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# A Parent at War and the "Invisible Wounds" They Carry Home: PTSD in Military Veterans and a Review of Psychosocial Family System Challenges

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A Parent at War and the “Invisible Wounds” They Carry Home: PTSD in Military Veterans and  
A Review of Psychosocial Family System Challenges

by

MELINA S. CALLE

A master’s thesis submitted to the Graduate Faculty in Liberal Studies in partial fulfillment of  
the requirements for the degree of Master of Arts, The City University of New York

2014

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This manuscript has been read and accepted by the Graduate Faculty in Liberal Studies in satisfaction of the dissertation requirement for the degree of Master of Arts.

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## Abstract

### A PARENT AT WAR AND THE “INVISIBLE WOUNDS” THEY CARRY HOME: PTSD IN MILITARY VETERANS AND A REVIEW OF PSYCHOSOCIAL FAMILY SYSTEM CHALLENGES

by

Melina S. Calle

Advisor: Dr. Colette Daiute

Operation Enduring Freedom and Operation Iraqi Freedom have created a new generation of military veterans and military families, many of which must manage and cope with psychosocial challenges such as posttraumatic stress, depression, anxiety, and alcohol abuse induced by the psychological trauma(s) faced during war. Risk factors, buffering factors, and war zone stressors influencing the development of PTSD following military-related trauma will be reviewed. As many of these affected veterans return to living with spouses and children, these psychosocial issues show to bring forth tension, stress, and friction to the family system. This thesis explores the literature of family system challenges faced by male and female U.S. veterans, and child outcomes.

Through a review of empirical literature, a case will be made that not only does the veteran affect his/her spouse and child(ren) while enduring difficult psychological conditions, but the spouses and child(ren) also have a reciprocal effect on the veteran’s coping efficacy and recovery process. Therefore, this text will contend that there is a need to view these mental health challenges as a family systems issue, with implications for a need to develop family system interventions for successful management and recovery for veterans, spouses, and children combined.

Key Words: Military, Trauma, Mental Health, Family System, Coping, Intervention

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## Chapter 1: Introduction and Background

The most recent wars engaging American military troops have created a new generation of armed forces veterans and military families within the United States. The war in Afghanistan (Operation Enduring Freedom; OEF), and the war in Iraq (Operation Iraqi Freedom; OIF) have currently placed the United States and its armed service (wo)men in a little over twelve years of war time (Torreon, 2012). Data compiling mental health diagnoses and assessing readjustment difficulties in the OEF/OIF cohort of military veterans have noted significant trends in diagnoses of post-traumatic stress disorder (PTSD), depression, and traumatic brain injury, along with increases in alcohol- and substance-abuse related disorders in OEF/OIF veterans (Seal et al., 2009; Tanielian & Jaycox, 2008; Manderschied, 2007). Tanielian & Jaycox (2008) refer to these mental health conditions as “invisible wounds of war” in the title and throughout their book. This phrase accurately and succinctly conveys the differential nature of this type of injury, not readily visible by others as would be an amputated limb or a scar across the skin. These “invisible wounds” are tied to distressing psychological and emotional injuries sustained during veterans’ combat experiences that they must carry with them back home.

According to *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013), Posttraumatic Stress Disorder is defined as psychological distress after being exposed to a traumatic or stressful event (p. 265). Those who suffer with military-related PTSD can exhibit a variety of symptom combinations with either immediate or delayed onset following the traumatic military experience. Reports have gone so far as to call PTSD and Traumatic Brain Injury (TBI) the “signature injuries” of the military conflicts in Afghanistan and Iraq (National Council on Disability, 2009; Tanielian & Jaycox, 2008). Unlike PTSD, Traumatic Brain Injury is a physical injury to the head that causes

cognitive impairment. Though it can be comorbid with mental health disorders, TBI in itself is not a mental health disorder. Although this “signature injury” from the OEF/OIF wars is also of significant importance, it is beyond the scope of this thesis, which will focus on the psychological injury of military-related PTSD and corresponding coping/recovery processes as a psychosocial family system challenge.

The current veteran diagnosis rate for PTSD is alarming. According to Milliken, Auchterlonie, and Hoge (2007) and Seal et al.’s (2009) descriptive studies of mental health trends, approximately one in five OEF/OIF veterans are being classified with a PTSD diagnosis. With over 1.6 million veterans deployed between 2001 and 2009, (National Council for Disabilities, 2009) that would create a mathematical estimate of around 320,000 veterans possibly suffering with this “invisible wound.” Even the most conservative estimates of 10% would create an estimate of 160,000 affected veterans (still a significant number of veterans) depending on the stringency of diagnostic criteria (Hoge et al., 2004). And this does not include the wealth of other mental health conditions that this veteran population is also being diagnosed with (i.e. depression, alcohol- and substance-abuse related disorders) and occurrences of comorbidity among these conditions with PTSD.

Living and coping with this psychological distress is not something that the veteran does independently from other domains of life (i.e. work, family, friends). These veterans suffering from posttraumatic stress impact those around them (e.g. spouses, children, caretakers) who are attempting to cope and live with the veteran’s condition (Galovski & Lyons, 2004). The psychological well-being of those living with and supporting the affected veteran can be impacted. Since the family is an important source of support in the coping/recovery process (National Council on Disability, 2009; Pietrzak et al., 2010; Zatzick et al., 1997) yet the family is

also at risk for developing mental health issues under this stressed environment, it is important to view the coping/recovery process as a family system challenge, implicating the need for whole family-based interventions. Veterans are shown to have poorer treatment outcomes when they face conflict at home (see Galovski and Lyons, 2004). A family that is psychologically impacted can create a negative reciprocal and cyclic effect with the veteran such that the PTSD creates friction with the spouse and children (Ray & Vanstone, 2009; Monson, Taft, & Fredman, 2009; National Council on Disability, 2009; Galovski & Lyons, 2004). This friction puts stress on the familial relationship, which in turn exacerbates the veterans symptom severity (further putting stress on the familial relationship, and so forth (See Figure 1, pg. 54). This has the potential to negatively impact both the recovery environment for the veteran, and the psychological well-being of the family members. Given that statistics show over 60 percent of service men and women to be married, and almost half have children (National Council on Disability, 2009), there is a significant number of military families that could be enduring these family system challenges associated with post-deployment reintegration further exacerbated by the PTSD stressor. Therefore, the focus of this thesis will be placed on the psychosocial challenges endured by military-related PTSD sufferers, the risk and buffering factors associated with resiliency and vulnerability to developing PTSD, the spouses and children as they are affected (and reciprocally affecting the veteran) thereby creating family system challenges (and therefore needing family system interventions), and general barriers to getting the care that is needed.

### **Unique Nature of OEF/OIF Wars**

There are notable differences in the nature of the OEF/OIF wars; distinct from prior wars that U.S. service (wo)men have fought in over the past fifty years. The differences impact

veterans' reactions and coping to combat experience and their adjustment to post-deployment civilian life. Manderscheid (2007) notes that the Gulf War and Vietnam War had relatively shorter deployments. Vietnam service (wo)men served for 1 year before returning home, and the Gulf War was only approximately six months, so lengthy deployments were not a significant issue. In contrast, some OEF/OIF veterans have already served more than two years (p. 122). Also, the OEF/OIF wars have shown an unprecedented pace of deployment of volunteer forces, with deployments lasting longer, re-deployment being common, and time off in between deployments being shorter (Tanielian & Jaycox, 2008).

Another significant difference is that while the Gulf and Vietnam Wars did indeed have some front-line combative warfare, they largely had clear battle zones and safe zones, whereas in Iraq and Afghanistan these demarcations have not been so distinct. (Manderscheid, 2007). Manderscheid discusses that every location has become a potential battle zone, which puts armed service (wo)men under constant threat of being hurt or killed (p.122). This environmental stressor likely impacts the veterans who must live under constant threat, without break from that stress of threatening surroundings. Furthermore, the Afghanistan and Iraq conflicts have yielded the historically low casualty rates of those physically wounded and killed as compared to prior wars such as the Vietnam and Korean Wars (Tanielian & Jaycox, 2008). These authors further discuss the contribution of advanced medical technology and body armor in lowering these casualty rates, thus producing many veterans who survive experiences that would have killed veterans of past wars (p. xix; p. 6). Surviving an experience that could have killed you may potentially produce traumatizing memories of that experience. Thus, with the increased survival rate from potentially fatal experiences, a different kind of wound is being increasingly manifested— invisible wounds of mental health conditions. Tuerk et al. (2009) posits “[I]t is

reasonable to expect that multiple deployments, the experiencing of numerous traumas, and the long periods of sustained threat associated with OEF/OIF deployment would increase the risk of developing PTSD” (p.762).

### **Nature of OEF/OIF Wars Affecting PTSD Symptom Presentation**

Discussing the differential nature of the OEF/OIF wars is also significant in its clinical application. These distinct characteristics of the OEF/OIF wars (i.e. longer and more frequent deployment, unclear safe-zones and battle-zones, and increasingly surviving lethal war situations) have possibly created a novel variation in symptom manifestation of PTSD. Tuerk et al. (2009) presented two case studies of a manifestation of PTSD that the authors believe to be occurring in increasing frequency among OEF/OIF veterans. While the veterans had traditional PTSD symptoms including arousal, reexperiencing, and avoidance, “the veterans exhibited compulsive checking behaviors that appear to be influenced by theater-specific combat duties and traumatic events” (p.762). The first case study depicted a veteran diagnosed with PTSD whose primary combat duty was to force entry into homes and clear them to secure neighborhoods. While performing that duty the veteran reported being exposed to various disturbing experiences (i.e. being in life-threatening situations, firefights, witnessing dead and mutilated bodies, losing two friends during combat). In addition to having more traditional PTSD symptoms, the veteran exhibited compulsive checking behaviors upon returning home in relation to his combat-duties of forcing entry into other’s homes. He continuously checked the locks on the doors, as well as continuously peering through the blinds of his windows in his home (Tuerk, 2009, p. 763). While living under continuous threat for a prolonged amount of time and performing intrusive combat-related duties into others’ homes, the veteran no longer

felt safe in his own home and engaged in compulsive checking behaviors related to hyper-vigilance and safety, in order to immediately assuage feelings of anxiety and imminent danger.

The second case study in Tuerk et al.'s (2009) article described a veteran whose two deployments to Iraq entailed the primary duty of providing security as a patrolman to truck convoys and checking the vehicles for bombs. While performing his duties, the veteran was also exposed to various disturbing experiences (i.e. being in life-threatening situations, seeing a convoy run over a little girl, witnessing an explosive device detonate during one of the convoys, seeing dead and mutilated bodies). Upon returning home and in addition to the presence of traditional PTSD symptoms, the veteran engaged in compulsive checking behaviors related to his combat-specific duties, wherein he felt compelled to check under the hood of his civilian car and check the car's undercarriage for bombs every time he had to drive to and from places (p.764-765). Again, after living a prolonged amount of time under constant threat during his two deployments, the veteran had issues readjusting and feeling safe in his daily life, thus engaging in compulsive checking behaviors related to hyper-vigilance and safety, in order to assuage feelings of distressing anxiety and danger.

These symptomatic occurrences of compulsive checking behaviors do not qualify veterans for obsessive-compulsive disorder (OCD) because as part of the diagnostic criteria for OCD in the DSM-V, the obsessive-compulsive symptoms cannot be attributable to another mental disorder (e.g. PTSD) (APA, 2013, p. 237). However, exhibiting OCD-related symptoms as an expression of PTSD is clinically important as it necessitates an adjusted treatment process addressing the OCD-like compulsive checking behavior in veterans exhibiting it. This novel symptom expression also complicates PTSD diagnoses because this is a PTSD-related symptom that does not fall under current diagnostic criteria, despite its connection to military-related

trauma. Although Tuerk and colleagues (2009) say that proper and extensive research has not been done on this new symptomatic expression of PTSD, they posit that this may be an increasingly frequent element specific to OEF/OIF-related symptom manifestation and report that “25% — 30% of OEF/OIF veterans diagnosed with PTSD who present to our clinic engage in compulsive checking” (p. 763).

Therefore, if further research into this topic confirms the notable observation of the authors, it would emphasize the need to expand and refine our understanding of PTSD within the context of the OEF/OIF wars as they may affect symptom identification, diagnosis, and treatment plans that are better tailored for this military cohort. In relation to issues raised throughout this chapter, with an alarming rate of PTSD diagnosis within the OEF/OIF military cohort, it is of utmost importance that we (as researchers and clinicians) understand the potentially evolving symptomatic manifestation of OEF/OIF-related PTSD so that those suffering from this invisible wound can receive the most appropriate diagnosis and treatment possible, and so that veterans in need of care do not go undiagnosed due to unidentified or misunderstood symptomology.

### **Summary and Overarching Focus**

In summary, the significant trend in PTSD diagnoses among the OEF/OIF military cohort has appropriately warranted empirical attention. The empirical support for a negative reciprocal and cyclic effect in between veteran-PTSD symptom severity and their familial relationships (See Figure 1, pg. 54; Ray & Vanstone, 2009; Monson, Taft, & Fredman, 2009; National Council on Disability, 2009; Galovski & Lyons, 2004) highlights the importance of examining the challenges of coping with PTSD beyond an individual-level, and more towards a family

system-level; especially since the family has been found to be a significant source of support in the veteran's coping/recovery process (National Council on Disability, 2009; Pietrzak et al., 2010; Zatzick et al., 1997). Given that the family is also at risk for developing mental health issues under this stressed environment, it is imperative to view the coping/recovery as a family system challenge. Therefore, it is important to examine the relationship between PTSD and family dynamics in order to better understand the issues facing contemporary military families coping with a veteran suffering from PTSD, and thus be able to better-tailor necessary whole family-based interventions for comprehensive care to both veterans and their families.

In order to increase our understanding of veterans suffering with PTSD, we must better understand their experiences during deployment that lead to trauma. As discussed, the unique nature of the OEF and OIF wars (i.e. longer and more frequent deployment, unclear safe-zones and battle-zones creating continuous threat to life, and increasingly surviving lethal war situations) seem to have driven alarming rates of PTSD and emerging symptomatic variation. Given the background of these OEF and OIF wars and these distinct war characteristics, it's important to examine the experiences and needs specifically of the OEF/OIF military cohort, distinct from prior cohorts (e.g. Vietnam War or Gulf War) because as circumstances, culture, and technology change over time, so may the issues and needs of contemporary veterans.

However, one's likelihood of developing PTSD is not solely based on experiences of war, but also on influences related to pre- and post-trauma factors. Therefore, it is important to review and examine the various factors that either protectively buffer one's likelihood of developing PTSD or increase one's risk of developing PTSD. An understanding of these influences beyond the war experiences can allow for the institution of better preventive and

buffering efforts supporting mental health in pre- and post-deployment. The subsequent chapter outlines the literature of the currently known influences.

Overall, this thesis will flow in its focus on the risk factors and buffering factors influencing the development of PTSD, and the resulting psychosocial family system issues facing both male and female OEF/OIF military veterans and families, in order to demonstrate the need for whole family-based interventions. A review of barriers to care will hopefully raise awareness of obstacles facing contemporary veterans with needs for mental health care so importance can be placed on addressing these issues, in order for veterans and their families to be able to receive the mental health services they need to support psychological well-being in the family system.

## **Chapter 2: What Makes a Veteran More Vulnerable or Resilient to PTSD from Military-Related Trauma?**

As mentioned in the prior chapter, one's likelihood of developing PTSD is not solely based on experiences of war. Empirical literature has revealed that pre- and post-trauma factors also influence one's vulnerability and resilience to developing PTSD. The subsequent sections will review the literature, organized sequentially beginning with factors related to (1) Pre-Trauma (risk factors and buffering factors), followed by (2) Peri-Traumatic Stressors relevant and present in the time of the deployment, and lastly (3) Post-Trauma factors (risks and buffers) that are relevant in the post-deployment context. The question posed in the chapter title (what makes a veteran more vulnerable or resilient to PTSD from military-related trauma?) is important as it relates to our understanding of the influences that foster either resiliency or susceptibility to developing PTSD from a traumatic war-time experience. In better understanding the factors impacting mental health in the pre-, peri-, and post-deployment context, more efficacious interventions can be made to ameliorate the alarming rates of PTSD discussed in the previous chapter.

### **Pre-Trauma**

**Pre-trauma risk factors.** Pre-trauma risk factors for military-related PTSD refer to the circumstances and life history of the veteran before enduring military-related trauma, which have been found to be associated with heightened chances of developing PTSD (See Table 1 for summary, pg. 55). Studies examining pre-war risk factors found differing salient factors between genders (King, King, Foy, & Gudanowski, 1996; King, King, Foy, Keane, & Fairbank,

1999). In both studies, structural equation modeling was used to analyze data from the National Vietnam Veteran Readjustment Study (NVVRS), which consisted on interview and self-reports on pre-war background, deployment experiences, post-war circumstances and mental health in male and female veterans. Data showed factors that were significantly associated with men's development of PTSD to include (1) age at entry into the armed service, such that younger males were at higher risk for developing PTSD, (2) early trauma history (i.e. assaults, abuse, natural disaster, accidents), (3) childhood antisocial behavior, and (4) prewar familial instability (King et al., 1996; King et al., 1999). These were all pre-trauma factors that were significantly associated with males' risk for PTSD following military-related trauma. For females, these authors found that early trauma history and prewar familial instability were found to be significantly associated with female risk of PTSD development (however, not age or childhood antisocial behavior). More recent data, however, that specifically examined OEF/OIF veterans in statistical analyses of mental health diagnoses trends obtained from the VA National Patient Care Database, found that the age of active duty veterans overall (i.e. both genders) was significantly associated with PTSD such that the sample of active duty veterans aged 16-24 had over twice the risk of a PTSD diagnosis than those active duty veterans over age 40 (Seal et al., 2009). This variance in data highlights the importance of examining military veterans by cohorts, as historical periods and circumstances likely produce cohort effects, which shift the issues and needs of veterans in the clinical setting.

**Pre-trauma protective factors.** Though recent research studies in this area have primarily sampled men (90+ percent male sample), there has been an emerging significant pre-trauma protective factor associated with buffered chances of developing PTSD (See Table 1 for

summary, pg. 55). Data show that a veteran's (1) "sense of preparedness" for deployment arising from perceptions of adequacy in preparation and training has a significant influence (Renshaw, 2011; King et al., 1999; Shea, Reddy, Tyrka, & Sevin, 2013). Both Shea et al. (2013) and Renshaw (2011) sampled OEF/OIF veterans' sense of preparedness and adequacy of pre-deployment training using the *Deployment Risk and Resiliency Inventory* (DDRI), which included 5-point Likert-scale questions on preparedness and perceived threat. This pre-deployment training would theoretically prepare troops for the kinds of events they may experience while deployed (specifically combat-related experience) such that the troops may mentally prepare for the threats to be encountered. Renshaw (2011), King et al., (1999), and Shea et al. (2013) have produced data that are in line with this notion. Their studies showed that "sense of preparedness" affected the pathways to developing PTSD by acting as a moderating factor in perceptions of threat.

First-hand combat experiences are either more or less likely to be traumatizing depending on the veteran's perceived level of threat in the situation. Further, these perceptions of threat during combat are influenced by the veterans' perceptions of adequate pre-deployment training and preparation such that the training yielded more realistic perceptions of threat during combat. Data showed that without perceived adequate training, veterans perceived high levels of threat to life even in low-combat settings, while perceived adequate training was associated with reported levels of threat perception that was in line with their combat experience (Renshaw 2011; Shea et al., 2013). In other words, the pre-deployment training and preparation could be yielding more realistic threat-level assessments during combat, which in turn would help buffer trauma from combat exposure (whereas those perceiving high threat in low-level combat settings would be more likely to develop PTSD). As initially mentioned, these studies primarily sampled male

veterans so it is important not to overgeneralize this factor as significant for women, though women were included in the study albeit the minority. It is likely that pre-deployment training would also be beneficial for any gendered veteran to be able to mentally prepare for the experiences of deployment, so as not to over-perceive threat and put themselves at a heightened risk for trauma. More research with female veteran samples would be helpful to solidify this impression with empirical data.

### **Peri-Traumatic War-Zone Stressor Risks**

Peri-traumatic war-zone stressors are any negative factors that encompass the environment and experiences of veterans during the military deployment to war (“peri-” meaning around). These stressors have a negative psychological impact on the veterans, which increase risks for developing PTSD (See Table 1 for summary, pg. 55). (1) Living in a harsh, hostile war zone environment with the continuous stress of war-related deprivations and pressures has been found to affect PTSD both directly and indirectly (Renshaw, 2011; King et al., 1999; King, King, Gudanowski, & Vreven, 1995). This significance has been found both in male and female Vietnam veterans as well as OEF/OIF veterans, as the hostile environmental depiction resonates with the prior discussed deployment milieu of OEF/OIF veterans. King et al., (1999) and King et al. (1995) compiled their analyses through self-reports from the data of the NVVRS, while Renshaw (2011) also used self-reports of the “combat experiences” subscale of the DDRI which consisted of 15 “yes/no” items to assess combat experiences.

First-hand combat events involving an immediate threat to life has consistently shown to have an indirect effect on PTSD, moderated by veterans’ (2) perceptions of threat (Renshaw, 2011; King et al., 1999; Shea et al., 2013). Secondly, scholars have found that (3) post-battle

experiences, involving witnessing traumatic events sans immediate threat to life or safety (i.e. seeing mutilated bodies, aiding wounded, watching friends die, witnessing abusive violence or atrocities towards others) have a direct association to PTSD for both genders (Renshaw, 2011; King et al., 1999; Iversen, 2008). These two trends (*indirect* path to PTSD via combat experience mediated by perception of threat to life VS. *direct* path via post-battle experiences) suggest that these different types of traumatic experiences have different pathways to PTSD development. This is comprehensible given that the traumas are likely caused by different types of terror (i.e. shock and horror of witnessing atrocities to *others* VS. fear and terror of threat to one's *own* life). Like Renshaw (2011), Iversen (2008) assessed experiences via Likert-scale questions on post-battle experiences. In addition, Shea et al., (2013) also found (4) "life/family concerns during deployment" to be a significant moderating factor between combat exposure and PTSD in their assessment of the "Life and family concerns" subscale of the DDRI (thus identifying another risk that creates a potential indirect pathway from combat exposure to PTSD).

These war-zone stressors of (1) living in a continuously hostile environment, (2) perceptions of threatening first-hand combat experience, (3) eye-witnessed atrocities to others associated with post-battle experiences, and (4) preoccupations with life/family concerns during deployment, were significant factors associated with the development of PTSD in military veterans. In addition, other military-related factors that were associated with a heightened risk of PTSD include being in the (5) lower echelons of the armed services as an enlisted member (versus being an officer), and (6) serving in the army (as opposed to another branch of service) (Seal et al., 2009; Iversen, 2008). A possible explanation for these findings could be that lower ranks of army servicemen are likely to be on the front lines of hand-to-hand combat during war conflicts, thus increasing the potential for exposure to traumatic experiences.

## **Post-Trauma**

**Post-trauma risk factors.** Following the experience of a traumatic event, certain post-trauma risk factors have been identified in the literature as being associated with decreasing resiliency from developing PTSD (See Table 1 for summary, pg. 55). These factors are post-deployment circumstances and experiences that occur upon the veterans' return home. Studies have found that (1) low morale in the veterans' military unit (Iversen, 2008) and (2) poor military unit support (Pietrzak et al., 2010; Iversen, 2008) were associated with increased risk for PTSD. In addition, Iversen (2008) found that veterans (3) not receiving a "homecoming brief" were at a higher risk for PTSD. Homecoming briefs are educative lecture presentations given to veterans upon their return from deployment that cover relevant topics of post-deployment functioning such as reintegration with family and friends, health, symptoms of stress, and guidance on existing resources to seek help if necessary (Iversen, 2008). Overall, unfortunately, neither of these two studies specified how many participants in their sample were male versus female. As the military is a male-dominated field, it can be safely assumed that these data are representative of male veterans, however one must be cautious of over-generalizing significant results to other specific populations (i.e. female veterans) without proper representation in empirical data.

A fourth post-trauma risk factor that has been identified in the literature is experiencing more stressful life events in the postwar context (King, King, Fairbank, Keane, & Adams, 1998; King et al., 1999; Shea, et al., 2013). The authors found this factor to be significant for both male and female veterans following a traumatic military experience. Additionally, (5) lower levels of post-deployment social support (Shea et al., 2013) were shown to be another risk factor for PTSD in the authors' primarily male (92%) sample. Pietrzak et al.'s (2010) data supports this

finding in OEF/OIF veterans as well in their assessment of the “postdeployment social support” subscale of the DDRI, though this study does not specify the gender of its veteran participants. Once again therefore, caution must be made before over-generalizing results to female veterans without definite sufficient representation in empirical study samples.

**Post-trauma buffering factors.** Post-trauma resources and supports (or lack thereof) build the recovery environment for veterans returning from deployment. Various factors in the post-deployment context have emerged in the literature as having positive buffering effects for veterans having experienced trauma (See Table 1 for summary, pg. 55). (1) Hardiness and (2) social support (both structural and functional) have been found to be significant for both male and female veterans (King et al., 1998; King et al., 1999; Bonanno, Galea, Bucciarelli, & Vlahov, (2007); Pietrzak et al., 2010). Hardiness refers to the capacity of enduring hardships, including having a sense of control and perceiving change as a challenge in such a way that stimulates as opposed to impairs. Structural support is the size and complexity of one’s social network, while functional support refers to one’s perceived received emotional and instrumental assistance from others (King et al., 1999). While King et al., (1998) and King et al., (1999) focused on self-reports of the NVVRS in their structural equation modeling, Pietrzak et al., (2010) also found these results in OEF/OIF veterans using the “*Connor-Davidson Resilience Scale*,” which is a self-report measure of psychological resilience. Having these hardiness and social support variables within the post-deployment context is shown to be positively and significantly influential for both genders. Pietrzak et al., (2010) found that this social support system, in addition to (3) military unit support, and (4) aspects of psychological resilience (i.e. “positive emotions, cognitive flexibility, meaning-making, and active coping”) (p. 189) buffer

against PTSD and psychosocial difficulties. These last two variables were part of a study sample that did not specify gender, and thus can only be safely assumed to be representative of male veterans. Additional post-trauma buffering factors include (5) relational capacity, which refers to the level of a person's ability to reach out, use, and maintain social relationships and supports during times of need (as opposed to withdrawing) is a protective factor against PTSD (see Benight & Bandura, 2004) and (6) perceptions of purpose and control (Pietrzak & Southwick, 2011), who also pull this data from the *Connor-Davidson Resilience Scale* questionnaire on a 4-point Likert scale. These factors can also be categorized under the umbrella term of aspects of "psychological resilience" used before.

Pietrzak & Southwick (2011) furthered the research on social support in their findings that (5) family and friends' *understanding* of deployment-related issues is significantly associated with veteran resiliency, in their analysis of the *Postdeployment Social Support Scale* self-report measure. This underscores the importance of family and friends in the recovery environment, and supports the need for psychoeducation of those primarily in the affected veterans' living/recovery environment (i.e. a kind of "homecoming brief" for the family as well) in addition to family support programs ideally helping to provide instrumental support. The understanding of these loved ones seems to lead to increased and better social support functioning.

## **Implications**

So what makes a veteran more vulnerable or resilient to PTSD from military-related trauma? The chapter suggests that the answer is not singular, and that these factors span both over time and across system levels. The literature shows that risk factors and buffering factors

associated with developing or buffering PTSD not only include individual-level factors (i.e. hardiness, relational capacity, age, individual perceptions of threat, etc.) but also more systemic-level factors beyond veteran's control (i.e. family support, further support from military unit and friends, etc.) in the pre- and post-deployment context, which are associated with veterans' PTSD symptom severity and psychosocial functioning. The implication of these findings is that it would be beneficial for the veteran's mental health if interventions expand beyond simply individual treatment to also address broader relevant factors impacting mental health. This understanding of the literature can help foster the institution of better preventive and buffering efforts to support military service (wo)men's mental health in pre- and post-deployment.

Now that it has been established that the family is an important factor that constitutes the veteran's coping and recovery, the following chapter will delve into the family level dynamics and challenges facing veterans suffering from PTSD and their families. As this chapter has begun to show, it will continue to become increasingly clear that aid in coping and recovery from military-related PTSD needs to expand beyond addressing individual-level factors, to also include building more family-level interventions in attempt to address the needs within veterans' living environment, which is (as has been discussed) simultaneously their recovery environment.

### **Chapter 3: PTSD Symptoms and Related Psychosocial Family System Difficulties**

So what does PTSD look like? How do its symptoms relate to psychosocial functioning and family system challenges? These questions orient us to the focus of this chapter, which will illustrate how the various currently identified symptoms of PTSD have distinct impacts on family functioning and psychological well-being, both for the veteran and other family members. Following a definitional synopsis of PTSD as established in the new edition of the Diagnostic and Statistical Manual of Mental Disorders (the DSM-V, recently published by the APA in May 2013), a review of the literature will be organized by symptom-clusters, addressing the significant impacts each symptom-cluster has on the family system. As the significance of PTSD in psychosocial family system difficulties is demonstrated throughout the sections, it will further bolster the case for whole family-based interventions, both for the purpose of supporting the veteran's coping and recovery, and also in support of the other family member's psychological well-being as it is potentially impacted.

#### **PTSD Symptoms**

The DSM-V categorizes indicators of PTSD among four symptom clusters: re-experiencing symptoms, avoidance symptoms, negative cognitions and mood, and arousal symptoms (See Table 2 for full summary, pg. 56). Individuals can exhibit varying combinations of these symptoms with varying severity. The impact of PTSD permeates affected individuals' moods, thoughts, and behavior (Tanielian & Jaycox 2008) and can affect or impair a broad spectrum of psychosocial function.

Re-experiencing symptoms encompass intrusive, mentally and physiologically distressing memories, dreams, and/or dissociative flashbacks of the traumatic event (possibly precipitated by internal or external triggers that are symbolic or reminiscent of the trauma). Avoidance symptoms are characterized by efforts to avoid stimuli that trigger re-experiencing. These avoidance symptoms can be severe to the point that they impede on one's ability to engage in daily activities (e.g. refusal to go to the grocery store to buy food because of efforts to avoid re-experience-inducing stimuli). Negative cognitions and mood constitute symptoms of distorted perceptions of self or environment (e.g. I am bad, I am permanently and mentally broken, the whole world is dangerous and untrustworthy), as well as persistent negative feelings (e.g. shame, sadness, guilt, fear, horror, or anger), feeling detached or estranged from others (i.e. family or friends), diminished desires to participate in activities, and persistent inability to engage in positive emotions (e.g. experience satisfaction, happiness, or affectionate/loving feelings), and more. These symptoms within the negative cognitions and mood symptom cluster, (especially the symptoms of being unable to engage in positive emotions and feeling detached), are often referred to as "emotional numbing" in the PTSD literature. Lastly, arousal symptoms are marked by irritability, angry outbursts, hypervigilance, amplified startle response, among other symptoms (DSM-V; APA, 2013, pg. 271-272).

In order to qualify for clinical diagnosis, one must meet the minimum symptom-presence criteria, and these symptoms must persist for more than a month (with delayed expression of symptoms being possible in some cases).

The DSM-V specifically notes the functional consequences of having this disorder. Coping with these disturbances and struggling with emotional regulation and maintaining interpersonal relationships produce "clinically significant distress or impairment in social,

occupational, or other important areas of functioning (pg. 272). Having a family member who is suffering from PTSD and is impaired in these areas of functioning perpetuates a negative cyclic effect that has the potential to impact all members of the family (i.e. spouses and/or children) (See Figure 1, pg. 54). Further, the DSM-V asserts that the intensity of symptoms can be influenced by ongoing life-stressors (among other factors), which makes the family/living environment an essential piece of the equation in the coping/recovery process, as family environment and dynamics can be sources of (or support from) life stress. A review of literature will demonstrate the frictional intersection between PTSD symptomatology and associated psychosocial challenges with family dynamics during post-deployment reintegration.

### **Impact of Hyper- Arousal and Reactivity Symptoms: Anger/Violence/Abuse**

**Physical abuse.** Male samples of veterans suffering from PTSD have been found to be more likely to engage in physical and verbal aggression against spouses and children in comparison to veterans who do not have PTSD (Jordan et al., 1992; Glenn et al., 2002). PTSD has been found to be associated with elevated levels of family conflict, hostility, and interpersonal violence (Glenn et al., 2002; Galovski & Lyons, 2004). In Marshall, Panuzio, and Taft's (2005) review of the literature, a comparison of intimate partner violence (IPV) in military populations found non-PTSD male veterans to have IPV rates around 13.5%, while rates for those male veterans with PTSD were between 33 and 58 percent. This comparison alerts mental health care providers of an alarming increase in the risk in veterans with PTSD to engage in physical abuse in the home. In addition, these authors report that there is a positive association between PTSD symptom severity and the severity of IPV. Specifically regarding the relevance of PTSD symptoms, Savarese, Suvak, King, and King (2001) found hyper-arousal

symptoms in male veterans to be relatively strongly associated with intimate partner aggression, which was further exacerbated when compounded with excessive alcohol consumption. Saverese and colleagues measured hyperarousal symptoms of PTSD using a 5-point Likert scale of 8 items from the *Mississippi Scale for Combat-Related PTSD*, in addition to measuring self-reports of marital abuse and violence from the *Conflict Tactics Scale*, which asks for frequencies in the past year of physical and psychological abuse items from both spouses. These studies discussed thus far have used samples of Vietnam-era veterans, which constitutes the majority of literature in this area. Teten et al., (2010) was the only recent study found (to my knowledge) to specifically and exclusively examine aggression in male veterans from the OEF/OIF military cohort, and compare their aggression to Vietnam veterans. This study similarly found that OEF/OIF veterans with PTSD are 1.9 to 3.1 times more likely to engage in aggression than those OEF/OIF veterans without PTSD. This finding was derived from analyzing data from participants using *The Conflict Tactics Scale-Revised* together with demographic information including marital status, number of children at home, duration of time in combat, and questions related to mental health. Overall, the authors also gathered that literature on partner aggression in Vietnam-era veterans may be comparable to OEF/OIF veterans, and encouraged further studies (Teten et al., 2010).

Martin et al., (2007) examined a sample of over 10,000 proven family violence offenders from the Army (though not specifically with PTSD). The authors examined both male and female veterans' patterns of spouse and child abuse, including reported frequencies and descriptions of abuse from spouses obtained from Army Central Registry data. Among these offenders undergoing Family Advocacy Programs which coordinate assessment and intervention of violence in Army families, 61% perpetrated spouse-only violence, 27%

perpetrated child-only violence, and 12% engaged in both spouse and child violence. Those offenders engaging in child-only violence were more likely to be female and unmarried (possibly linked to women being the primary childcare provider, and extra responsibility and possible stressor). Soldiers committing both spouse and child abuse were the most likely to have multiple incidents. Though the data is unlinked to veterans specifically with PTSD, this was the study found within a paucity of literature examining female veteran engagement in physical aggression. Recent literature on women with PTSD, instead, focuses on women's future risk as *victims* of IPV (e.g. Iverson et al., 2011; Resick et al., 2012). This trend in the literature is interesting to note, perhaps related to gender stereotypes as females being victims of violence, as opposed to perpetrators. It is, most assuredly, important to explore and reduce women's future risk of IPV victimization, but the examination of possible participation in perpetration should not be ignored either. Martin et al., (2007) is a step toward a balanced view of both male and female service (wo)men participation in physical aggression in the home.

This abuse brings forth detrimental consequences for spouses and children. Living with a veteran suffering from PTSD has shown to take its toll on the well-being of the children coping within this living environment, thus affecting child outcomes. Children of veterans suffering with this condition have been shown to have greater anxiety and aggression, (Lombardo & Motta, 2008; Ahmadzadeh & Malekian, 2004) and increased behavioral problems (Beckham et al., 1997; Jordan et al., 1992; Galovski & Lyons, 2004). Marshall et al.'s (2005) review of male veterans additionally found intimate partner violence to be associated with lower academic performance, lower social competence, along with increased hostility, aggression, and behavioral difficulties. Glenn et al. (2002) noted a significantly positive

relationship between veteran combat exposure and violent behavior in older adolescents and adult children. Glenn et al. concluded that their study with older children demonstrated similar associations and adjustment outcomes as studies examining younger children, which suggests that there may be similar risks for developing behavioral issues across younger childhood into adolescence.

For spouses and partners, Marshall et al.'s (2005) review noted that intimate partner violence from male veterans with PTSD was associated with psychological maladjustment in spouses/partners, including anxiety and depression, in addition to physical injury. Female spouses also report higher levels of demoralization compared to spouses of veterans without PTSD (Jordan, et al., 1992). Engaging in IPV is even detrimental to the veterans themselves, as IPV is associated with lower parental satisfaction (Marshall et al., 2005), and perpetuates an impaired and frictional relationship in the family (See Figure 1, pg. 54). The cognitive and behavioral difficulties associated with PTSD erode beneficial social support by driving it away (Ray & Vanstone, 2009).

**Psychological abuse.** Saverese et al., (2001) found psychological abuse towards partners to be even more common than physical abuse, with 84% of the male veteran sample disclosing engagement in psychological abuse. This kind of psychological aggression included threatening, insulting, or swearing at the spouse, throwing, breaking, or kicking objects, or other actions (both verbal and not) that “symbolically hurt” the spouse, as opposed to physical injuries (pg.723). Glen et al. (2002) also found heightened results of psychological abuse in his study of male veterans, with reports of coercive control and emotional-verbal abuse by the spouse/partner. A study specifically examining female veterans found that PTSD symptom severity was correlated

with female veteran-perpetrated psychological abuse to male partners (Gold et al., 2007). These studies focusing on psychological aggression, as opposed to physical aggression, deserve equal attention and perceived importance. O’Leary (1999) emphasizes that this form of abuse (i.e. psychological abuse) is just as deleterious as physical aggression. He also asserts that psychological violence is often a precursor to physical violence, which gives further reason to address this issue plaguing families dealing with veterans suffering with PTSD.

### **Impact of Re-experiencing & Hyper-Arousal Symptoms: Traumatization**

**Primary traumatization.** Children can develop direct trauma from the parent’s violent behavior stemming from the hyper-arousal symptoms of PTSD (Dutton, 2000; Galovski & Lyons, 2004). This trauma takes form through repeated exposures to episodes of rage, aggression, and violence from the affected veteran in the family environment. Whether the child develops psychological trauma through directly experiencing violence targeted towards them, or through exclusively witnessing spouse-only violence among parents, data show negative mental health outcomes for children and adolescents (Johnson et al., 2002; Holt, Buckley, & Whelan, 2008; Evans & DiLillo, 2008). Witnessing violence among parents may range in definition from physically seeing the abuse, hearing hits and screams, and/or seeing the resulting bruises and injuries. Data examining children witnessing family violence demonstrated the exposure to be a significant predictor of child PTSD (Kilpatrick & Williams, 2010). Significant prevalence of PTSD is also seen in children who experience the abuse first-hand (Ackerman, Newton, McPherson, Jones, & Dykman, 1998).

**Secondary traumatization.** Secondary trauma is an indirect form of psychological impact, which has had two interpretations in the PTSD literature. The first interpretation of the term entails a PTSD-like reaction wherein the individual actually experiences symptoms that mimic the PTSD symptoms of the affected veteran. Dekel and Monson (2010) list some of the expressions of this distress including, but not limited to, “headaches, breathing difficulties, intrusive imagery, heightened sense of vulnerability, difficulty trusting others, and emotional numbing” (p. 304).

Potential mechanisms for transmitting secondary trauma to spouses and/or children have been proposed and noted (Tunac de Pedro et al., 2011; Galovski & Lyons, 2004; Dekel & Goldblatt, 2008). One form of transmission can be made through (1) *identification* with the veteran, in being constantly exposed to the parent’s PTSD symptoms. The modeling of traumatic stress coupled with empathetic identification with the spouse/parent can induce a mirrored experience of symptoms. Another mechanism of transmission is through (2) *over-disclosure* of traumatic experiences, including telling elaborate, raw, and graphic details of the event, continually retelling war stories, and/or persistently expressing guilt for partaking in war violence/killing. Over-disclosure of powerful and disturbing experiences can be potentially unsuitable and frightening, particularly for children at younger developmental ages. Third, those veterans whose symptomology includes flashback re-experiences of the trauma can transmit trauma through (3) *reenacting* the experience. In this situation, the veterans feel or act as if event is reoccurring and can be unaware of their actual surroundings, thereby inadvertently engaging the child in reenacting the flashback of the trauma. Another potential transmission of stress or trauma can be through (4) *partial disclosure*, in which only fragments of the experience are disclosed to the child. In these cases, sometimes the

children's attempt to fill in the unknown gaps of what happened can lead them to use their imagination for missing details and produce even more horrifying ideas than the reality (Tunac de Pedro et al., 2011; Galovski & Lyons, 2004; Dekel & Goldblatt, 2008).

The second use of the term "secondary traumatization" entails a broader interpretation of any distress transmitted through the relationship between the individual and the PTSD-sufferer, which does not necessarily mimic PTSD symptoms (Dekel & Monson, 2010; Galovski & Lyons, 2004). This distress could potentially take form through anxiety, depression, anger, aggression, confusion in role functioning, or stress related to poor family functioning, et cetera. This secondary traumatic stress could be developed by spouses/partners, children, or other caregivers (Dekel & Monson, 2010). One form of stress transmission that has been noted in the literature is a pattern of communication at the opposite extreme of over-disclosure, being "all-consuming silence" (Tunac de Pedro et al., 2011, p. 603). In this situation, family members attempt not to produce any stimuli that could intensify the veteran's distress; walking on a metaphorical tightrope, avoiding any conversations or behaviors that may trigger hyper-reactivity in the veteran. If the child is not told why their parent is behaving this way (e.g. sad, irritable, sometimes non-functional), it can create confusion and stress in not understanding the reason for the poor family functioning. The lack of clear or effective communication could become a barrier in maintaining a meaningful parent-child relationship (Dekel & Goldblatt, 2008; Galovski & Lyons, 2004). Recent findings have suggested that children's secondary trauma is positively correlated with the parent's trauma severity, in their primarily female sample reviewing secondary trauma in children of parents with mental illness (Lombardo & Motta, 2008). Lombardo and Motta used a *Secondary Trauma Scale* (STS) and *The Revised Children's*

*Manifest Anxiety Scale* (RCMAS) to assess the impact on children. The STS consists of an 18-item self-report questionnaire that gathers symptoms of intrusion and avoidance, while the RCMAS entailed a 37-item self-report questionnaire that measures anxiety in children.

These studies are largely one-sided in reviewing fathers and their children regarding trauma transmission (Dekel & Goldblatt, 2008; Galovski & Lyons, 2004), which does not address possible differences in mothers transmitting distress to spouses and/or child(ren). When discussing the construct of secondary traumatization, Dekel & Monson (2010) specifically state that “[s]upport for this conceptualization comes from studies of wives and children of war veterans of PTSD” (p. 304), which speaks to the lack of literature specifically examining secondary trauma transmission from female military veterans to spouses/child(ren). This is problematic given that contemporary military families have an increasing and unprecedented number of women serving their country and being deployed (Boyd, Bradshaw, & Robinson, 2013).

### **Impact of “Emotional Numbing” / Avoidance Symptoms**

**Relationship adjustment and satisfaction.** The majority of the literature found examining PTSD symptoms and relationship adjustment and satisfaction were focused on male veterans and their female wives/partners. In other instances, the samples were overwhelmingly male veterans (90% or more) or one article by Sayers (2011) used gender neutral terms of “veterans” and “spouses” in reviewing marital problem literature, without specification of what gender samples were being reviewed. Echoing what has been emphasized earlier, studies within a male-dominated field such as the military can be pretty safely presumed by probability to be representative of the male veteran population, but should not be too quickly generalized to all

veterans when the experience of female veterans has not been properly represented. Therefore, caution must be taken in extending these studies' findings to family dynamics and challenges in female-veteran households.

In a study surveying a 93% male veteran sample, most of the veterans in relationships conveyed a major concern being getting along with their significant others (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011). Across the literature, data have consistently revealed male veterans with PTSD and their spouses/partners to report significantly higher relationship conflict, relationship distress, marital problems and lower relationship adjustment, as compared to relationships of veterans without PTSD (Dekel & Monson, 2010; Galovski et al., 2004; Monson, Taft, & Fredman, 2009; Carroll et al., 1985; Riggs Byrne, Weathers, & Litz, 1998; Jordan et al., 1992). Studies have observed a positive correlation between the number of PTSD symptoms reported, and relationship dissatisfaction (Khaylis et al., 2011; Goff, Crow, Reisbig, & Hamilton, 2007). Similarly, and more specifically, Riggs et al., (1998) found the positive correlation between relationship distress and PTSD symptom severity to be particularly strong for “emotional numbing” symptoms. This relationship was found by Riggs and colleagues by assessing various scales of relationship distress including the *Dyadic Adjustment Scale*, *Marital Status Inventory*, *Relationship Problems Scale*, and *Fear of Intimacy Scales*, which are all self-report questionnaires that assess various relationship adjustments and challenges. These scales were analyzed with the *PTSD Checklist Military Version*, which assesses PTSD symptom presence and severity, to analyze the relationship between these two variables. Overall, veterans' difficulties to self-disclose, express and experience a range of emotions in order to effectively engage and maintain intimate relationships can negatively affect intimate relationship

attachments, sexual satisfaction, (Dekel & Monson, 2010), and impairs intimacy (Monson et al., 2009).

Ray and Vanstone's (2009) study outlined the negative cyclic dynamic that emerges between family relationships and emotional numbing symptoms among veterans with PTSD (90% male). "Emotional numbing/avoidance and anger affect[s] familial relationships negatively with an intensified cycle of emotional withdrawal and retreat for both the veterans and their families creating a struggle with healing from trauma" (p. 841). In other words, the emotional numbing and avoidance symptoms exhibited by the veteran influence behaviors of withdrawal from family support, eroding relationships (and with it, sources of support) which then have a negative impact on the veteran's recovery from trauma. These authors used an "interpretative phenomenological approach," with tape-recorded in-depth interviews asking, "What was the experience of contemporary peacekeeping and how did it lead to trauma? What is the experience of healing from the trauma of peacekeeping?... What is the impact of PTSD on veterans' family relationships; and what is the impact of these relationships on healing from trauma?" (Ray & Vanstone, 2009, p. 840-841). These inquiries lead to the emergence of themes of negative cyclic family dynamics.

Reports of relationship and intimacy issues among male veterans with PTSD yielded more steps toward separation and divorce than among male veterans without PTSD (Riggs et al., 1998). This effectively responds to a study that found reductions in risk of divorce following OEF/OIF deployment, and deployment effects to be insignificant or even beneficial (see Karney & Crown, 2011). These authors did not compare post-deployment impact between veterans with and without "invisible wounds" of trauma. All of the studies that have been referenced throughout this text have demonstrated and supported negative impacts to relationships and

families when mental health challenges associated with war trauma is added as a post-deployment stressor.

**Family role functioning: Role ambiguity and ambiguous presence.** As has been established, emotional numbing and avoidance symptoms negatively affect relationships through generating difficulties of self-disclosure, engagement and expression of a range of emotions that are important in effectively maintaining relationships. These hindrances toward effective communication give rise to ambiguity in family role expectations (Galovski & Lyons, 2004). Isolation resulting from emotional withdrawal, detachment, and avoidance symptoms of PTSD impact the veterans' ability to optimally function in prior-held family roles, thereby creating a significant functional loss in the family role structure (Dekel & Goldblatt, 2008; Galovski & Lyons, 2004).

Dekel and Monson (2010) suggest viewing family role functioning ambiguity through the model of ambiguous loss, which describes the state of uncertainty family members are in when unaware of the fate of loved ones (e.g. missing or kidnapped child, soldiers declared missing in action, etc.). Veterans suffering from PTSD can be seen through this lens of ambiguous loss for the family, through physical presence but psychological "absence" so to speak, in their altered, withdrawn behavior. The veterans may not be as involved with the family as they once were before deployment, and family members may be left wondering if their veteran will one day return to pre-deployment behavior (Dekel & Monson, 2010; Faber, Willerton, Clymer, MacDermid, & Weiss, 2008). Faber and colleagues (2008) express this ambiguity in their study (86% male sample) with the term "ambiguous presence" and its effect on resumption of roles and responsibilities. The idea of ambiguous presence is the veteran being physically present,

however feeling psychologically disconnected while trying to reintegrate into the family. Participants in the study reported hesitance and uncertainty in whether the veteran was ready to resume roles once held. These results were found through doing seven waves of semi-structured interviews after deployment, conducted at 3 weeks after return, 4, 6, 12, 24, 36, and 52 weeks after return from deployment, in order to longitudinally follow reported the family dynamics. These interviews entailed questions of areas of stress, coping, marital and parent-child relationship, and social supports. Dekel and Goldblatt (2008) assert that the “persistence of such ambiguity over a prolonged period can lead to emotional distress among those who are close to the father. Consequently, family members experience a confusion of boundaries, which is manifested by transferring the father’s roles to the mother and/or children” (p. 285). Literature expanding to female and mother veterans would be beneficial in bettering our understanding of effects on family role functioning, since men and women often hold different roles within the family structure.

In Ray and Vanstone’s (2009) analyses and interpretations of PTSD on family relationships and its reciprocal effect on healing from trauma (90% male sample), the authors suggest a cyclic effect. The dynamic being that as returning spouses cannot optimally fulfill roles once held, it may produce more stress on the family which may affect their ability to be an effective source of support for the affected veteran. In turn, this could negatively impact the veteran’s coping and symptom severity, thus deepening the veteran’s challenges in fulfilling the desired roll (p.845).

Challenges in fulfilling prior-held roles can spread beyond the family sphere. Faber and colleagues (2008) discussed ambiguous presence in the context of returning to work after deployment in their qualitative interviews of non-clinical veterans (87% male sample). While

for some, returning to work provided a structural routine that reduced ambiguity, for others the ambiguity remained high as veterans encountered difficulties and set backs in finding a job, maintaining a job, returning to a different position, satisfaction with their job, or being laid off. “These setbacks fostered feelings of loss and prolonged ambiguous presence by delaying psychological adjustment...” (p. 227). In applying this occupational challenge to PTSD-veteran population, Sayer et al., (2010) found occupational challenges to be a significant reintegration issue among OEF/OIF veterans screening positive for PTSD compared to OEF/OIF veterans who screened negative for PTSD. According to the data asking for areas of “some to extreme difficulty over the past 30 days,” 43% of those positively screened for PTSD had problems finding a job (compared to 13% of non-PTSD veterans). 60% of those with PTSD reported difficulties doing what is needed for work or school, compared to 17% in those without PTSD. And 35% of the PTSD veteran sample experienced job loss, versus 16% in veterans without PTSD (Sayer et al., 2010, see table 5, p. 595). In military PTSD samples, PTSD is also associated with absenteeism from work (DSM-V; APA, 2013). These data support the impression that symptoms of PTSD in military veterans exacerbate difficulties in resuming prior-held roles after deployment, not only in the family sphere but in other social roles as well (e.g. work roles). These occupational challenges have an inevitable effect on the family as well, who may depend on the veteran’s income. Difficulties in securing and maintaining occupational roles can create or worsen financial strains, further distressing family relationships and dynamics (Faber et al., 2008).

**Parenting difficulties.** Literature on military-PTSD and parenting, which has been largely focused on male veterans of the Vietnam era, show that PTSD symptoms put stress on

the parent-child relationship (see Galovski & Lyons, 2004). Among these studies, inquiries have focused on the deleterious effects of PTSD symptoms (and particularly the emotional numbing symptoms) on male veterans' ability to foster healthy, quality father-child relations and therefore contributing to family dysfunction (Davidson & Mellor, 2001; Jordan et al., 1992; Ruscio, Weathers, King, & King, 2002). Male veterans with PTSD were found to be 3 times as likely to fall in the highest category of the "Parenting Problems Index" than those veterans without PTSD, which assessed "the extent to which respondents felt their children presented problems for them, the extent to which they found being a parent enjoyable, their degree of satisfaction in getting along with their children, and their satisfaction as a parent with the way their children were developing" (Jordan et al., 1992, p. 918-920). Studies of male Vietnam veterans have also shown emotional numbing and avoidance symptoms to be significantly and negatively correlated with father-child relationship satisfaction (Samper, Taft, Taft, & King, 2004; Glenn et al., 2002). While the mechanisms through which these symptoms affect parenting satisfaction and family dynamics should receive deeper examination, Samper and colleagues (2004) speculate that children play a role in co-creating this poor parent-child relationship through a cyclical effect wherein the fathers' cognitive and behavioral difficulties may cause the child to act out, which negatively affects parenting satisfaction and co-creates a cycle perpetuating an impaired parent-child relationship. Overall, current data in father-child parenting dynamics support negative effects on the parent-child relationship.

On another note, Ray and Vanstone (2009) observed some interesting details in their qualitative data that pointed to some fathers viewing their emotional numbing and avoidance as a protective strategy. In the veterans' attempts to shield children and/or spouses from their intrusive and disturbing memories and angry outbursts (especially if the family members

triggered these intrusive memories), they physically and/or emotionally withdrew from family members. The authors interpreted that these avoidant-based problem solving strategies “interfere with the father seeing and meeting the child’s needs... causing estrangement, emotional difficulties and other consequences” (p.845). However, it is equally important to question and examine possible positive outcomes in these strategies, specifically if it shields family members from disturbing memories and angry outbursts. More studies that inquire about potential positive dynamics or outcomes would be beneficial in seeking a balanced view of family dynamics of families dealing with PTSD. Dekel and Goldblatt’s (2008) review touches upon this possibility of positive outcomes in their literature review. These authors note that literature exists pointing to potential “posttraumatic growth” wherein those exposed to traumatic events “report positive changes in their self-perceptions, in their perceptions of others, and in the objectives and meaning of their lives” (p. 287). This may be tied to a renewed appreciation of life after facing traumatic situations that may have entailed near-death, or death of others. Dekel and Goldblatt (2008) further posit that it is possible that children of those with traumatic experiences may develop some positive outcomes as well. While more studies in this vein are sorely needed for PTSD family dynamics, these authors note the beginnings of positive inquiries in family violence, wherein children of abusive families report that children may become more empathetic “or take on various functions within the family, which they perceive as a source of responsibility, power, and development” (Dekel and Goldblatt, 2008, p. 287). I would not be too quick to say that this maladaptive environment can produce solely positive outcomes, but that it is possible that some positive outcomes may also arise simultaneously as some negative outcomes may arise. Further empirical study would help tease these outcomes apart with a more balanced view.

In another area of a paucity of literature, more attention should also be shifted toward research in parenting difficulties of the *mother*-child dyad in female veterans and in OEF/OIF-era U.S. veterans would be beneficial for better understanding contemporary veteran-child issues in those American veterans suffering from PTSD. Studies found among the literature that specifically examine female veterans with children have only been among Vietnam-era veterans. These studies found significant negative relationships between PTSD symptom severity (particularly emotional numbing symptoms) and family adjustment, including parenting satisfaction (Berz, Taft, Watkins, & Monson, 2008; Gold et al., 2007).

One study focusing on contemporary veterans has begun to delve into combat-PTSD and parenting behaviors in OIF era veterans, albeit an all-male sample (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). Gewirtz and colleagues' longitudinal data demonstrated a direct positive relationship between PTSD symptom levels and self-reports of parenting difficulties, measured through reported frequency of perceived inconsistent discipline, positive parenting, positive father-child involvement, father-child arguments, child supervision, and perceived connectedness to child(ren) compared to pre-OIF deployment. This study suggests that parenting issues are a noteworthy challenge among contemporary military veterans. This observation has been supported by a study that surveyed military-related PTSD sufferers (92% male sample) about concerns and treatment preferences. The majority of parents voiced their concern to be primarily regarding *child-rearing* (Khaylis, et al, 2011). "OEF and OIF veterans express both a need for and an interest in family-based interventions, and an increased focus on this area in treatment may significantly improve outcomes for our newest generation of veterans suffering from PTSD" (p.130). These studies emphasize the need for further research on the

parent-child dyad (particularly for female veterans) developing with the PTSD stressor, and the potential benefits in incorporating children into a family-system level treatment process.

### **Overall Family System Functioning**

This chapter has illustrated how the various symptom clusters of PTSD have a negative impact on family functioning, and a potential negative impact on the psychological well-being of the other family members living with the affected veteran. Issues of physical abuse, psychological abuse, primary and secondary traumatization, intimate relationship adjustment, role ambiguity, and parenting difficulties all tie together in unique combinations (depending on varying symptomatic presence and severity) to add stress and dysfunction to the family system. This stressful environment is not only detrimental to the family members dealing with their psychologically injured veteran, but also harmful to the coping-veteran through reciprocal effects. A lack of effective social support (due to decreased family functioning and psychological well-being) impedes the family from being able to provide that effective and positive social support to aid the veteran in the coping and recovery process (National Council on Disability, 2009; Pietrzak et al., 2010). Therefore, the maladaptive environment emerging from the functional consequences of Posttraumatic Stress Disorder is potentially deleterious for all involved—spouse/partner, child(ren), caregiver, and the affected veteran him or herself. However, in addition to the overwhelming support of these negative family dynamics, there is a lack of a balanced view in examining positive inquiries of potential positive family dynamics that emerge in this environment. More focus on this area would give a more complete picture of family functioning.

This chapter sets the stage for a case to be made that PTSD in military veterans is a family-system level issue (as opposed to an individual issue) and thus warrants a family-system level intervention and treatment in order to be comprehensive and efficacious. Further examination of these dynamics in OEF/OIF-era veterans, particularly female veterans, would be beneficial in elucidating and solidifying the experiences and needs of this contemporary military cohort suffering from the invisible injury of PTSD.

## **Chapter 4: Contemporary Challenges & Issues Faced By Female Military Veterans and Their Family Systems**

Chapter 3 exhibited a wealth of research that has focused on veterans' psychosocial issues associated with PTSD resulting from war-trauma. Unfortunately, as the chapter showed, the issues and experiences of war, deployment, and mental health has favored focus upon male veterans, thus overshadowing the experiences of female veterans. Mattocks et al. (2012) offer some possible justifications for this unbalanced focus: One being that the number of male veterans is much higher than the number of female veterans, and therefore the numbers of men with mental health challenges are more as well; and second, that male servicemen have occupied military roles that are more exposed to combat-trauma (at least historically-speaking until the present). I would counter that direct combat is not the only means to induce trauma, given that even as past servicewomen were restricted to supportive roles such as military nurses, that role entailed being continuously faced with handling dead and mangled bodies from the aftermath of combat. Seeing horrific atrocities that happen to others is another recognized form of potentially inducing trauma. The experiences of women in the military (especially as their roles continue to expand and evolve) should not be minimized or underestimated. This chapter aims to focus on studies that have begun to shed light on the contemporary female veteran experience.

Boyd, Bradshaw, and Robinson (2013) compiled an informative historical review of women's evolving role and opportunities in the U.S. military throughout history. Currently, there are an unprecedented number of female U.S. military personnel serving in the armed forces and being deployed on active-duty. Whereas in the past women were only allowed to comprise a maximum of 2% of the military, this cap has since been removed and the number of females in

the military has jumped to 14.5% of the active duty sector, and 18% of the reserve forces sector, with a projected expectation of female numbers increasing by an average 11,000 per year over the next 20 years (Boyd et al., 2013). Boyd and colleagues note that although women are still barred from direct combat roles such as infantry, they are nevertheless being given increasing opportunities to be involved in combat-related jobs (most recently, in a 2012 military policy amendment by the Department of Defense). While there is a heavy concentration of women in medical and administrative positions, women are also taking roles such as military police which provide security to convoys and are responsible for checking vehicles for improvised explosive devices, thereby being exposed to potentially lethal danger (Mattocks et al., 2012; Boyd et al., 2013). Furthermore, as discussed in Chapter 1, the wars in Iraq and Afghanistan have been characterized by unclear battle zones and safe zones (Manderscheid, 2007). Manderscheid discusses that every location has become a potential battle zone, which puts armed service (wo)men under constant threat of being hurt or killed (p.122). These guerilla-style attacks being endured by American service (wo)men increase the potential of women being exposed to combative situations and stressful war environments (Street, Vogt, & Dutra, 2009).

In light of OEF/OIF-era female veterans' expanding and evolving roles and experiences in the military, it is important to focus this chapter on OEF/OIF-era studies of female veterans, since it is less likely that older female military cohort experiences may be relatable (aside from experiences in medical roles). "While many of the mental health readjustment issues of female service members are likely to mirror those of the majority male population, this newest generation of women veterans may also face unique threats to their mental health (Street et al., 2009, p. 686). Unfortunately, this area of research is "still in its infancy," (Street et al., 2009, p. 693) and so there is a need for more empirical research. Studies have begun, however, to try to

delve into the female veteran experience. Two categories of stress have been focused upon in the literature as salient in the female veteran experience: (1) deployment-related stressors (i.e. sexual trauma, combat and traumatic experiences, and separation from family), and (2) post-deployment reintegration challenges. The literature review of this chapter will be organized in the same categorical fashion. While the current knowledge is not in any way comprehensive, it is an important start of an eye-opening qualitative glimpse into the female veteran experience that will help pave the way for future research and hopefully subsequently build better-tailored treatment for this population.

### **Deployment-Related Stressors**

**Combat and traumatic experiences.** In order to have a better understanding of female veteran issues, it is important to explore what kinds of traumatic experiences women are reporting to have faced. One should also ask if there are gender differences in combat exposure on mental health, or in PTSD rates. Recent literature is revealing support for men having higher rates of combat exposure (which is in line with combat roles being occupied largely by men), but also finding that women may also be experiencing substantial combat exposure, and that PTSD rates for men and women are very similar (see Street et al., 2009). Maguen, Luxton, Skopp, and Madden (2012) conducted a study comparing gender differences in traumatic experiences and mental health and findings suggested that, for women, there was a stronger correlation between injury and PTSD symptoms than for men. In Street et al.'s (2009) review of what is currently known about male versus female combat experiences, one particularly helpful study was cited that showed both men and women reporting engagement in various combat situations, but men were more likely to engage in active combat while women were more likely to be involved in

handling the brutal aftermath of combat. Boyd, et al.'s (2013) review of mental health issues of female OEF/OIF veterans reports findings of combat exposure being a strong predictor of PTSD symptoms for female military personnel (as has already been established in the male veteran population).

Qualitative studies provide a sobering peek into examples of women's disturbing military experiences. Women in Mattocks et al.'s (2012) study reported witnessing horrible combat-violence and "acknowledged that these experiences had left them struggling with significant mental health problems, including PTSD and depression" (p. 540). One female diagnosed with PTSD who had worked as a military policewoman providing security to a convoy in Baghdad painfully recounted having to kill a child in a life-or-death situation. Another female who had worked as an emergency room nurse in Iraq discussed her distressing memories of having to see and handle adults and children with severe injuries such as limbs being blown off from explosives. She also reported mortar attacks and other explosive attacks that were going on outside that were so powerful that she would be knocked down from the loud and powerful boom of the explosions. Her retellings described a "dual stress" of having to both tend to disturbingly injured people while also being in continuous fear for her own life from the random guerilla-style attacks of launched explosives (p. 540). Feczner and Bjorklund (2009) also published a case report of the experiences of a female OIF veteran with post-deployment PTSD. She was also a military nurse in Kuwait and Iraq, and recounted a "never-ending flow...of young, mangled bodies" (p. 285). One of her more traumatic memories dealt with soldiers who had been victims of explosives, which produced strong odors of burning flesh; and receiving the victim's body missing its upper half, then later separately receiving his head. These qualitative accounts of a sample of female veterans' experiences help us to understand some of the situations females

encounter during deployment. The severity of the traumatic recollections should hopefully begin to demonstrate the need for more empirical focus on the female experience and mental health outcomes.

**Military sexual trauma.** Military sexual trauma (MST) is an event of sexual harassment, sexual coercion, or rape occurring within the military sphere that is highly correlated with mental health issues such as PTSD, depression, anxiety, or substance abuse (Boyd et al., 2013; Mattocks et al., 2012). Males or females can be victims of MST, but studies show that women experience MST at a much higher frequency (see Williams & Bernstein, 2011; Maguen et al., 2012; Street et al., 2009). Unfortunately, even the numbers that have been tallied from reports are inaccurate, as it appears that MST is vastly underreported; with indications that around half of all sexual assaults go unreported (Boyd et al., 2013).

Why is MST being underreported? What is encouraging this phenomenon? William and Bernstein (2011) touch upon barriers to reporting MST. If one wishes to simply receiving counseling and medical assistance then a file can be reported anonymously, however if one wishes to pursue penalties against an attacker then reports cannot be anonymous. The lack of anonymity creates hesitance in concern for negative backlash. In addition, if a service (wo)man confides in another about the sexual assault then the confidant is obligated to report it, which creates an isolating and silencing effect on the victim if they do not want an un-anonymous report filed. Also, being that the military is a male-dominated field, women are likely to have to report sexual assaults or harassment to male superiors, which may not feel comfortable (Williams & Bernstein, 2011). Another potential barrier is that MST can often be perpetrated by comrades or superiors that the victims must continue to live and work with, and who even may

have power over career decisions (Boyd et al., 2013). The stress of having to work in an environment of sexual threat, and potential negative career penalties if one does not endure it silently, can leave a victim in silent distress and dealing with PTSD instead of getting help (Williams & Bernstein, 2011). Williams and Bernstein also report “unit cohesion” as a source of silencing victims, because if a victim reports sexual assaults then they are seen as violating unit cohesion. This is a form of victim blaming and shaming, instead of holding the perpetrator responsible for violating unit cohesion through their sexual misbehavior. Since a supportive military unit has been found to be a significant resilience factor in buffering PTSD from stressors (as mentioned in chapter 2) (Pietrzak et al., 2010; Street et al., 2009), victims of MST who report their attackers are at risk of damaging or losing supportive unit relationships, which would likely have negative mental health impacts on victims trying to cope with traumatic experiences.

Further, data are suggesting that MST occurring during military enlistment is more strongly associated with PTSD than sexual assaults occurring before or after military service (see Street et al., 2009). Street and colleagues speculate that it may be tied to feelings of there being no escape since you must continue to live and work with the perpetrators in the military sphere, in addition to stress of potential negative repercussions by peers or superiors if any reports are made. Boyd et al.’s (2013) review reports findings that MST is highly associated with PTSD and other mental health problems. Furthermore, Williams and Bernstein’s (2011) review reports finding that MST “poses a risk for developing PTSD that is as high as or is higher than the risk from combat exposure” (p. 142). These issues of developing PTSD does not only affect the veteran on an individual level, but also on a family-level as they return home and must cope with their PTSD symptoms just as any other veteran must. Further study of MST and affected family

dynamics would be beneficial to better understand MST's effect on the family domain as the veteran reintegrates.

**Separation from family.** Separation from family has been noted in the literature as another significant theme for the female veteran experience (Boyd et al., 2013; Mattocks et al., 2012), since women are often the primary caregivers for their children. "Family separation during deployment is a major source of stress for many women deployed to Iraq and Afghanistan and contributes to the development of PTSD (Boyd et al., 2013, p. 15). Boyd and colleagues also reported findings that single mothers were particularly stressed with the separation, as they left children with grandparents or other members of the family.

Mattocks et al.'s (2012) qualitative study showed different reactions in women, wherein some found it easier than others to separate from their children. One female discussed that she grew up in a military family and so was accustomed to being cared for by a single parent while the other was away, and recounted that leaving her 4 month old behind was not that difficult, especially since at that age the child does not know what is going on. Another woman, on the other hand, described much emotional difficulty in leaving her 3 children behind. She recounted that while speaking on the phone with her children, she purposefully only discussed superficial topics because if the conversations were too deep about their lives it would make her emotional, which was difficult to tolerate and balance amidst the harsh deployment environment. These varying reactions support the notion that women have varying levels of tolerance or difficulties in family separation during deployment. These qualitative accounts bring forth questions of what influences the perceived difficulty level in family separation? Possible factors include female veteran's personality, level of maternal drive, age of children, number of children,

culture, support system (spouse, extended family or other), past experiences (e.g. growing up in a military family), or other unknown influences. Further empirical studies are needed to shed further light on “family separation” as a stressor.

### **Post-Deployment Reintegration**

The second major category of stress that female veteran participants have reported in the literature is reintegration challenges once they have returned home after deployment. As Boyd and colleagues note, the exploration of specifically female post-deployment reintegration issues in OEF/OIF-veterans is a newly budding area of research, meaning there is much still to be examined. Topics such as relationship issues, parenting challenges, role renegotiation (especially as females often hold the role of primary caregiver), are all points of interest that are in need of more empirical attention.

Relationship issues in female veterans can be potentially complex in those suffering from PTSD and MST, as these likely affect the female’s ability effectively engage in her romantic relationship. In some, MST can make the victim withdrawn and have issues communicating (Boyd et al., 2013), which is very reminiscent to the impact of avoidance and emotional numbing symptoms among male veteran populations. As was noted near the beginning of this chapter, it is likely that many of the mental health and readjustment issues are similar between male and female veteran populations (especially since symptom-clusters of PTSD are the same for men and women). It is just important to remember that this newest female military cohort may additionally encounter unique threats to their mental health (Street et al., 2009). Further empirical investigation is the only way to tease these similarities and differences apart between genders. Mattocks et al.’s (2012) qualitative study sampling female veterans coping with combat

and military sexual trauma found that the majority of women reported specifically choosing not to discuss their experiences during military service, but rather, keeping to themselves. A study focusing on PTSD symptom presence in female veterans as they correlate with reported psychosocial issues would help to link post-deployment psychosocial issues to the root of mental health concerns, and identify the most appropriate and efficacious treatment strategy based on women's specific challenges and needs.

There is a paucity of literature specifically on mother-child relationships in with female veterans after returning from deployment. What are the challenges that mothers report upon their return? Boyd and colleagues' review (2013) report findings from one study that observed a short-lived honey-moon period upon the mother's return. As time passes, "the children's developmental changes and the impact of the separation can create barriers and increase attachment insecurity" (p. 17). Issues in communication can create further stress on the relationship as the mother tries to readjust out of military mode and back into civilian life, while simultaneously juggling attempts to renegotiate family roles (Boyd et al., 2013). There are many dynamics going on at once that could be potentially overwhelming. Mattocks et al. (2012) described qualitative data that supports the notion of challenges surrounding children undergoing developmental changes in the mother's absence and reintegration challenges following deployment. One mother under the name "Rita" specifically noted how she did not know her children anymore after being gone a year and a half. Before deployment, she had known their clothing and shoe sizes, their likes and dislikes, but in the time she was away everything had changed, and the feeling of not knowing her children was dispiriting. Rita also mentioned not knowing her roles in the family as her husband had started new routines to fulfill her roles in her absence. In instances of female veterans returning with PTSD and/or MST, how does this affect

role renegotiation, parent-child relationships, and child outcomes? Studies with male veteran populations should be extended to female veteran populations to better understand family dynamics and functioning in families who have female veterans, especially those females with mental health issues such as PTSD or MST returning from war, as they may react and cope differently from their male veteran counterparts.

## **Summary**

This chapter aimed to focus on the empirical literature that has begun to shed light on the contemporary female veteran experience as their roles have continued to expand and evolve over time, yet remain largely over-shadowed by research on male veteran samples. As Street and colleagues (2009) noted, many of the mental health readjustment issues of female service members likely mirror those of the majority male population, but females may also face unique threats to their mental health, as the chapter discussed. While preliminary studies have begun to give more attention to the family system of those female veterans suffering from PTSD and/or MST, much more research is needed to better understand the spousal dynamics, mother-child dyad, and family-level dynamics that are significant for an efficacious treatment process. In addition to a lack of understanding of these family-system challenges of this population, veterans overall face barriers in receiving the mental health care that they need. This also hinders the coping and recovery process. The following chapter will review these barriers to veterans and its impact on the coping/recovery process for the veteran and family system.

## Chapter 5: Barriers to Needed Care

Literature focusing on military-related PTSD and other adverse mental health outcomes for military personnel has noted various barriers that hinder veterans and their families from seeking or receiving needed mental health care. One such barrier is the (1) *stigma* that is associated with having a mental health disorder. Veterans may feel embarrassed, ashamed, or reject the possibility of having a psychological injury of war as they may feel it means they are “crazy.” Veterans may also feel that others will stigmatize them by treating them differently, not trusting them to do their job, perceiving them as mentally weak, or even blaming them for their mental health issue (National Council on Disability, 2009). Another barrier to seeking care is veterans’ fears of (2) *perceived potential negative career repercussions*. This concern is borne from a perceived “structural stigma” that if treatment is not kept confidential then it will affect career advancement. There is a difficulty in balancing confidential mental health care with superiors needing to know if a soldier is mentally unfit to perform his or her duties. This potential (3) *lack of confidentiality* creates hesitation in veterans from seeking care, in order to avoid possible negative career outcomes (Tanielian & Jaycox, 2008; Miliken et al., 2007; National Council on Disability, 2009).

Certain minority groups may encounter barriers in a (4) *lack of culturally competent mental healthcare providers* or issues of (5) *language barriers*. “Although most service members and veterans are fluent in English, their family members may have limited English proficiency. Given the important role of families in encouraging veterans to seek services and in locating those services, multilingual outreach and family support is necessary” (National Council on Disability, 2009, p. 53-54). Practical barriers have also been identified across veterans in

general. These include (6) *long wait lists*, (7) *inconvenient distance to mental healthcare providers*, (8) *limited clinic hours*, and (9) *lack of knowledge in what services are offered and where to locate treatment* (National Council on Disability, 2009).

Chapter 4 delved into the barriers for women in reporting military sexual trauma. Women also seem to be facing an interesting (10) *barrier on the societal level*. Literature on the female veteran experience note that since “women’s roles and experiences in the military are often minimized or misunderstood by family, friends, and healthcare professionals, women themselves tend to minimize their contributions” (Mattocks et al., 2012, p. 543). Data from Mattocks qualitative study showed various women expressing that they did not feel their physical or mental health issues were worthy of receiving care from the VA. Street et al., (2009) echoed this issue in their section on perceptions of the “veteran woman” identity. In this section, the authors note that the fact that female veterans have not been deeply exposed to direct combat (at least until recently) may have affected society’s view of female veterans as not “real Veterans” or not experiencing “real danger,” thereby also minimizing their need for VA care (Street et al., 2009, p. 692). This text has tried to raise awareness in female exposure to trauma and danger in both combative and non-combative situations, and hopefully further research into the female veteran experience can change public perceptions and empower women to view their contributions as equally significant to those of men, and that they too are worthy of mental healthcare.

A final barrier to receiving necessary care for some is a (11) *lack of tailored family-system level treatments for those suffering with PTSD*. How can one receive the care they need, if the treatment does not exist? When military-related PTSD sufferers were asked via survey about concerns and treatment preferences, those veterans who had “significant others” voiced

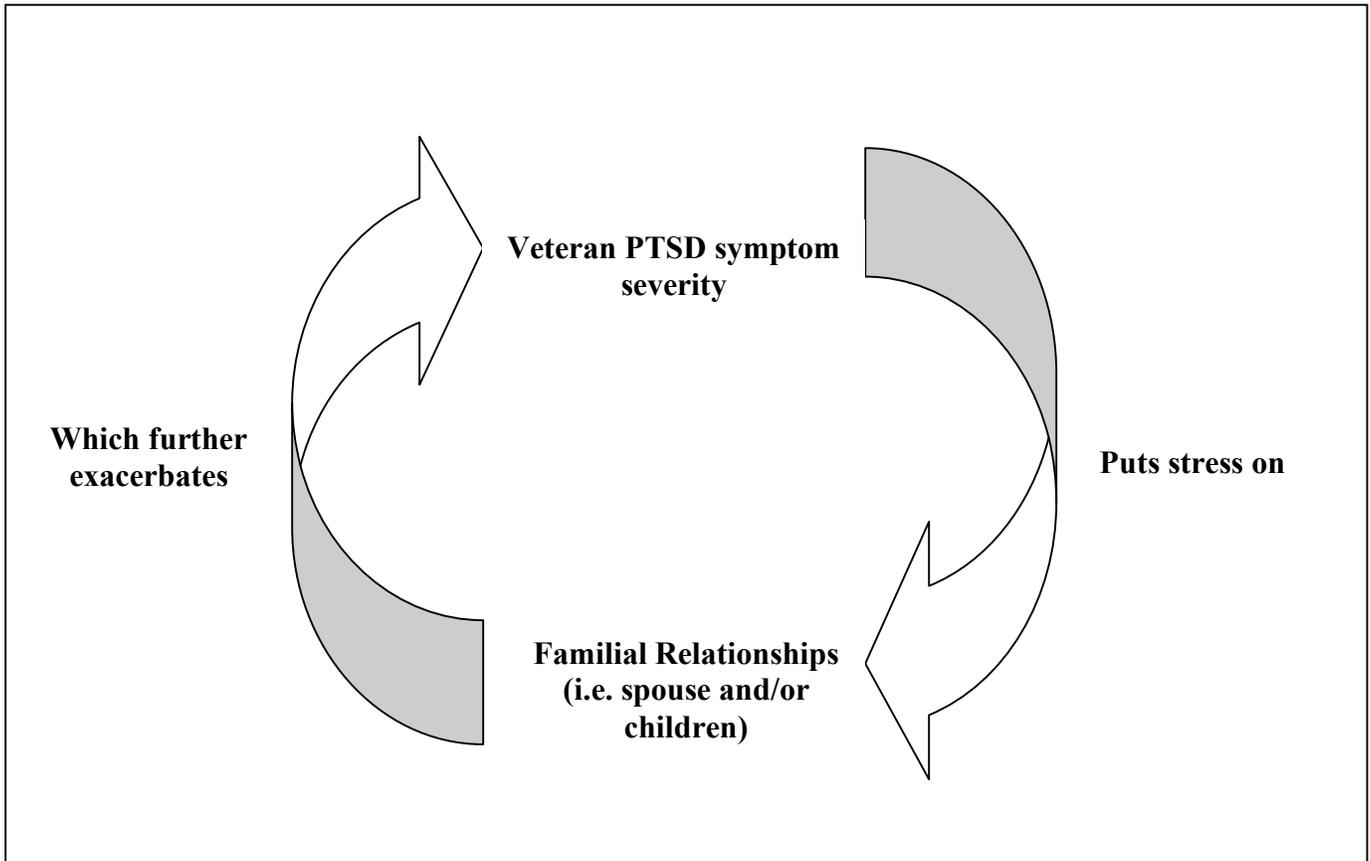
concerns about getting along in these close relationships, and the majority of parents voiced their concern to be primarily regarding *child-rearing* (Khaylis, et al., 2011). “In spite of the urgent need for family-based interventions for returning OEF or OIF veterans, there has been limited treatment development and evaluation in this area” (p.129). The current gold standard of treatment for PTSD is cognitive behavioral therapy (CBT), and the partner of the veteran is often included in the treatment efforts, known as Cognitive-behavioral conjoint therapy (CBCT) for PTSD. Monson, Taft, & Fredman (2009) identified CBCT for PTSD as “the only disorder-specific BCT designed to ameliorate all of the symptoms of PTSD and to enhance relationship functioning concurrently” (p. 709). To reiterate in the same vein, there are no current identifiable disorder-specific treatments for veterans suffering from PTSD who are also parents that include a specific intervention of the parent-child dyad (Galovski & Lyons, 2004; Dekel & Monson 2010). Throughout the chapters of this text, the family (including children) has repeatedly come up as significant in the coping and recovery process. Veterans who are parents need better tailored treatment on a family-system level by including spouses and children in the treatment and intervention process, in order to provide a more comprehensive and efficacious treatment process and break the negative cyclic effect (See Figure 1, pg. 54) of impaired family dynamics, towards more healthy family functioning, and therefore, a healthier recovery environment and stronger social support system for the veteran.

## **Conclusion**

Operation Enduring Freedom and Operation Iraqi Freedom have created a new generation of military veterans and military families, many of which must manage and cope with psychosocial challenges such as posttraumatic stress induced by the psychological trauma(s) faced during war. As many of these affected veterans return to living with spouses and children, these psychosocial issues were shown to bring forth tension, stress, and friction to the family system through a variety of forms, including physical abuse, psychological abuse, primary and secondary traumatization, avoidance and emotional numbing damaging intimate relationships, parent-child relationships, spouse and child psychological well-being, and aggravating role ambiguity. Overall, PTSD and mental health literature has shed light upon the various ways that PTSD symptom-clusters negatively impact family functioning. Further focus should be placed in seeking a balanced view of these family dynamics, through inquiries of potential positive dynamics and outcomes within this environment.

While further research is deeply needed to further understand the female veteran experience, and mental health outcomes interacting with family functioning and dynamics, preliminary studies have shown that female military personnel also have a great need for family-based interventions. This family-system level approach has the potential to increase the efficacy of veteran coping and recovery by helping veteran's living and recovery environment (i.e. family environment). A family-based approach is also necessary for the psychological well-being of the spouses and children as well, who are impacted through living under the environmental stressor of a spouse/parent suffering from PTSD, negatively affecting family dynamics and functioning. Increasing family functioning, (both for the psychological well-being of the family system), removing barriers to necessary treatment, and understanding risk and buffering factors in

fostering resilience to developing PTSD are critical for building a positive and effective recovery environment and social support system for the veteran.



*Figure 1.* Negative reciprocal and cyclic effect between veteran and family  
(Ray & Vanstone, 2009; Monson, Taft, & Fredman, 2009; National Council on Disability, 2009;  
Galovski & Lyons, 2004)

Table 1. Summarized compilation of empirical literature findings examining factors associated with development of PTSD in male and female veterans.

	<b>Pre-Trauma Risk Factors</b>	<b>Pre-Trauma Buffering Factors</b>	<b>Peri-Traumatic War-Zone Stressors</b>	<b>Post-Trauma Risk Factors</b>	<b>Post-Trauma Buffering Factors</b>
<b>Male Veterans</b>	<p>(1) Age at entry into active military service (younger age associated with higher risk of PTSD)</p> <p>(2) Early Trauma History</p> <p>(3) Pre-war Instability in Family of Origin</p> <p>(4) Childhood Antisocial Behavior</p>	<p>(1) "Sense of preparedness" via perceptions of adequate pre-deployment training</p>	<p>(1) Living in continuously hostile environment</p> <p>(2) Perceptions of threat to life in combat experience</p> <p>(3) Witnessing atrocities happen to others</p> <p>(4) Preoccupied with life/family concerns during deployment</p> <p>(5) Lower echelons of ranking (enlisted VS. officer)</p> <p>(6) Serving in the Army (as opposed to other branches of service)</p>	<p>(1) Low morale (in military unit)</p> <p>(2) Low unit support</p> <p>(3) Not receiving a "homecoming brief"</p> <p>(4) Low levels of post-deployment social support</p> <p>(5) Experiencing additional stressful life events post-deployment</p>	<p>(1) Hardiness</p> <p>(2) Social support (both structural and functional)</p> <p>(3) Military unit support,</p> <p>(4) "Aspects of resilience" (i.e. relational capacity, perceptions of purpose and control, positive emotions, cognitive flexibility, meaning-making, active coping)</p> <p>(5) Family and friends' <i>understanding</i> of deployment-related</p>
<b>Female Veterans</b>	<p>(1) Age at entry of service into active military (younger age associated with higher risk of PTSD)</p> <p>(2) Early Trauma History</p> <p>(3) Pre-war Instability in Family of Origin</p>	<p>* <b>More research needed</b></p>		<p>(1) Experiencing additional stressful life events post-deployment</p> <p>* <b>More research needed</b></p>	<p>(1) Hardiness</p> <p>(2) Social support (both structural and functional)</p> <p>(3) Family and friends' <i>understanding</i> of deployment-related issues</p> <p>(4) Relational capacity</p>

Note. Asterisk (\*) indicates lack of female representation in empirical data samples.

Note. Compiled from King et al., 1996; King, et al., 1998; King et al., 1999; King et al., 1995; Seal et al., 2009; Shea et al., 2013; Renshaw, 2011; Iversen et al., 2008; Pietrzak et al., 2010; Pietrzak & Southwick, 2011; Benight & Bandura, 2004; Aldwin et al., 1994)

Table 2. Summary of symptom-clusters of PTSD as stipulated by the DSM-V (APA, 2013, pg. 271-272)

<b>Re-Experiencing Symptoms</b>	<b>Avoidance Symptoms</b>	<b>Symptoms of Negative Cognitions and Mood</b>	<b>Arousal Symptoms</b>
<ul style="list-style-type: none"> <li>- Intrusive and distressing memories of the traumatic event</li> <li>- Recurrent distressing dreams related to the traumatic event</li> <li>- Dissociative flashbacks to traumatic event; feeling or acting as if event is reoccurring</li> <li>- Intense distress may manifest psychologically or physiologically; may be tied to triggers that are symbolic or reminiscent of trauma</li> </ul>	<ul style="list-style-type: none"> <li>- Persistently avoiding any stimuli that are associated with or remindful of trauma (may include people, places, objects, activities, conversation topics, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>- Unable to recall significant aspects of the trauma</li> <li>- Distorted perceptions of self or environment (e.g. I am bad, I am permanently and mentally broken, the whole world is dangerous and untrustworthy)</li> <li>- Distorted perception of cause or consequences of traumatic event, leading to displaced blame on self or others</li> <li>- Persistent negative feelings (e.g. shame, sadness, guilt, fear, horror, or anger)</li> <li>- Feeling detached or estranged from others (i.e. family or friends)</li> <li>- diminished desires to participate in activities, and</li> <li>- Persistent inability to engage in positive emotions (e.g. experience satisfaction, happiness, or affectionate/loving feelings).</li> </ul>	<ul style="list-style-type: none"> <li>- Prone to irritability and angry outbursts</li> <li>- Hyper-vigilance</li> <li>- Difficulties Concentrating</li> <li>- Amplified Startle Response</li> <li>-Disturbance of sleep (i.e. issues falling asleep, staying asleep, or having restless sleep)</li> <li>- Engaging in behavior that is reckless and/or self-destructive</li> </ul>

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