A Female Spouse/Intimate Partner Perspective

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ABSTRACT The purpose of this qualitative study was to identify perspectives of female spouses/intimate partners regarding posttraumatic stress disorder (PTSD) in returning Iraq and Afghanistan combat Veterans. Through the use of a self-administered questionnaire based on Flanagan’s critical incident technique, reports were obtained from a purposive sample of 34 spouses/intimate partners of Veterans recruited through a social group for military spouses and a university in southeastern North Carolina. Two-thirds of the participants reported not having received formal education about PTSD. The main perceived barriers to PTSD treatment seeking were denial of symptoms, fear, and stigma about disclosing PTSD symptoms. Spouses/intimate partners observed Veterans for changes in behavior and routines, disturbed sleep patterns, and nightmares. In the event of PTSD treatment resistance, spouses/intimate partners reported they would suggest the need for treatment, issue an ultimatum, take action, or offer patience and support without taking any action.

INTRODUCTION

The unique combat circumstances in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq pose substantial mental health challenges to American service men and women. Wars in both regions include the use of improvised explosive devices (IEDs), high rates of blast exposures, multiple tours of duty that are longer in duration, and shorter intervals between deployments. In addition, many Veterans are surviving combat injuries due to advances in military technology. Battlefield medical advances are also responsible for high rates of survival. As this generation of Veterans returns home from duties in Iraq or Afghanistan, many will face the physical and psychological after-effects of their combat experiences. Despite the military’s increased responsiveness to mental health needs this past decade, rates of psychological difficulties among returning OEF/OIF Veterans remain high. Research suggests that posttraumatic stress disorder (PTSD) is one of the most prevalent mental health disorders afflicting combat Veterans returning from current military deployments in Iraq and Afghanistan. A major problem affecting Veterans with PTSD is the lack of health care utilization. The stigma surrounding this disorder, the threat of a ruined military career, and other barriers such as access to care and services, often prevent military personnel who are in dire need of PTSD treatment from receiving the care they need. Of the OEF/OIF combat Veterans diagnosed with mental health disorders, including PTSD, only 23 to 40% receive mental health care.

Since the spouses or intimate partners of OEF/OIF Veterans may play a potential role in facilitating combat Veterans’ engagement in mental health treatment, there is a need to better understand their perspectives and actions in this regard. Very little research has been directed toward identifying specific strategies or actions used by spouses/intimate partners in the recognition of PTSD symptoms or the initiation of PTSD treatment. Because of the important role that social support plays in promoting recovery from trauma, this information is useful for planning early intervention strategies that incorporate spouses/intimate partners.

The purpose of this study is to determine the perspectives of spouses/intimate partners regarding PTSD in returning OEF/OIF combat Veterans. Specific aims include (1) examining the sources and levels of PTSD knowledge of spouses/intimate partners of military combat Veterans, (2) identifying strategies that spouses/intimate partners would use to recognize PTSD symptoms in a combat Veteran, (3) examining methods that spouses/intimate partners would use to determine a Veteran’s readiness for PTSD treatment, and (4) identifying behaviors for facilitating Veteran access to mental health care.

Literature Review

A growing body of literature links combat duty in Iraq and Afghanistan to the development of post-deployment mental health problems, particularly PTSD. Studies of OEF/OIF combat Veterans have shown that the rates of PTSD are higher in deployed soldiers, compared with non-deployed soldiers. A series of large-scale studies of PTSD prevalence in OEF/OIF Veterans reports widely varying rates from 9% to 38%. In a study of over 2,800 soldiers deployed to Iraq, 16.6% met the criteria for PTSD. Strong associations were found between PTSD and more sick call visits, lower ratings
of general health, more physical symptoms, more missed workdays, and increased number and severity of symptoms.\textsuperscript{14}

The severity of PTSD symptoms has been associated with serious combat injury as well as the intensity of combat exposure.\textsuperscript{6,13} Research also suggests that PTSD often develops months after exposure to trauma.\textsuperscript{11} Increasing rates of PTSD symptom severity overtime highlight the persistent effects of OEF/OIF combat exposures and emphasize the need for continued post-deployment care.\textsuperscript{6,13}

Studies of OEF/OIF combat Veterans have generally shown that trauma exposure and PTSD increase the need for mental health services in combat Veterans, but that mental health services are not utilized as often as necessary.\textsuperscript{24,16,17} In an early study following deployments to Iraq and Afghanistan, only 23 to 40\% of combat Veterans who screened positive for PTSD sought mental health care.\textsuperscript{4} When researchers examined the rates of mental health care utilization among active duty and National Guard soldiers with mental health problems at 3 and 12 months following combat in Iraq, they found that active duty soldiers had significantly lower rates of service utilization and higher ratings of mental health stigma than did National Guard members.\textsuperscript{18}

Substantial barriers to the treatment of psychological distress, including PTSD, have been identified in combat Veterans returning from Iraq and Afghanistan, including stigma, mistrust, and poor access to care.\textsuperscript{4} Additional barriers to receiving health care include the fear of being perceived as weak, lack of information or access to services, and the eagerness to return to life as it was predeployment.\textsuperscript{4}

Research on spouses/intimate partners of combat Veterans with PTSD has traditionally focused on the impact of PTSD symptoms on marital or partner relationships or social and psychological outcomes.\textsuperscript{19,20} In an overview of recent research, strong associations between PTSD in combat Veterans and relationship problems with spouses/intimate partners, including marital instability, decreased relationship satisfaction, and high levels of caregiver burden, were identified.\textsuperscript{21} Research also indicates that spouses/intimate partners of Veterans with PTSD are at greater risk for aggression and interpartner violence than spouses/intimate partners of Veterans without PTSD, with reported rates up to three times higher than that for civilians.\textsuperscript{22,23} Additional research indicates that PTSD symptoms in a returning combat Veteran have a disruptive effect on the psychological well-being of spouses/intimate partners.\textsuperscript{24,25}

A growing body of research suggests that involving intimate partners and close family members in PTSD treatment can potentially lead to decreased interpersonal stress and improvements in PTSD symptoms.\textsuperscript{2,21} For example, researchers conducting a pilot study found that cognitive-behavioral couples' treatment proved effective in the treatment of PTSD.\textsuperscript{26} Seven couples participated in this study, which recognized that a couple's behavior and belief systems interact, and can reciprocally reinforce relationship discord and PTSD symptoms. Upon completion of the treatment, clinicians and partners reported that Veterans had substantial improvement in their PTSD symptoms. Veterans, however, reported less dramatic improvement in their PTSD symptoms. Another small study found that a 10-session, couples-based treatment named "Strategic Approach Therapy" was associated with reductions in partner, clinician, and Veteran ratings of PTSD symptoms.\textsuperscript{27}

Although research has focused on the perspectives of spouses/intimate partners of combat Veterans with PTSD, their role in the recognition of PTSD symptoms and their behaviors and actions in facilitating engagement in mental health treatment has been relatively overlooked. One exception is a recent study of 10 Vietnam Veterans with PTSD who were participating in a PTSD recovery program and their female live-in partners.\textsuperscript{28} Through the use of semi-structured interviews, the researchers identified key themes regarding attitudes toward participation in family mental health treatment for PTSD. Respondents noted potential benefits of services such as improved relationships and enhanced understanding of PTSD, but also described fears about treatment. These included Veterans' concerns about worrying their partners on the seriousness of their condition and the partner's wishes to avoid pressuring Veterans to address their problems. The authors used the findings to propose recommendations for increasing treatment engagement for couples struggling with PTSD.

While previous studies have focused on spouses and their intimate partners affected by PTSD, no studies to our knowledge have examined the attitudes of spouses/intimate partners towards and knowledge of PTSD before a diagnosis is made. Given that spouses/intimate partners may be the first to notice and might have a strong influence on whether a Veteran seeks treatment, it seems important that they have accurate information about the disorder and warning signs, and begin to plan strategies for communicating any concerns with their Veteran loved ones. This study purports to examine the perceptions and knowledge of PTSD among spouses/intimate partners to help inform the development and implementation of effective educational and therapeutic services for both partners.

**METHODS**

A valid and reliable qualitative research method, the critical incident technique developed by Flanagan,\textsuperscript{29} was selected as the research methodology for this study. Flanagan's research methodology has been effectively used by health services researchers to identify patient behaviors related to critical health outcomes\textsuperscript{30,31} and determine patient experiences in health care settings.\textsuperscript{3,5} In this study, critical incident interviews were used to identify specific behaviors and strategies used by spouses/intimate partners related to PTSD in combat Veterans.

The critical incident technique is essentially a classification method consisting of systematic, organized procedures for collecting descriptions of behaviors causally linked with outcomes.\textsuperscript{3,5} The primary aim of this methodology is the development of a classification system or taxonomy that can be used for finding solutions to practical problems or for determining the prevalence and distribution of critical behaviors.\textsuperscript{3} This practical and efficient method for obtaining data helps
participants be as specific as possible in describing specific incidents from memory and to include all relevant details. Critical incident questions are designed to pinpoint facts and eliminate personal opinions or generalizations. They are used to increase knowledge about little known phenomena and require only simple types of responses and judgments from the participants. Data can be gathered through a variety of structured or unstructured methods including face-to-face interviews or self-administered questionnaires. According to Flanagan, incidents from memory can be recalled to provide adequate data. Only simple types of judgment are required from the observer and only reports from qualified participants are included. Observations become fact when a number of independent observers make the same report.

Evidence regarding the accuracy of reporting is contained within the incidents themselves. When full details are given, it can be assumed that the information being recalled by the participants is accurate; vague reports that lack detail suggest that the incident is not well remembered and may be incorrect.

**Participants**

Study participants were recruited through a social group for military spouses and intimate partners and also through a Veteran’s organization for students and their spouses at a university in rural southeastern North Carolina. Criteria for admission into the study included (a) being a spouse or intimate partner of a combat Veteran deployed to Iraq or Afghanistan and (b) the ability to read and write English. Spouses or intimate partners of a military service Veteran who was not deployed to Iraq and Afghanistan were excluded from the study. The study was approved by the Institutional Review Board at the University of North Carolina, Wilmington.

**Instruments**

A demographic questionnaire inquired about age, gender, the length of marriage or relationship with the Veteran, the number of times that the Veteran was deployed to Iraq or Afghanistan, and sources of information about PTSD. The open-ended self-administered critical incident survey consisted of the following questions: (1) How would you know if your spouse/intimate partner needed treatment for PTSD? (2) What behaviors would indicate that your spouse/intimate partner is willing to receive treatment for PTSD? (3) In the event that your spouse/intimate partner needed treatment for PTSD but resisted seeking or going to treatment, what would it take on your part for you to get him/her into treatment? Respondents were also asked to identify reasons that their spouse or partner might give for not seeking PTSD treatment.

**Procedure**

Research packets containing a cover letter inviting study participation, a demographic data sheet, and a critical incident questionnaire were distributed to a total of 100 potential participants through the mail and also from a stack available to the social group. Those who elected to participate in the study were instructed to record their responses on the critical incident survey and to return them by mail via prestamped envelopes. A total of 36 questionnaires were returned. Two questionnaires that were completed by participants who did not meet the inclusion criteria were deleted from the analysis, leaving a final total of 34.

**Data Preparation and Analysis**

Statistical Package for the Social Sciences (version 16.0, SPSS Inc.; Chicago, Illinois) was used to assess the demographic characteristics of respondents. The narrative data obtained through the written surveys were analyzed through an inductive classification process developed by Flanagan. During the first phase of data management, the narrative critical incidents were reviewed by two members of the research team and a critical incident methodology expert who made a determination about which incidents should be included in the analysis. Only incidents that met the following criteria described by Flanagan were included in the analysis: (1) an incident must include a description of a single behavior or strategy, (2) an incident must refer to the behavior of a specific person, (3) another person must be able to understand what is going on, and (4) unstated inferences do not have to be made. Incidents that were vague or lacked detail were discarded.

Two separate teams of researchers conducted an initial sort of the incidents. Incidents that were judged to be nearly identical or very similar were grouped together. Similar groupings were combined to form subcategories of behaviors. Subcategories were sorted and grouped together to define more inclusive major categories. Categories were then modified and redefined through a repeated sorting process until all the incidents were classified. A review of the incidents within each category determined the definition. The teams of researchers resorted the incidents and their discussion was used to refine and determine the final set of mutually exclusive and exhaustive categories for each question. The reliability of the categories was determined through a final sort. After the final listing of categories was identified, the 4 researchers resorted all the written incidents by category. Percentages of agreement between the researchers were calculated for each critical incident analysis. As an estimate of the importance of each category, the number of incidents sorted by the researchers were counted and placed into a hierarchical structure, or taxonomy that identified categories and their related frequencies.

**RESULTS**

**Demographic Characteristics**

A total of 34 spouses/intimate partners of military combat Veterans deployed to Iraq or Afghanistan participated in this study. The all-female sample had a mean age of 35.7 years (range = 29–40 years) with an average length of marriage/relationship of 12.8 years (SD = 8.35). The average length
of time spent apart as a result of military deployments was 30.8 months (SD = 23.5), with a range of 0 to 84 months. Approximately 53% of the Veterans had been deployed to Iraq or Afghanistan at least 1 time, with the average number of deployments of 1.7 times (SD = 0.77). Two participants (5.9%) were on active duty military status when the study was conducted (see Table I).

**Spouse/Partners Sources of PTSD Training and Levels of PTSD Knowledge**

Seven participants reported that they received formal PTSD training through military sources including post-deployment training (n = 3; 9%), workshops/training materials provided to family members by the military (n = 2; 6%), and family-team building during a return home briefing (n = 2; 6%). Three additional participants reported that they learned about PTSD through college courses (n = 3; 9%). Two-thirds of the spouses or intimate partners reported that they had not received training on PTSD.

The majority of spouses or intimate partners learned about PTSD through informal sources. The media was identified as a primary information source by eight respondents (24%). As one participant stated, "Most of what we know comes from news broadcasts, the movies, or the Internet." Six participants (18%) reported learning about PTSD through a personal experience or from friends and family members diagnosed with the disorder. They offered the following:

I once dated a guy who eventually was diagnosed with PTSD and it explained so much once that happened. He had just come back from Iraq and was really a great guy at first. Then he changed. He would make plans and not keep them. He became an alcoholic and got into a car accident and got a DUI [driving under the influence]. He would sleep a lot and complained about headaches and had nightmares.

I learned a lot about PTSD through a personal experience that occurred prior to meeting my husband. I received extensive therapy and was diagnosed as having PTSD during that time.

I've learned so much about PTSD as I go with my spouse through treatment.

Three participants obtained PTSD information from their spouses or other active duty members. One participant stated:

The little bit of knowledge that I have about PTSD comes from listening to other spouses and service members who make comments about PTSD. I know that there are a lot of wives who go through a lot because their spouses have PTSD.

When participants were asked to describe their knowledge of PTSD, seven participants (21%) correctly identified the causes of PTSD. Seven participants listed one or two key symptoms, whereas eight participants (24%) accurately described 3 or more symptoms. Four (12%) acknowledged they knew very little about the symptoms of PTSD.

**Perceived Barriers to PTSD Treatment**

When participants were asked to list perceived causes for Veterans not seeking PTSD treatment, the most frequently mentioned causes included denial of symptoms (n = 25, 29%), stigma surrounding PTSD (n = 20; 23%), and fear of harming a military career (n = 18; 21%). Reported reasons for Veterans not seeking PTSD treatment are presented in Table II.

**Critical Incident Analysis**

**Spouses/Partners' Strategies for Identifying PTSD**

A total of 60 incidents describing strategies for identifying PTSD in their Veterans were generated through the self-administered questionnaire. All 34 participants responded to this question, providing a mean response of 1.8 incidents. When the incidents were analyzed, five major categories emerged. After the categories were identified, all raters were unanimous

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35.68</td>
<td>7.63</td>
<td>20–49 years</td>
<td>34</td>
</tr>
<tr>
<td>Length of Marriage/Relationship</td>
<td>12.77</td>
<td>8.35</td>
<td>2–36 years</td>
<td>34</td>
</tr>
<tr>
<td>Length of Time Apart due to military deployment</td>
<td>30.82</td>
<td>23.46</td>
<td>0–84 months</td>
<td>33</td>
</tr>
<tr>
<td>Number of Times Veteran has been Deployed</td>
<td>12.44</td>
<td>5.98</td>
<td>6–24 months</td>
<td>34</td>
</tr>
<tr>
<td>Active Duty</td>
<td>2 (5.9%)</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Nonactive Duty</td>
<td>32 (94.1%)</td>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Spouse/Partner PTSD Training</td>
<td>Yes (29.4%)</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>No (70.6%)</td>
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<td>24</td>
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in the classification of 95% of the incidents. The taxonomy of strategies is presented in Table III.

Major categories of spouse/partner behaviors included watching for changes in everyday habits and behaviors, observing for physical changes, paying attention to mental state, feeling that I wouldn’t know what to look for, and waiting for my spouse/partner to tell me he has PTSD. The largest category, watching for changes in everyday habits and behaviors, accounted for 26 incidents (43%). As one participant stated, “I’d watch for unexpected behaviors, like jumping up and slamming doors or any other unusual behavior...differences in behaviors would be the biggest sign.” Other participants added:

My spouse has very predictable patterns of behavior. If any of those were to change, I’d suspect PTSD. That would be the red flag for me.

...If any of his behaviors were extreme or lasted for a long time. For example, when my husband returned home, my daughter dropped something in the dining room and it made a loud noise. My husband, who was asleep upstairs, was down the stairs and in the dining room before I made it from the living room.

I’ve already recognized the changes in his behaviors, the distancing between [him] and the family and the emotions when he discusses his experiences.

The second largest category, observing for physical changes, included 26% (n = 16) of the incidents. Disturbed sleep patterns and nightmares were mentioned most frequently. As one participant stated, “If I witnessed him having a nightmare, I would consider PTSD.” Other physical signs that spouses/intimate partners observed in their Veterans included “sleeping too much,” “having insomnia,” “not eating,” “having an increased heart rate,” and “sweating.”

Behavioral incidents in the third largest category, paying attention to changes in mental health, reflect the increased psychological risk that Veterans with PTSD experience. Incidents placed in this category related to “having flashbacks” or “hyper-arousal.” Others include the following:

If he began having mood swings or became very nervous in certain situations...that would be red flags for me.

My spouse would need treatment for PTSD if he had outbursts of anger, suffered from depression, became physically abusive, or became addicted to alcohol and drugs.

A fourth category, feeling that I wouldn’t know what to look for, accounted for 5% (n = 3) of the total number of incidents, whereas the fifth category contained incidents that described the behavior of waiting for my husband to tell me he has PTSD (n = 2; 3%).

Identifying Veteran’s Readiness for PTSD Treatment

A total of 45 critical incidents described strategies that spouses/intimate partners use for identifying readiness for PTSD treatment in a Veteran. All 34 participants responded to this question, providing a mean number of incidents at 1.3. When the incidents were analyzed, three major categories of behaviors were determined. After the three major categories were identified, all raters were unanimous in the classification of 100% of the incidents. The categories included listening for an acknowledgement of PTSD, observing a Veteran collecting PTSD information, and, recognizing a disinterest in things going on around him. The taxonomy of spouse/partner behaviors is presented in Table IV.

The largest major category, listening for an acknowledgement of PTSD, accounted for the majority of incidents (n = 37; 82%). More than one half of the incidents placed within this category (n = 19) reflected listening for a Veteran’s expressed concerns about behavior changes or symptoms. As one of the participants wrote:

My spouse began talking to me about the problems that he is experiencing and admitting that the problems are serious. He admitted that he has a problem with insomnia and nightmares and talked to me about the possibility of him suffering from PTSD.

A second participant shared the following:

My spouse would recognize that his life is not the same as before he deployed to war and begin talking to me about all of the symptoms that have changed him. He told me he doesn’t like life as it now is and has expressed the need to change. I believe because he recognizes the problem, he is more willing to find help.
The second largest sub category within this major category involved listening for an expression of concern about the effect of PTSD on the children or the family (n = 8; 22%). As one participant stated:

If my spouse felt that his behavior was causing the quality of our family’s life to deteriorate, he would try to talk to me about it and that would be an indication to me that he was ready to seek treatment.

A third largest subcategory contained incidents that described waiting for the Veteran to ask for help in scheduling PTSD treatment (n = 6; 16%), while 8% (n = 3) of the incidents involved recognizing an openness to concerns about PTSD. An additional incident described hearing a Veteran express approval of coworkers with PTSD who seek treatment.

Behavioral incidents in the second largest major category, observing a Veteran collecting PTSD information, reflect an effort on the part of the Veteran to learn about the disorder (n = 4; 60%) focused on observing a Veteran’s efforts to obtain research information on PTSD through the Internet or via printed materials. Additional incidents placed in this category included talking to other Veterans about their PTSD (n = 1; 16%) and attending PTSD briefings sponsored by the military (n = 1; 16%).

The third major category, recognizing a disinterest in things going on around him, or general unresponsiveness, accounted for 4% (n = 2) of the total number of incidents. Both the incidents placed within this category reflect the increased potential for depression in war veterans.34 As one spouse wrote, “Total apathy towards everything might indicate that my spouse was at a point where he would accept treatment.”

Spouse/Partner Behaviors if Veteran Resists Treatment for PTSD

A total of 58 critical incidents identified behaviors that spouses/intimate partners would use if their Veteran resisted seeking PTSD treatment. All 34 participants responded to this question, providing a mean number of incidents at 1.7. When the incidents were analyzed, seven mutually exclusive major categories were determined. Raters were unanimous in the classification of 90% of the incidents. Behavioral categories included suggesting the need for PTSD treatment, issuing an ultimatum, taking action, offering patience and support without taking any action, providing proof of the need for PTSD treatment, feeling it is not possible to do anything, and refusing to enable behaviors or symptoms (see Table V).

The largest category, suggesting the need for PTSD treatment, accounted for 22% of the incidents (n = 13). Incidents in this category focused on telling, suggesting, or gently encouraging the Veteran to seek treatment. As one spouse reported, “If I expressed a concern, he would take the necessary action because he takes his commitment to me and our marriage and family seriously.”

<table>
<thead>
<tr>
<th>TABLE V. Major Categories of Spouse/Partner Behaviors if Service Member Resists Seeking PTSD Treatment (N = 58 Incidents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Category</td>
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<tr>
<td>----------------</td>
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<tr>
<td>I. Suggesting the Need for PTSD Treatment</td>
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<tr>
<td>1. Telling Him There is a Problem</td>
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<tr>
<td>2. Encouraging Him to Seek Treatment</td>
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<tr>
<td>3. Describing the Impact on the Family and Marriage</td>
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<tr>
<td>II. Issuing an Ultimatum (12 Incidents, 21%)</td>
</tr>
<tr>
<td>1. Ordering Him to Seek Treatment</td>
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<tr>
<td>2. Using the Relationship as Leverage</td>
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<td>3. Involving Family in Confrontation</td>
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<td>III. Taking Action (12 Incidents, 21%)</td>
</tr>
<tr>
<td>1. Doing What it Takes to Arrange for Treatment</td>
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<tr>
<td>2. Appealing to Command</td>
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<tr>
<td>3. Gathering Facts About PTSD</td>
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<tr>
<td>4. Educating Spouse/partner About PTSD</td>
</tr>
<tr>
<td>IV. Offering Patience and Support Without Taking any Action (12 Incidents, 21%)</td>
</tr>
<tr>
<td>1. Offering Support and Understanding</td>
</tr>
<tr>
<td>2. Showing Empathy</td>
</tr>
<tr>
<td>V. Providing Proof of the Need for PTSD Treatment (5 incidents, 9%)</td>
</tr>
<tr>
<td>1. Providing a Written Description of Behavior Changes</td>
</tr>
<tr>
<td>VI. Feeling it is not Possible to do Anything (3 Incidents, 5%)</td>
</tr>
<tr>
<td>1. Feeling Powerless</td>
</tr>
<tr>
<td>2. Feeling Unsure of a Specific Action</td>
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<tr>
<td>VII. Refusing to enable behaviors or symptoms (1 incident, 1%)</td>
</tr>
<tr>
<td>1. Refusing to Enable Addiction Behaviors or PTSD Symptoms</td>
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</table>
In the second category, issuing an ultimatum, participants indicated that an effective strategy would be to order the Veteran to seek treatment \((n = 6)\). As one participant stated, "I’m one of those wives who would tell my spouse that it’s something [he had] to do and not give him any options. I wouldn’t beat around the bush!" Additional incidents placed in this category described the use of leveraging the relationship in an effort to facilitate PTSD treatment \((n = 4)\). One participant wrote, "I’d threaten to divorce him if he did not go to treatment," and another added "I’d have to agree to remain married." Additional incidents placed in this category suggested that involving family members in a confrontation would also prove effective \((n = 2)\). A participant shared the following:

If I got the whole family to confront him and request that [he’d] seek help because he was hurting himself, that might work.

A third category, taking action, referred to gathering knowledge about PTSD resources, seeking advice from medical professionals, and arranging for PTSD treatment \((n = 12; 21\%)\). As one participant wrote, "I’d gather all of information, make the appointments, and then go with him to treatment." Four participants indicated that they would also appeal to the commanding officer:

If my husband needed treatment and wouldn’t go, I would contact his command and insist he go. I would take action and it would be out of his control.

A fourth category, offering patience and support without taking any action, identified the strategy of supplying constant support and encouragement \((n = 12; 21\%)\). One participant added:

I’d have to show understanding, compassion, a willingness to help, and an ability to empathize to get him into counseling. I’d also have to be patient and supportive of his needs.

Five incidents \((9\%)\) described the importance of providing proof of the need for PTSD treatment. One participant wrote, "I’d have to keep a journal of his behavior because I’d need proof of how he’s changed and how that makes me feel." Another added, "I’d have to present him with a thorough cost-benefit analysis because he’d need proof of the need for treatment." Three incidents \((5\%)\) described the participants’ feelings of powerlessness and uncertainty about a course of action.

**DISCUSSION**

This descriptive study examined the knowledge of spouses/intimate partners of military combat Veterans regarding PTSD and identified strategies that spouses/intimate partners use to recognize potential PTSD in a combat Veteran. The study also described strategies that spouses/intimate partners use to determine a Veteran’s readiness for mental health treatment and the ways they might use to make a reluctant Veteran seek PTSD treatment.

A noteworthy finding is that spouses/intimate partners of combat Veterans had very little knowledge about the symptoms of PTSD. Only one-third of the participants in this study reported receiving formal training on PTSD. The majority of participants in this study obtained facts about PTSD through informal sources, including the media \((e.g.,\) news, movies, Internet\), family and friends diagnosed with PTSD, or from spouses of other active duty military. These findings highlight the need for increased PTSD education for spouses/intimate partners of combat Veterans. Although the participants in this study had received little formal training on PTSD, they were aware of the most consistently reported barriers to receiving PTSD treatment, including denial of symptoms, stigma about disclosing PTSD symptoms, and fear of harming a military career.\(^5,18\)

The primary strategy that the spouses/intimate partners who participated in this study used to recognize potential PTSD was to watch for changes in behavior patterns or daily routines. Disturbed sleep patterns and nightmares were the most frequently identified physical symptom of PTSD. This finding is consistent with previous work by others in which spouses, clinicians, and Veterans with PTSD were asked to rate their most serious problems.\(^37\) While spouses and intimate partners in this study had little knowledge of underlying PTSD pathology, they were most likely to identify observable behavior problems such as difficulties with interpersonal problems or avoidance, rather than physical or mental symptoms. Primary strategies for determining a Veteran’s readiness for PTSD treatment included listening for a Veteran’s acknowledgement of PTSD symptoms or a voiced concern about the effect of PTSD on the children or family. To a lesser extent, spouses and intimate partners indicated that they would remain alert for the Veteran, gathering information about PTSD.

Four predominant behaviors were identified that spouses/intimate partners might use in the event a combat Veteran resisted PTSD treatment: suggesting the need for treatment, issuing an ultimatum, taking action, and offering patience and support without taking any action. Several spouses/intimate partners in this study perceived that their relationship with the Veteran was strong enough to serve as leverage for facilitating treatment. Although some participants felt that a more supportive approach would be most effective, others perceived a sense of responsibility for the Veteran’s well being and initiated PTSD treatment on their own. Given the findings of previous research on the treatment of alcohol problems, suggesting that family members can play a critical role in facilitating successful engagement in treatment,\(^18\) identifying these categories may move us forward in the process of customizing or tailoring PTSD treatment needs of Veterans and/or their spouses and intimate partners.

There are several limitations to this study that must be considered when interpreting the results. First, we only examined...
the perspectives of female spouses and intimate partners recruited from two sites in a single geographic region. We did not examine data on race/ethnicity of the participants in this study. As a result of the recruitment strategies, the average age of the participants (35 years) may not be representative of the broader population of military spouses/intimate partners. In addition, the majority of the participants in this study had a very enduring relationship with their Veterans, with an average length of a relationship at 12.8 years. Many voiced that they would “do what it takes” to get the Veteran into needed mental health treatment once they became aware of the potential for PTSD. This may be tied to the maturity of the participants in this study and also to their cultural awareness of the military environment.

Several additional factors affect the generalizability of the study findings. The participants in this study did not have to be involved with Veterans who were diagnosed with PTSD and there was no way to determine how many Veterans actually had PTSD. An additional factor must also be considered. Because the sample was self-selected, it is possible that spouses and intimate partners who were more willing to participate in the study were also more likely to be involved in their Veteran’s seeking of PTSD treatment. Given the increasing number of women in the military, gaining the perspectives of male non-military spouses would be an important consideration in future studies. Future studies should also include the perspectives of the combat Veterans and those of the spouses/intimate partners from a larger, more geographically diverse sample. The development of quantitative assessment measures for military family members would also provide important information, especially for those Veterans who are reluctant to seek care.

Despite the limitations, the main value of this study lies in its identification of the wide variety of strategies used by spouses/intimate partners of combat Veterans to recognize and facilitate treatment for PTSD, should it arise. Study findings provide important information for planning early intervention strategies that incorporate spouses/intimate partners of combat Veterans and also inform future research.

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