UNDERSTANDING THE EFFECTS OF WAR-RELATED TRAUMA AND DEPLOYMENT ON THE COUPLE RELATIONSHIP: EVIDENCE FOR THE COUPLE ADAPTATION TO TRAUMATIC STRESS (CATS) MODEL

by

STEPHANIE WICK

B.S., Kansas State University, 2001
M.S., Kansas State University, 2005

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2010

Abstract

The purpose of the current study is to understand the lived experiences of military couples regarding the effects of war-related trauma and deployment on couple functioning. An interpretive phenomenological perspective was utilized during data analysis. This type of phenomenological perspective suggests that human phenomena can only be understood in a situated context (Packer & Addison, 1989). This is to suggest that a person's emotions, behaviors, and experiences cannot be separated from the context in which they occur. For the purpose of this study, the "context" under consideration was the Army culture and customs in which each of the participant couples was embedded.

The Couple Adaptation to Traumatic Stress Model (CATS; Nelson Goff & Smith, 2005) offers a constructive step forward in systemically understanding and treating the impediments created by war-related trauma and deployment. The current study utilized the core terms included in the CATS Model (Nelson Goff & Smith, 2005) as sensitizing concepts to guide the qualitative analysis process. This includes the CATS Model couple functioning variables of attachment, satisfaction, stability, adaptability, support/nurturance, power, intimacy, communication, conflict, and roles.

Using qualitative interviews from 90 participants (n = 45 couples), five themes were identified as salient, including *communication*, *conflict management*, *roles*, *support/nurturance,* and *post-traumatic growth*. Participants were divided into subgroups (n = 15 couples, 30 total participants) according to their scores on the Purdue Post-Traumatic Stress Disorder Scale – Revised (PPTSD-R; Lauterbach & Vrana, 1996) and the Dyadic Adjustment Scale (DAS; Spanier, 1976). This subsample was selected to examine differences in themes among couples with high and low levels of marital satisfaction, as well as those with high and low levels of post-traumatic stress symptoms.

Many similarities were found among the couples with high marital satisfaction and those with low levels of post-traumatic symptoms. Likewise, similarities were also discovered among the couples with lowest levels of marital satisfaction and those with highest levels of post-traumatic stress symptoms. From the current study, there is clear evidence in support of the CATS Model elements of communication, conflict, roles, support/nurturance, and satisfaction. A new contribution to the CATS Model can be made from the current study, which is the inclusion of post-traumatic growth.

UNDERSTANDING THE EFFECTS OF WAR-RELATED TRAUMA AND DEPLOYMENT ON THE COUPLE RELATIONSHIP: EVIDENCE FOR THE COUPLE ADAPTATION TO TRAUMATIC STRESS (CATS) MODEL

by

STEPHANIE WICK

B.S., Kansas State University, 2001
M.S., Kansas State University, 2005

A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2010

Approved by:

Major Professor
Briana S. Nelson Goff, Ph.D.

Abstract

The purpose of the current study is to understand the lived experiences of military couples regarding the effects of war-related trauma and deployment on couple functioning. An interpretive phenomenological perspective was utilized during data analysis. This type of phenomenological perspective suggests that human phenomena can only be understood in a situated context (Packer & Addison, 1989). This is to suggest that a person's emotions, behaviors, and experiences cannot be separated from the context in which they occur. For the purpose of this study, the "context" under consideration was the Army culture and customs in which each of the participant couples was embedded.

The Couple Adaptation to Traumatic Stress Model (CATS; Nelson Goff & Smith, 2005) offers a constructive step forward in systemically understanding and treating the impediments created by war-related trauma and deployment. The current study utilized the core terms included in the CATS Model (Nelson Goff & Smith, 2005) as sensitizing concepts to guide the qualitative analysis process. This includes the CATS Model couple functioning variables of attachment, satisfaction, stability, adaptability, support/nurturance, power, intimacy, communication, conflict, and roles.

Using qualitative interviews from 90 participants (n = 45 couples), five themes were identified as salient, including *communication*, *conflict management*, *roles*, *support/nurturance,* and *post-traumatic growth*. Participants were divided into subgroups (n = 15 couples, 30 total participants) according to their scores on the Purdue Post-Traumatic Stress Disorder Scale – Revised (PPTSD-R; Lauterbach & Vrana, 1996) and the Dyadic Adjustment Scale (DAS; Spanier, 1976). This subsample was selected to examine differences in themes among couples with high and low levels of marital satisfaction, as well as those with high and low levels of post-traumatic stress symptoms.

Many similarities were found among the couples with high marital satisfaction and those with low levels of post-traumatic symptoms. Likewise, similarities were also discovered among the couples with lowest levels of marital satisfaction and those with highest levels of post-traumatic stress symptoms. From the current study, there is clear evidence in support of the CATS Model elements of communication, conflict, roles, support/nurturance, and satisfaction. A new contribution to the CATS Model can be made from the current study, which is the inclusion of post-traumatic growth.

Table of Contents

List of Figures

List of Tables

Acknowledgements

Thank you to my major professor, Dr. Briana Goff, who has been a continual presence and source of encouragement throughout my entire graduate career. Her mentorship, friendship, and "realness" have propelled me through many years of trying to balance work, family, and school. For all the hours she spent meticulously editing my work and offering suggestions, I am grateful. And for the "bar" that was set high early on, I am thankful that she had the confidence that I could meet it.

Many thanks to all of the faculty and staff of the Marriage and Family Therapy program, to Dr. Rusty Andrews for giving a rookie a shot at being a therapist years ago, and to all of the FSHS faculty and staff that aided my journey in any way, large or small.

Dedication

This entire project is dedicated to my husband, who has stood next to me for years now, unwavering in his support of my professional endeavors. This project is "our" project—it would not have been possible without his understanding, patience, assistance, and support. It is dedicated to al l the times he left work early, prepared meals, bathed children, changed diapers, cleaned the house, washed and folded laundry, read children's books and played games, listened as I cried, and reminded me that "If it was easy, everyone would be doing it."

CHAPTER 1

Introduction

Exposure to traumatic stressors that involves an actual or threatened death or serious injury, or any other threat to one's physical integrity, may result in a post-traumatic stress reaction, and in the most severe cases, posttraumatic stress disorder (PTSD; American Psychiatric Association [APA], 2000). Posttraumatic stress reactions may also occur after witnessing an event that involves death, injury, or a threat to the physical integrity of another person or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, 2000). Catastrophes that can be avoided, such as war, are especially difficult to overcome emotionally (Figley, 1985). These types of events are not only unexpected, they are viewed as being preventable and often contain an element of blame and perceived injustice.

The National Center for PTSD (NCPTSD, 2009) estimates that 8% of the U.S. population will experience PTSD symptoms at some point in their lives, with women being more likely to develop PTSD than men. Those at greatest risk are those who have: (a) had an earlier life-threatening event or trauma, such as being abused as a child; (b) have another mental health problem; (c) have family members who have had mental health problems; (d) have little support from family and friends; (e) have recently lost a loved one, especially if it was unexpected; (f) have had recent, stressful life changes; (g) use alcohol to cope; (h) are female; (i) are less educated; and (j) are younger (NCPTSD, 2009). It is worth noting, however, that experiencing a traumatic event does not mean that a person will develop PTSD. Although nearly 60% of men and 50% of women will experience a traumatic event at some point in their lives, only about 8% of men and 20% of women will meet criteria for PTSD (NCPTSD, 2009).

Involvement in combat exposes a soldier to unheralded sources and amounts of stress that can lead to immediate and delayed stress reactions that can potentially impair their psychological well-being, physical health, and overall functioning (Waysman, Mikulincer, Solomon, & Weisenberg, 1993). It has been estimated that nearly 30% of Vietnam veterans, 10% of Gulf War (Desert Storm) veterans, 6-11% of Afghanistan War (Operation Enduring Freedom, OEF) veterans, and 12-20% of veterans of the Iraq War (Operation Iraqi Freedom, OIF) have developed PTSD as a result of their time on the battlefield (NCPTSD, 2009). Earlier efforts to understand combat-related PTSD focused primarily on its impact on the soldier. More recent studies, however, have begun to recognize the systemic impact of PTSD on the veteran's spouse and family system (Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough, & Weiss, 1992; Mikulincer, Florian, & Solomon, 1995; Nelson & Wright, 1996; Nelson Goff & Smith, 2005).

Besides the damaging effects of PTSD and trauma on the veteran and his or her family system, the unprecedented number of soldiers deployed to assist with Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) since 2001 has left thousands of families to cope with longer and more frequent absences of their loved ones. Recent Pentagon data suggests that over 1.6 million military personnel have deployed to OIF/OEF since the war in Afghanistan began in late 2001 (Tanielian & Jaycox, 2008). The ongoing need for military families to cope with the ambiguity of their loss, concerns over their loved one's safety, re-negotiation of roles and responsibilities within the family, and other deployment related stressors places them at risk for extreme strain on family relationships and family functioning. Without question, deployment has implications that extend well beyond the battlefield. It is experienced daily by the families who must find ways to cope and maintain a semblance of family under demanding and exhausting conditions.

Purpose of the Current Study

The purpose of the current study is to understand the lived experiences of couples regarding the effects of war-related trauma and deployment on couple functioning. The Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005) offers a constructive step toward a systemic understanding of the impediments created by trauma in dyadic systems. The current study will specifically address the couple functioning variables included in the CATS Model in a sample of OIF/OEF soldiers and their spouses to determine which of these variables are reported as salient among couples who have experienced exposure to war-related trauma and deployment. The current literature related to the systemic impact of war deployment and trauma will be reviewed in Chapter II.

CHAPTER 2

Literature Review

Systemic Impact of Deployment and War-Related Traumatic Events

The Military Culture

Even beyond war and deployment-related separations, military families are faced with numerous life stressors that are inherent in the military culture, all of which must be dealt with as an aggregate (Black, 1993). This pile-up of stressors, often deemed "par for the course," places military families at a higher risk for experiencing crisis than their civilian counterparts. Among these stressors are frequent moves, the potential of being deployed into hostile environments, frequent periods of family separation, geographic isolation from extended family support systems, low pay, young age as compared to the general civilian populations, and a high incidence of young children living in the home (Black, 1993). Perhaps the most potent stressors are those imposed on the veteran and his or her family system as a result of extended deployments and war-related traumatic events. All of this constitutes the culture in which military families are embedded, which is unquestionably inextricable from the day-to-day lived experiences of military families. Interpersonal dynamics, communication styles, roles and leisure time within the family system are all—at least in part—influenced by the values, time commitments, command structure, and segregated living quarters (i.e., living on post/military base) common to the military environment.

Literature indicates that war deployments significantly affect the military personnel as well as their family members. The following sections will (a) provide a definition of key terms essential to the understanding of the current research; (b) summarize the recent literature on the

systemic impact of deployment and combat stress/post-traumatic stress disorder; and (c) review theoretical models of systemic traumatic stress.

Definitions

One of the most critical prerequisites to understanding the current research is having a clear comprehension of what is meant by *trauma* and *traumatic stress*. By definition, *trauma* refers to anything that causes psychological injury or pain—"a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury" (Merriam-Webster Dictionary, 2010). Trauma often results in *traumatic stress*, "a psychological reaction occurring after experiencing a highly stressing event" (Merriam-Webster Dictionary, 2010). Traumatic stress that is severe enough may result in posttraumatic stress disorder (PTSD), characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the traumatic event. However, not all traumatic stress results in PTSD. Trauma may result from many different types of experiences, including rape, assault, abuse, or any situation that poses a threat to one's life. For the current study, *war-related trauma* refers to the any type of trauma or traumatic experience that may be encountered on the battlefield that may or may not result in a diagnosis of combat stress reaction (CSR) or PTSD. This may include, but is not limited to, experiences with direct combat, witnessing death/destruction, and experiencing the deaths of fellow military service members. The experience of deployment may be considered a traumatic experience by some people and not so for others. In the current study, deployment and war-related trauma are considered separate and mutually exclusive experiences.

Deployment

A survey of military spouses completed by the National Military Family Association (2005) measured stress levels at various points during the deployment cycle. Of those surveyed,

62% reported the greatest stress during the deployment or absence of the service member. More specifically, Rosen and colleagues (2000) outlined three types of stressors experienced by military spouses during deployment situations. The first involves *emotional stressors*, which are often associated with the impact of those aspects of deployment that are beyond the spouses' control, such as missing the soldier, problems with communication, concern about the soldier's safety and living conditions, and uncertainty about the length of deployment. A second stressor identified by Rosen and colleagues (2000) involves *deployment related events*, such as problems with managing the household budget, confusion over military entitlements, getting repairs done, increases in childcare costs, and problems exercising power of attorney. The third category involves stressors related to *general life events*, such as financial difficulty and pre-existing marital difficulties.

Years ago, military induced family separation was considered one of the major dissatisfactions of military life (Military Family Resource Center, 1998). One can imagine the potency of this facet of military life given the present day conflict, which has necessitated numerous deployments extending upwards of 18 months at a time. And although a soldier's homecoming is presumed to be a predominantly joyous occasion, the reality is often quite different. Commonly, the family reunion is more stressful than the separation, especially following a long separation or a separation where the service member faced very adverse living conditions (Black, 1993). Returning service members may expect that their family system remain unchanged in their absence; therefore, any shift in family roles that occurred during the separation must again take place when the family is reunited (Black, 1993). In multiple deployment situations, families must undergo this process each time the service member leaves and returns. Commonly, the returning soldier enters a household in which the spouse has

assumed a more independent and assertive role, and who may be reluctant to return to his or her previous role. Furthermore, service members often feel as though their families do not understand what he or she experienced during war and may experience frustration over pressure to assume their former responsibilities (Solomon, 1988).

The inherent nature of deployment might be best described as an *ambiguous loss*—a loss that is overwhelmingly uncertain, vague, unclear, and indeterminate in character (Whiting & Moody, 2009). Ambiguous loss is a situation that arises when a person is psychologically absent but physically present, such as in cases of dementia, or when a person is physically absent but psychologically present, such as in cases of war deployment (Boss, 1999). It is a situation of dysfunction that arises from chronic ambiguity that freezes grief and the resolution of a loss (Boss, Beaulieu, Wieling, Turner, & LaCruz, 2003). The ambiguity of deployment often exposes families to chronic trauma—uncertainty over how long the deployment will last, when the service member will return home for visitation, if the service member is alive, how much risk the servicemember is enduring, to what degree to reorganize the family system, and how adverse the living conditions are (Boss et al., 2003).

It has been suggested that the ambiguity experienced by many military families begins when they begin to wonder about if, or when, their military service member's unit will mobilize and then deploy (Pincus, House, Christenson, & Adler, 2004). Huebner and colleagues (2007) posit that this ambiguity continues at both a *practical* level, such as when a family must reorganize their daily routines so they can function without the physical presence of the deployed member, and at an *emotional* level, such as when a family of a deployed member knows that their loved one is in harm's way, but at any one time cannot know how close to conflict he or she may be.

War-Related Trauma

The most common psychological results of war-related trauma include combat stress reaction (CSR) and post-traumatic stress disorder (PTSD). Combat stress reaction is the most immediate response to extreme combat stress, which is marked by a psychological breakdown on the battlefield (Solomon, Waysman, Avitzur, & Enoch, 1991). It entails extreme losses of safety and security and of trust and self-esteem, which may have a profound and prolonged impact, particularly in the realm of interpersonal relations (Solomon, Waysman, Belkin, Levy, Mikulincer, & Enoch, 1992). In some cases, the debilitating effects of CSR will subside, while in others they may "crystallize" into PTSD (Solomon et al., 1991). When this occurs, veterans experience prolonged effects on personality development, patterns of adjustment, coping styles, and interpersonal functioning (Williams, 1980). The most notable characteristics of PTSD include: (a) Re-experiencing the trauma through nightmares, obsessive thoughts, and flashbacks (feeling as if you are actually in the traumatic situation again); (b) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma); and (c) Persistent symptoms of increased arousal (APA, 2000).

Especially relevant, as noted by Solomon and colleagues (1991), are the symptoms that interfere with the service member's social relations, such as numbing of responsiveness and reduced involvement with the external world, diminished interest in previously enjoyed activities, feelings of detachment and alienation, constricted affect, diminished sexual drive, and difficulty controlling aggression. The interpersonal impact of trauma will be described next.

Interpersonal Impact of Trauma

The interpersonal impact of CSR and PTSD has been well-documented (Carroll, Rueger, Foy, & Donahoe, 1985; Jordan et al., 1992; Mikulincer et al., 1995; Nelson & Wampler, 2000;

Nelson Goff, Reisbig, Bole, Scheer, Hayes, Archuleta, et al., 2006; Nezu & Carnevale, 1987; Riggs, Byrne, Weathers, & Litz, 1998; Solomon, 1988; Solomon et al., 1991; Solomon, Waysman, Levy, Fried, Mikulincer, Benbenishty, et al., 1992; Solomon, Waysman, Belkin, et al., 1992; Waysman, Mikulincer, Solomon, & Weisenberg, 1993; Verbosky & Ryan, 1988). In fact, it has been reported that as many as 70% of veterans with PTSD and their partners report clinically significant levels of relationship distress (more relationship distress, difficulties with intimacy, and relationship problems) than non-PTSD couples (30%) (Riggs et al., 1998). Other reports suggest that Vietnam veterans with PTSD are twice as likely as their non-PTSD counterparts to have been divorced and almost three times as likely to have experienced multiple divorces (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, 1990). Riggs et al. (1998) found that PTSD positive vets and their partners had taken more steps toward separation than the non-PTSD couples in their study.

Solomon, Waysman, Belkin, et al. (1992) suggested that a husband's breakdown in combat may have detrimental consequences for the marital relationship because it often results in lowered self-esteem, depression, and lack of confidence in self and others, all of which impair the veteran's ability to maintain and nurture marital relations. These authors found that wives of CSR veterans reported significant reductions in marital cohesion and satisfaction and an increase in conflict during the immediate post war period, and consistently viewed their marriages as having less consensus, less intimacy, less expressiveness, less cohesion, less satisfaction, more conflict, and poorer integration than the wives of non-CSR veterans (Solomon, Waysman, Belkin, et al., 1992).

It has been suggested that the reasons individuals with CSR/PTSD experience difficulties with intimate relationships may be connected to the PTSD symptoms of emotional numbing (i.e.,

loss of interest in activities, detachment from others, restricted affect) and those related to hyperarousal (i.e., irritability, concentration problems) (Riggs et al., 1998). PTSD veterans tend to be withdrawn, edgy, and preoccupied with themselves and their traumatic experiences (Solomon, Waysman, Levy, et al., 1992). The presence of PTSD interferes with their ability to engage in affectionate, mutually supportive relationships and with resuming his prewar responsibilities (Solomon, Waysman, Levy, et al., 1992). This perpetuates a cycle in which spouses tend to be overworked, underappreciated, and lonely. The changes resulting from CSR and PTSD may undercut the veteran's ability to fulfill his prior emotional and instrumental roles. As a result, the veteran's spouse may feel caught in a marriage with a "changed spouse" who cannot meet her needs and places added responsibilities on her (Solomon, Waysman, Levy, et al., 1992).

One of the most prominent and debilitating effects of trauma is the difficulty with developing and maintaining intimacy in close relationships. Sheehan (1994) noted that trauma intensifies fears of intimacy and, thereby, inhibits the traumatized person's ability to be intimate. Normal relationship activities that are used to soothe and calm non-traumatized couples, such as confiding and sex, become at minimum a source of threat and at worst a source of retraumatization, and are thereby diligently avoided (Johnson & Williams-Keeler, 1998). An earlier study on the marital and cohabitating adjustment of Vietnam veterans with PTSD confirms this (Carroll et al., 1985). The researchers found that the close relationships of PTSD veterans tended to be characterized by less expressiveness and self-disclosure with their partners (Carroll et al., 1985). The rift that is created by this "silence" complicates efforts to manage current stressors and propagates a cycle in which ineffective efforts to cope exacerbates the PTSD symptoms, which increases distress and widens the rift even further (Nezu & Carnevale,

1987). The ability to derive comfort from another human predicts more powerfully than trauma history itself whether symptoms improve and whether self-destructive behavior can be regulated (van der Kolk, Perry, & Herman, 1991). It can be assumed, then, that the inability to derive comfort from another human can have detrimental effects on symptom management and behavior.

Effects on the Spouse/Partner

Perhaps most relevant to war-related trauma is the prevalence of secondary traumatic stress (Figley, 1985). The theory of secondary traumatic stress contends that being in close contact with and emotionally connected to a traumatized person becomes a chronic stressor, and family members often experience symptoms of traumatization (Arzi, Solomon, & Dekel, 2000). In other words, although trauma can have a direct impact on the trauma survivor through the manifestation of his or her spouse's/partner's trauma symptoms, the couple may also experience individual and interpersonal problems including marital disruption, sexual dysfunction, communication problems, and problems with intimacy (Nelson & Wampler, 2000).

Research on the effects of secondary traumatic stress on spouses of CSR and PTSD veterans have yielded evidence of its penetrative effects on those in closest contact with the traumatized veterans. In a study of 120 wives of Israeli combat veterans diagnosed with CSR, Solomon, Waysman, Levy, et al. (1992) found that wives who reported current PTSD symptoms in their husbands were found to have elevated levels of depression, somatization, obsessive compulsive problems, anxiety, paranoia, interpersonal sensitivity and hostility, as well as loneliness, impaired marital and family relations, and lack of social support. Another study by Solomon et al. (1991) reported that husbands' PTSD was the factor most strongly associated with wives' psychiatric symptomatology, and the only factor that consistently acts as a buffer to

the wives' psychopathology was their relationship with their veteran husbands. In another study of 31 wives of veterans with CSR, wives of CSR vets reported more severe psychiatric symptomatology and more somatic complaints six year after the Lebanon war than wives of non-CSR veterans (Mikulincer et al., 1995). The same study found that the more marital intimacy wives reported to having felt immediately after the war, the less severe their symptomatology and the lower the number of somatic illnesses they endorsed six years later.

Mikulincer et al. (1995) proposed that the association between the veterans' trauma in the war and the wives' long term reactions suggest that living with a trauma survivor promotes a process of secondary traumatization due to the chronic stress brought on by the shift in roles that occurs in the family, with wives taking on almost total responsibility for child care and household maintenance (Mikulincer et al., 1995). Other authors have suggested that the wives of PTSD veterans become caught in a "compassion trap" in which they sacrifice too many of their own needs for the rest of the family, promoting a state of chronic distress in which they feel overwhelmed, helpless, hopeless, depressed, anxious, guilty, worthless, hurt, rejected, or angry (Williams, 1980). Wives of PTSD veterans may also overcompensate for their partners' limitations, thereby enhancing more pathology and immature dependence on their companions (Verbosky & Ryan, 1988). Additionally, veterans' inability and unwillingness to engage in communication with anyone other than their partners can make the women their sole contact with the world (Verbosky & Ryan, 1988).

Additional research on the phenomenon of secondary traumatic stress has found that soldier's trauma symptoms significantly predict their female partners' individual trauma symptoms (Hamilton, Nelson Goff, Crow, & Reisbig, 2009). This research also found that, of the three clusters of PTSD symptoms, avoidance symptoms in the soldiers accounted for 13% of the

individual trauma symptoms in the female partners. These results suggest that the trauma in one partner has a propensity to affect the manifestation and maintenance of trauma symptoms in the other partner (Hamilton et al., 2009).

The presence of trauma symptoms has been found to be significantly associated with marital satisfaction. The results of one study consisting of 45 male soldiers and 45 female partners found that the soldiers' trauma symptoms significantly predicted their own and their partners' marital satisfaction (Nelson Goff, Crow, Reisbig, & Hamilton, 2007). For these couples, the presence of sexual problems, dissociation, and sleep disturbances significantly impaired relationship satisfaction for both partners. The results of this study indicate a robust interpersonal quality associated with trauma symptoms (Nelson Goff et al., 2007).

In a slightly smaller qualitative study, Nelson Goff and colleagues (2006) used interviews from nine clinical couples in which at least one couple had experienced a traumatic event. The purpose of this study was to understand the lived experiences of the couples regarding the effects of trauma on their interpersonal functioning. Their findings suggest that interpersonal relationships of trauma survivors may have characteristics that are uniquely trauma based. For example, communication was found to play a significant role in increased relationship functioning. Conflict avoidance patterns may also be due to trauma survivors' symptoms of arousal, which can be extremely detrimental to interpersonal functioning. Other salient themes identified in this study included those associated with levels of cohesion/connection, support, understanding, sexual intimacy and relationship distress.

Summary

The reverberations of war, deployment, and PTSD transcend far beyond the individual veteran. The systemic implications of military-induced family separations and war-related

trauma are visible through the impact they have on the psychological well-being of the veterans' partners, as well as through the strain they place on maintaining a satisfying marital relationship. The shifting of roles and responsibilities, inability to establish intimate connections, and heightened arousal create a "black hole" into which many marriages plunge. In what follows, theoretical models of systemic traumatic stress will be discussed.

Theoretical Models of Systemic Traumatic Stress

With greater awareness of the impact of war and war-related trauma on the family system, researchers have begun to investigate the impact of a soldier's trauma on his or her family. To provide clarity on this phenomenon, Figley's (1995) theory of secondary traumatic stress has been used to understand the impact of one person's traumatic symptoms on the family. More recently, Nelson Goff and Smith (2005) have introduced the Couple Adaptation to Traumatic Stress (CATS) Model, which incorporates Figley's theory of secondary traumatic stress and seeks to provide a systemically-oriented explanation of how individual and couple systems are affected when trauma has occurred. In the following section, each of these constructs will be described in detail.

Secondary Traumatic Stress Theory

Figley (1985) posits that families are affected by traumatic events in four separate ways. The first way is through *simultaneous effects*, such as when a catastrophic event strikes an entire family (e.g., natural disasters, auto accidents). *Vicarious effects* occur when an event strikes a family member who is not in contact with the family (e.g., war, coal mine accidents). *Chiasmal, or secondary, effects* occur when traumatic stress appears to "infect" the entire family after making contact with the victimized family member. Finally, *intrafamilial trauma effects* occur when a catastrophe strikes from within the family (e.g., incest, violence, divorce).

As previously noted, the theory of secondary traumatic stress (STS) suggests that continual and close contact with a traumatized person can become a chronic stressor for non-traumatized family members (Arzi et al., 2000). As such, family members often experience symptoms of traumatization that mimic or resemble those experienced by the traumatized person. Sometimes referred to as "compassion fatigue" (Figley, 1995), secondary traumatic stress includes a cluster of symptoms characteristic of PTSD including exhaustion, hypervigilance, avoidance and numbing. Figley (1995) described three content domains of symptoms, including: (1) re-experiencing of the primary survivor's traumatic event; (2) avoidance of reminders and/or numbing in response to reminders; and (3) persistent arousal.

Secondary traumatic stress is not to be mistaken for vicarious traumatization, which refers to changes that occurs in a professional's or family member's perspective of themselves, others, and/or the world as a result of exposure to explicit, graphic, and/or traumatic material (McCann & Pearlman, 1990). Vicarious traumatization disrupts five separate areas of *cognitive* reasoning, including safety, trust, esteem, intimacy, and control—each of which represents a psychological need—and challenges an individual's desire to believe that the world is a safe place (Baird & Kracen, 2006). Secondary traumatic stress does not focus solely on cognitive phenomenon, as with vicarious traumatization. Instead, it encompasses a much broader syndrome of post-traumatic stress symptoms (Baird & Kracen, 2006), each of which can be experienced by family members who remain in long-standing contact with a traumatized family member.

The Couple Adaptation to Traumatic Stress (CATS) Model

One of the most current and comprehensive models of systemic traumatic stress is the Couple Adaptation to Traumatic Stress (CATS) Model (Figure 1) proposed by Nelson Goff and

Smith (2005). This model includes the primary and secondary trauma effects in the individuals, as well as the interpersonal effects within the couple system and is supported by several empirical studies.

> The CATS Model provides a systemic description of how individual and couple systems are affected when trauma has occurred. The model assumes that a primary survivor's level of functioning or trauma symptoms will set in motion a systemic response with the potential to result in the development of secondary traumatic stress symptoms in the partner. Because the model is circular, symptoms of secondary trauma in the partner may intensify symptoms of primary trauma in the spouse. However, the CATS Model proposes that adaptation to traumatic stress in the couple dyad is depended on the systemic interaction of the three primary concepts: Individual level of functioning, predisposing factors and resources, and couple functioning (Nelson Goff & Smith, 2005; p. 151).

Individual Level of Functioning

The authors conclude that adaptation to traumatic stress occurs in a circular fashion, with the symptoms of the primary trauma survivor affecting the secondary trauma symptoms in the partner, which in turn affect the presentation and intensity of the primary trauma survivor's symptoms. Symptoms in either partner may occur on the emotional (e.g., sadness, anger, anxiety), behavioral (e.g., isolating tendencies, angry or violent outbursts), cognitive (e.g., difficulty concentrating, flashbacks), or biological (e.g., fatigue, headaches) level. For each of the partners, the severity of trauma symptoms may range from acute to chronic.

Predisposing Factors and Resources

Predisposing factors refers to individual characteristics or unresolved stress experienced by either partner prior to the primary trauma. These may include pre-existing mental illness, childhood stress or trauma, individual coping responses, and other trauma-related characteristics such as age, gender, and other factors (Shalev, 1996). The cumulative effect of these pre-existing factors may result in increased role disruption and interpersonal conflict, and decreased relationship functioning. Personal resources of the individual family members may include financial resources, education, physical health, self-esteem, positive coping strategies, and other psychological resources. Additionally, the presence of cohesion, adaptability, shared power, and social support serve as couple and family system level resources. The authors noted that the presence of predisposing factors and personal resources can serve as risk or protective factors that influence adjustment to the traumatic event for both partners or within the couple system.

Relational Functioning and Dynamics within the Couple System

Taken together, the individual levels of functioning and any predisposing factors and personal resources directly affect the quality of relational functioning within the couple system. Nelson Goff and Smith (2005) noted that relationship problems faced by couples who have experienced trauma may include role disruption, parenting problems, poorer family adjustment, difficulties with intimacy, lower relationship cohesion and satisfaction, greater conflict, anger and violence. The "couple functioning" component in the CATS Model is based on specific areas identified in the clinical and empirical literature, including issues relevant to attachment, relationship satisfaction, support/nurturance, power, role disruption, stability, adaptability, intimacy, communication, and conflict, which the authors have indicated as mutually influential components of the couple system.

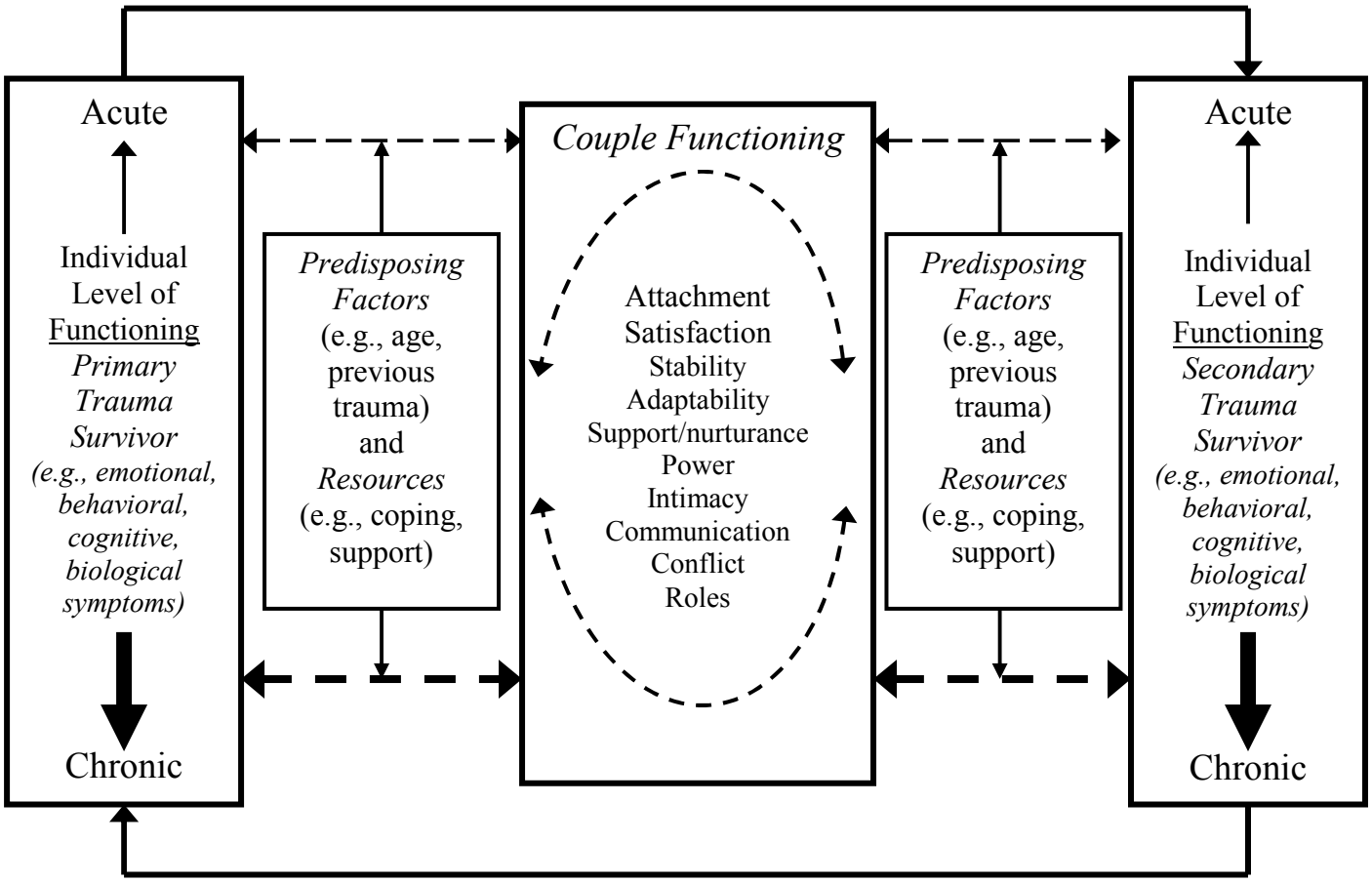

Figure 1. The Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005)

Confirmatory evidence is needed to validate the existence of the "couple functioning" components of the CATS Model (Nelson Goff & Smith, 2005). To do this, the current study has focused specifically on this dimension of the model to determine the variables military couples most consistently endorse.

Summary

The present conflicts in Iraq (OIF) and Afghanistan (OEF) have necessitated frequent, long-term deployments of service members. This has left thousands of families to cope with the ambiguous absence of their loved one, only to be re-united with a person who has likely

undergone immense personal change as a result of war-related trauma. The resulting strain imposed on couples and families by the primary trauma survivor frequently encourages the development of secondary trauma symptoms in family members. The circular and mutually influential nature of trauma, coupled with the high numbers of returning veterans with PTSD, has created a situation in which countless couples are experiencing strain and dissolution as a result of the complications created by the presence of trauma. The CATS Model (Nelson Goff & Smith, 2005) offers a constructive step forward in understanding and treating the impediments created by the presence of war-related trauma and deployment. The current study will specifically address the couple functioning variables from this model in a sample of OIF/OEF soldiers and their spouses. The research methodology will be described in Chapter III.

CHAPTER 3

Methodology

Procedure

This study is part of a larger study of trauma in couples completed by the Trauma Research, Education, and Consultation at Kansas State University (TRECK) Team that utilized a research team of three doctoral students and faculty members to conduct a series of interviews with military couples. The original study included results from 45 couples in two small cities in the Midwest that are close to Army posts near Kansas State University. At the time of the initial TRECK research study, Fort Riley had approximately 10,000 active-duty military personnel and 12,020 family members, and Fort Leavenworth had a population of approximately 5,253 military personnel and 4,613 family members ("Where are the Legions?", 2005).Each of these original interviews was audiotaped and reviewed by the original research team. The research team included a faculty advisor and doctoral students (under the supervision of the faculty advisor) conducting the research interviews, and undergraduate and graduate student assistants transcribing the interviews. All interviews were cross checked for accuracy, with the final interviews resulting in verbatim transcripts of each individual interview that were used for data analysis.

The original study focused on three separate primary research questions that related to primary and secondary trauma symptoms in both partners, mechanisms by which systemic functioning may be affected by trauma, and the effects of trauma on interpersonal functioning. For the current study, secondary data analysis was utilized to address one primary research question, *"In what way(s) is couple functioning affected when there is a history of deployment and war-related trauma?"* Specifically, this study utilized the core terms included in the CATS

Model (Nelson Goff & Smith, 2005) as sensitizing concepts to guide the analysis process. This includes the CATS Model couple functioning variables of attachment, satisfaction, stability, adaptability, support/nurturance, power, intimacy, communication, conflict, and roles.

Various methods were used to recruit participants from the local communities, including publicly posted flyers and newspaper announcements; referral from Army Family Readiness Groups, chaplains, and other local military sources; and referral by other research participants. All recruitment occurred through contacts in the surrounding communities or through contacts to the researchers. None of the participants were recruited by contacting staff or soldiers directly through the military bases.

The sampling method of the original study was both purposive and convenience. This type of sampling technique was selected to ensure that cases were rich in information, depth, and detail. The intent was not to extrapolate the findings to the general population; rather, it was to elucidate on the impact of trauma on a very specific population (i.e., war deployed couples). Couples who met the outlined inclusion criteria volunteered to participate. These inclusion criteria included recent deployment to OIF or OEF, a minimum age of 18 years, involvement in their current relationship for at least one year, and no substance abuse or domestic violence at the time the initial telephone screening was made. Participating couples who completed questionnaires and the interview were compensated $50.

The research procedure was approved by the Kansas State University Institutional Review Board (IRB), with assurances made to follow informed-consent procedures and to protect participant privacy and confidentiality. Military IRB approval was not included in the research procedure because the research project was not completed within the military system,

nor were data collected on the military posts. Data collection began on August 25, 2004, and concluded on June 20, 2005. Of 56 total couples who initially agreed to complete the study protocol, 11 cancelled or did not show for their appointment, resulting in a final sample size of 45 couples with complete data (response rate = 80.36%).

For the analysis portion of the current study, scores from several quantitative research instruments administered during the original data collection were utilized to create sub-groups. These measures included the Dyadic Adjustment Scale (Spanier, 1976), the Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996), and the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994).

Quantitative Measures

Dyadic Adjustment Scale (DAS). Relationship satisfaction/quality was assessed with the Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS is a 32-item measure designed to assess the quality of the relationship as perceived by both partners. The DAS has demonstrated good internal consistency on the total score (alpha = .96), and on each of the subscales: dyadic satisfaction (.94), dyadic cohesion (.81), dyadic consensus (.90), and affectional expression (.73) (Fischer & Corcoran, 1994). The total DAS score will be used in the current study. The DAS has adequate convergent validity correlations (.86 - .88) with the Locke-Wallace Marital Adjustment Test (LWMAT, Locke & Wallace, 1959, as cited in L'Abate & Bagarozzi, 1993), from which it was derived.

Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R). The Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996) consists of 17 items that correspond to each Diagnostic and Statistical Manual for Mental Disorders, 4th Edition, diagnostic criteria for PTSD (APA, 1994), with three subscales that reflect the three

general symptom categories of Re-experiencing, Avoidance, and Arousal. The scale has been shown to have adequate internal consistency, with coefficient alpha for the total score at .91 and subscale alphas at .84, .79, and .81 for the Re-experiencing, Avoidance, and Arousal subscales, respectively (Lauterbach & Vrana, 1996). The scale also has demonstrated good test-retest reliability for the total score (.72) and the subscales (.48 - .71). Convergent validity has been shown by moderate correlations with the Mississippi Scale for PTSD (C-Mississippi; Keane, Caddell & Taylor, 1988) (r = .50) and with the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979) (r = .66) (Lauterbach & Vrana, 1996). Thus, the PPTSD-R items represent the three general classes of trauma symptoms described by DSM-IV diagnostic criteria.

Traumatic Events Questionnaire (TEQ). The Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) was used to confirm the history of trauma and type of trauma. This scale has two versions: a civilian version (with 13 questions) and a military version (with 16 questions). The TEQ was adapted into one form for the current study. The purpose of the scale is to determine the experience of each participant with 11 different types of trauma that have the potential to produce symptoms of post-traumatic stress (Lauterbach & Vrana, 1996). In the original version, participants were asked questions about the specific circumstances of the event (e.g., how old the participant was at the time, how traumatic the event was for them at the time); however, in the current study, these follow-up questions were omitted to reduce the length of the questionnaire. For those participants who answered "no" to all questions, a residual question was included that asked them to describe the most traumatic event they have ever experienced.

Qualitative Interviews

For the current study, data from all 45 soldiers and 45 female partners was included in the initial analysis. Of the 34 questions included in the original qualitative interviews, the current

study focused on the participants' responses to the questions pertaining to couple relational and interpersonal functioning. All of the questions included in the original interviews were developed prior to the development of the CATS Model. For the soldiers, these questions included:

1. In general, how would you describe your relationship?
2. How would you describe your communication with your partner?
3. Who expresses emotions more freely in your relationship?
4. How would you describe your "role" or "position" in the relationship?
5. How satisfied are you with your current "role"?
6. How do you and your partner resolve conflict in your relationship?
7. How would you rate your ability to talk to your partner about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)
8. How would you rate your partner's ability to listen when you talk about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)
9. How did your partner support you in your deployment or other trauma experience?
10. How is your relationship most affected by your deployment (or other past trauma)? Your partner's (past trauma)?
11. When has your deployment (or other trauma) had the most negative effect on your relationship?
12. When has (your partner's experience) had the most negative effect on your relationship?
13. Have there been any positive effects from (that experience) on your relationship?

For the female partners, the questions included:

1. In general, how would you describe your relationship?
2. How would you describe your communication with your partner?

3. Who expresses emotions more freely in your relationship?
4. How would you describe your "role" or "position" in the relationship?
5. How satisfied are you with your current "role"?
6. How do you and your partner resolve conflict in your relationship?
7. How would you rate your ability to talk to your partner about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)
8. How would you rate your partner's ability to listen when you talk about the deployment or the events that happened in your past? (Scale of 1 poor to 10 excellent)
9. How did your partner support you during his/her deployment or in your other trauma experience?
10. How is your relationship most affected by the deployment?
11. When has the deployment (or your partner's other trauma experiences) had the most negative effect on your relationship? Explain.
12. Have there been any positive effects from (the deployment/other trauma) on your relationship?

Research Participants

Original Sample

The total sample in the original study included 45 male soldiers and 45 female partners. Although female soldiers were not excluded from the sample, no female soldiers elected to participate. Soldier participants reported a mean age of 31.18 (*SD* = 6.90), and female partners reported a mean age of 29.36 (*SD* = 6.27). The age range for all participants was 20 to 48. The sample was predominantly European-American (82.2% [*n* = 37] for soldiers, 77.8% [*n* = 35] for partners). The ethnicity of other participants included African-American (11.1% [*n* = 5] for

soldiers, 4.4% [*n* = 2] for female partners); Native American (2.2% [*n* = 1] for soldiers, 8.9% [n = 4] for female partners); Mexican American/Latino (2.2% [*n* = 1] for soldiers, 2.2% [*n* = 1] for female partners); Asian or Pacific Islander (no soldiers; 4.4% [*n* = 2] for female partners); and "other" (2.2% [*n* = 1] for soldiers, 2.2% [*n* = 1] for female partners).

Twenty-nine (64.4%) soldiers had at least a high school degree, and 35.5 % (*n* = 16) had a college degree or an advanced degree. Twenty-four (53.3%) of the partners had some high school or a high school degree, while 46.6% (n = 21) had a college degree or advanced degree. Reported income levels of soldiers indicated that 51% (*n* = 23) had an annual net income of less than $40,000, 35.6% (*n* = 16) had an annual net income of at least $40,000 but less than $80,000, and 11.1 % (*n* = 5) had an annual net income of $80,000 or above. Employment status indicated that 95.6% (*n* = 43) of husbands and 33.3% (*n* = 15) of wives worked full-time. The participants indicated that 95.6% (n = 43) were currently married, that 68.9% (*n* = 31) of soldiers and 64.4% (*n* = 29) of partners were in their first marriage, and that the average relationship length was 5.31 years (*SD* = 5.47; range = 5 months to 21 years; 5 months was the length of marriage for couples who had been together as a couple longer but recently had been married).

Among the soldiers, 95.6% (*n* = 43) served in OIF, and 4.4% (*n* = 2) served in OEF. The average length of deployment was 10.03 months (*SD* = 3.98), and the average time elapsed between when the soldiers redeployed home and when they completed the research study was 5.10 months (*SD* = 3.39). Employment status indicated that 95.6% (*n* = 43) of soldiers worked full-time in the military, with 4.4% (*n* = 2) reporting that they were unemployed. (Note: Military rank was not included in the original data collection; this was an accidental omission by the original researchers. Therefore, participant rank is not reported here as a demographic variable because the data are unavailable.)

For the female partners, 51.1% (n = 23) worked full- or part-time, compared with 46.3% of Army spouses who were employed full- or part-time (Peterson, 2002). The participants indicated that 95.6% (n = 43) were currently married, compared with 51% of total Army soldiers (Office of Army Demographics, 2004). The average relationship length was 5.31 years (SD = 5.47; range = 5 months to 21 years; 5 months was the length of marriage for couples who had been together as a couple longer but recently had been married). Soldiers' rank was not collected in the original study demographics.

Subsample Included in the Current Study

Among the total sample, 15 couples (n = 30 participants) were selected to comprise the subsample, which was the primary sample utilized throughout data analysis (Table 1). Among these participants, the average age for male partners was 30.3 years and for female partner it was 28.4 years. The age range for all of the participants included in the subsample was 22 to 41 (SD = 5.11). For the male partners, 73% were White (n = 11), 20% were African-American (n = 3), and 7% were Mexican-American (n = 1). For the female partners, 80% were White (n = 12), 7% were African-American (n = 1), and 13% were American Indian/Alaska Native (n = 2). Among the female partners, 27% (n = 4) reported having a Masters degree, 20% (n = 3) reported having completed college, 40% reported some college, and 13% (n = 2) completed high school. For the male partners, 13% (n = 2) had completed some graduate school, 20% (n = 3) had completed college, 60% (n = 9) had completed some college, and 13% (n = 2) had completed high school.

Nearly all of the male participants reported being employed full-time (93%, n = 14), and one participant reported being unemployed (not due to a disability). The income levels reported by the participants ranged from $10,000 to $79,999 annually, with the median income falling between $40,000 and $49,999. Female participants reported a full-time employment rate of 33%

Table 1

Summary of Subsample Demographic Information

Couple Number	Age		Race		Education		Income Level	Relationship Length (yrs.)
	Male	Female	Male	Female	Male	Female		
2	25	25	White	White	Completed College	MS Degree	$60,000 - $69,999	3.00
3	34	31	African-American	African-American	Some Graduate	Some College	$50,000 - $59,999	12.00
5	29	30	African-American	White	Some College	Some College	$20,000 - $29,999	2.00
6	26	29	White	White	Some College	Completed College	$20,000 - $29,999	3.00
13	24	23	White	White	Completed College	MS Degree	$10,000 - $19,999	0.50
20	31	31	White	White	Completed College	MS Degree	$60,000 - $69,999	4.00
21	41	31	White	White	Some Graduate	High School	$70,000 - $79,999	11.00
27	25	24	White	White	High School	High School	$30,000 - $39,999	3.00
29	25	22	White	White	Some College	Some College	$20,000 - $29,999	1.60
33	36	34	Mexican-American	White	Some College	Some College	$50,000 - $59,999	10.00
35	23	24	African-American	American Indian/ Alaska Native	High School	Completed College	$10,000 - $19,999	0.60
41	33	35	White	White	Some College	Some College	$60,000 - $69,999	12.00
43	31	22	White	White	Some College	Completed College	$30,000 - $39,999	6.30
44	31	33	White	American Indian/ Alaska Native	Some College	Some College	$20,000 - $29,999	3.00
45	40	32	White	White	Some College	MS Degree	$20,000 - $29,999	3.00
Mean	30.3	28.4					Median: $40,000 - $49,000	5.00

(n = 5), part-time employment rate of 13% (n = 2), and an unemployment due to disability rate of 13% (n = 2). One female partner was a full-time student and five (33%) were full-time homemakers. The average relationship length was five years, with a range of .5 to 12 years (SD = 3.84). All of the participants in the subsample were in married relationships at the time of data collection.

Data Analysis

For the current study, an interpretive phenomenological perspective was utilized during data analysis. The goal is to understand the lived experiences of the couples regarding the effects of war-related traumatic experiences and deployment on couple functioning. Interpretive phenomenology suggests that human phenomena can only be understood in a situated context (Packer & Addison, 1989). This is to suggest that a person's emotions, behaviors, and experiences cannot be separated from the context in which they occur. For the purpose of this study, the "context" under consideration was the Army culture and customs in which each of the participant couples was embedded. Integrating context into the analysis process provides a greater understanding of the behaviors and experiences of the participants, particularly those that may be directly influenced by context.

The primary purpose of the current study was to provide empirical validation for the existing CATS Model by finding evidence of the multiple "couple functioning" variables included in the model. The current study also sought to understand how the presence of these variables differed among couples with high and low levels of marital satisfaction and those with high and low trauma symptoms. Using the CATS Model as an existing framework (which is based on secondary trauma theory), items categorized under the "couple functioning" component

were explored. These items include deduced hypotheses from previous literature and theory identified by Nelson Goff and Smith (2005). Then, through a process of inductive analysis, new themes were identified. Indigenous concepts (i.e., key phrases, terms, and practices that are "special" to the participants) identified by the study participants (Patton, 2002) were inventoried and defined. Retroductive analysis was chosen because it allows the use of secondary trauma theory and the existing CATS Model as a basic framework from which to view the data, but it also allows new themes to emerge so that gaps in the literature can be filled.

The original intention of this study was to utilize multiple coders and team consensus throughout the coding and analysis process. In the current study, a single coder/analyst was used and interviews were reviewed multiple times to ensure a thorough investigation of themes. Data triangulation was achieved by using both quantitative (e.g., PPTSD-R, DAS and TEQ scores) and qualitative (e.g., information-rich interviews) data sources. Triangulation was also achieved by utilizing theory-based and stratified purposeful sampling methods (Patton, 2002). The use of stratified purposeful sampling helped to illustrate the characteristics of particular subgroups of interest (e.g. high/low DAS, high/low PPTSD-R, high/low TEQ) within the framework of the CATS model (theory-based sampling).

The full data set from the original study was comprised of 90 interviews, which were reviewed in their entirety two times during the initial phase of the data coding and analysis process for the current study. Analysis was conducted using the "couple" as the unit of analysis. Although all of the interviews were collected from individual partners, the analysis examined responses from couples. The first of the reviews was to acquire a general sense of the content of the interviews and potential themes and to initiate a process of convergence. By recognizing patterns revealed through recurring regularities within the data, a preliminary "sorting" of

patterns into categories was possible. In an effort to creatively synthesize and present the findings (Patton, 2002), a preliminary codebook of themes based on the CATS Model was then established. This codebook utilized terms within the "couple functioning" portion of the CATS Model as sensitizing concepts (e.g., attachment, satisfaction, stability, support/nurturance, adaptability, power, intimacy, communication, conflict, roles).

Once the initial version of the codebook was clearly outlined, thorough content analyses of the interviews was again performed by the researcher. During this second round of analysis, several of the sensitizing concepts originally included in the codebook were also eliminated due to lack of support (attachment, stability, intimacy, and power) and one was added (perceived post-traumatic growth). It was also during this process that sub-themes began to emerge within the data. For example, sub-themes within "communication" were identified as open/closed, frequent/rare, and high/low information sharing. The "roles" theme was divided into perceived role equality/inequality and role satisfaction/dissatisfaction. The "conflict" theme was divided into conflict avoidance and conflict resolution, and "support/nurturance" was divided into varying levels of empathy/affirmation/effort and frequency of deployment contact

Interviews were then divided into groups based on the participants' quantitative scores on three measures that were administered during the original data collection (Table 2). The intent of this type of stratified purposeful categorizing was to capture major variations in themes among sub-groups of participants based upon their scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976), Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996) scale, and the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994). For each of these evaluative instruments, the five couples with the highest mean scores and the

Table 2

Participants' scores on the Dyadic Adjustment Scale (DAS), Traumatic Events Questionnaire (TEQ), and the Purdue Post Traumatic Stress Disorder-Revised scale (PPTSD-R)

Couple Number	**DAS Scores**			**TEQ Total Scores**		**PPTSD-R Scores**		
	Male	Female	Couple	Male	Female	Male	Female	Couple
2* **	149	149	149	7	0	36	27	31.5
3* **	140	124	132	7	3	19	27	23
5*	75	95	85	4	5	17	78	47.5
6**	102	119	110.5	9	9	61	69.95	65.5
13*	139	120	129.5	6	0	31	23	27
20**	121	122.5	121.75	4	1	19	27	23
21*	133	136	134.5	8	2	45	17	31
27*	89	88	88.5	10	0	66	28	47
29**	111	117	114	9	4	59	56	52.5
33* **	138	134	136	4	2	18	17	17.5
35**	111	110	110.5	6	7	53	66	59.5
41*	100	73	86.5	6	3	22	49	35.5
43* **	77	63	70	8	9	52	68	60
44**	105	101	103	10	7	53	47	50
45* **	69	74	71.5	11	6	53	51	52

**Included in DAS analysis **Included in PPTSD-R analysis ***Included in both the DAS and PPTSD-R analysis*

five couples with the lowest mean scores were identified for further analysis. This was accomplished by pairing all of the participants with their partners to calculate their mean scores (i.e., couple score). Once these scores were figured, the five couples with the highest average scores and the five couples with the lowest average scores on each measure were evaluated and analyzed for thematic similarities and differences. This provided within couple interview data to analyze and compare.

One of the unique features of the current study is the use of survey data from both partners to develop groups. Couples included in the highly satisfied group had mean DAS scores ranging from 129.5 to 149 and included couples 2, 3, 13, 21, and 33. Those in the lowest DAS group had mean scores ranging from 70 to 86.5 and included couples 5, 27, 41, 43 and 45. Full interview data was not available for one couple (29F) due to a recording error during the original interview process, although all quantitative data was accessible. Data for this couple was included in the analysis because of its value to the overall analysis process. However, to supplement the group in which this couple is included (i.e., high trauma symptom group), an additional couple was added (couple 44), bringing the total number of couples in the high trauma symptom group to six.

Couples with the lowest trauma symptoms included couples 2, 3, 13, 21, and 33, all of whom had mean PPTSD-R scores ranging from 17.5 and 23. Finally, couples included in the high PTSD group included couples 6, 29, 35, 43, 44, and 45, all of whom had mean PPTSD-R scores ranging from 52 to 65.5. Incomplete data was available for couple 29; however, due to the value of this couple to the overall analysis, they remained in the high PTSD group. An additional couple (couple 44) was added to supplement the findings.

All analyses were conducted using the "couple" as the unit of analysis. For this reason, all of the participants selected to represent a particular group (i.e., high/low PPTSD-R, high/low DAS) had scores on the PPTSD-R or DAS that were similar to their partners'. For example, both partners either had relatively high scores or relatively low scores. This continuity enabled a more accurate examination of the thematic differences between groups. Due to a marked variability in TEQ Total scores within couples, this same type of grouping was not possible. Furthermore, examination of the TEQ Total scores revealed little differences or consistencies among participants' responses. As a result, TEQ Total scores were omitted from further analysis.

Several couples were excluded from certain analyses due to highly differential scores between the partners. These couples had high levels of between-partner variance in their overall scores on either the PPTSD-R or DAS. For example, the husband and wife in couple five had PPTSD-R scores of 17 and 78, respectively, and were therefore omitted from the PPTSD-R group on the basis that both partners were not experiencing similar levels of post-traumatic stress. The same couple, however, was included in the DAS sub-group because of their similarly low scores. The couples omitted from the DAS group had scores differing by at least 35 points (couples 5, 39, 26, 27), whereas the couples excluded from the PPTSD-R group had scores that differed by at least 23 points (couples 11, 14, 26, 31, 39). Several of the couples met criteria for both the DAS and PPTSD-R groups and were therefore included in both sub-groups (couples 2, 3, 33, 43, 45). The following chapter will discuss the major research findings from the current study.

CHAPTER 4

Results

Analysis of the qualitative data resulted in five salient themes involving *communication*, *conflict management*, *roles*, *support/nurturance,* and *post-traumatic growth*. Within each of the broad themes, multiple sub-themes were also discovered. Communication was delineated into *openness of communication, information sharing, and reciprocity.* Conflict management included the sub-themes of *conflict resolution* and *conflict avoidance*. Roles were delineated into *perceived role equality* and *role satisfaction*. Sub-themes within support/nurturance included *empathy/affirmation/effort, deployment contact,* and *lived experiences*. Lastly, post-traumatic growth revealed four sub-themes including *individual and relational post-traumatic growth.*

Communication Patterns

One of the most prominent themes from the participants' interviews involved some aspect of relational communication patterns, a finding consistent with previous investigations conducted by Nelson Goff and colleagues (2006). One obvious attribute to the communication patterns reported by the couples was that communication often occurred on a continuum from open to closed and high information sharing to low information sharing. Couples who engaged in open communication were more likely to use communication as their primary form of coping and conflict resolution. These couples were more likely to report respectful, supportive, and empathetic communication patterns, to listen attentively, and to avoid direct criticism. Elements of reciprocity were also evident in the couples who practiced open communication. That is, couples practicing open communication were more likely to demonstrate a series of mutual exchanges and messages while alternately affirming and listening to one another—a "back and forth" style of communication. These couples were also more likely to engage in higher levels of

information sharing about their thoughts, feelings, and experiences (e.g., daily experiences, deployment and trauma experiences) than those who exhibited closed communication patterns.

Opposite of open communication is closed communication. Not surprisingly, couples with closed communication styles were less likely to disclose or voluntarily share information about their thoughts, feelings, and experiences (i.e., low information sharing). Due to a more restricted style of communication often characterized by bitterness and hurt, avoidance tactics were often reported during conflict management (which will be discussed more in the following section). Also characteristic of the closed communication styles reported by the participants was greater levels of criticism, one-sided communication efforts (i.e., an absence or deficiency of reciprocity), and infrequent efforts to communicate.

The degree to which couples practiced open versus closed communication was occasionally contingent upon the topic being discussed. For example, some couples reported being more adept at talking openly about relational or everyday issues, but were challenged when discussing deployment and/or trauma related issues. Conversely, other couples could openly discuss deployment and trauma issues, but struggled to communicate effectively regarding relational and interpersonal issues.

Data analysis revealed strong commonalities among the highly satisfied couples and those with low levels of trauma symptoms. Significant commonalities were also found among couples with low relationship satisfaction and those with high levels of post-traumatic symptoms. Therefore, as the discussion of the communication and subsequent themes unfolds, each salient sub-theme will be discussed within the context of: (a) highly satisfied couples and couples who report low trauma symptoms; and (b) couples with low marital satisfaction and high trauma symptoms. When there are differences between the groups, these differences will be

separated out by individual group (i.e., low marital satisfaction and high trauma symptoms). Several couples are included in both the DAS and PTSD groups. Throughout this chapter, couples are identified by their couple number and gender, such that 2F represents the female partner from couple 2, 33M represents the male partner from couple 33, and so on.

Highly Satisfied Couples and Those with Few Trauma Symptoms

Some of the most robust communication themes found in the participants' interviews were strongly related to the level of marital satisfaction and post-traumatic symptoms experienced and reported by the couples. Couples with the highest relationship satisfaction and lowest post-traumatic stress symptoms consistently reported use of open communication and high information sharing in their relationships. Numerous times during their interviews, the phrase "we talk about everything" was used to describe their style of communication. These couples tended to rely on their ability to communicate as a means of coping with everyday and deployment-related stressors, as well as a means to connect with one another: "We talk about everything…we discuss every-, every aspect of our lives entirely" (2F). Exchanges between spouses were often highly affirming, non-threatening, and purposeful. These couples were more likely to make communication a priority, even if the content of the message or timing was not welcomed:

> We talk just about everything, even if it's a conversation with our parents or about something like that. His mother right now is going through a divorce which was very hard for him to talk about that. He feels very comfortable talking to me about it and I say "I understand" and when he told me he's going back again in February…he told, just told me flat out and he said "You know, I expected you to react a lot worse," but so, he tells me pretty much everything whether I want to hear it or not…Well, the openness, we talk

about everything, whether it's good or bad, um, whether he has to pry it out of me or I have to pry it out of him. We talk pretty much about everything, like he kind of just reads my facial expressions to know if I'm having a bad day and he'll kind of pry it out and usually it's something underlying, not really what I was worried about. (13F)

In many ways, communication was experienced as a form of intimacy between the couples and as such played a central role in helping them cope with and mitigate the effects of stress and trauma:

There were a lot of things that we figured out about each other while we were separated. Our communication has gotten this, so much better now. Because we understand each other and the mechanisms behind some of our actions a lot more, uh, things that have always been problems were figure out per say uh, while we were separated. And now we have appreciation for the differences that we have. As well as have our inside view on weaknesses that we have, and agree to compensate for each other in those areas. (3F)

Couples with high levels of satisfaction and low trauma symptoms were also more likely to practice emotional transparency or high levels of emotional sharing than couples with low relationship satisfaction. Emotional sharing tended to differ among men and women, with men slightly more likely to display overt anger and frustration and women slightly more likely to display overt sadness and crying. For some, emotional sharing did not always spontaneously emerge; however, upon prompting or probing from their partner, satisfied couples were able and willing to communicate about their emotional experiences:

She expresses what she feels a lot more and she wants me to understand how she feels on a particular topic. Whereas myself, I may feel a certain way but I do not express myself…unless somebody asks. (3M)

Frequently, the ability to openly communicate was the foundation of the relationship. It provided the ability to bond through emotional and information sharing, to resolve conflict, and to make important decisions. For these couples, communication did not cease just because of the deployment. Efforts to communicate continued despite physical separation. When asked how she would describe her communication with her partner, one spouse responded:

> Much better. Year ten was better than year nine, which was better than year eight. Every year it just gets better. And actually, this last year we were able to internet message and talk on the phone some and email. And so it was like we never really lost that communication. So when he came home it was like, it's like he had almost never left…because we talked so much while he was gone about everything, about what was going on at home and making decisions. He was part of all the major decisions while he was gone, even though he wasn't here. (33F)

It would seem that the number of trauma symptoms experienced by these couples is low enough that they do not interfere with the partners' ability to communicate effectively and affirmatively. However, it also begs a fundamental question: To what degree does their ability to effectively communicate mitigate the manifestation of the trauma symptoms?

In most cases, the degree to which couples were able to communicate openly about deployment and war-related issues mirrored their ability to communicate on other issues. Satisfied couples and those with low trauma symptoms tended to openly share the details of the deployment and traumatic experiences. In this regard, these couples had a propensity to demonstrate high levels of mutual respect and proper discernment when deciding when to share, how much to share, and when to avoid pursuing the issue.

> I kept a journal the whole time I was there…And I read it to her. Usually can't read more than a few pages. It takes a lot. I usually tend to get very emotional after I've read it 'cause a lot of these things I've just let go, forgot about as much as possible…But, you know, she has a right to know so I tell her if she asks me. At first, 'cause she knew I kept it and I told her I had it and if she ever wanted me to talk to her about it, I would. (13M)

> We talk about so many things and we talk very freely with each other. I know that he has seen some things that he doesn't want to talk about it, and he's told [me] that. But when he does want to talk about it, he will…I think he maybe doesn't want to talk about it. But we have talked about some things, just I know that he's seen some things that he would rather just not talk about. (33F)

In sum, couples who reported higher levels of marital satisfaction as indicated by higher scores on the Dyadic Adjustment Scale (DAS) and those with the lowest levels of post-traumatic symptoms also tended to engage in open communication that was exemplified through higher levels of information sharing, more frequent communication exchanges marked by higher levels of reciprocity, higher levels of emotional transparency, higher levels of trust, and better capabilities when discussing deployment and war-related issues.

Couples with Low Relationship Satisfaction and High Trauma Symptoms

Most characteristic of the couples with the lowest relationship satisfaction (and highest trauma symptoms) was their tendency to practice predominantly closed communication marked by low levels of information sharing and minimal reciprocity. The frequency of communication exchanges between these couples also tended to be lower than the number of exchanges between the satisfied couples, and when exchanges did occur, they were more likely to be negatively

tinged. When asked to describe their communication with their partners, participants with low relationship satisfaction/high trauma symptoms tended to reply with "It's closed pretty well all the way around," "No communication," "Not very good," "Poor," "It sucks," and "Hard."

One of the most significant characteristics of the communication styles reported by couples with low relationship satisfaction and high trauma symptoms was the lack of reciprocity. That is, these couples tended to report more one-sided communication efforts, little feedback from their spouses when communication efforts did occur, and more negative responses from their spouses when communication was initiated. For example, when asked to describe communication in her marriage, one spouse replied: "That's poor. I'd say he doesn't pay any attention at all to what I have to say, and he says I just hear parts of the conver- what parts I wanna hear and dwell on those parts. So, we usually tend to argue like that" (5F). Another stated, "I'm talkative, he's not. So I gripe at him for not talking, and he gripes at me because he doesn't want to talk. So we have quite a bit of problem with communication" (27F). A third spouse replied by stating, "I try to talk about things and he'd rather watch T.V., things like that. So, that's hard. And sometimes I've got to the point where there's no point in bringing it up because he's not going to listen anyway" (45F).

For many of the couples who reported low relationship satisfaction and who reported high levels of trauma symptoms, significant difficulties were experienced when attempting to discuss issues related to the deployment and trauma exposure. It seems natural that couples who experience communication issues in their routine lives would encounter the same types of issues when discussing issues laden with emotion and possible traumatization. For many of the partners with low marital satisfaction (n = 8), this appeared to be true. For some, the absence of

communication was due mostly to the soldier's inability or unwillingness to discuss the events of the deployment, even if his spouse was willing to listen.

One soldier commented, "I can't talk to her about anything. Well, she probably listens well…she listens good but just me telling her something, I just can't do it" (45M). One spouse rated her ability to talk with her partner about the deployment a 2 (on a scale of 1-10, with 10 being highest/best), stating "…he doesn't want to speak of anything over there…He'll say I don't understand, I was not there, and I can agree with him, you know. I wasn't there. I don't know what happened or what went on" (27F). One participant noted the stark difference in her husband's willingness to engage in open information sharing and reciprocal communication when discussing the deployment:

> We can talk about anything, especially from my past. Um, as far as things related to the deployment, um, sometimes I wouldn't really say argument, but we get into a debate because he doesn't understand why something particularly affects me the way it does or something of that nature. But we can still talk about it….He can usually {listen} if it's not, um, Army or war related, he does fine. If it's…if it's Army or, um, deployment related, or something like that, he usually, um, wants to be more fidgety or he has things to do as he's listening to me and it's, 'huh, huh, huh' every 2-3 words. Kinda, outa sight, outa mind, kinda thing for him. I mean, he says he tries to leave work at work, you know, and stuff, so it works for him I guess….we have two totally different views with it, too, and he tries to avoid it. (5F)

Several of these partners attributed their communication challenges to recent deployments, separations, or placement within the Army. For example, participants described their communication by stating, "And so I came back from the Army about a year ago,

communication went back down. I can hardly talk to her anymore about anything" (45M); and "Communication trouble, it's gotten worse since things with the Army. I think partially because there's things he can't talk about. And it's just kind of carried over a lot more. So, we really don't talk about much of anything" (45F). Another spouse stated:

> No communication. He's had a, no desire since he's been home to do anything but for himself, which makes me angry…He acts like a big kid, and like he says "Shut up" to me all the time, just like my five year old does…The communication we have is about the kids and work. That's our communication. (43F)

Interestingly, not all of the unsatisfied couples or those with high trauma symptoms practiced closed communication and low information sharing when confronted with issues related to the deployment and trauma exposure. A few of the participants reported moderate to high levels of information sharing regarding deployment and trauma. The soldiers in these couples tended to demonstrate a willingness to engage in conversations related to the deployment, even if the actual frequency of those conversations was minimal. In at least one case, it was the perception that the partner was unwilling to entertain a conversation related to the deployment that prevented such conversations from taking place:

> Anything she asks me, I tell her. You know, we don't really talk about it. I don't know if she just, um, doesn't want to talk about it, anything she would ask me, I would tell her…While I was there, I didn't like to talk to her about it. I wouldn't tell her anything because I just didn't want her worrying. You know, um, and but now if she would ask me something, I would tell her or she would start a conversation about it, I would talk about. But I really don't think she wants to talk about it. She don't want to know. That's just the impression I get, so I don't bring it up. (41M)

Also characteristic of the unsatisfied couples and those reporting high levels of post-traumatic symptoms were impairments in emotional expression, which were commonly typified through a scarcity of meaningful emotional exchanges and more negative “start-ups." These couples tended to experience greater difficulty when trying to initiate emotional exchanges and often intentionally limited their emotional disclosures out of discomfort, self-protection, or fear. For example, one soldier described his wife’s expression of emotion by saying:

> Never shares her own. She’s, her ex-husband pretty much knocked that out of her. She’s afraid to share her emotions most of the time. And when she does, it’s all of them at one time. She keeps ‘em bottled up until it pops. And then I get three months worth of emotions in twenty minutes. (6M)

Couples with more post-traumatic stress symptoms seemed to have significantly more difficulty discussing traumatic experiences than couples with low levels of post-traumatic stress symptoms. Although not unanimous, many of the couples with high levels of post-traumatic stress symptoms reported impairments in their ability to communicate openly about the deployment or other trauma related experiences, to listen empathetically to their partners, and to engage in reciprocal communication. Trauma-focused communication was often restricted or absent. The low frequency of trauma-focused communication and low information sharing was often motivated by one or more factors, including a desire to protect their partners from difficult information, challenges in expression or articulation, uncertainty over their spouses’ reactions to the information, perceptions of an unwilling partner, or a lack of desire to share the information. One soldier stated it this way:

> I really don’t like to tell her things that I don’t know because she might think I have a weakness or something like that. Well, not really a weakness, but, uh, I, I don’t like to tell

her things that happen to me. Of course, I told her some things that happened over there, so I mean, but I really don't want her to hear it. And it's hard for, I can tell her the things but it's hard for me to explain my feelings about things too…I don't want her to have any, be upset about anything too, which is another reason why. (29M)

When asked to rate his ability to talk to his spouse about his deployment experience, one soldier stated:

> Actually, I really haven't. I don't know how to rate that…Well, if she was to be here right now, she'd be crying. I don't think she knows how it really affected me. And I don't, I look at it like…I don't know if she would understand, there's no telling with her, even if she would believe me….I haven't really said anything negative. I don't know. I mean, I'm pretty sure she would listen…I know she would listen, but I don't know how she would take it. (35M)

Summary

Communication patterns among highly satisfied couples and those with low trauma symptoms were unanimously positive, encouraging, open and reciprocal. For couples who reported low relationship satisfaction and those with high trauma symptoms, communication patterns were more varied, with the majority reporting deficits in openness, positivity and reciprocity, and only a few couples reporting communication comparable to satisfied/low trauma symptoms couples. The following section will discuss the results for conflict management styles employed by the participating couples.

Conflict Management

Closely related to communication styles is conflict management, which is presumably intertwined with, and perhaps inseparable from, a couple's ability to communicate effectively.

This theme was separately identified because of its salience within the interviews. Participants were directly asked to describe their ability to manage conflict, therefore providing clear and meaningful data on conflict management styles within and among groups. Not surprisingly, couples with the greatest degree of communication difficulties in their day-to-day communication also tended to experience the greatest difficulty in managing and resolving conflict in their marriages. Early examination of the participants' interviews revealed two distinct conflict management styles: (a) conflict resolution, and (b) conflict avoidance.

Couples who engaged in regular conflict resolution were most likely to utilize their ability to communicate as their primary conflict resolution agent. The ability to successfully navigate through conflict toward a point of resolution is mediated by a couple's ability to communicate with honesty and openness. Efforts to address conflict were most often marked by open and reciprocal communication, low levels (if any) of criticism, higher levels of empathy and understanding, and fewer negative exchanges. Greater levels of discretion among partners tended to be honored as couples chose carefully the "battles" they wished to address. In short, verbal communication was employed to "flush out" the issue and reach resolution.

Conversely, the greatest use of conflict avoidance came from couples whose day-to-day communication efforts could be rendered ineffective, critical, or even absent. In these couples, the use of avoidance tactics was often employed by both partners. Efforts to address a source of contention were commonly met with criticism, stonewalling, or physical departure by at least once spouse. Resolution was rarely, if ever, reached, resulting in a potential pile-up of unresolved conflict, relationship "scars," and emotional devastation.

Highly Satisfied Couples and Those with Few Trauma Symptoms

Across the board (n=10), partners with high levels of relationship satisfaction and those with low levels of trauma symptoms (n=10) endorsed conflict resolution as their method of dealing with conflict. Each of the partners also tended to describe their communication as open and reciprocal, as noted in the previous section. These couples were consistent in their use of verbal communication as a means to dispel and resolve potential conflicts. They tended to rely on their ability to articulate and express their thoughts, feelings, and emotions, and in each of these cases, they were provided a "safe" environment in which to do so. That is, partners tended to display reciprocal and equal effort in their use of active listening skills, empathy, and willingness to negotiate and compromise. These couples also frequently demonstrated a steadfast and unwavering determination to discuss the issue until it was resolved.

When asked to describe how they resolve conflicts in their relationships, these participants repeatedly responded with statements such as, "We just talk about it." For example, one spouse stated, "Uh, we talk about it extensively until it is gone. And it, I mean it's, we pretty much try to air it out until, to the least common denominator so we don't have to be confronted with it again" (3F). Another participant stated, "We talk about it. Um, bring up pros and cons, whatever the conflict is or the discussion. And, you know, we freely express our, our emotions if we have any about the, about it, um, and our opinions on it. So, I mean, we don't hold back" (33M). One spouse described her conflict management style by stating:

> We, whether it's a heated conversation or not, we always calm down and discuss it and apologize or discuss who was right and who was wrong and try to work out a way that would fit both of our views and how we feel about things. (20F)

Satisfied couples and those with low trauma symptoms also demonstrated an ability to exercise proper discernment about when and for how long to pursue an issue. Many of these

couples engaged in negotiated time-out procedures at some point during their conversation to allow ample time for each partner to gather his or her thoughts before re-entering the conversation. Characteristic of these "time-outs" was a mutual agreement and/or expectation that the partners would reunite at some point to fully resolve the issue. For example, one spouse made the following comment:

> We're both pretty stubborn, so, eh, usually if it's something that we just don't want to talk about and hash out immediately, generally we just kinda stop talking about it for a while, let it cool down, and then come back to it again. I mean, we're not the kind of people, don't let things bottle up for too long. (13M)

In short, couples with high levels of marital satisfaction and low trauma symptoms practiced what one soldier described as "mindful communication" (21M), a practice of reciprocal and respectful communication in which proper discernment allows couples to carefully and methodically discuss the issues and to bypass the things that are not relevant. In this manner, effort is taken to diffuse conflicts before they arise by taking a proactive position of early and preventative communication. When responding to questions regarding communication and conflict management in his marriage, this particular soldier responded:

> …sometimes you just need to pull back and think about what you want to say and how you want to articulate it with being mindful not to inferioriate somebody else or step on somebody's toes. And, and sometimes we do say that. We do say things that would not intentionally hurt each other, but just say things off the spur of the moment. And that doesn't happen too often. But when it does there's usually, there's very rarely, if ever, an argument, you know. Everything's already always resolved. If we have an issue about, you know we always talk it out…I think one is that we respect each other's opinions.

> And then secondly, if she has a valid point that negates an argument, then I accept it and we drive on. Likewise with me…I think that how we settle or resolve conflict is that we just don't have a lot of conflict. You know, we avoid conflict by being mindful of, of any potholes in, or flashpoints in, in a situation. And we just diffuse them before they happen. (21M)

Couples with Low Relationship Satisfaction and High Trauma Symptoms

Unlike their highly satisfied counterparts, couples with low relationship satisfaction almost unanimously (9 out of 10 partners) endorsed conflict avoidance as their method for managing conflict. Likewise, 6 out of the 10 of the partners with high trauma symptoms also reported a propensity toward conflict avoidance. Not unlike their highly satisfied counterparts, however, couples with low levels of relationship satisfaction and many of those with high trauma symptoms exhibited conflict management styles that were reflective of what they reported in their day-to-day communication styles. Most of these couples reported predominantly closed and non-reciprocal communication patterns in their everyday attempts to communicate (as noted in the previous section). In like fashion, their attempts (if there were any) to resolve conflict were often met with resistance, low reciprocity, higher negativism, and little closure. Common behaviors reported by the couples included overt refusal to discuss an issue, an inability or unwillingness to engage in meaningful emotional exchanges, threats to leave the marriage or suggestions of divorce as a solution, and physical separation from each other. One soldier described the presence of these behaviors in his marriage by stating:

> …once or twice a month we have a big argument. She'll threaten to leave. I'll leave the house. I'll sit in the car. I'll come back in. I'll ask her how she's feeling. She says "I

> don't want to talk to you." She goes upstairs and sits on the computer and I'll sit downstairs and play on my Playstation. So we separate ourselves. (44M)

When asked to describe how she and her husband resolve conflict in their marriage, one spouse described it by saying:

> Conflict. If it pertains to kids, it's dealt with calmly and 'cause our kids are the most important thing in our life. If it revolves around us, there's, we fight and argue and then I just walk away 'cause then he'll, he thinks it's all better when we go to sleep, and it's not all better. Nothing else, nothing is getting resolved either. I tried telling him, "Look, nothing's getting solved. We need to sit. We need to talk about this. This is how I feel. I need to know how you feel about it so we can work this out." And it's, "I'm busy. Why do you always have to do this right now?" Or some other lame excuse. Um, so then I'll go to bed and then he'll come to bed and try to cuddle and curl up and I don't want it. And it used to not be like that at all. (43F)

The most common response to conflict, as stated by many of these couples, was to walk away from the issue and hope that it supernaturally dissolved on its own. Unlike the satisfied couples and those with low trauma symptoms who engaged in negotiated time-outs with the intent to revisit the issue, unsatisfied couples and those reporting high trauma symptoms were more likely to engage in time-outs with the intent to avoid dealing with the issue. In response to a question about how they resolve conflict, one spouse replied:

> I'm not sure we do. Um, my opinion is the typical male philosophy that if you just sweep it under the rug or walk away, it goes away. Like if you disagree with one of your buddies and later you see him, then it's over with. Um, so his philosophy is to just, I

should just walk away from it, it will go away. So, I'm not really sure that we resolved issues. I think they just wait until a later date to come back to the surface again. (41F)

In his interview, her partner stated:

> Usually by dropping the subject and walking away from it. I think too often we [don't] actually finish an argument. Usually, usually we just end it and walk away from it and then a couple hours later, it's forgotten hopefully. (41M)

One partner commented on the perpetual nature of the conflict avoidance:

> Most of the time, we just shut it out. We don't talk about it. That's what the problem is. We don't, we don't solve it. It just goes on to the next day, next day and ain't never have figured out how to solve it yet. (45M)

Surprisingly, not all of the couples with high levels of trauma symptoms reported conflict avoidant behaviors. For some, their attempts to resolve conflict were comparable to satisfied couples and those with low levels of trauma symptoms. For these couples, the extent of avoidant behaviors tended to exist on a continuum from extreme avoidance to resolution. Nonetheless, couples with lower relationship satisfaction and many of those with high trauma symptoms demonstrated overall higher levels of conflict avoidance than couples who report being more satisfied in their marriages. For those with low levels of relationship satisfaction, it begs the illustrious question of "Which came first?" Are these couples less equipped to communicate and resolve conflict because of poor relationship quality? Or, do they experience low relationship quality because of their inability to communicate effectively? Or, is it a delicate and intricate cycle of mutual influence, in which one fuels the other? This debate will be addressed in later sections. For now, it is clear that couples with low relationship quality and high levels of trauma

symptoms experience significantly higher levels of avoidance and lower levels of resolution than more satisfied couples and those with few trauma symptoms.

Summary

Satisfied couples and those with few trauma symptoms strongly endorsed conflict resolution as their method for coping with challenging issues in their marriages. Conflict tended to be dealt with in a respectful and mindful way with the ultimate goal to resolve the conflict and move forward. Conversely, unsatisfied couples and couples with high trauma symptoms were more likely to engage in conflict avoidant behaviors and have exchanges that were marked by higher negativity, closed communication, and lower reciprocity. Specific to the latter group was greater disparity in their responses. Unsatisfied couples, and more specifically couples with high trauma symptoms, reported greater variability in their conflict management styles. Although a majority of them reported the use of conflict avoidance, a few participants reported efforts to manage conflict similar to satisfied couples with low trauma symptoms. The following section will discuss the findings relevant to roles.

Roles

Analysis of the interviews resulted in a clear delineation of sub-categories pertaining to roles: *perceived role equality* and *role satisfaction.* Couples who perceived their roles in their relationship to be relatively equal were more likely to describe their relationship as a partnership and were subsequently more likely to experience higher levels of satisfaction with their roles. Couples tended to formulate their own classifications of equality and inequality. That is, what may have been perceived as equitable for one couple may not have been perceived as such for another couple. Role satisfaction was often related to the degree to which they felt supported and appreciated in their respective roles. Couples who reported greater perception of role inequality

were more likely to be dissatisfied with their roles. Role inequality often occurred when there was a significant imbalance of responsibilities within the relationship in which one partner assumed a considerably greater amount of responsibility than the other.

Role equality was often discussed in terms of successful negotiation, decision making, and problem solving. Roles were more likely to be perceived as equitable when both parties felt like they had contributed equally to a decision and had effectively compromised to meet the needs of both partners.

Highly Satisfied Couples and Those with Few Trauma Symptoms

Couples with higher levels of relationship satisfaction and low trauma symptoms overwhelmingly reported higher levels of perceived role equality and role satisfaction. Participants discussed role equality in terms of the division of chores, decision making, financial management and provision, caregiving, mutual support, and spiritual leadership. The couples used words and phrases such as "partnership," "50/50," "equal partners," and "co-partners" to describe their relationships. Most couples had a clear delineation of roles such that (for example) the husband may assume the role as spiritual and financial leader, whereas the wife assumed the roles of caretaker and manager of the home. Regardless of how the roles were divided, all of these couples (n = 10) were very satisfied with the division of roles and were aware of and appreciative of the roles that their spouses assumed. For example, one spouse stated:

> When it comes to [child's name], I am more in control. Otherwise, on like finances and other issues, we agree on, we equal out. We, we try to ask each other before making a decision, "What do you think?" And, so we try not to make a decision without each other. (20F)

When describing his role in his relationship, one soldier responded:

> I guess, I view us as equals. But, as a Christian, I'm the spiritual leader of the house, so I view that now, I guess I am the overall head of the house. Not to say that, you know, what I say goes, 'cause I take into consideration opinions and we've talked about everything. We make a decision together. So overall I guess we're equals. (33M)

Underlying couples' perceptions of role equality were elements of respect and flexibility. Couples tended to respect each other's contributions to the relationship and were more willing to assume flexible roles to accommodate their situational requirements (e.g., deployment, transition time, work, days off). When asked to describe her role in her marriage, one spouse responded:

> I used to be like the bossier one. I wanted to be in control more and I've kind of tried to take more of a backseat to my husband and let him be the man. We're equal like when we have to make a big decision. We, he doesn't belittle my opinion. He counts my opinion as very high. (33F)

Another soldier responded:

> I kind of do most of the manual stuff around the house as far as like, you know, picking up, moving things, you know. See, I'd say we help each other in the kitchen. It's kind of hard to say. We help each other in just about everything, so um, I'd say more like manual labor type tasks, like working with the car stuff like that, I do. She does more of the household things than I would do. (13M)

The responses of the satisfied couples often suggested an ability to be flexible and to adapt their roles based on the demands of their current situation. One soldier described his transition from college into the military and his expected transition out of the military:

> I don't know. I just co-partner…there is really no set rules. When we were in college, I did more of the housekeeping stuff like that and doing money things. And then as I

> became the person who worked more often 'cause she had two majors in college, and she worked a lot more than I did, so I did a lot of the housekeeping stuff and cooked dinner most of the nights. But then as I came into the military, I ended up having to work later, and so she ended up taking up the duties. ..I was deployed…but, as I get out of the military, I see a transition of pretty much back to the way it was. (2M)

In short, satisfied couples and couples with low levels of trauma symptoms enjoyed greater role equality and satisfaction. Roles tended to be very complimentary and balanced. Partners were content with not only their own roles, but also those filled by their spouses.

Couples with Low Relationship Satisfaction and High Trauma Symptoms

Couples with low relationship satisfaction and high trauma symptoms were less likely to describe their roles as equal. For these couples, their perceptions of role inequality were based on a number factors including low levels of intimacy and/or closeness, low visibility and/or recognition in the partnership, unwelcome changes in character or attitude as a result of role changes, inability to fill a desired role due to medical complications, and having to unwillingly assume a role. For one spouse, the stress of having to assume a motherly role in her marriage had resulted in extreme role dissatisfaction. When asked how she would describe her role or position in her relationship, she responded:

> A mom. A prostitute and like one of his ex-girlfriends, like I'm nothing. Like his ex-wife, the way he treats her. Which I don't understand either because he jumps to her needs, and he don't even jump to mine or our kid's needs sometimes. So, I feel like I'm taking care of him, and he's 31 years old. He needs to learn how to take care of himself. Yes, being a wife you're supposed to take care of your family, and you're supposed to be there for your family. But, there are some things you can only do so much and then just get fed up

with it. Like I shouldn't have to remind him to take his pills every single day, but I do. Because if he would, I look at it, if he was to have al-, I can't even say the word now, Alzheimer's, if he was to have that, I would remind him and things like that. I would do that. Or if he came home from the war, and he was broken and missing limbs, obviously I know myself, I would help him in any way I could. So that's why I go on with it. Maybe he really don't remember, I don't know. All I know is I feel like a mom to him. (43F)

Additional reasons for role dissatisfaction included: perceptions that they should be doing more to assist their spouses financially or within the home; dissatisfaction over the amount of time they were able to spend together; perceptions of disrespectful and degrading behaviors by their spouses related to their roles; and dissatisfaction over the uneven distribution of responsibilities. One spouse discussed her dissatisfaction with her marital role by saying:

Very observing. I got to say that, careful, and cautious in every way, as far as sexually, emotionally, physically. I just, you just don't want to do too much. You don't want to do too [little]. You don't want to say too much. You don't want to say too [little]. So we kinda keep everything at a level. (35F)

For some, the unequal distribution of responsibilities resulted in guilt that they could not do more to assist their partners in their day-to-day tasks. One soldier described his experience in this way:

…I'm the guy, and like, I take care of her, you know. I, I, I do the finances, and us, she, I, I um, I think it's a partnership though. I mean she takes care of all the house with me and everything. I try to help her out as much as I can, but, you know, she takes care of that stuff and I can't say that I give her that much help, and I feel bad about it. Um, but, I mean, I take care of the finances and I work long hours. I wish I could spend more time

> with her. It's not, I guess, I say a partnership. She takes care of the home front and I take care of, you know, all of the putting the food on the table…Of course I wish I could make more money for her. Um, I wish I had spent more time with her and could help her more with chores, and I guess it would be so-so. I mean, I'm doing the job, but I would like to do it a lot better, I guess. (29M)

The definition of role equality can be self-defined in part by the expectations participants have not only of their spouses, but of themselves to assume certain roles, to take responsibility for certain tasks, and to meet certain needs. In the case of the previous example, it was the belief that he was not fulfilling his role that seemed to contribute to his role dissatisfaction. Interestingly, however, not all couples were dissatisfied with having unequal roles. In fact, several participants reported being very satisfied despite inequitable roles. For spouses, satisfaction came from a sense of empowerment and independence, knowing they could handle the home and children if their husbands were absent. One spouse commented on the unequal roles in her marriage:

> I'm very satisfied with it. I mean, I think, I wish he'd take a little bit more initiative. But as towards bringing all that on, I brought it upon myself because it's what I like to do. I like being able to handle everything myself so. And I know what's going on. I don't have to depend on him to tell me. (27F)

For one soldier who admittedly assumed a less present role in his family life, satisfaction came from knowing that his wife had raised their son. He stated:

> I like my role because she pretty much raised my son. I've been in my son's---he's five years--his life, I've been maybe two years, I've always [been] gone. So, she's pretty much the parent and I'm just the worker. (43M)

Summary

Satisfied couples and those with low trauma symptoms were very consistent in their reports of perceived role equality and role satisfaction. These couples were able to establish a balance of responsibilities that were viewed as equitable by both partners, which ultimately contributed to their level of satisfaction with those roles. Conversely, couples with low marital satisfaction were similar to couples with high levels of trauma symptoms in that they frequently reported dissatisfaction with their marital roles, which were commonly perceived as being unequal. However, this finding was not consistent for all of the couples in these groups. Several couples reported perceived role equality and satisfaction comparable to satisfied couples. The following section will address the findings related to levels of support and nurturance among the couples.

Support and Nurturance

This category embodies three different sub-themes, including *empathy/affirmation/effort, levels of deployment contact,* and *lived experiences.* Participants who demonstrated high levels of empathy, affirmation, and effort were more attentive and aware of their partner's experiences. They were better able to identify with or vicariously experience the thoughts, feelings, and attitudes of their spouses (i.e., shared lived experience). These couples were diligent in their efforts to affirm and encourage one another before, during, and after the deployment and often seized any opportunity to do so (i.e., effort). They openly demonstrated compassion and were able to maintain supportive relationships throughout the duration of the deployment.

Conversely, couples who engaged in low levels of empathy, affirmation, and effort also reported greater relationship dissatisfaction, less frequent and more negative interactions, less effort to reassure and affirm each other, and a stunted ability to identify with or vicariously

experience their partner's thoughts, feelings, and attitudes (i.e., detached lived experience). These couples generally reported lower relationship satisfaction and lived predominantly individually focused lives during and following the deployment.

Highly Satisfied Couples and Those with Few Trauma Symptoms

Couples with high marital satisfaction and those with low trauma symptoms were fervent in their efforts to remain connected to each other throughout the deployment to the degree possible. Higher levels of energy were expended to remain in contact through whatever means were available (i.e., effort). For most, this was a combination of emails, hand-written letters, videoconferencing, and phone calls. One of the differences between couples with high and low levels of marital satisfaction was that highly satisfied couples were more opportunistic in their efforts to remain connected. That is, they were more likely to take advantage of down time and access to phones and computers, which consequently resulted in higher levels of deployment contact. Certainly, access to communication venues was largely dependent on the soldier's placement and job responsibilities while deployed. Nonetheless, couples with higher levels of marital satisfaction engaged in higher levels of deployment contact than those with low relationship satisfaction.

In addition to experiencing higher levels of deployment contact, satisfied couples engaged in more positive exchanges, as did the couples with low trauma symptoms. For many, these exchanges were a source of support, strength, and encouragement. Also noticeable was a strong sense of empathy and understanding—the ability of spouses to vicariously experience and appreciate the role the other was playing, and to subsequently communicate that to one another. In many ways, satisfied couples enjoyed shared lived experiences. In other words, even though they were geographically separated and living two very different lives, they were able to

empathize with one another in such a way that each partner remained connected and involved in the life of the other and demonstrated a strong interest in what was occurring in each other's lives. When asked how her husband supported her while deployed, one spouse responded:

> I think the most important thing that he did was write. I mean he wrote every single day. He wrote all of his feelings, all of his thoughts. He just constantly, anytime he had a chance, he was writing home or emailing home, and that was incredible. Having that was, I think, the best thing I could have had. Having that connection with him and he was always very supportive and just supporting me in believing, himself believing that, you know, the spouses have, I mean we're not going through war, we're not there being shot at or shooting people, but that for us it's also a hard situation. And he knew that and he understood that and he always let me know everything I did he appreciated it. And he was proud of me for it and just constantly he wrote and let me know how he felt and I think that was the best, the best thing that he could have done. (2F)

The same spouse later stated:

> The fact that we did communication so well and I feel like I'm talking to myself. I didn't feel like we had grown apart over the year. I felt like we had grown together, rather than apart. Having that communication and the fact that we are so open with each other, that we talk about everything, made all the difference in the world, because we went through it together. We were apart for a year, but we went through the experience together. (2F)

Throughout deployment, satisfied couples tended to engage in higher levels of information sharing regarding their lived experiences. For example, one spouse described how her husband supported her while deployed:

> He um, just our communication, um, him sharing everything that he was experiencing and seeing and thinking. As well as listening and asking a- asking questions about what I was experiencing, you know, just the interaction, the sharing. (3F)

One soldier stated:

> There's, there's nothing I haven't talked to her about. Nothing that's come up. I mean, you can't count all of your experiences, but anything I think about that I think is interesting, or that I thought was sad, or that was weird, you know, I, I told her about it. Usually the time it happened I, cause we had, I'd write her. I'd write her a lot of letters and then we actually got some e-mail capabilities and we actually got to make phone calls. I told her about stuff like that, too. (2M)

For many of these couples, there was a strong sense of mutual support and partnership—a sense that both partners were involved with the deployment experience, not just the soldier. Contact with one another was mutually initiated, eagerly anticipated, and met with enjoyment, relief, and a sense of connection.

Couples with Low Relationship Satisfaction

Among the couples with low marital satisfaction, there was greater variability in the amount of empathy, affirmative messages, and effort extended by soldiers and spouses. Several of the participants experienced a near absence of support ($n = 4$). When asked how his wife supported him during his deployment, one soldier responded, "Not at all, the whole time. All I got was negative stuff," (43M). Another stated, "Okay, she sent things that I requested, hmmm, she wrote letters…well, actually most of it's not support, complaining. Well, she took care of our family" (5M). One spouse simply responded, "He didn't" (43F). One soldier seemed to be disappointed in his wife's effort to be available when he called home. He stated, "…I called her a

few times and every time I called, she was, like get the answering machine. She's not there. So she'd be out shopping some" (45M).

What seems to be absent from the experiences of many of couples with low relationship satisfaction was the same zealous effort that was unanimously extended by the satisfied couples to remain in contact, express support and empathy, and demonstrate a robust interest in the lived experiences of one another. Instead, couples with low marital satisfaction had a greater tendency to live relatively detached lives and to engage in more negative exchanges. For many, there was little effort to empathize or understand the other's situation. Interestingly, even those who remained in close contact and described their spouses as supportive were less likely to report their spouses as emotionally supportive or to comment on their level of interpersonal relating throughout the deployment. For example, one soldier described his wife's efforts to support him by saying:

> She did all kinds of stuff. She sent videos, sent letters and pictures, and put together care packages and organized through my kid's school for them to adopt us and send us all kinds of stuff…My wife, she must have sent three or four hundred dollars of our own money just on shipping boxes and stuff…so she had a big role in that…So that was a big, you know, that was a big thing she helped support, 'cause she knew that was one thing that made us feel good about what we were doing, you know. (41M)

However, when asked explicitly about the type and amount of emotional support he received from his wife, he responded,

> Half the time, the other half the time I wasn't too supportive for her, so we kind of just switched back and forth, you know. It was a roller coaster, but I'd say, you know, most of the time. (41M)

Noticeably absent from the responses of many of the couples with low relationship satisfaction were reports of regular efforts to console, comfort, and encourage one another during the deployment.

Couples with High Trauma Symptoms

Not all of the couples with high levels of trauma symptoms reported significant decreases in the amount of support and affirmation offered during their deployment experience, a finding that was slightly unexpected. For many of the couples, they reported levels of support, affirmation, and effort that were comparable to couples with much lower levels of post-traumatic symptoms. When asked how his wife provided him with emotional support during his deployment, one soldier stated:

> She would e-mail me constantly. I mean, I just found e-mails on my Army Knowledge Online (AKO) today about next week when I got off, ala-cause we were in the field until Monday of last week and I was on the computer Monday, and I was checking my AKO and I'm like "Wow!" Click on it and it's a love note that she sent me, that she sent me in Iraq….So she said, "Hopefully you can get this. If you do, just want to let you know how much I love you with all my heart and soul. Love, [Spouse's name]." You know, little letters like that. Even today she does the same thing…That was through the entire deployment, and I still see it now. (44M)

However, this finding was not universal. High levels of empathy/affirmation/effort were not consistent among all of the couples with high trauma symptoms. For a few of the participants, significant deficits existed in the amount of support they received from their partners. For these couples, their interactions were more likely to be laden with negative affect

and occurred less frequently. They lacked the ability or willingness to understand the hardships faced by their partners and engaged in primarily detached lived experiences.

Summary

Highly satisfied couples and those with low trauma symptoms consistently reported high levels of support and nurturance, characterized by high levels of empathy/affirmation/effort, frequent and positive deployment contact, and shared lived experiences. Alternately, couples with low martial satisfaction most frequently reported low levels of empathy/affirmation/effort, moderate to low deployment contact, and detached lived experiences. Perhaps most interesting were the mixed findings among couples with high trauma symptoms. These couples reported a blend of high and low levels of empathy/affirmation/effort, frequent to low levels of deployment contact, and a combination of shared and detached lived experiences. The following section will address the last of the major themes identified in the data: post-traumatic growth.

Post-Traumatic Growth

The notion of post-traumatic growth (PTG) has gained salience in the literature over the past few years. It suggests that individuals can experience individual growth, positive changes in relationships, new potential for one's life, a greater appreciation of life, a greater sense of personal strength, and heightened spiritual development as a result of traumatic exposure and/or experiences (Tedeschi & Calhoun, 2004). Commonly, trauma survivors report valuable gains as a result of enduring a traumatic event. Among the participants in this study, two sub-categories of PTG were evident, including *individual post-traumatic growth and relational post-traumatic growth.*

Participants who endorsed individual PTG were able to identify areas of growth and resilience within themselves that were the result of the deployment, trauma exposure, and/or

physical separation from their partners, whereas participants who reported relational PTG cited their deployment experience as a source of relational growth and resilience, evident through a more committed and stronger marriage. For some, the changes that occurred as a result of the deployment and/or trauma experiences were temporary and eventually faded away once the novelty eroded. However, others reported changes that continued to endure for long periods of time.

Highly Satisfied Couples and Those with Few Trauma Symptoms

All five couples who reported the highest relationship satisfaction reported significant accounts of post-traumatic growth and improved relationship cohesion as a result of their deployment and trauma experiences. Similar results were reported by the five couples with the lowest reported trauma symptoms. These couples consistently reported improvements in levels of intimacy, ability to communicate with one another, sense of cohesion and connection to each other, appreciation of their relationship and partner, and confidence in the strength of their relationship. Their ability to recognize and "label" traumatic events as opportunities for growth signified a level of resilience not consistently evident in the couples with lower levels of relationship satisfaction and higher levels of post-traumatic symptoms. One soldier described how the deployment and other trauma experiences had most affected his relationship with his wife:

> It's been affected very well, very positively. Again it was the deployment helped to bond us together better. Helped us to be able to be stronger and to really see what our relationship is made out of, that even in the midst of being away from one another, we can still, still hang in there…The trauma has drawn us closer together. You know, I say that because we don't allow the traumas to define our relationships. But we can let them

> help validate our relationship. Meaning that it's worth being in there, that even in spite of the trauma, that even in the miscarriage, that we're in there for better or for worse. And it shows that our relationship isn't so much external, but it's more than that. That we can make it through the external problems, whether it's the miscarriage or the deployment, you know, can see what we're made out of. (3M)

In her interview, his wife responded:

> No, I just think we understand each other a lot more than we used to. And in some ways, we'd say the deployment saved our relationship. We've even discussed that aspect of it, cause there's some things that I don't see how they could have been resolved if he wasn't away (3F)

As she continued her response, she addressed her individual post-traumatic growth:

> I think currently everything that I've experienced, I really appreciate because it's all made me who I am, and what I, the way I see things is based on what I've experienced. And so, in the way that I contribute to the relationship and the way that I receive the relationship, I've believed that it has been totally enhanced. (3F)

Other couples used phrases such as "We've always been close, but we're closer," "A finer appreciation of each other," and "Having that faith in the strength of our communication" to describe areas of relational growth. In each of these cases, the positive changes that occurred seemed to be enduring, extending beyond the post-deployment transition period.

These couples were able to demonstrate resiliency in the face of adversity and were better able to incorporate "lessons learned" into their marriages that served to promote relationship quality. One soldier shared his thoughts on how his relationship had been affected by his recent deployment:

> I think it's stronger. I've always thought, I, I would never do it on purpose, but separation, being separated from each other for periods of time is, is, has definitely strengthened us, our relationship…Unless you develop some of your own interests and unless you go out and try things that maybe your partner's not interested in. It also lets you appreciate the time you have together because you realize there are people out there that haven't even been away from their spouse for more than five days. And that for them, being apart from their spouse for five days is a traumatic event. And it is, there's no doubt about it. Being away from the person that you care about the most is a big deal, but it gives you perspective when you're gone for a year. And not only are you gone for a year, but one of you is in imminent danger most of the time. It makes you appreciate how much, how great it is just to have that person around. (2M)

These couples shared an ability to find the "silver lining," to recognize the potential for growth in less-than-ideal circumstances and were able to focus their attention on the positive facets of their experience rather than ruminating over the negative ones.

Couples with Low Relationship Satisfaction

Couples with low relationship satisfaction were far less likely to report post-traumatic growth or improvements in relationship cohesion. In fact, 8 out of the 10 partners included in the low relationship satisfaction group indicated no relational post traumatic growth. Instead, many of them reported relationship struggles and tension that emerged as a result of the deployment and trauma experiences. One spouse stated:

> Just that it hindered the communication a lot more and I think part of it is that a lot of that stays so much in his mind and there's things he can't talk about, and other things in our lives probably seem kind of trivial in some ways. (45F)

Some of the participants reported issues with trust resulting from real or suspected infidelity. One spouse recounts her experiences when asked how her marriage was most affected by the deployment:

> Trust issues…it's just, it's very hard. And fortunately I do trust him, but it's very hard. When this first time, when he went I was only here with him twelve days before he left. And he was only here like just a week longer than that. This time, I'm gonna know a bunch of the people he's going with. And, I didn't like him sharing tents with females the first time around. Now that I know some of these females, I don't like it at all. And he's like, "Well, you don't trust again." It's not necessarily a matter of trusting him always. Um, and the same vice versa. Um, he, I was like chatting and stuff on the internet and he knew about that in the beginning. Well, he knew about it, but then he, I guess he really wasn't very familiar with how it operated. And then he found like out, how it worked. And he's like, "Well, you might as well be talking to people on the phone." It wasn't just males I was talking to, but that ended up being a big, big trust factor. Which, you know, I can, although I felt like I wouldn't doing anything wrong, if the shoe was on the other foot, you know, I would have felt the same way. I mean, 'cause, you have access, they can see you/ hear you. If you have a web cam, whatever, you know. And even if you don't, they can send you stuff. (5F)

Perhaps more common were reports of individual post-traumatic growth. In these cases, participants were unable to recognize areas of relational growth, but were able to identify how they had been changed as individuals. For example, one spouse stated, "I discovered I can do it on my own. Financially I couldn't, but I know I could do it on my own" (41F). Another spouse described her newfound independence:

> Well, the only thing I can think of is, um, while he was gone, I kind of came and went and did things as I wanted to. And like now he wants it to be like it used to be, where we went everywhere together kind of thing. And if I want to go do something by myself or go somewhere, he's like, doesn't want me to and it causes a lot of bitching and stuff like that…But I've really like being able to do that while he was gone." (45F)

The same spouse continued by describing her experiences with enduring relational struggles since reuniting with her husband:

> You have to flip back and forth between different ways of living and different ways of communicating, and different ways of talking about things. It's just everything and you have to do one way when they're here. And you have to totally do another way when they're gone. It's like being two different people adjusting back and forth. (45F)

For some, the experience of deployment resulted in temporary, and perhaps transient, post-traumatic growth. In such cases, the couples experienced a surge in relationship cohesion and satisfaction during the acute post-deployment phase, only to have it fade away as old habits and ways of functioning were resumed. One soldier stated:

> Every time I've ever left home for a period of time, whether it was couple of months for some sort of training or whatever, we both kind of realize—to a point—how much we take each other for granted. And we do better for a while and then we start taking each other for granted again. It's time for me to leave, so we realize it again. In some way, leaving, me leaving, being away for short periods of time really does us some good. Plus, I just get tired of her. (41M)

In short, couples with low relationship satisfaction generally did not experience significant and enduring post-traumatic growth or increased relationship cohesion as a result of

their deployment and/or trauma experiences. Instead, many reported an increase in relationship struggles, individual post-traumatic growth, short-term relationship post-traumatic growth, and a lack of resilience.

Couples with High Trauma Symptoms

Couples with high levels of trauma symptoms were more varied in their experiences of post-traumatic growth. For some, the relationship cohesion that ensued following their deployment experience was very similar to the experiences of couples with lower levels of post-traumatic stress. That is, some of these couples were able to identify ways in which their relationship had been strengthened as a result of the deployment. For others, however, there was little indication that post-traumatic growth had occurred. These couples were more likely to express the difficulties they experienced with resuming a marriage after such an extended separation and their experiences of "lost time." For example, in response to a question about how her relationship was most affected by her husband's recent deployment, one spouse commented:

> Lost time. Definitely, definitely lost time. A lot of things could have happened a lot sooner, um, a lot of, could have slowed down too, but…it's that and you have to get to know each other all over again. It's like start from scratch. So it's like you're walking up to this person in an airport and you're like "Hi, I'm [Spouse's name] and you are?" (35F)

Her husband responded during his individual interview to the same question in this way:

> I would say a lot because it's not fair to her. I don't, I mean I'm not just saying that for her. I'm just saying that because I know…because of what it's done to me and the way I am now. 'Cause it's so much differently to her from what she knows…I mean I've known, I mean we've known each other since high school so she has that, and she has, we used to work together, go to parties, go out, go everywhere, you know. (35M)

Another spouse stated:

> I hate to say, though we pretty just had to start our relationship all over. Because he was gone for eight months, back for six weeks, gone for six months, back for a month, gone for three months, back for two months, and gone for a year. So we pretty much had to start the relationship all over again. (6F)

These couples experienced no improvements in relational cohesion or growth as a result of their deployment experiences. Instead, the extreme separation stunted their ability to remain connected to one another and to grow from their experiences. It is difficult to attest the degree to which their experiences were affected by their *perceptions* of the deployment and separation and how much was due to *actual* differences in their experiences.

Summary

Satisfied couples consistently reported high levels of relational post-traumatic growth and cohesion that was enduring in nature, a finding shared by couples with low trauma symptoms. These couples were able to recognize opportunities for growth as a result of their deployment experience. On the other hand, couples with low relational satisfaction were more consistent in their reports of individual post-traumatic growth. These couples were often unable to identify areas of growth or improved relationship cohesion as a result of the deployment. Interestingly, couples with high trauma symptoms were far more varied in their reports of post-traumatic growth. Some of these couples reported enduring relational post-traumatic growth, while others only reported individual growth.

Results Summary

Analysis of the data resulted in five consistent and recurring themes including communication, conflict management, roles, support/nurturance, and post-traumatic growth (Table 3). In the following chapter, an overview of the study will be provided, as well as implications for clinical practice and future research.

Table 3

Summary of findings

Themes	Couples with ***high*** relationship satisfaction and ***low*** levels of post-traumatic symptoms	Couples with ***low*** relationship satisfaction and ***high*** levels of post-traumatic symptoms
Communication Styles	*Consistent findings*; open communication marked by high levels of information/emotion sharing, high levels of reciprocity	*Consistent findings*; closed communication patterns marked by restricted information/emotion sharing, minimal reciprocity
Conflict Management	*Consistent findings*; conflict resolution	*Inconsistent findings*; combination of conflict resolution and conflict avoidance
Roles	*Consistent findings*; perceived role equality and high levels of role satisfaction	*Inconsistent findings*; variable reports of role satisfaction/dissatisfaction and perceived role equality/inequality
Support/Nurturance	*Consistent findings*; high levels of empathy/affirmation/effort, high levels of deployment contact	*Inconsistent findings*; variable levels of empathy/affirmation/effort and deployment contact
Post-Traumatic Growth	*Consistent findings*; high levels of enduring post-traumatic growth and improved relationship cohesion; high levels of resiliency	*Inconsistent findings*; variable reports of individual and relationship PTG

CHAPTER 5

Discussion

The goal of the current study was to understand the lived experiences of military couples regarding the effects of war-related traumatic experiences and deployment on couple functioning. More specifically, this study utilized the core "couple functioning" variables included in the CATS Model (Nelson Goff & Smith, 2005) as sensitizing concepts to guide the analysis process (i.e., attachment, satisfaction, stability, adaptability, support/nurturance, power, intimacy, communication, conflict, and roles). Using an interpretive phenomenological perspective, qualitative data analysis was performed to extract key themes from a total sample of 45 military couples. Using quantitative scores from the Dyadic Adjustment Scale (DAS; Spanier, 1976) and the Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996), a subsample of 15 couples was selected to examine differences in themes among couples with high and low levels of marital satisfaction, as well as those with high and low levels of post-traumatic stress symptoms. The following sections will: (a) provide a summary of the research; (b) address the limitations of the current study; (c) make suggestions for clinical implications; and (c) provide direction for future research.

Summary of Research Findings

Five salient themes were consistently reported by the participating couples in the current study, including communication, conflict management, roles, support/nurturance, and post-traumatic growth (Figure 2). Many similarities were found among the couples with high marital satisfaction, as measured by the Dyadic Adjustment Scale (DAS; Spanier, 1976) and those with low levels of post-traumatic symptoms, as measured by the Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996). Likewise, similarities were also

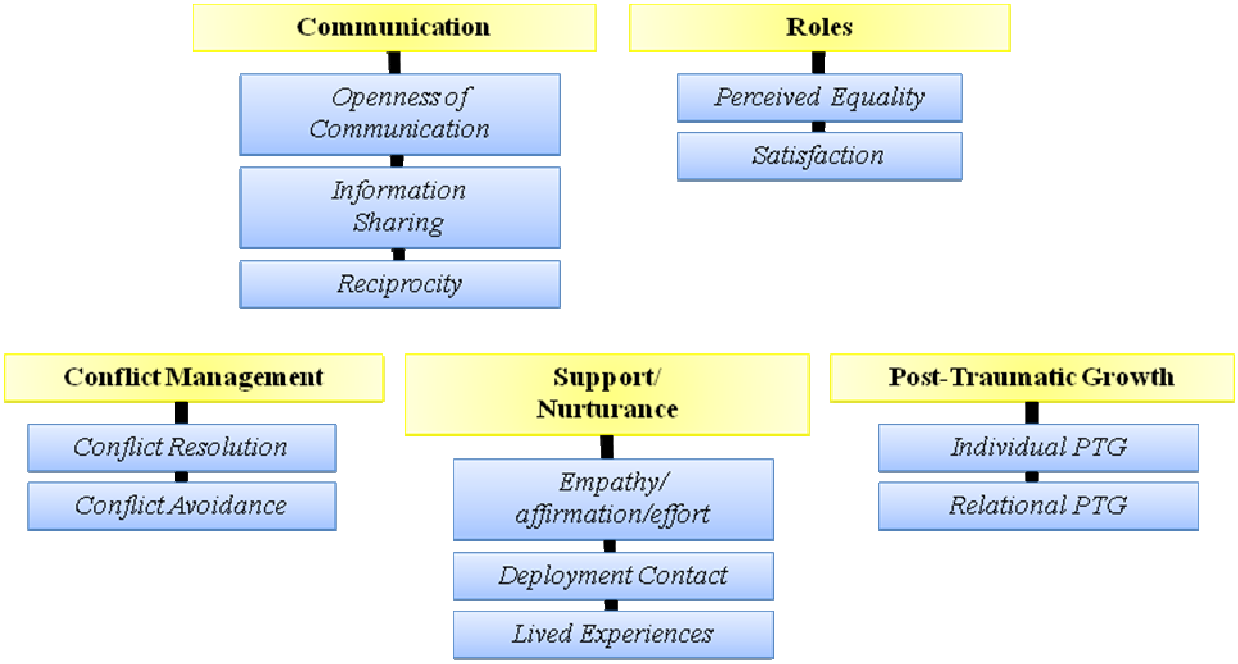

Figure 2. Summary of Major Themes and Sub-Themes

discovered among the couples with lowest levels of marital satisfaction and those with highest levels of post-traumatic stress symptoms.

Highly satisfied couples, as well as those with the lowest presence of post-traumatic stress, were more likely to engage in open communication marked by high levels of information sharing and emotional expression. They were also more likely to engage in behaviors that were conducive to conflict resolution and were highly satisfied in their roles. These couples were most likely to enjoy higher frequencies of deployment contact and were predominantly supportive, nurturing, and empathetic towards their spouses. All of these couples were able to identify post-traumatic relational growth and were apt to share in each other's lived experiences. In short, these couples were equipped with the skills and desire to openly communicate, resolve conflict, share in their roles and responsibilities, offer regular and ongoing support and nurturance, and seize opportunities for growth. These couples demonstrated high levels of resilience commonly

characteristic of highly satisfied couples. The significance of these findings is the consistency with which they were reported, which seems to suggest that there are specific relational factors that are characteristic of well-functioning, satisfied, and resilient couples.

On the other hand, couples with low relationship satisfaction and those with high trauma symptoms were far more varied in their responses. Although they were more likely to report poor communication patterns marked by low information sharing, little reciprocity, higher reactivity, less positive emotional expression and more conflict avoidant behaviors, as well as greater dissatisfaction in their current roles and fewer efforts to embrace opportunities for growth, they were also likely to report couple functioning experiences similar to highly satisfied couples. The variable nature of their experiences suggests that less is known about what contributes to poor relationship quality and/or what an unsatisfied relationship "looks" like.

Nonetheless, the findings of the current study do support previous findings in which the wives of combat stress reaction (CSR) veterans reported significant reductions in marital cohesion and satisfaction and an increase in conflict during the immediate post war period, and consistently viewed their marriages as having less consensus, less intimacy, less expressiveness, less cohesion, less satisfaction, and more conflict than the wives of non-CSR veterans (Solomon, Waysman, Belkin, et al., 1992). More so, it has been documented that the presence of PTSD interferes with a veteran's ability to engage in affectionate, mutually supportive relationships and with resuming his prewar responsibilities (Solomon, Waysman, Levy, et al., 1992), a finding similar to the current study's findings of less role satisfaction, less perceived role equality, less emotional expression, lower relationship satisfaction, and lower levels of supportive behaviors among couples with high levels of post-traumatic stress symptoms. The low levels of emotional expression reported by the couples with high levels of trauma symptoms and low marital

satisfaction in the current study supports an earlier study on the marital and cohabitating adjustment of Vietnam veterans with PTSD in which the close relationships of PTSD veterans tended to be characterized by less expressiveness and self-disclosure with their partners (Carroll et al., 1985).

Underlying each of the major themes were elements of good communication, an indication that a couple's ability to successfully engage in meaningful, supportive, and open communication affects multiple dimensions of the marital relationship. A couple's ability to effectively communicate is critical to their ability to navigate through conflict, to discuss the division of roles, to offer ongoing support and encouragement, and to examine ways in which their relationship has grown or changed. It can be posited, then, that the ability to communicate is the foundation of many other critical relationship dynamics, and the presence or absence of good communication is a determinant of numerous areas of couple functioning.

The Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) was one of the research instruments used during data collection to gauge participants' trauma exposure. Early review of the data indicated no significant themes associated with participants' total TEQ scores. One explanation of this may be that the presence of trauma symptoms bears more significance on individual and relational functioning than the number or type of traumatic events an individual experiences. Therefore, it may be that certain individuals possess inherent traits, coping mechanisms, worldviews, or relationships that enhance or enable their propensity toward resilience, while other may lack the same characteristics, disabling or hindering their efforts to effectively manage the trauma symptoms. It may also be that participants' perceptions of what is considered to be a traumatic event vary; therefore, the number of traumatic events each participant reported may be contingent on his or her perceptions. For example, two individuals

may have experienced similar events but perceived them very differently. In the current sample, there were greater within couple variations in the number of traumatic experiences reported by the partners, which made it impossible to select five couples to represent a high TEQ and low TEQ group as was done with the DAS and PPTSD-R. Although some of the couples shared similar total scores on the TEQ, many others had total scores that were very different. Selecting couples to represent the high and low DAS and PPTSD-R groups was done with relative ease because of similar within couples scores. Unfortunately, because so many of the couples had significant variations in their total TEQ scores, it was not feasible to utilize a mean score to represent a "couple" score. Doing so would have distorted the findings and skewed the analysis.

A significant overall finding was the degree of consistency reported by the couples with high relationship satisfaction and a low presence of post-traumatic stress symptoms. These couples were uniform in their reports of communication and conflict management styles, roles, support and nurturance, and post-traumatic growth. However, this consistency was not replicated by the couples with low relationship satisfaction and high levels of post-traumatic symptoms, as might be expected. These couples tended to be far more variable in their reports of the above mentioned areas. They maintained a propensity toward a certain trend (e.g., closed communication, conflict avoidance, role dissatisfaction); however, a few of the couples in each group provided feedback that was counter to the overall trend (e.g., role satisfaction, high levels of support and nurturance, conflict resolution).

Partners generally tended to share similar opinions and attitudes toward their relationship in both groups. That is, if one spouse reported good communication, then most often the other spouse also reported good communication. If one spouse felt unsupported, the other spouse also felt unsupported. This finding may be due to the system by which participants were chosen for

particular groups in which only couples in which both partners had high or low scores were included. This enhanced the likelihood that couples would have similar beliefs about their relationship.

While it seems clear from the current data that satisfied relationships tend to be predominantly open, reciprocal, equal, and supportive, unsatisfied couples demonstrate a range of interpersonal dynamics from open to closed communication, conflict avoidance and conflict resolution, role satisfaction and dissatisfaction, and high and low levels of support. One explanation of this may be that the presence of high levels of trauma symptoms creates challenges within the marital relationship that contribute to low relationship quality, a finding that is consistent with those presented by Nelson Goff et al. (2007). This may be due to the PTSD symptoms of emotional numbing and hyperarousal (Riggs et al., 1998) and the potential for trauma to cause individuals to be withdrawn, edgy, and preoccupied with themselves and their traumatic experiences, all of which can interfere with their ability to engage in affectionate, mutually supportive relationships and with resuming prewar responsibilities (Solomon, Waysman, Levy, et al., 1992).

Nonetheless, this presents researchers with some interesting questions, as noted in the previous chapter: Are these couples (i.e., those who are unsatisfied and those with high trauma symptoms) less equipped to communicate and resolve conflict because of their poor relationship quality? Do they experience low relationship quality because of their inability to communicate effectively? Is it an intricate cycle of mutual influence in which one fuels the other? To what degree does their ability to effectively communicate mitigate the manifestations of the trauma symptoms? Each of these questions addresses the potential of the marital relationship to act as a

buffer for the development and maintenance of trauma symptoms, an area that has been largely untouched by previous research efforts.

One of the more compelling questions that emerged as a result of the current research is: Do couples with high relationship quality enjoy greater satisfaction because of low levels of trauma symptoms, or do couples have low levels of trauma symptoms because they have satisfied and fulfilling relationships? Prior research has uncovered a link between the presence of trauma symptoms and marital satisfaction (Nelson Goff et al., 2007; Riggs et al., 1998; Solomon, Waysman, Belkin et al., 1992). Each of these studies has noted the negative impact of trauma symptoms on the marital relationships. However, what has yet to be documented is the buffering effect of the marital relationship on the manifestation of trauma symptoms. Can a high functioning, satisfied marriage help mitigate post-traumatic stress symptoms or, better yet, prevent them from developing altogether? Some support for this theory may have come from a study by Mikulincer et al. (1995) which found that the more marital intimacy wives reported to having felt immediately after the war, the less severe their symptomatology and the lower the number of somatic illnesses they endorsed six years later. From this information, it could be posited that a marital relationship marked by higher levels of intimacy has the potential to ward off post-traumatic symptoms.

The Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005) proposed ten elements of couple functioning that may be affected when there is a history of trauma in one or both partners, with the notion that individual levels of functioning and any predisposing factors and personal resources directly affect the quality of relational functioning within the couple system. One of the purposes of the current study was to elucidate areas of couple functioning that are affected when there is a history of deployment and/or war-related

trauma, and in doing so, to provide some empirical support for the couple functioning component of the CATS Model. From the current study, there is clear evidence in support of the elements of communication, conflict, roles, support/nurturance, and satisfaction. However, the current study did not find significant themes involving power, attachment, adaptability, or intimacy. There were irregular accounts by some of the participants that were indicative of adaptability; however, this was not supported by the group as a whole. This is not to suggest that power, attachment, adaptability, and intimacy are not relevant themes and/or issues among military couples. In fact, numerous researchers have found associations between the presence of PTSD and difficulty establishing and/or maintaining intimacy in close relationships, noting difficulties with emotional numbing, expressiveness and self-disclosure, hyperarousal, and fears of intimacy as specific challenges for married couples (Riggs et al., 1998; Sheehan, 1994; Solomon, Waysman, Levy, et al., 1992). It serves only to suggest that these themes were not consistently reported among the couples in response to the particular questions asked of them or reported by the selected subsample of couples in this study.

The most original contribution to the CATS Model (Nelson Goff & Smith, 2005) from the current study was the inclusion of post-traumatic growth (PTG) into the couple functioning portion of the model and the critical link that communication plays in all areas of couple functioning (Figure 3). As reported by many of the highly satisfied couples and those with low levels of trauma symptoms, the experience of post-traumatic growth suggests that resiliency and relational growth are possible, even in difficult situations such as deployment and war. The ability for couples to recognize and embrace opportunities to strengthen their marital relationship implies that such opportunities exist. However, it also appears that such opportunities are "in the eye of the beholder" and are not consistently recognized or embraced by

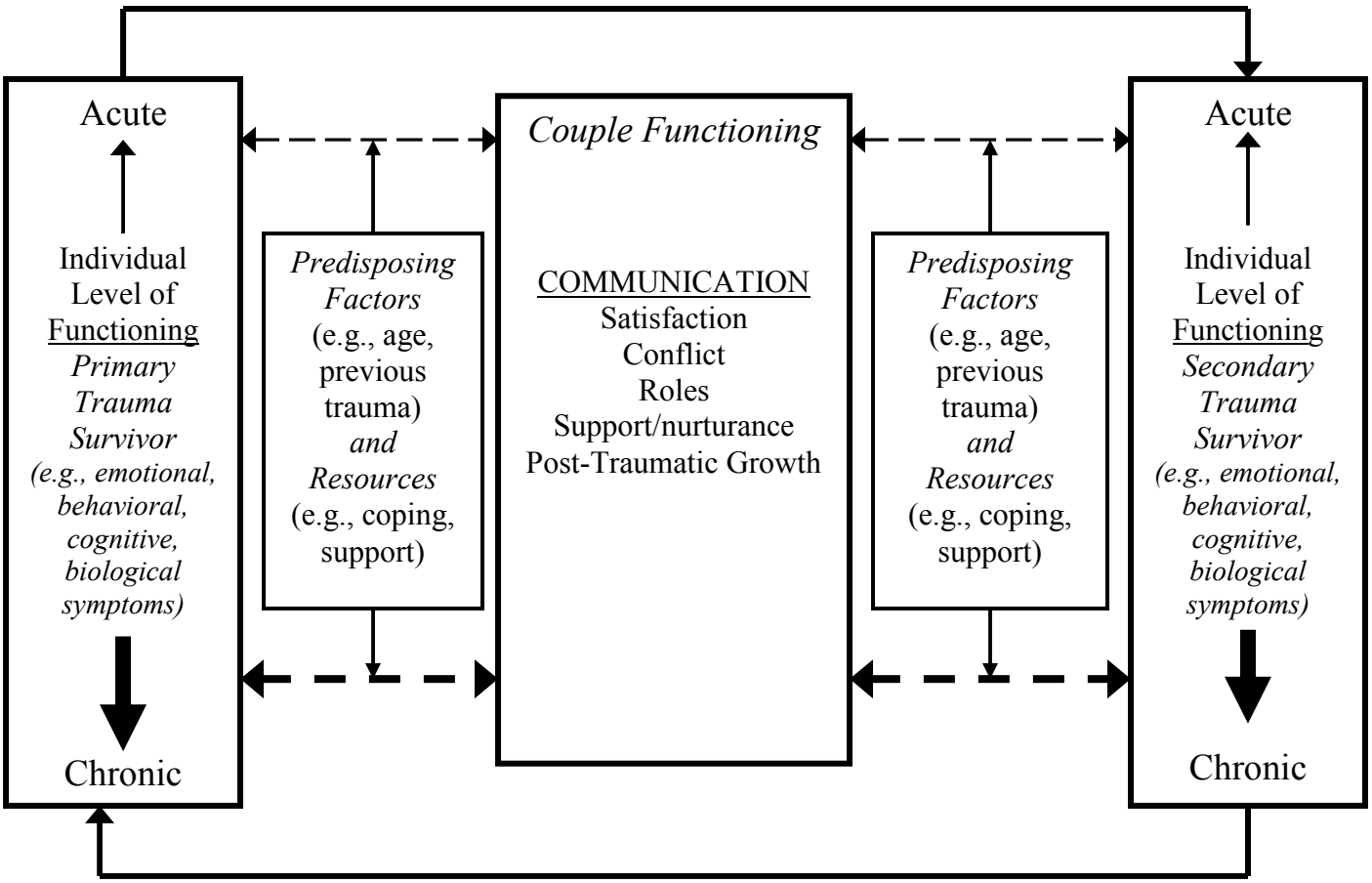

Figure 3. Revised Couple Adaptation to Traumatic Stress (CATS) Model

couples with low martial satisfaction or those with higher levels of trauma symptoms. It also appears that individual PTG is not always conducive to relational PTG. Therefore, it can be concluded that relational PTG is possible only when the perceptions of both partners align. That is, it is most likely to occur when *both* partners similarly define a situation as an opportunity for growth and when both partners have a similar growth "trajectory." If one partner grows more or counter to the relationship or his/her partner, relational functioning may actually be hindered.

The current study is important because it contributes an intimate knowledge of the lived experiences of military couples who have endured the separation of deployment and trauma of war. It provides empirical support for the CATS Model (Nelson Goff & Smith, 2005) by

elucidating how couple systems are affected when trauma has occurred. Furthermore, this study identified key relational and interpersonal dynamics that contribute to adaptation to traumatic stress in the couple dyad, namely those associated with communication, roles, conflict management, support and nurturance, and post traumatic growth. Although this study focused solely on the couple functioning component of the CATS Model (Nelson Goff & Smith, 2005), it provides useful insight into the potential for the marital relationship to serve as a buffer to the manifestation of trauma symptoms in one or both partners. It is particularly unique in its use of couple-level data. Having data that is inclusive of both partners provided a richness and depth that is unmatched by individual level data. This type of data allowed for within couple, as well as between couple, comparisons.

Limitations

The current study possesses several limitations. One of these is the static design of the study. The data collected provides a glimpse of these couples at a moment in time, which is helpful in assessing a level of relational functioning at that particular point. However, a longitudinal design would offer greater insight into the effects of deployment and traumatic experiences on couple functioning over time. For example, it would allow researchers to assess for changes in the couple relationship during specific points throughout the deployment cycle (e.g., pre-deployment, early deployment, mid-deployment, late deployment, reintegration). This type of longitudinal data would be helpful in more accurately determining the effects of traumatic experiences and deployment on couple functioning by providing researchers with ongoing feedback on couple functioning and satisfaction. It would be helpful to have longitudinal data on relationship satisfaction in order to gauge the potential for the marital relationship to act as a buffer to the development and maintenance of trauma symptoms.

All of the data for the current study was collected prior to multiple deployments and the 2007 troop surge in which thousands of troops were deployed to provide security to Baghdad and Al Anbar Province; therefore, little is known about the effects of multiple deployments on the marital relationship and/or how this differs from a single deployment. Furthermore, the current study does not assess for pre-deployment functioning or marital stability. Without knowing this, it is difficult to fully assess the impact of post-traumatic stress on couple functioning or the degree to which the marital relationship exacerbates or minimizes the effects of trauma.

All of the participants in the current study were self-selected, which may have resulted in a skewed participant pool and subsequently skewed results. Just as the current couples opted to partake in the study, many others self-selected out of participating. As a result, it is difficult to ascertain the personal or relational factors that contributed to the decision to opt out, and furthermore how these differences may have affected the overall findings. The current study examined between couple variations and did not examine the differences between partners. Only couples with similar scores on the DAS and PPTSD-R were included in the final analysis; those with highly differential scores were eliminated from the current study, and any resultant data on within-partner differences was not included.

Clinical Implications

When viewed as a systemic phenomenon instead of simply an individual one, trauma symptoms can best be treated when treatment is inclusive of family members. Although the current research offers less clarity about what typifies an unsatisfied couple, it does offer solid insight into the characteristics of highly satisfied and resilient couples. Clinicians may integrate the findings from the current study into the therapeutic process to help strengthen marital relationships and encourage resilience by integrating core concepts such as communication, roles

and responsibilities, conflict management, and support/nurturance. For example, the current study suggests that maintaining open communication is a critical part of establishing a satisfied relationship. More so, this study suggests that open communication envelopes a number of interpersonal dynamics such as reciprocity, high information sharing, emotional transparency, and conflict resolution. Each of these may be dealt with specifically within the therapeutic process through modeling, experiential exercises, and homework assignments. Couples may be assisted in sharing details of their traumatic experiences and offering affirming and supportive feedback. They may utilize the therapy room as a "safe" zone in which to disclose difficult emotions or thoughts. It is clear from the current results that communication is a critical component of successful and satisfying marital relationships, a notion that is quite rudimentary and well-known, but nonetheless deserves re-stating and emphasizing. Communication underlies nearly every aspect of relational functioning, and therefore its inclusion into the therapeutic process as a central element retains great merit. It can also be suggested that intense preventative actions and training (i.e., those that would occur prior to deployment) would significantly benefit military couples as they prepare for extended separations and possible trauma exposure.

The current study also emphasizes the importance of achieving a balance in roles and responsibilities within the marital relationship, a task that can be addressed within the therapeutic context. One of the defining features of highly satisfied couples and those with low trauma symptoms was their ability to "find the silver lining." In other words, they were more likely to experience post-traumatic growth. With this in mind, clinicians can encourage post-traumatic growth by helping couples recognize areas of growth within their relationships and by building on pre-existing strengths. Maintaining a strengths-focus would allow clients to become aware of the parts of their relationships in which they excel.

Furthermore, the implications from the current research suggest that maintaining high levels of support and nurturing behaviors is important in enhancing marital satisfaction for couples facing deployment. This involves regular frequent contact between spouses that is markedly positive and affirming. It also involves the sense of a "shared lived experience" in which both partners respect and empathize with one another. Within the clinical realm, practitioners can assist couples in recognizing the efforts of their partners and in affirming each other, with the ultimate goal of increasing the number of supportive and nurturing behaviors shared between spouses.

Other researchers and academicians have developed methods of treating traumatized client systems. For example, Figley (1985) proposed a method of treatment he called "The Family Treatment" and suggested that there are four ways in which family members help facilitate recovery from traumatic stress. These include:

1. *Detecting traumatic stress*. When a family member has experienced a traumatizing event, everyone in the family becomes aware of the habits, dispositions, and patterns of behaviors in others, and come to expect variations in the pattern of behavior.
2. *Confronting the trauma*. Family members are in a key position to help the victim confront the causes of the trauma.
3. *Urging the recapitulation of the traumatic experience*. Family members can assist the victim to reconsider the traumatic event and to review what happened.
4. *Facilitating resolution of the conflicts*. Family members can help the victim work through his or her trauma and accompanying conflicts by answering five victim questions (i.e., What happened? Why did it happen? Why did I act as I did then? Why did I act as I have since? Why if it happens again?).

Much of Figley's model focuses on the role of family members to act as supportive conduits for the resolution of trauma. Family members are to provide ongoing support and empathy for the traumatized person, and in doing so assist that person in confronting and communicating about the trauma. The current study provides support for Figley's model by emphasizing the importance of support, empathy, and open communication as key factors in strengthening the marital relationship and creating a place in which the trauma survivor can feel appreciated and supported.

As mentioned, one of the most incapacitating effects of trauma is the survivor's inability or unwillingness to engage in intimate relationships. Sheehan (1994) proposed that the most effective treatment strategies to help traumatized people establish or rebuild intimacy access and intervene with the fears of intimacy in an indirect and metaphorical way. "Healing metaphors," as the author refers to them, bypass resistance because they do not directly confront the issue of fear. The fears referred to by this author are those originally described by Feldman (1979), and include:

1. *Fear of Merger*: Fear of losing one's identity, freedom, or control over one's life. It causes people to avoid communication and negotiation. They fear that if they allow the other person to deeply know them, the other person will use that information to control them.
2. *Fear of Abandonment*: Fear of loving someone and then losing them.
3. *Fear of Exposure*: Fear of being seen or having character flaws and weaknesses seen by others; fear of being viewed as weak, stupid, undesirable, inadequate, bad, or repulsive.
4. *Fear of Attack*: Fear of being emotionally or physically hurt.

5. *Fear of One's Own Destructive Impulses*: Fear of personal rage or anger and the fear of the ability or willingness to hurt other people.

The use of healing metaphors is used in conjunction with traditional marital therapy approaches of establishing or reestablishing effective communication, correcting misunderstandings, and fostering amends and forgiveness (Sheehan, 1994). Much like the findings from the current study, Sheehan's model emphasizes the importance of open and supportive communication and empathy as methods of building marital intimacy and closeness. In like fashion, Feld (2004) suggested that couples therapy can provide a "holding and facilitating environment" that promotes the expression and exploration of each partner's relational patterns and the couple's relationship processes, keeping in mind each partner's need for safety. It is suggested that couples therapy with trauma survivors aims to help the partners to become aware of and better regulate the co-created, interactive aspects of their relationship, which includes aspects of listening to each other (Feld, 2004).

Perhaps one the most well documented treatments for trauma couples is the use of Emotionally Focused Marital Therapy (EFT; Johnson & Williams-Keeler, 1998), which focuses on the creation of trust and secure attachment, and in doing so provides an antidote to the isolation and alienation associated with traumatic experiences, as well as increases the sense of emotional connection (McFarlane & van der Kolk, 1996). The current study provides support for the use of EFT and the need for creating supportive, positive, and emotionally connected relationships.

Traditional EFT therapists must engage in two primary tasks: (1) accessing and reprocessing affect (e.g., helping a partner to access the despair and hopelessness that underlies a withdrawal/avoidance position, or the grief and desperation that underlies an attacking/pursuing

position); and (2) shaping new interactions using an expanded emotional experience to create new dialogue with the partner that encourages contact and compassion (Johnson & Williams-Keeler, 1998). Relative to traumatized couples, the authors have delineated three stages of Emotionally Focused Therapy, including:

1. *Stabilization (Steps 1-4 of EFT):* Discussion and recognition of the legacy of the trauma, rapport building; Couple articulates and identifies the negative cycles in their interactions, such as critical pursuit followed by withdrawal and avoidance.
2. *Building Self and Relational Capacities (Steps 5-7 of EFT)*. Therapist helps partners cope with the trauma in new ways that actually bring them together and nurture the bond between them by fostering contact and trust, rather than damage this bond by such coping methods as withdrawal; Accessing, formulating, and reprocessing specific fears that arise from the attachment insecurity and the traumatic experience.
3. *Integration (Steps 8-9 of EFT)*: Newly processed emotional experiences and a new sense of self are affirmed, specified, and integrated into the survivor's model of self; New, positive patterns of interaction become self-reinforcing.

Each of these treatments share a common thread—a focus on systemic inclusion and the recognition that traumatic experiences can be dealt with most effectively when spouses and/or family members are active participants in the treatment process. Furthermore, the implications of the current research reinforce each of these treatment modalities, the most important of which is the need for open and compassionate communication, emotional sharing and connectedness, and frequent and ongoing supportive behaviors and empathy. Clinicians can guide couples through the process of regaining relational closeness and cohesion by offering in-session guidance and

opportunities for clients to engage in these types of behaviors, with the hope that such "training" can be translated into everyday interactions.

Research Implications

The current study is helpful in providing empirical support for the CATS Model (Nelson Goff & Smith, 2005) and sheds more light on the impact of deployment and trauma on couple functioning. Future research endeavors should focus on collecting data on relationship functioning throughout the deployment cycle, from pre-deployment through reintegration and should be mindful to gather data on pre-deployment functioning and marital stability. This type of longitudinal data would provide valuable insight into the manifestations of trauma symptoms and couple resilience. It would also help to elucidate the buffering effects of the couple relationship on the development and maintenance of trauma symptoms.

The couples included in this study were selected based on self-reported trauma exposure, not on the basis of a PTSD diagnosis. Considering the lack of significant themes associated to scores on the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994), future research should also seek to clarify whether it is the presence of trauma symptoms or the types and amounts of traumatic experiences that bears greater significance on individual and couple functioning. In turn, this research could influence clinical practice by shifting focus to the management of trauma symptoms within the couple or marital relationship.

To date, there is little evidence of the impact of multiple deployments on the marital relationship and/or how these effects may differ from a single deployment. This information is particularly important due to the significant increase in multiple deployments in recent years. Future research efforts should seek to understand how the relational and interpersonal implications of multiple deployments are different, and in what ways clinical practice should be

modified to better encourage healing, cohesion, and satisfaction among military couples before, during, and following deployment.

All of the couples included in the current study were couples in which the male partner had active military duty and had been deployed. Future research should assess the differences (if any) in post-traumatic stress symptoms in female soldiers and how these symptoms are manifested or maintained in the couple relationship. The "stay at home" experiences of male spouses married to female soldiers is far less common and is therefore less understood. Likewise, the experiences of female soldiers who experience separation from spouses and/or children during deployment is not well documented. Additional research in this area would elucidate the interpersonal and relational dynamics common to these types of couples and provide useful insight into clinical implications and encouraging resiliency.

Conclusion

As long as men and women continue to be deployed into war zones, marriages will be at the mercy of extended separations and traumatic experiences. However, what is becoming more evident is that these things do not have to be the end all for military marriages. In fact, it is possible for the marriages of military couples to be strong, resilient, and to prosper in the face of such adversities. As research continues and more is understood about how to prevent marital dissolution in military marriages, how to encourage resilience and growth, and how to manage trauma symptoms within the couple relationship, psycho-educational and treatment programs can be tailored to directly address these needs in a proactive and preventative manner.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.

Arzi, N.B., Solomon, Z., & Dekel, R. (2000). Secondary traumatization among wives of PTSD and post-concussion casualties: Distress, caregiver burden, and psychological separation. *Brain Injury, 14*, 725-736.

Baird, K., & Kracen, A. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counseling Psychology Quarterly, 19*(2), 181-188.

Black, W. (1993). Military-induced family separation: A stress reduction intervention. *Social Work, 38*(3), 273-280.

Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief.* Cambridge, MA: Harvard University Press.

Boss, P., (2006). *Loss*, *trauma, and resilience: Therapeutic work with ambiguous loss*. New York: W.W. Norton.

Boss, P., Beaulieu, L., Wieling, E., Turner, W., & LaCruz, S. (2003). Healing loss, ambiguity, and trauma: A community based intervention with families of union workers missing after the 9/11 attack in New York City. *Journal of Marital and Family Therapy, 29*(4), 455-467.

Brannen, S., & Hamlin, E. (2000). Understanding spouse abuse in military families. In J.A. Martin, L.N. Rosen, & L.R. Sparacino (Eds.), *The military family: A practice guide for human service providers* (pp. 169-183). Westport, CT: Praeger.

Carroll, E., Rueger, D., Foy, D., & Donahoe, C. (1985). Vietnam combat veterans with posttraumatic stress disorder: Analysis of marital and cohabitating adjustment. *Journal of Abnormal Psychology, 94*(3), 329-337.

Di Nola, G. (2008). Stressors afflicting families during military deployment. *Military Medicine, 173*(5), v-vii.

Feld, B. (2004). Holding and facilitating interactive regulation in couples with trauma histories. *Psychoanalytic Inquiry, 24,* 420-437.

Feldman, E. (1979). Marital conflict and marital intimacy: An integrative psychodynamic-behavioral-systemic model. *Family Process*, *18*(1), 69-78.

Figley, C. R. (1995). *Compassion fatigue*. New York: Bruner/Mazel.

Figley, C.R., (1985). From victim to survivor: Social responsibility in the wake of catastrophe. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of PTSD* (pp. 398-415). New York: Brunner/Mazel.

Fischer, J., & Corcoran, K. (1994). *Measures for clinical practice: A sourcebook* (2nd ed., Vol. 1). New York: The Free Press.

Hamilton, S., Nelson Goff, B.S., Crow, J.R., & Reisbig, A. (2009). Primary trauma of female partners in a military sample: Individual symptoms and relationship satisfaction. *The American Journal of Family Therapy, 37*, 336-346.

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of Events Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.

Huebner, A., Mancini, J., Wilcox, R., Grass, S., & Grass, G. (2007). Parental deployment and youth in military families: Exploring uncertainty and ambiguous loss. *Family Relations, 56,* 112-122.

Jensen, P., Martin, D., & Watanabe, H. (1996). Children's response to parental separation during Operation Desert Storm. *Journal of the American Academy of Child Adolescent Psychiatry, 35*(4), 433-441.

Johnson, S., & Greenberg, L.S. (Eds.). (1994). *The heart of the matter: Perspectives on emotion in marital therapy*. New York: Brunner/Mazel.

Johnson, S., & Williams-Keeler, L. (1998). Creating healing relationships for couples dealing with trauma: The use of emotionally focused marital therapy. *Journal of Marital and Family Therapy, 24*(1), 25-40.

Jordan, B.K., Marmar, C., Fairbank, J., Schlenger, J., Kulka, R. Hough, R., et al. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 60*(6), 916-926.

Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56*, 85-90.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B .K., Marmar, C.R., et al. (1990). *Trauma and the Vietnam war generation*. New York: Brunner/Mazel.

L'Abate, L., & Bagarozzi, D. A. (1993). *Sourcebook of marriage and family evaluation*. New York: Brunner/Mazel.

Lauterbach, D., & Vrana, S. (1996). Three studies on the reliability and validity of a self-report measure of posttraumatic stress disorder. *Assessment, 3*, 17-25.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131–149.

McCarroll, J., Ursano, R., Liu, X., Thayer, L., Newby, J., Norwood, A., et al. (2000). Deployment and the probability of spousal aggression by U.S. Army soldiers. *Military Medicine, 165*, 41-44.

McFarlane, A. C., & van der Kolk, B. A. (1996). Trauma and its challenge to society. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 24-46). New York: Guilford Press.

Merriam-Webster Dictionary. (2010). Retrieved September 1, 2010 from http://www.merriam-webster.com/.

Mikulincer, M., Florian, V., & Solomon, Z. (1995). Marital intimacy, family support, and secondary traumatization: A study of wives of veterans with combat stress reaction. *Anxiety, Stress, and Coping, 8,* 203-213.

Military Family Resource Center. (1998). Military families staying in step in the 1990s. *Military Family Resource Center*. Retrieved October 2, 2009 from http://mfrc.calib.com/pdffiles/mffactsheet.pdf.

National Center for Post Traumatic Stress Disorder. (2009). Retrieved October 2, 2009 from www.ncptsd.va.gov.

Nelson, B.S., & Wampler, K. (2000). Systemic effects of trauma in clinic couples: An exploratory study of secondary trauma resulting from childhood abuse. *Journal of Marital and Family Therapy, 26*(2), 171-184.

Nelson, B.S., & Wright, D. (1996). Understanding and treating post-traumatic stress disorder symptoms in female partners of veterans with PTSD. *Journal of Marital and Family Therapy, 22*(4), 455-467.

Nelson Goff, B.S., Crow, J., Reisbig, A., & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychology, 21*(3), 344-353.

Nelson Goff, B.S., Reisbig, A., Bole, A., Scheer, T., Hayes, E., Archuleta, K., et al. (2006). The effects of trauma on intimate relationships: A qualitative study with clinical couples. *American Journal of Orthopsychiatry, 76*(4), 451-461.

Nelson Goff, B.S., & Smith, D. (2005). Systemic traumatic stress: The Couple Adaptation to Traumatic Stress Model. *Journal of Marital and Family Therapy, 31*(2), 145-157.

Nezu, A., & Carnevale, G. (1987). Interpersonal problem solving and coping reactions of Vietnam veterans with posttraumatic stress disorder. *Journal of Abnormal Psychology, 96*(2), 155-157.

Office of Army Demographics. (2004). *Army profile FY 2004.* Retrieved April 28, 2006, from http://www.armyg1.army.mil/Demographics

Packer, M. J., & Addison, R. B. (1989). *Entering the circle: Hermeneutic investigation in psychology*. Albany, NY: State University of New York Press.

Patton, M. Q. (2002). *Qualitative research and evaluation methods,* 3rd ed. Thousand Oaks, CA: Sage.

Peterson, M. (2002). *Survey of Army families: IV. Final executive summary.* Retrieved October 5, 2009 from http://www.armymwr.com/corporate/docs/planning/ SAFIVExecutiveSummary.pdf.

Pincus, S., House, R., Christenson, J., & Adler, L. (2004). *The emotional cycle of deployment: A military family perspective*. Retreived October 2, 2009 from http://hooah4health.com/deployment/familymatters/emotionalcycle.htm#.

Riggs, D., Byrne, C., Weathers, F., & Litz, B. (1998). The quality of the intimate relationships of male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress, 11*(1), 87-101.

Rosen, L., Durand, D., & Martin, J. (2000). Wartime stress and family adaptation. In J.A. Martin, L.N. Rosen, & L.R. Sparacino (Eds.), *The military family: A practice guide for human service providers* (pp. 123-138). Westport, CT: Praeger.

Rosen, L., Teitelbaum, J., & Westhuis, D. (1993). Children's reactions to the desert storm deployment: Initial findings from a survey of Army families. *Military Medicine, 158* (7), 465-469.

Shalev, A.Y. (1996). Stress versus traumatic stress: From acute homeostatic reactions to chronic psychopathology. In B.A. van der Kolk, A.C. MacFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The overwhelming experience on mind, body, and society* (pp. 71-101). New York: Guilford.

Sheehan, P. (1994). Treating intimacy issues of traumatized people. In J.F. Sommer & M.B. Williams (Eds.), *Handbook of post-traumatic therapy* (pp. 94-105). Westport, CT: Greenwood Press.

Solomon, Z. (1988). The effect of combat-related posttraumatic stress disorder on the family. *Psychiatry, 51,* 323-329.

Solomon, Z., Waysman, M., Avitzur, E., & Enoch, D. (1991) Psychiatric symptomatology among wives of soldiers following combat stress reaction: The role of the social network and marital relations. *Anxiety Research, 4,* 213-223.

Solomon, Z., Waysman, M., Belkin, R., Levy, G., Mikulincer, M., & Enoch, D. (1992). Marital relations and combat stress reaction: The wives' perspective. *Journal of Marriage and the Family, 54*, 316-326.

Solomon, Z., Waysman, M., Levy, G., Fried, B., Mikulincer, M., Benbenishty, R., et al. (1992). From front line to home front: A study of secondary traumatization. *Family Process, 31*(3), 289-302.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15-28.

Tanielian, T., & Jaycox, L. (Eds.). (2008). Invisible wounds of war: Cognitive and psychological injuries, their consequences, and services to assist recovery. *RAND Corporation*: Santa Monica, CA.

Tedeschi, R. & Calhoun, L. (2004). Posttraumatic growth: A new perspective on psychotraumatology. *Psychiatric Times, 21*(4). Retrieved on 15 July 2010 from http://www.psychiatrictimes.com/p040458.html.

van der Kolk, B., McFarlane, A., & Weisaeth, L. (1996). *Traumatic stress*. New York: Guilford.

van der Kolk, B., Perry, C., & Herman, J. (1991). Childhood origins of self-destructive behavior. *American Journal of Psychiatry, 148*, 1665-1671.

Vrana, S., & Lauterbach, D. (1994). Prevalence of traumatic events and post-traumatic psychological symptoms in a nonclinical sample of college students. *Journal of Traumatic Stress, 7*, 289-302.

Verbosky, S. J. & Ryan, D. A. (1988). Female partners of Vietnam veterans: Stress by proximity. *Issues in Mental Health Nursing, 9,* 95-104.

Waysman, M., Mikulincer, M., Solomon, Z., & Weisenberg, M. (1993). Secondary traumatization among wives of posttraumatic combat veterans: A family typology. *Journal of Family Psychology, 7(*1), 104-118.

Where are the legions? [SPQR] Global deployment of US forces. (2005). Retrieved November 30, 2005, from http://www.globalsecurity.org/military/library/news

Whiting, P., & Moody, E. (2009). In the wake of combat: Stories of survivorship and coping. *ADEC Forum, 35*(4), 9-10.

Williams, C. (1980). The "Veteran System" –With a focus on women partners: Theoretical considerations, problems, and treatment strategies. In T. Williams (Ed.), *Post traumatic stress disorders of Vietnam veterans* (pp. 73-124). Cincinnati, OH: Disabled American Veterans.