the veteran's presence was prolonged for many of the partners in the study (2014). Women's narratives also added support to the relevance of caregiver burden as an explanation for some women in this population. Several women described taking on tremendous amounts of responsibility for their families when veterans functioning declined significantly and while they recognized the costs of this care for themselves, they felt they had no other options. However, caregiver burden was not relevant to all participants and appears to be one of several mechanisms that can lead to distress in this population.

One important finding of the current study was that women's experiences were not consistent with the idea of secondary traumatic stress via exposure to veteran's traumatic memories. Women emphasized that veterans' lack of sharing about military experiences was more commonly upsetting to them. They reported appreciating opportunities to support veterans through listening to their stories and thereby coming to better understand their struggles with PTSD. While some women did report some distress associated with hearing about traumas, it was more often connected to concerns about providing the veteran appropriate support than it was focused on disturbing content of disclosures. Women did not describe reflection on these stories as a source of continuing distress, but did talk about feeling empathy for their partner when thinking about these events.

As has been mentioned, the term secondary traumatic stress can also be applied more broadly, to indicate systemic effects of trauma on those close to individuals with PTSD. This study supported the more broad application of this term in that the results provide strong evidence of the idea that women's relationships with veterans with PTSD led them to experience increased distress. Some previous research on partners' distress have emphasized the potential for it to mirror veterans' symptoms, suggesting that PTSD is therefore communicable in some way. Each of the theories outlined in the previous paragraphs posit a particular etiology for partners' distress, but none explain why partners' symptoms may mimic those of veterans at times. Results of the current study point to the role that the family environment plays in the transmission of this distress. Research on combat PTSD suggests that veterans' symptoms often result from their adaptations to the dangerous and unpredictable environment of war. Many women described their lives in their relationships as including elements of unpredictability, confusion, and danger (to either themselves or their loved ones.) Veterans' PTSD-related behavior may lead to disruptions in women's sense of safety, trust, and worth, and consequently, as women adapt to these circumstances they may develop some of the symptoms of anxiety and depression that are typical of trauma-related problems.

Clinical Implications

The results of the current study, while not generalizable to all members of this population, can certainly inform our understanding of possibilities for how women

married to OEF/OIF veterans with PTSD may make sense of their experiences and what their needs may be when presenting to therapy. Women's narratives include a number of themes that are very pertinent to clinical work with this population. Across interviews, women shared the experience of not feeling understood. Many women remarked on the pain associated with the lack of empathy they received from their significant others. The symptom of detachment that is characteristic of PTSD can compromise veterans' abilities in this regard and leave women feeling that their partners do not recognize their thoughts and feelings. Many participants also had trouble accessing support from others whether it was due to past experiences of judgment or out of a sense of protectiveness for their partners. Given these obstacles to the experience of feeling understood, therapy can offer women a valuable chance to share their struggles and to have their experiences acknowledged and validated.

Individual therapy was one of the strategies that women most frequently mentioned was beneficial in managing their distress. As they were often busy providing care for others, women reported having this time to focus on their own needs was valuable. In fact, spending too much of her time talking about her partner and not enough time talking about herself was the reason Diana cited for deciding to discontinue her individual therapy. Diana expected that her therapy would include the chance to talk about her "stuff as well, from [her] family, [her] childhood" and was frustrated by focusing entirely on her relationship. Clinicians working with this population need to create space in the therapeutic work for the recognition of women as whole, multi-

dimensional people. Nearly half the sample volunteered that they had experienced upsetting events in their own lives (such as child abuse, sexual molestation, and parental substance abuse) that had deeply affected them. These narratives highlight the importance of attending to the complexity of women's histories in individual therapy in order to help women to better understand their struggles in a larger context. Other women expressed concern about losing their sense of individual identity apart from their roles of wife and mother as more and more of their time was absorbed by caregiving. Approaching clinical work with an openness that allows for the exploration of identity and its intersections with the many aspects of women's lives can help stabilize women who are at risk of feeling overwhelmed by the needs of others. Therapy that prioritizes empathy, acceptance, and curiosity can help women to make sense of their experiences in a way that promotes their growth and builds awareness of their resiliency.

In addition to highlighting the importance of an attuned therapeutic space, women's narratives speak to some of the common concerns that clinicians working with this population should be prepared to address in treatment. Women reported experiencing considerable distress as a result of their confusion about the nature of PTSD and how it may or may not affect veteran behavior, which indicates that psychoeducation on this topic may be an important component of interventions with this population. A better understanding of this complex condition may help a woman to appraise her partner's symptoms differently and to connect withdrawal and numbing to his illness rather than seeing these behaviors as a reflection of the veteran's feelings for her. Shannon reported

that covering this material with her therapist was enlightening, and that although she did not retain all the details of the explanation, it rendered some of her husband's behavior less mysterious and therefore, less distressing. For some women, gaining perspective on their own attachment style may provide another important piece in helping them understand their reactions to veterans' withdrawal. For example, Kendra had educated herself about PTSD and logically knew that her partner's periodic lack of affection and attention fit the symptoms of this disorder, but she still experienced these as rejections that escalated her anxiety. In his work at the Menninger Clinic, psychologist Jon Allen advocates for educating patients on attachment processes in the course of "plain old therapy" to help them make sense of and improve their interpersonal relationships (2013). He suggests that patients can learn through receiving information about this model and, most importantly, through the clinician's attention to and transparency about attachment processes unfolding in the therapy room (Allen, 2013). Recognition of her own attachment style and of her partner's behavior as triggering natural attachment processes, might help Kendra to view their interactions differently and ultimately be less distressed by them.

Attending to the intense emotions that women reported experiencing in response to veterans' symptoms, is likely to be an important component of clinical work with this group. Several women in the sample expressed significant anger or resentment about their situations. Because women sometimes feel guilty about entertaining negative feelings toward their ill partner, women may need to be given permission to express the

anger that is often associated with feeling unappreciated or rejected by the spouse despite their efforts to "hold it all together". Another common experience that women reported was depression or sorrow resulting from the ambiguous loss of the partner or from internalizing responsibility for the partner's health. Helping the female partner to recognize and process her grief over her loss may be another important treatment goal. For women struggling with issues of self-worth because of their relationship dynamics, encouraging women to recognize their strengths is also valuable. Women mentioned feeling proud about aspects of their identities that had helped them maintain their commitments despite the difficulties they had faced and enhancing these positive feelings about the self can serve to diminish self-blame. Lastly, women experiencing intense feelings of fear and anxiety related to veteran behavior may benefit from learning coping skills to manage these experiences. Allison reported that learning deep breathing techniques from her therapist was very useful for her in learning to calm herself down when she was distressed.

The extent of the interpersonal problems that the participants described indicates the value of utilizing couples treatments with this group. In this case, clinicians should be cautious not to let the treatment encounter be completely dominated by the veteran's suffering, and ensure that a partner has the opportunity to be heard as well. Couples therapy may be expressly pursued to attend to relationship functioning, or as a primary means of targeting PTSD. In the former case, a variety of approaches may be useful depending on the veteran's presentation and the couples' most pressing concerns, but of

central importance is the therapist's attention to some of the dynamics that women touched on in their narratives. For example, the pattern of overfunctioning by the wife to compensate for underfunctioning by the veteran can be a considerable source of psychological distress for the female partner and relationship dissatisfaction for both partners, however this may also be a stabilizing pattern that reinforces veteran dysfunction. Women's narratives suggest that these patterns may be perceived to be necessary for the functioning of the family, and therefore an empathetic approach to increasing the couples awareness of this dynamic may play an important role in beginning to shift responsibilities in the relationship. While there is considerable overlap between this idea and the recently adapted concept of partner accommodation, even women who are not taking on many additional responsibilities, may be changing their behavior to avoid upsetting their significant others. If it appears to be problematic for the couple, this pattern is also important to address and clinicians may want to explain exposure-based principals for anxiety extinction and the evidence for the link between higher levels of partner accommodation and reduction in relationship satisfaction in both members of the couple. Highlighting this additional information may be helpful in such conversations as women's narratives illustrate that behavioral accommodations are typically made in order to support veterans.

Evidence for the delivery of PTSD treatment in dyads is also mounting and based on the participants in this study, female partners appear to be interested in involvement in veteran care and in enhancing their skills to support their partners effectively. One

recently developed approach that appears to match well with women's reported concerns about veterans' struggles with empathy, communication, and intimacy is Structured Approach Therapy. Created specifically for couples that include a veteran with PTSD, this manualized treatment draws from an attachment perspective in emphasizing the crucial roles of empathy and emotion regulation in communication between members of the couple (Sautter, Glynn, Cretu, Senturk, & Vaught, 2015). Emotional disclosures build in intensity over the course of treatment to a point where veterans are encouraged to communicate about their trauma experiences with their partners in the sessions (Sautter, Glynn, Thompson, Franklin & Han, 2009). Treatment targets include a reduction of veteran's PTSD symptoms and improvement in intimacy in the couple, and recent trials indicate early successes on these outcomes (Sautter, Glynn, Cretu, Senturk, & Vaught, 2015).

The experiences of the women in the study are also instructive for clinicians working primarily with veterans with PTSD in individual treatment. They demonstrate the significant interpersonal consequences of this condition, which can often be overlooked in the context of a therapy room. Frontline cognitive behavioral treatments for PTSD do encourage veteran to increase engagement with others, however, in the course of the work being done to process traumas or approach avoided behaviors in a relatively short amount of time, clinicians may not attend to how the veteran's symptoms are affecting his relationships. The process of disclosing to the therapist and feeling supported and understood can be a great model for the veteran who struggles to trust in

others, however, if there is no discussion about how to transfer these skills to his closest relationships, this opportunity may be lost. To encourage the recognition of the veteran as a whole person who exists within a network of relationships, clinicians should consider the inclusion of periodic conjoint sessions with the partner. The women in the sample who had participated in such sessions found them extremely helpful as a way to express their concerns to the treatment team (sometimes about behavior that veterans were not disclosing), to gain more understanding of PTSD, and to have a space to safely communicate their perspectives to the veteran. Such involvement ultimately allows women to be better equipped to support veterans in positive ways and to encourage their recovery.

Finally, given the prevalence of intimate partner violence in this population, screening should be a priority for clinicians that have any clinical contact with female partners of veterans with PTSD. If a woman does reveal concerns for the potential of violence, clinicians should be prepared to assist her in the creation of a safety plan for her and her family and to provide relevant local resources.

Policy Implications

The results of the current study point to the importance of recognizing the effects of combat trauma on the entire military family, not just the veteran. Women's narratives clearly illustrate the potential for relationships with veterans with PTSD to have costs for partners' health and wellbeing. Consequently ensuring that women in relationships with

veterans have access to the appropriate support services should be a priority for governmental agencies. VA medical centers typically only offer services to partners if they are seen in group or couples therapy or in conjoint therapy sessions targeting veteran's health. Vet Centers are more likely to offer individual counseling for partners or groups services for this population, however, the women in the study who reported involvement with counseling had either accessed services through military-serving non-profits (i.e., Give and Hour and Wounded Warrior Project), their private health insurance, or through private-pay providers. Some participants did not appear to be aware of what types of services were available to them or where to access appropriate services. The VA has made recent efforts to address the needs of partners and other family members who support veterans through the establishment of the Caregiver Support Line and appointing Caregiver Support Coordinators at VA medical centers. The expansion of services at these facilities is an important first step, but there appears to be the need to continue to educate military families about the services that are available to them, to strengthen relationships with military-serving non profit organizations to ensure that they have the resources needed to serve this population, and to expand efforts to educate community providers about military culture, PTSD, and issues that may be pertinent in working with this population.

The *Caregivers and Veterans Omnibus Health Services Act of 2010* established that additional services should be available to seriously injured post-9/11 veterans and their family caregivers. The benefits associated with the Comprehensive Assistance for

Family Caregivers Program that resulted from this legislation include financial assistance, access to mental health services and medical insurance for those who qualify for the program. This has been an important advancement in the recognition of military caregivers; however, of the participants in the study only two participants reported applying for these benefits and their experiences illustrated problems with this process. After quitting her job to focus on her husband's care Lucy applied and initially qualified for the program, but after receiving assistance for a period of time was informed her husband no longer required her care and was abruptly discharged from the program. The stress of the appeal process, including the challenge of communicating the contradictory information she received from her husband's medical providers that he husband does continue to require constant supervision to officials and the failure of her attempts to reinstate their assistance, has significantly contributed to her depression. Robin reported that when she applied for the program after quitting her job to care for her husband, she was informed that because of her role as a professional caregiver she did not qualify for assistance. These stories suggest that legislation alone is not enough to ensure that families receive the support that they need, and that the implementation of such policies should be frequently reviewed in order to make sure that the individuals they were designed to help are actually benefiting.

In addition to improving access to appropriate healthcare services and financial support for families, results of the study highlight the importance of promoting an atmosphere at VA medical centers that is welcoming to family members of veterans who

are involved in their care. Partners of veterans can be valuable resources in improving the health of veterans with PTSD, and some of the women in the study expressed how helpful it was to their families when they were able to be involved in their partners care. However, some of the women who shared their experiences with advocating for their significant others reported that despite veterans' desire for them to be involved in their care, medical providers were reluctant to communicate with them or involve them in treatment planning. I have personally observed an attitude among some VA clinicians of viewing veteran partners as nuisances rather than resources and believe that system-wide attention to this issue is necessary in order to ensure that the culture of VA medical centers are open to those who veterans want to be involved in their care.

Limitations and Future Directions

The current study has focused on the narratives of a small group of women in committed relationships with OEF/OIF/OND veterans with PTSD in order to provide a rich description of the meaning of this experience for these women. Participant's narratives have been brought into conversation with one another and with previous research on this topic; however, the small size and the lack of racial diversity within the sample may limit the generalizability of the results. With the military continuing to diversify in multiple ways, future research on this topic is needed in order to determine if there are important differences in the way partners of other racial or ethnic backgrounds,

males partners of female veterans, same sex partners, and dual military couples that include a veteran with PTSD understand their experiences.

Results of this study suggest that women's appraisals of veterans' behavior have significant implications for their distress. Focused study of what factors influence these appraisals may be helpful. In particular, how a veteran's communication about military traumas may influence the way that a female partner appraises his PTSD-related behavior. Given the findings of this study that the experience of ambiguous loss is also tied to women's distress, larger scale studies are warranted to determine the usefulness of this construct in clinical work with this population. In addition, the chronicity of this confusion around veterans' ambiguous presence suggests the importance of investigating factors that may help women to resolve this loss, for example, whether therapeutic treatments or educational interventions are effective in this regard.

The results of this study also suggest the importance of increased attention to the ways that PTSD effects veterans' abilities to connect to partners through emotional and sexual intimacy. The prominence of problems with sexual intimacy among the women in this sample reinforces recent research suggesting that problems with sexual functioning or compulsive sexual behavior are likely underreported by veterans. Additional research to identify the prevalence of these issues and develop effective clinical interventions would be beneficial in reducing relationship distress in this population.

Although the results of the study highlighted the significant challenges that partners of veterans with PTSD often face, women's narratives also included examples of ways in which the struggles that they had experienced in their relationships had led to opportunities for personal growth and strengthened bonds between themselves and their partners. Research which seeks to clarify the factors that are associated with these outcomes is needed. A better understanding of how these positive changes can be promoted would be valuable in meeting the clinical needs of this population.

Appendix A

Interview Guide

First Interview:

The goal of the first interview in the series will be to collect background information that helps to create a context for the participant's experiences with her partner's PTSD. The researcher will ask open-ended questions that encourage the participant to share as much as possible about her life up to the present as it relates to her experiences of being the partner of a veteran with PTSD.

Can you describe any familiarity you had with the military or veterans prior to your partner?

How did you come to be in your relationship?

Tell me about your relationship with your partner before his deployment(s) to OEF/OIF/OND?

What was the deployment experience like for you?

What did you know or think about PTSD prior to your partner's development of this disorder?

Second Interview:

During the second interview the participant will be asked to reconstruct concrete details related to the topic being investigated with a focus on the detailed description of her experience as the partner of a veteran with PTSD.

Please describe how your daily life is affected by your partner's PTSD symptoms.

Can you describe a specific interaction with your husband that you believe was shaped by your partner's PTSD? Please include the thoughts and feelings you remember having during the interaction.

Can you think of a time that your partner has shared details about a combat event that is associated with his PTSD? If so, can you describe what the experience of hearing about the trauma was like for you?

How do you think his PTSD has influenced your relationship? Your sense of emotional or physical intimacy? (Added after first 4 interviews)

Has your partner's condition changed the way you think or feel about yourself? If so, how?

How would you describe the role you play in managing your partner's health and well-being and how you feel about that role?

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