HOMECOMING FOR THE MILITARY COUPLE: COPING WITH THE CHALLENGES OF A COMBAT DEPLOYMENT AFTER THE WAR EXPERIENCE

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HOMECOMING FOR THE MILITARY COUPLE: COPING WITH THE CHALLENGES OF A COMBAT DEPLOYMENT AFTER THE WAR EXPERIENCE

A Project

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Abstract

of

HOMECOMING FOR THE MILITARY COUPLE: COPING WITH THE CHALLENGES OF A COMBAT DEPLOYMENT AFTER THE WAR EXPERIENCE

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This study explores the challenges faced by a military couple after a wartime deployment and incorporates responses from combat veterans including Vietnam, Panama, Kosovo, Somalia, the Gulf War, Iraq, and Afghanistan. Understanding the biological, psychological and social impact of combat deployment on active duty and/or military veterans and their significant others is vital to the care of the mental and physical health of our troops. Participants were members of a couple at the time of deployment and still together after the combat tour was completed. The questions pertain to the experiences and challenges participants faced when returning to the family environment after combat. They include areas of marital satisfaction, general contentment and peer interaction, and were answered on a Likert-scale survey. Also included were limited, non-identifying demographic questions. Key findings include a disruption of sleep patterns in combatants and a lack of interest in being busy or active, as might be indicated in a person who is depressed. The challenges associated with combat deployment and the readjustment difficulties for couples after the deployment are real, but there is a resistance to speaking of the problems. The most realistic arena
for this research is within the military or the Veterans Administration, although this is also contraindicated by the culture of the military and the stigma associated with asking for help. As a society, civilians must continue to engage with military families and the mental health community has a duty to be prepared to provide services to this sector of the nation when called upon. The utilities and appropriateness of using questionnaire survey for this type of survey of the military families are also discussed.

_______________________, Committee Chair
Francis Yuen, DSW

_______________________
Date
DEDICATION

This is dedicated to all the fine men and women who serve our country, often at great cost to themselves, and their families, who also serve. I appreciate the dedicated members of the Sacramento Vet Center who have assisted me in gaining knowledge and understanding of veteran issues through my time as an intern in their office. This is also for my husband, a United States Marine Corp Combat Photographer and veteran of Vietnam, who fully understands the hidden ravages of war. My thanks to all who serve and my love to my Marine, who supports me in all I endeavor to accomplish.
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Chapter 1

THE PROBLEM

Introduction

There is much trepidation and fear when a family member deploys far from home, and this is magnified when a spouse is deployed into a wartime combat zone. The family member focuses on a safe return for the military member, and counts the days until their spouse or significant other is once again home and safe. Even with the current availability of the spouse by phone and email, and often by skype or Internet video, nothing replaces the knowledge that your loved one is out of harm’s way, securely on American soil, and home.

Unfortunately, this is the world’s knowledge of the homecoming: the relief of the spouse and the joyful reunion. Few people talk about after the return, the hidden battles and challenges, the oft time complexity of the reunion. This reintegration period can be difficult for both persons and it is fraught with situations neither one knew they might encounter after the battlefield exposure. The military services have developed many support functions for the military spouse, especially when the spouse is either living in base housing or close enough to access the base for events and services. This support structure is not available to the spouse who has no base access, and still may not include relevant information for the spouse who does have this support structure.

This paper will explore some of these troublesome factors and the alienation faced by the military couple after the spouse returns home. In looking at other research,
but finding none that includes the area of Northern California as the targeted population; there is a need for this segment of the nation to also have the questions asked and the possible solutions explored. One of the major deployment bases for military personnel reporting to the Middle East combat arena is Travis Air Force Base in Fairfield, California, located roughly halfway between San Francisco, to the south and the state capital of Sacramento, to the north. The base is home to approximately 7,260 active military, 4,250 reservists and the 3,770 civilians who are their family members (GlobalSecurity.org, 2010).

In their 2006 research into how clinicians measure the areas of concern in a couple’s relationship, Lavee and Avisar found 4 items in the top area of concern for couples who expressed they were experiencing difficulties, with all in the 90% or higher range of importance. Style of communication (96.3%), the couples’ level of commitment (94.5%), the trust between the two (93.8%), and the satisfaction in their relationship (92.6%), all ranked the highest, followed by how the couple managed or resolved conflict (89.6%), the areas of conflict (87.8%), and the strengths of the couple (87.1%), which tied in importance with the expression of emotion within the pair (87.1%). Rounding out the top listed items were the relationship of power between the individuals in the couple (79.1%) and the couple’s marital cohesiveness and their ability to adjust (67.7%). This study shows these are all potential areas of readjustment difficulties the couple face, after one member in the dyad has returned from a wartime deployment.
The Pennsylvania National Guard represents a microcosm of the situation faced by our service members in many areas of the Nation. After September 11, 2001, the military was called into combat in the Global War on Terror (GWOT). In their 2008 study with Purdue University, the Pennsylvania National Guard and Veterans for America (VFA) found confirmation of their concerns regarding the deployment of the Guard forces. The Pennsylvania National Guard forces had already seen the largest deployment experienced by their troops since the Korean War. With over 20,000 members, they are one of the largest contingents of Guardsmen in the United States, and over 25% of their force has been deployed at least once (VFA, 2008). Many have faced multiple deployments. They found the Guardsmen had difficulty readjusting to civilian life after each deployment, and the difficulty was increased with each succeeding deployment (VFA, 2008). Close to one half of those who have served in Iraq have experienced significant psychological issues since their combat deployment, but do not always report their symptoms in fear that they will not be felt eligible for future combat duty or that they will not be accepted back into their civilian lives (VFA, 2008).

Veterans For America further report this condition is exacerbated by the resistance of some employers to hire those known as active or reserve National Guard, as they fear their employee will be called to duty, leaving the employer with a hole in their workforce for up to a year at a time (2008). Some employers have heard stories about how the Guardsmen might change after combat service and are afraid the employee will “freak out” (pg. 2) while on the job (VFA, 2008). Those who decide not to reenlist can have assorted problems in their post-enlistment paperwork. Veterans For
America have found the veteran faces an eight to sixteen month wait in receiving their service-related disability or confirmation of their discharge records in order to be eligible for the health care or pensions they have earned through their service (2008). Even the National Guard and Veterans Administration (VA) government employees interviewed during their research acknowledge there is a great need for higher levels of funding and personnel to process the paperwork for the returning forces (VFA, 2008).

Faber, Willerton, Clymen, MacDermid, and Weiss (2008), stated there were 152,000 military members deployed in GWOT, with 80,000 National Guard-related troops serving in 40 different nations abroad. They further relate that 31% of the military forces are experiencing longer and more frequent tours of duty (2008).

Bowling and Sherman (2008) report over 600,000 military members have separated from their respective service branches, representing the largest number of new combat veterans entering the nations system since the Vietnam War. As a nation, we need to be prepared and proactive in facing the challenges these numbers represent, beginning with efforts to keep the family unit intact and strong. Cohesive and strong families are a base for healthy communities.

The National Guard of California has a 71-page *Family Readiness Handbook* (2008) for their members. In this large booklet there is only one paragraph on one page about the availability of individual counseling, offering six no-cost therapy sessions to ease the changing nature of the family unit. There are also one-and-a-half pages devoted to the returning Guardsman and the transition difficulties they or their families may face. If the military member is traumatized, there is a reasonable expectation that
their family members will suffer from secondary symptoms of their loved one’s trauma as well. Early treatment offers the best results for any type of psychological or trauma-related disorder, a lesson learned from Vietnam veterans who are only recently asking for assistance in Veteran Readjustment Centers (Vet Centers) across the United States. Grieger and Benedek cite a study that found an amazingly low instance of Post Traumatic Stress Disorder (PTSD) in the period immediately following initial injury for combat soldiers, but when those same soldiers were reevaluated only half a year later, the symptoms of depression and PTSD were as high as those of their cohorts (2006). Also according to Grieger and Benedek, this presents an even higher degree of difficulty for the National Guardsman who often returns from duty in a demobilized state, without access to mental health care through the VA (2006).

**Background**

This country has a long tradition of military service, starting in 1775, when United States of America (formerly the 13 colonies of Britain), France, Spain and The Netherlands went to war for American independence (Lee, R. 2010). In 1761, according to Madeline Baran at Minnesota Public Radio, the term used for a battle-induced mental condition was nostalgia, believed caused by a longing to go home. This led to soldier’s heart or exhausted heart, of the same cause, with symptoms of changes in mood, the shakes, heart palpitations, or even paralysis (2010). President James Garfield admitted his time on the battlefield opened his eyes to the ease at which life, sacred before the war, could be ended in a moment, and that he never felt the same after this self-revelation (Baran, 2010). In World War I, the term used was shell shock or
combat fatigue, with a detachment from life or amnesia as two of the conditions noted. Baran states this was a belief that the shock to the system suffered by the soldier from the shelling they experienced was the reason, but soldiers who had not been shelled also suffered from the malady, so doctor’s learned the condition was not a physical reaction (2010).

World War II increased the episodes of this mysterious disorder, battle fatigue, and gross stress reaction were then thought to be a condition of long deployments, and the symptoms seemed to worsen (Baran, 2010). Gross stress reaction became the term in 1952, and it was the official diagnosis in the first Diagnostic and Statistical Manual of Mental Disorders (DSM), and as Baran reports, the term was used for combat soldiers and those who had been through a civilian disaster, like earthquake or floods (2010). In 1968, this term was removed from the DSM, but it came back later with a vengeance as post-Vietnam syndrome. Baran notes that without a mention in the DSM, no official diagnosis could be made for Vietnam vets, leaving them without medical or mental health coverage for their symptoms until the term post traumatic stress was agreed upon and included in the DSM in 1980 (2010). Baran also states a government study that quotes 15% as the number of Vietnam veterans who still suffer from the 1968 to 1980 non-diagnosable disorder (2010).

PTSD is now widely accepted and a much better understood phenomenon. As long as men, and now women, have been going to war, the families they left to serve their country have been deprived of their physical presence and support. Then, when the combatants return to their families at the end of their tours, the real disheartening
truth emerges; that these people are not the same as before the war, and likely will never be the same. It is again the family who is left to pick up the threads of their life and tries to carry on.

Military families are used to doing this, as support for one’s soldier is a tradition as old as the military service. There was a saying during World War II to which my mother related and later repeated to me, “Those also serve who only sit and wait.” Weiss, Coll, Gerbauer, Smiley and Carillo speak about this in their research on military culture. The services teach core values, a conduct code, military ethics, including the mission must come first, and adhere to a stringent hierarchal structure of who is to command and who is to follow (2010). The spouse embraces these values and military traditions, especially if the spouse is female, and they are taught to the children, becoming the culture of the family as well (2010). Weiss, et al. state it is the military spouse who is the best predictor of the mental health and stability of the family unit, leading to the retention of the family member in their military service and increasing the chances of a strong and stable armed forces for the United States (2010).

Military families face many challenges, according to Weiss, et al., including prolonged combat deployment, frequent relocation of the family to an entirely new and often not sought for location, financial inequality, stress related to the job that goes beyond normal levels and long time psychological or physical injuries and their related burdens (2010). Sometimes the results of this are substance use or abuse and a greater possibility for partner or domestic violence (2010). Faber, et al., conclude that deployment, as viewed by the military family, equates to a loss, less emotional support,
loneliness, a shift and reallocation of accepted roles, the burden of being a single parent, and fears about the safety and well-being of the deployed spouse or family member (2008). They further cite that 70% have problems being able to communicate with the deployed member, 80% worry about where the loved one is living and their overall safety, and almost 90% view their future as uncertain, increasing the stress level for the family and service member (Faber, et al., 2008).

The soldier returns home with increased anxiety, problems in relating to the civilians they meet, which can include family members, and they may have trouble adapting back to a loving intimate relationship with their spouse (Bowling & Sherman, 2008). The military member even may miss their combat buddies who offered them friendship, support and camaraderie during the last year, especially if those buddies are still in harm’s way after the combatant has returned home (Bowling & Sherman, 2008). Often the family does not understand this nostalgia for some aspects of the combat service, only seeing the negative areas of deployment, and may resent these feelings.

**Statement of the Research Problem**

The Military Family Research Institute (MFRI) at Purdue University found six matters were cited as areas of concern for counseling needs at MilitaryOneSource (2005). Of these six, marital and family issues ranked as the biggest concern to the spouse, and were secondary only to areas of conflict, anxiety and stress for the military member. The second concern of spouses was marital issues as they relate to family members (2005). MFRI found most responding spouses were female, and accounted for one-fifth of the responders, and the military members, largely male, were one-half of
the responders (2005). Fully 46% of the responses were about family related issues or problems, and only 28% were regarding deployment issues, confirming that family issues are of the most concern to both the military member and the spouse.

It was interesting that the military members found it easier to seek help from those counselors who were brought in for the study and not military, as they did not see the seeking of help from a non-military counselor to be a threat to self or career (MFRI, 2005). Conversely, the counselors felt they did not have the knowledge level of the military culture or about deployment issues that they felt they would have liked to have, and would have felt more comfortable with more training in these areas (MFRI, 2005). This speaks again to the stigma attached to seeking help for a perceived mental disorder, which is emphasized in the macho culture of the military, as well as the need for civilian social workers with a working knowledge of the military atmosphere.

**Purpose of the Study**

The study of the bio-psycho-social impact of combat deployment on active duty and/or military veterans and their significant others is very important to the health of our troops and has, heretofore, been largely overlooked by researchers. There is an increasing need to understand and mitigate the effects of combat on military individuals, and this study intends to show the growing need for information and education for the military spouse as well. By including the issues faced by the couple, not only the combat veteran, one gains a better understanding of the nature of the effects of a combat deployment, and can effectively develop programs and counseling assistance that will ease the transition of this difficult experience for the military couple.
This information will serve our nation and the military structures already in place to service our military members and veterans, while expanding these efforts to include the family members, thereby providing an opportunity to retain these marriages, intact and healthy.

**Theoretical Framework**

Solutions-focused brief therapy, according to Weiss, Coll, Gerbauer, Smiley and Carillo, can build strengths-based resiliency in the family as a whole and separately (2010). Military families are often resilient, showing flexibility with changing work tasks and locations, adjusting to deployment, a loyalty to their branch of service and to service in general and a willingness to make new friends, so to build on that foundation can work very well. It involves collaboration between the therapist and the family members, building on the ideas of military unity, mental and physical strength, and the courage the military shows in its traditions and values (Weiss, et al., 2010). This approach fosters flexibility, closeness, and an open communication component that allows the inclusion of humor, while giving the family members support from each other, opening them to community support (Weiss, et al., 2010).

The narrative component of the solutions-focused approach helps the family to give new meanings to their individual experiences, building a stronger relationship to each other at the same time (Weiss, et al., 2010). The family works at increasing the coping abilities that incorporate the values of the military and each step in the creation of a stronger family helps give them a foundation to build upon, as they recognize their positive achievements (Weiss et al., 2010). This positivism carries over into their
environment and allows the family to build both interpersonal and intrapersonal rapport. Resiliency involves acting with intelligence, a positive mindset, support of and for others, and a loving environment, resulting in familial cohesiveness (Weiss, et al., 2010).

In families where there is a dyad, without children, emotion-focused therapy for couples is indicated. Greenberg, Warwar and Malcolm (2010) posit that a block in expressing one’s emotions, as is common after a combat tour, can deteriorate communication and loving responses in the couple. Greenberg, et al. call the negative cycles of “attack-blame” and “defend-withdraw” (p. 28) a circular dysfunctional approach to problems that cannot be resolved without recognition and therapeutic intervention. The therapist works to instill a secure feeling within the couple and to use mutual validation to forge a deeper, more trusting emotional bond between them, creating positive change that can mitigate distress and distrust (Greenberg, et al., 2010).

In order to have a healthy identity, as an individual and a couple, one needs good boundaries (Greenberg, et al., 2010). Encouraging the two as individuals will open the couple to processing their disempowered feelings or even mitigate feelings of loss that may carry over from the deployment. Dispensing anger or perceived injury at issues raised during the deployment can promote mutual respect and encourage closeness, building trust at the same time. This is especially helpful if one partner felt abandoned, or if basic feelings of support, reliability and safety are eroded after the separation, and an emotion-focused approach can work extremely well.
In the study of uncertain boundaries, brought on by a wartime separation of the family, Faber, Willerton, Clymer, MacDermid and Weiss (2008), discovered that families try to keep the loved one’s presence in the home by moving the boundaries of the family members. In World War II, families who partially realigned the boundaries managed both the separation and the reunion better. (Farber, et al., 2008). To close a boundary is to reassign the duties of family members so the missing member is not missed, to avoid the media or news, to shield one from distress, to not want to hear or to share the situation of the military member by hearing any details, etc. If the military member or family does this too often, it is tough for the reintegration of the missing member.

Families who completely closed the boundary may adjust better to the deployment, but not to the reunion, while the family who remains completely open in the parameters of the family have more distress during the deployment itself (Farber, 2008). It is best to make sure the family member is present in a psychological way, allowing them room when they return, and to return to the family routine as quickly as possible, for the ease of the family. Unfortunately, this is contraindicated for the military member, who needs the decompression time offered by the military to adjust to living with civilians again, out of the rigors and dangers of war (Faber, et al., 2008). This presents a problem only solved by open communication about each person’s expectations. The couple or family should share the decisions on how the soldier may resume as many roles as possible, while granting the option of readjusting without pressure by the spouse and family (Faber, et al., 2008).
**Definition of Terms**

*Biopsychosocial* – The overall assessment of a person’s situation, covering biological, psychological and social, or environmental, structures that may be helpful in assessing the conditions which impact an individual.

*Branch of Service* – This phrase is used as a general term to refer to more than one military service. Each service, Marine Corps, Army, Navy, Air Force, Coast Guard or National Guard military units are branches of the overall services of our Nation and states.

*Diagnostic and Statistical Manual of Mental Disorders (DSM)* – A manual which focuses on clinical practice, for educational and research purposes, employing empirically based information used to diagnosis mental illness. This manual is widely utilized by doctors, clinicians and insurance companies to validate a recognized diagnosis. The current version is the DSM-IV-TR as revisions are being made prior to the release of a DSM V. (DSM-IV-TR, 2000).

*Emotion-Focused Couples Therapy* – This type of therapeutic approach focuses on the one’s experiences, how the feelings about them are expressed and how one processes their emotions, an empirically proven approach to marital therapy, proven to be one of the most efficacious therapy techniques for couples (Greenberg, Warwar, & Malcolm, 2010).

*MilitaryOneSource* (MOS) – A 24/7/365 information and referral service of the Department of Defense for each branch of military service. This is available through a toll-free telephone number or over the Internet and gives families an information
resource for all areas and aspects of military life (California National Guard Family Readiness Handbook, 2008)

*Post Traumatic Stress Disorder (PTSD)* – If, following a traumatic event in which the person feared for their life or witnessed another person threatened or killed, they experience extreme terror, defenselessness, or fright, a person may be diagnosed with PTSD, if they meet the diagnostic criteria in the DSM. (DSM-IV-TR, 2000).

*Resiliency* – According to the American Heritage College Dictionary (2004), this is the ability to have a quick recovery from change in one’s fortune or from a life-altering event. In social work this extends to environmental factors that contribute to a supportive atmosphere, like good schools, a loving family or a secure neighborhood as well as one’s own positive attitude and intelligence.

*Solution-Focused Brief Therapy* – A therapy that is strengths-based, conceived in the combination of social construction theory and multiple family therapy approaches, successfully used with youth and family relationship issues. (Roberts, 2009)

*Traumatic Brain Injury (TBI)* – May occur after an explosion that knocks one out, covers them with debris or a concussion that causes the brain to be injured inside the skull. According to Bowling and Sherman, 2008, a TBI can bring about changes in mood or behavior, resulting in anxiety, depression, and increased impulsivity, as well as decreased cognitive abilities in the areas of memory and concentration.
Assumptions

The assumptions of this study are:

1. There will be some negative aspects of the combat deployment, which will affect the behavior, feelings, and emotions of the returning military service member.

2. It is crucial that all members of a military family, including significant others, spouses, children and parents are educated in the effects of a wartime deployment and applicable ways to function to mitigate the possible negative effects.

3. There must be adequate funding and personnel to ensure the smooth return and transition of service men and women from combat to stateside duty, including medical, mental health and counseling, as needed.

4. The United States needs a strong military force to preserve our freedom and traditions, the military is only strong if we all work to ensure the individual members and their families are healthy and secure as well.

5. All clinicians must be knowledgeable and aware of the military culture in order to effectively work with veterans, active duty personnel and their families.

Justification

As mentioned by the Military Family Research Institute, counselors from outside the military were seen as a safer person from which to seek assistance in any matter that related to mental health, without the risk of damage to one’s career or fitness for duty (2005). This is an especially important factor for social workers, who are the most widely recognized support personnel to utilize in the military system, as evidenced
by the emphasis placed on the social work degree when the VA is seeking a new clinical employee. Social workers are in a good position in terms of desirability and respect in the echelon of the military ranks.

In the study mentioned by the MFRI, all counselors were employed part time, for short term counseling services, which may not have been as effective as long term rapport building and in-depth counseling in addressing the entire realm of issues and their ramifications on the service member and their individual family members (2005). This is also highlighted by the desire the counselors expressed for more training in order to both understand and be more effective in working with members of the military. Increased levels of training and knowledge of the military culture and demands the military places on their members would benefit any clinician who works in an environment rich in military service personnel.

The Family Support Group (FSG) is a long-recognized and respected method of treatment and would be of enormous benefit to the military family unit. Faber, Willerton, Clymer, MacDermid and Weiss (2008) studied an area where no military family support group (MFSG) existed, and an area where an effective group was in place. They asserted that the effectiveness of the group structure, as a way to procure and share information, plus find others who understood their concerns and corroborated them, was enormous. The families learned to become more flexible in their boundaries and reduce uncertainty about the military routine. The groups helped them to see areas where improvement was needed, leading to reestablished routines and a more predictable daily life, diminishing stress caused by ambiguity and doubt.
The choice of the facilitator largely determined the efficacy of the group. It was observed that a group needed a vibrant and self-motivated person to seek out the necessary information and be able to distribute this information to those people who would find it most useful (Faber, et al., 2008). This person was also required to interface with the military in order to obtain helpful content for the group meetings. When an experienced group leader acted as the catalyst for the discussion, the transitions to new neighborhoods, deployment, and schools, the resulting dialogue could be very effective and useful for the group members.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

This study sought to examine the general trauma-induced issues that many couples experience, researching the symptoms couple face that are not treated in the Veterans Administration (VA) at present. As such, it encompasses many general issues without addressing specific diagnoses, such as PTSD, due to the nature of the study. It is accepted that a diagnosis of PTSD exacerbates any problems the couple may face (The International Society for Traumatic Stress Studies, 2005, Grieger & Benedek, 2006, Nelson Goff, Crow, Reisbig, & Hamilton, 2007). If a Vet Center or VA facility is not in their locale, couples are advised to seek a clergy member, a counselor or a Chaplin for assistance (National Center for PTSD, 2009, California National Guard Family Readiness Handbook, 2008), or face a long journey from their home for their mental health care. The research largely centers on the worst-case scenario, so many of the citations and information given relates to the broad spectrum of trauma caused conditions.

Starting with current conditions of the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) conflicts in Iraq and Afghanistan, and tying in other areas of interest from the Vietnam War, this section seeks to inform people about the present situation. Over 35,000 of those combatants returning from the current Global War On Terror (GWOT) conflict who have seen a mental health physician at the VA (Bowling & Sherman, 2008), and as of June 2006, have sought care for possible PTSD.
Also according to Bowling and Sherman (2008), of those who were seen and received a diagnosis at a VA facility between 2001 and 2005, approximately one-third were given a mental health or psychosocial diagnosis. In one group of 1,700 Army and Marines, fully 15 to 17% met the diagnostic criteria for their symptoms, including generalized anxiety disorder, major depression and PTSD. In specifics about the readjustment issues faced by our military, I cite these numbers because they indicate a solid need for individual and spousal counseling. There are unreported numbers of persons who suffer in silence, and there are those who are seen for symptoms that are serious enough to seek care but considered not strong enough for an official diagnosis. Given the official numbers for those diagnosed, the totals are most certainly large, but unknown and unresearched. The stigma associated with mental health care, especially to those in a military culture, will be discussed in a section on the reasons that stand in the way of seeking help.

Recent studies and publications assert that the main points of consideration for couples after a combat deployment are the interaction between the couple, including communication, trust and relationship satisfaction, the experiences of the military member of the couple when in the combat theater and the likelihood of the military member or the couple seeking services for adjustment issues after the homecoming. The spouse may develop her or his own set of symptoms while the service member is deployed, increasing the readjustment issues and decreasing the relationship satisfaction between the couple.
Veterans For America (2008), in their study on 5,000 deployed members from the Pennsylvania National Guard, found the two largest problems to be friction within the marriage and familial discord. Historically, military members and their families often face lengthy separations, combat deployment mental and physical stressors affecting all family members, and the reality of lasting debilitating psychological and physical injury (Weiss, Coll, Gerbauer, Smiley and Carillo, 2010). There is a separate discussion area concerning secondary PTSD, which can be analogous to other issues of depression and anxiety, as investigation shows the couple can often share symptomology.

Weiss, et al. (2010) found that over fifty percent of military members have families, and despite the family culture of stoicism and resiliency, these families face a wide range of problems from Traumatic Brain Injury (TBI), combat anxieties, and multifaceted areas of physical injuries, leading to multiple biopsychosocial adjustment issues. Due to the complex nature of the stigma associated with seeking help for areas perceived to be of a mental health nature, these adjustment difficulties may lead to self-medication rather than counseling sessions. Bowling and Sherman (2008) state 24 to 33% of those returning from deployment report they utilize alcohol as a release much more than they intend so to do.

In February of 2007, the American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members (Presidential Task Force) released their 67-page study titled The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report. The study
was to ascertain the psychological risks and service needs related to mental health facing our military families since September 11, 2001. They cite “the significant barriers to receiving mental health care within the Department of Defense (DoD) and Veterans Affairs (VA) system” (p. 4). The Presidential Task Force admitted they could not find research on the psychological needs of service members and their families, as nothing has been done that is system-wide within the military. They recommend a detailed and comprehensive research study be undertaken. The lack of research on the family or spouses’ issues after a military member’s return from a wartime deployment is remarkable, which relates to the small amount of scholarly publications concerning readjustment and satisfaction levels after combat service.

Current Conditions

The American Psychological Association Presidential Task Force of 2007 found 1.5 million service personnel have been deployed to a GWOT conflict. One-third of these warriors have been deployed at least two times, 70,000 have served for three tours and 20,000 have gone to war for five tours. Today’s combatants face longer deployments than in previous conflicts, and according to Grieger and Benedek (2006), this additional time in the combat arena increases the likelihood of suffering from trauma. Today’s war is like Vietnam in the constant awareness of danger, and the mortar fire present in all wars. It is the increase in improvised explosive devices (IEDs), car bombs, and suicide bombers that give military personnel no respite from the threat of injury or death. This unvarying vigil in one’s living quarters, dining facilities,
and routine travel wears on one and causes heightened arousal (Grieger & Benedek, 2006).

Citing a study of 894 Army members returning from Iraq, Bowling and Sherman (2008) state 95% have seen dead bodies or human remains, 93% experienced small arms fire where they were the target, 89% were attacked or ambushed by the enemy, 65% witnessed wounded or deceased Americans and 48%, after firing upon the enemy, felt they were responsible for the death of another. Of the 35,000 seen for PTSD, many more have experienced depression, substance abuse, and difficulties in their relationships. Like Vietnam; the current conflicts are different than previous wars, because these wars are within the home country (Dohrenwend, Turner, Turse, Adams, Koenen & Marshall, 2007). The enemy and the friendly native are indistinguishable from one another and there is no discernable front line of combat. These facts may increase the hypervigilance and arousal of stress response, as a reaction to the unremitting watchfulness.

In addition to the other similarities of the Vietnam era, Dohrenwend, et al. (2007) found that a diagnosis of PTSD has impact in other areas. Vietnam veterans were found to suffer more unemployment after their service, a lowered ability to remain in a satisfying relationship or marriage, and as a group, rose to a lower socioeconomic level than their peers without PTSD. The affects of untreated trauma stayed with them throughout their lifetime, and contributed to reduced situations of the family members as well.
Trauma Reactions

According to Figley and Figley (2009), “Trauma is defined here as an experience that is sudden and potentially deadly, often leaving lasting and troubling memories” (p. 173). The symptoms of a nervous demeanor, fearful outlook, depression, numbed feelings, anger, sleep disturbances and substance abuse (National Center for PTSD, 2009, International Society for Traumatic Stress Studies, 2005, Grieger & Benedek, 2006, Nelson Goff, Reisbig, & Hamilton, 2007, Figley, 2005) are all shared effects after exposure to trauma. The feelings of self-blame, survivor’s guilt and shame (National Center for PTSD, 2009) are all part of the body’s reaction to the severe mental stressors found in combat.

The body may strive to continue in the fight or flight mode, when the body is in constant arousal, ready to do battle or retreat (Coon, 2004) long after returning from a danger situation. It is possible for those who experience damage to the amygdala to stop reacting to danger, but that comes at the cost of losing one’s positive emotions as well. The amygdala is the primitive part of the brain that generates fear (Coon, 2004), and the fear emotions. The jumpy reactions, anxiety, exaggerated startle response and numbing are all related to the involuntary reaction of the autonomic nervous system, and one reacts long before one has the ability to think about the reaction.

The relationship satisfaction areas most concerning to the spouse, when their soldier returns from deployment, concern sexual dysfunction or lack of desire, dissociation or numbing, and disturbance of the sleep patterns, including disruptive nightmares (Bowling & Sherman, 2008, Figley, 2005, Nelson Goff, et al., 2007). These
are the areas that have the most negative impact on both members of the couple, and those that are the most widely reported. Other areas can impact one or the other of the dyad, but these are the most troublesome for the couple during the readjustment period.

Other traits experienced after trauma are often presented as somatic issues (National Center for PTSD, 2009, Nelson Goff, et al., 2007, Figley, 2005), which in some instances could also be related to the cultural background of the trauma sufferer. Some cultures frequently present mental health symptoms as aches or pains in the body or as physical rather than mental ailments (Tseng & Strelzer, 1997). The stomach upset, trouble eating or sleeping, exhaustion and various body pains can be a manifestation of the troubled mind in many Latin or Asian countries, and so may carry over to the first or second generation person born in the United States. It is easier for the blame to be deemed a medical need for a physical condition rather than to mental stress or a psychological reaction.

Grieger and Benedek, in their 2006 study of Vietnam Veterans, found that there were many former military personnel who had a complicated readjustment to integrating back into civilian life after combat. They discovered a 10% incidence of life long depression and a 50% occurrence of alcohol abuse in those who had experienced extreme situations on the battlefield. The National Center for PTSD (2009), Bowling and Sherman, 2008, and Nelson Goff, et al. (2007) found a common reaction to one’s war experience is self-medication, leading to drug and alcohol abuse and dependence. James Dao, of The Sacramento Bee published an article in February of 2011, quoting a Defense Department survey that ascertained there is widespread illegal usage of
prescription drugs by military personnel, and that the abuse was three times higher in 2008 than it was in 2005. Currently, the abuse of prescription drugs is more prevalent than the use of illegal street drugs. The article continues, alleging self-medication by the military member in an effort to feel normal again, to feel more like they felt prior to their deployment. If their prescriptions seem insufficient for this purpose, it is easy for the service person to find a battle buddy who will recommend a medication that worked for their needs, and is willing to share with a fellow-suffering combatant. In the present, this sharing of and perhaps over-prescribing of narcotic painkillers has led not only to abuse but dependency, suicide and fatal accidents, all attributed by the Army to prescription drug consumption.

**Civilian Spouse Deployment Stressors**

According to the Army data, one-half of spouses reported regularly feeling anxiety while almost that many stated they were depressed during the deployment (SteelFisher, Zaslavsky, & Blendon, 2008). Merolla (2010) quotes McCubbin (1979) as saying the separation of a deployment increases the responses that are dysfunctional, such as depression, acting out behaviors and complaints that are psychosomatic in nature. During the first war in the Gulf, approximately 70% of spouses exhibited symptoms of depression and anxiety (Rosen, 1996, as quoted in Padden, Conners & Agazio, 2011). Wives experienced more difficulties in all aspects of their life, marital, family relationships and social interactions, when their spouse was deployed (Solomon, Waysman, Levy, Fried, Mikkulincer, Benbenishty, et al., 1992, as quoted in Nelson Goff, et al., 2007).
Padden, et al. also stated they found couples who had been married longer found the deployment easier, as did the higher military rank of the deployed member. The spouse who has an intimate understanding or was raised in the culture of the military also found it easier to cope with deployment issues (2011). Additional results show that up to 20% of the spouses who seek help for mental health issues during a military member’s deployment only approach their primary physician for assistance, rather than a mental health specialist (Padden, et al., 2011).

Rosen tested Army spouses during the time their military spouses were deployed, then re-tested the spouses a second time, several months after the military members returned (1996). Rosen discovered that 70% had stress symptoms during the time of deployment, but after the return, 24% still stated they experienced stress. There was also a finding of 4% of Army spouses who only had stress symptoms after the return of the soldier. While 40% felt they had recovered and they were no longer stressed, almost 30% reported stress symptoms upon the return of their soldier.

When a returning military member is physically there, but not psychologically available, the reunion is stressful (Faber, 2008). The constant concern over the safety of the soldier, the added responsibilities and lessened availability of the spouse for consultation, and the lack of understanding as to the nature of the relationship during reunion all increase the strain of a deployment (Faber, et al., 2008). The secondary wartime effect on the family is widely known, but not readily studied (Dirkzwager et al., as quoted in Figley, 2005), but it is reported by Dirkzwager that the mental health of the soldier is mirrored in the spouse.
Selye (1974) defined stress “as a specific psychological and physical reaction to acute or enduring demands” (p. 106, as quoted by Randall & Bodenmann, 2009), as well as stress is something which happens between a person and the environment they experience. Bodenmann (2005) also looks at the stress in a couple as a direct concern of both partners over the same strain during an event or an encounter or as a shared experience of stress during an event they encounter (as quoted in Randall & Bodenmann, 2009). In other words, if one takes a systemic view of stress, when one member of a couple experiences stress, it also affects the other member, thus individual stress becomes partner stress.

**Shared Stressors of Deployment**

Merolla quotes studies on the couple during deployment, in his 2010 research. Merolla states the Department of Defense Mental Health Advisory Team in 2007 found 27% of married soldiers deployed in Iraq reported some type of problems in their marriage while deployed. The separation of a deployment is a factor that heightens anxiety, ambiguity, and loneliness (Burrell, Adams, Durand & Castro, 2006, and Wood, Scarville & Gravino, 1995, as quoted in Merolla, 2010). Padden et al. quote Mansfield’s 2010 study that agrees with the depression and anxiety, but also states acute stress reaction, sleep pattern disruption and disorders surrounding adjustment are added encumbrances a couple faces during the separation and reunion after deployment (2011).

In the arena of trauma specialization, most attention is given to the traumatized individual, not the family, even though the social support provided and the methods the
family develop to mitigate the consequence of the trauma are very important to the positive outcome for the traumatized individual (Figley & Figley, 2009). The family has the most important impact on the individual’s recovery and wellness. There is a systemic reaction in the family to the functioning of the person with trauma, and the symptoms exhibited, and there is a propensity for secondary trauma in the family (Figley, 1983, 1998, as quoted in Nelson Goff, et al., 2007). Nelson Goff, et al. postulates, “We can no longer consider trauma to be a strictly individual experience” (2007, p. 350).

According to Goff, Crow, Reisbig and Hamilton (ND) in Nelson Goff and Smith, 2005, the Couple Adaptation to Traumatic Stress (CATS) model hypothesizes that a military person who has diagnosed PTSD will increase the possibility of the secondary PTSD in the spouse. It becomes a situation where the cycle of their interaction will increase the negative reactions of both. Studies show this will negatively impact the satisfaction of the relationship for both parties, and be harmful to both persons as well as to the relationship (Nelson Goff & Smith, 2005).

Another relatively new approach with dyads who exhibit trauma, including the military member with a diagnosis of PTSD, is Cognitive Behavioral Couples Therapy for PTSD (Renshaw, Rodebaugh, & Rodrigues, 2010). The therapeutic cornerstone is communication; including discussing the possible traumatic combat events, and the process explores the interaction of the couple by addressing the relationship concerns and the PTSD symptoms at the same time. In the event of the soldier seeking care at the request of the spouse, this method has proven effective for continued attendance for
the therapy sessions and better adherence to the interventions suggested by the therapist
of counselor (Renshaw, et al., 2010).

The Presidential Task Force (2007) “was not able to find any evidence of a well-
coordinated or well-disseminated approach to providing behavioral health care to
service members and their families” (p. 5). The Task Force continued to state their
findings were the same no matter which branch of the service was explored, or what
area of the country they researched. The military does not seem to have a well-
conceived idea of the scope of the issue, an idea of the number of people who may need
service, or a plan on how best to approach the need for counseling or mental health
adjustment concerns.

Readjustment Issues

The Presidential Task Force (2007) determined that as many as one-fourth of the
returning troops are wrestling with matters of a psychological nature after their
experience with multiple areas of strain during their deployment. The stress can be
more severe when the service person is part of a couple. The changes they undergo test
their ability to return to civilian life after combat. The family with a strong support
system from their community, extended family members and other social arenas has a
better time readjusting to the homecoming. Unfortunately, as Wiens and Boss (2006,
quoted in Bowling & Sherman, 2008) discovered, a young couple, new family, or
family with other strain, like being far from home during the loved one’s deployment,
are more at risk for difficulty in their relationship.
Bowling and Sherman, quoting Hutchinson and Banks-Williams (2006), call this reunion the traumatized meeting the traumatized (2008). The military person finds it is difficult to experience feelings different from the anger that kept them alive on the battlefield, and will need to re-learn how to allow themselves those feelings once again. Both the soldier and the family members will need to establish a reconnection to each other and the constricted feelings they all held while living with a deployed family member will need to relax. Often this is more difficult when the family faces another deployment, as the barrier is easier to maintain rather than to minimize the restriction and then go back to constricted again (Bowling & Sherman, 2008). The military member may feel like they no longer belong in their community or their family, like an unwanted visitor instead of a loved and trusted member of society.

Families must create new boundaries when the soldier is deployed. The boundary must shrink, to allow for the missing person to be there, while not actually being present, and then must expand again once the member returns (Faber, Willerton, Clymer, MacDermid & Weiss, 2008). This necessitates new roles and responsibilities as well, as it is not possible to just start again where the family was pre-deployment. In some cases, the military member needs let down the eternal vigilance, may be uncomfortable in crowds, in public places, and may have difficulty learning to trust their surroundings again, after deployment in a hostile environment. The family may want to relinquish the new responsibilities, and the service person may need to adjust for longer than the family realizes. Conversely, the spouse will not be accustomed to the multitude of questions about his or her life, and actions. They may feel they were
perfectly able to get along without the protection of their soldier while the soldier was deployed, so they should continue to remain independent once the person returns (Faber, et al., 2008). The need for independence and the need to allow the military member their place again may be at odds with each other.

As stressful as the deployment may have been, it is a strain to establish new patterns of interaction and communication. The couple needs to discover what is important to them, and to the relationship, and how to adjust to these needs in order for harmony to prevail. The service person must have a place in the family, must feel needed again (Faber, et al., 2008), especially after having so many life-threatening situations during the deployment.

**Relationship Satisfaction**

According to Renshaw, et al. (2009), an exposure to combat is positively linked with the severity of symptoms of depression and PTSD. The symptoms developed after the war experience have a significant impact on the marriage, reducing the level of marital satisfaction. In the 2008 study by SteelFisher, et al., 10% of spouses felt their service person’s deployment undermined their marriage. Bowling and Sherman relate that an intimate relationship seems to show more strain after a deployment to a combat arena (2008).

The areas of concern most reported are the sleep disturbances and the sexual problems, but Nelson Goff et al. (2007) feel this may be because these are external and visible matters. Other issues that are internal, and thus not as easily recognizable, are the anxiety and depression. These symptoms may be more readily hidden or masked,
explained as one feeling tired or stressed rather than the more serious areas not observable by the naked eye. The inability to be emotionally present for their spouse, or the numbing of one’s feelings may be attributable to a high level of trauma, but not as difficult to rationalize as caused by other reactions, thereby deemed not as serious to the traumatized person (Nelson Goff et al., 2007). This may contribute to the soldier not seeking help with these symptoms.

**Mental Health Stigma in the Military**

Bowling and Sherman state it is the stigma associated with asking for or receiving care that is the largest factor in the service person not seeking care for their symptoms (2008). The Presidential Task Force (2007) report the need to alter the perception of mental care within the military establishments, in order to make mental health care more acceptable to military personnel and not seen as a derogatory statement about the person seeking help. Grieger and Benedek (2006) found that those who stated their symptoms were problematic in their daily life, and who met the established criteria for a diagnosis from the DSM IV-TR did not intend to ask for services for fear it would be damaging to their career or that others in the military would not think as highly of them.

Friedman (2004) found Marines and soldiers who felt the need to seek care are concerned about being stigmatized. Further, those who need mental health services are not likely to ask for care for fear that they will be seen as weak, as failures in their military service, and their commanding officers will see them as less fit for the military.
To quote Friedman, the need for mental health services will be viewed “as evidence of an innate deficiency of the right stuff” (p. 77).

Nelson Goff et al. held the view that the military offers all personnel the best possible training on the issues and symptoms of PTSD, as a preparatory and preventative measure. This may backfire, as an active duty soldier who knows the possible detriment to one’s career may believe it is best to minimize specific PTSD or other symptoms that might indicate a need for care (2007), and increase the more general symptoms that are more easily explained as the expected stress and strain of battle.

In 2004, Hodge, Castro, Messer, McGurk, Cotting and Koffman stated that only 23 to 40% of those who are diagnosable with PTSD would ask for help, because of the stigmatized viewpoint of the military toward the need for mental health care. Unfortunately, this stigma extends to the non-military spouse as well, and the tendency is for the spouse to also not seek care. Hodge, et al. also found it is often the Army and Marine personnel from Iraq and Afghanistan who most require assistance with adjustment and mental health concerns that are least likely to ask for help, because of the perceived stigma associated with mental health issues.

**The Need for Research**

Padden, Conners and Agazio are three nurses who see military personnel in their work and who studied 105 Army spouses from a large East Coast military base facility for their 2011 study. They found that there is very little scholarly research on the response of the spouse to current wartime deployments. Their concern is for the overall
health, as well as what types of coping strategies are offered to these civilian spouses. Spousal stress has been mentioned in medical journals and the small amount of research that has been done since the 1930s, but most of the mention has been anecdotal in nature rather than true research. The need for answers to these issues has been with us as long as war has been, but little is actually done about exploring solutions. Padden, et al. were interested in their research precisely because of the obvious need and the lack of solution-based response, especially as the United States is actively involved in wars in Iraq and Afghanistan. This perception on their part was the reason for this study, to investigate the needs of the dyad and whether there is any current effort to mitigate the potential damage to the health of military marriages or relationships.

In one study quoted by Merolla (2010), the need for support of the spouse during and after deployment, and on the preservation of the relationship is not well researched, as stated by Drummet, Coleman and Cable in 2003. The Presidential Task Force (2007) could not see any comprehensive, establishment-wide data on the clinical needs of our military or the family members of those serving our country. The Task Force did not find any current research or plans to research these concerns and questions related to the need for supportive measures for the families.

Based on the current literature, which highlights the need for services to the spouse and family, this study was conducted to verify this information would also apply in Northern California. Very little data that this researcher could access has been done in this specific location. California is considered to be a key location for any operation conducted in the Pacific (globalsecurity.org) and of the 33 military bases in California,
eight of them are located in the northern area of the state (militarybases.com). Personnel involved in many types of military operations, in the Pacific and all over the world, are recruited, trained and deployed through these facilities.

Veterans of the military live all over the United States, but California has the largest number of veterans as permanent residents of any state in the Nation. According to the Department of Veterans Affairs (2007), of the 23,816,018 veterans in the United States, 2,131,939 veterans live in California. The states that are closest in number to California and also have the highest population of veterans are Florida (1,746,539), Texas (1,707,365), New York (1,065,749) and Pennsylvania (1,057,073). California is the only state with over two million veteran residents, increasing the need to have information concerning the health and well being of these veterans and their families.

With limited access to veterans, consisting of veteran’s groups and personal contact with members of veteran population, this research will not be done in an all-access manner of much of the literature reviewed in this chapter. The impact of that limitation may adversely impact the validity and amount of data collected, but this should in no way restrict the importance of the topic or the concern given to this area of interest.
Chapter 3

METHODOLOGY

Research Question

The purpose of this study is to better understand the nature of the effects a combat deployment creates in the military couple, in order to effectively develop programs and counseling assistance which may be necessary to ease the transition of this difficult experience. The study of the bio-psycho-social impact of combat deployment on active duty and/or military veterans and their significant others is very important to the health of our troops and has, heretofore, been largely overlooked by researchers. There is an increasing need to understand and mitigate the effect of combat on military individuals, and this study intends to show the increasing need for information and education for the military spouse as well. This information will serve our nation and the military structures already in place to service our military members and veterans, while expanding these efforts to include the family members, thereby providing an opportunity to retain these marriages, intact and healthy.

Research Design

The study design was a descriptive design, utilizing a qualitative approach and deductive reasoning (Yuen, Terao & Schmidt, 2009). The survey utilizes questions adapted from The Clinical Measurement Package by Walter W. Hudson, 1982, from a Generalized Contentment Scale (GCS), an Index of Marital Satisfaction (IMS), and an Index of Peer Relations (IPR). The research questions were chosen to examine these three areas of a person’s feelings upon the return home of both a military person and
their spouse or significant other after combat. The GCS shows issues concerning depression, while the other two instruments measure the degree of discontentment within the marriage and the interrelational discord one may find with peers, respectively (Hudson, 1982).

**Study Population**

The participants for this study were to include California State University, Sacramento (CSUS) students enrolled in SWRK 196A Exploration of Veteran Studies: An Ethnographic Approach (with agreement received from instructor Dr. Chrys Barranti), but that proved impossible as the IRB approval came through after the semester had ended and the class members were no longer available to this researcher. Additionally, the possible participation of clients from the Sacramento Vet Center was impossible to utilize, based on the necessary agreement that would have been required from the Veterans Administration.

Surveys were completed by members of the CSUS Campus Student Veteran Organization Center (SVO), who were recruited through convenience and snowball sampling, and with the support of the fine staff and administration of the SVO. Additional surveys were completed by members of the Viet Nam Veterans of Diablo Valley (VNVDV) Group, through the recommendation of one of their members. This researcher also found participants from several individuals who heard of the study from other participants and agreed to contribute their information. All participants were over the age of eighteen and voluntarily agreed to state their experience for the study.
Sample Population

The participants were recruited utilizing a convenience sampling method (Yuen, et al., 2009) from selected groups, choosing subjects who meet the necessary requirements. All participants were over the age of eighteen, and met the established criteria of prior military combat, either service members or veterans with combat experience, and their spouses or significant others. After qualifying that they met the conditions, the researcher used a purposive sampling method to meet the specified nature of participants for the study. The researcher also recruited persons through the use of nonprobability snowball sampling (Babbie, 2005), as participants spoke to other qualified persons and recommended their participation as well. Potential subjects were asked if they would like to participate in the research study concerning the experience and possible challenges faced during the service member’s return from combat deployment.

It was estimated that approximately 30 to 50 volunteers would participate in the data collection, using the provided survey. In the end, 30 participants volunteered to fill out the surveys and contribute to the research. This researcher did not have any formal, business, or professional relationship with the potential respondents and there was no conflict of interest during the sampling.

Instrumentation

The design used for the research utilizes a five-page questionnaire (see Appendix A) that has a five-point Likert-type rating scale, plus some fill-in-the-blanks areas for additional short answers. The 23 questions pertained to the experiences and
challenges participants faced when returning to the home environment after combat, and
included the specified areas of marital satisfaction, general contentment and peer
interaction.

The survey included some of the same questions for the military member or
veteran and their civilian spouse. Also, one page was directly related to the military
member’s experience, and a separate page was geared to the experiences of the civilian
spouse, with directions so the participant answers their questions only, on their
individual survey form. There were seven additional questions of a demographic
nature, and instructions for the survey stated the participant should only answer the
questions they felt comfortable answering. In employing questionnaires that were
already established measurements (Hudson, 1982), the face validity of the survey was
deemed accurate for these purposes. The data collection instrument was not formally
statistically tested for reliability or validity. The survey tool’s face and content
validities were established through the reviews by a social work researcher and an
acknowledged expert on military matters on the California State University, Sacramento
campus.

Data Gathering Procedure

The procedure began with participants who were asked to volunteer for this
survey, and were told the study is directed at further understanding possible issues
surrounding their experience, as it related to the marital and personal challenges faced
after homecoming of a combat participant. They were provided a detailed consent form
(See Appendix B) to read, given the opportunity to ask questions, and then asked to sign
the form, stating they agree to participate in the research without any further inducement. The form included their name, signature and date, with only the conflict name indicated on the survey; there were not any other identifying marks or names. Each consent form was collected and secured in an envelope, separate from the survey envelope, and the surveys were distributed. The researcher informed the potential participant of the emotional discomfort they might experience during the survey data collection, but reassured each participant that their information was anonymous and confidential, for research purposes only, and that any discomfort would be momentary.

Each participant was given a thank you message on a debrief form (See Appendix C) by this researcher at the conclusion of their participation, one that included relevant contact numbers should the participant decide to speak to a counseling agency after their participation. These numbers are valid for both military members and civilians, as there is some resistance among the active military personnel to speak with military sources if they are still attached to the military. The information was collected in an entirely confidential and anonymous manner, without inclusion of any possible identifying data regarding the individual participant.

Every consent form was collected and secured in an envelope, separate from the survey envelopes. Both the consent forms and the surveys were securely protected, always in the researcher’s possession, before being stored in separate locations in the researcher’s home. All materials were destroyed in a secure manner at the conclusion of all data analysis that was deemed necessary.
Data Analysis

After the collection of all of the surveys used to conduct the research, the data was coded, producing numerical equivalents of the phrases used in the survey tool. The data for this study was analyzed using an automatic statistics tool originally called Statistical Package for Social Science, or SPSS. Norman Nie developed this tool in the late 1960s (Harvard-MIT Data Center, n.d.). This tool is the standard software applied to the interpretation of research data. The data was entered into current SPSS analytical software and then the frequencies tables were run to show the mean and percentages of the various variables produced by the coding of the survey tool. Utilizing these frequency numbers and the corresponding percentages, the data produced was examined for trends, tendencies and statistical anomalies, and those data interpretations were used in chapter four to discuss the study findings.

Protection of the Human Subjects

The researcher considered this a “minimal risk” study. There was a possibility of a minimal risk of discomfort or harm to participants. Since each was a voluntary participant, informed of the topic, the reason for the study and the nature of the questions prior to reading and signing the consent forms, the discomfort or unease was felt to be minimum. All participants were reminded orally and in writing that they did not need to answer any questions they felt uncomfortable answering and that any opinions expressed in the write-in section would be completely anonymous and confidential.
The Research Committee in the Division of Social Work determined this research was including an “at risk” population, in utilizing combat veterans as a sample group. The Division Committee indicated that the application had to be reviewed by the Sacramento State University Committee for the Protection of Human Subjects. Subsequently, my research was approved conditionally, as an “at risk” application in October 2010.

After meeting the conditions suggested by the department, the stipulations imposed were that this researcher would inform the committee promptly if there were any participants who exhibited a reaction to the data collection survey that is harmful to them in any way. The possible areas of harm included physical, emotional or mental injury, or any damage brought about by the release of personal data. There might be other areas of potential damage, and I was advised to consider that possibility during my data collection efforts as well. This researcher’s ability to gather data, under approval FWA00003873, expires on the thirtieth of November 2011, and would need to be renewed by requesting an extension of the approval, which will not be necessary.
Chapter 4

DATA ANALYSIS

In the research undertaken for this analysis, the goal was to show the challenges faced by couples in the military after a wartime deployment. The military member who goes into combat must face certain aspects of deployment after the return home and these changes impact the relationship of the couple. With these anticipated difficulties, it is to be expected that the adjustment back to a civilian environment will be fraught with inconsistencies and frustrations for both members of the couple. As the literature review has indicated, this will foster a need for both persons to find a way to deal with the challenges.

This study attempted to comprehend the effects of combat deployments upon the military couple. It aims to provide a better understanding to develop effective and appropriate service programs and counseling assistance needed to ease the transition after this difficult experience. The knowledge concerning the biopsychosocial impact of combat deployment on active duty and/or military veterans and their significant others is very important to the health of our troops and to the strength of our military. Researchers have largely overlooked this potentially negative impact thus far. There is an increasing need to understand and mitigate the effect of combat on military individuals, and this study intended to show the increasing need for information and education for the military spouse as well. This information would inform our nation’s officials and the military structures already in place to service our military members and
veterans, plus expand the efforts to include the family members, thereby providing an
topportunity to retain military marriages, intact and healthy.

This descriptive design study utilized a quantitative approach and deductive
reasoning (Yuen, Terao & Schmidt, 2009). The survey questionnaire includes questions
adapted from The Clinical Measurement Package by Walter W. Hudson, 1982, from a
Generalized Contentment Scale (GCS), an Index of Marital Satisfaction (IMS), and an
Index of Peer Relations (IPR). The research questions were chosen to examine these
three areas of a person’s feelings upon the return home of both a military person and
their spouse or significant other after combat. The GCS shows issues concerning
depression, while the other two instruments measure the degree of discontentment
within the marriage and the inter-relational discord one may find with peers,
respectively (Hudson, 1982).

Surveys were completed by members of the California State University,
Sacramento, Student Veteran Organization (SVO) through their offices on the
University campus. Participants were recruited through convenience and snowball
sampling, and with the support of the staff and administration of the SVO. Additional
surveys were completed by members of the Viet Nam Veterans of Diablo Valley
(VNVDV) Group, through the recommendation of one of their members. This
researcher also found several individuals who heard about the study from other
participants and agreed to contribute their information. All participants were over the
age of eighteen and voluntarily agreed to include their experience for this study.
This researcher did not have any formal, business, or professional relationship with the potential respondents and there was no conflict of interest during this convenient sampling process. Out of the approximately 140 surveys provided to potential participants early in the year of 2011, 30 individuals volunteered to fill out the surveys and contributed to this research. Chart number 1 depicts the conflict these respondents and their spouse or significant other were involved in, for five categories, the Gulf War, Global War on Terror including Operation Iraqi Freedom, Operation Enduring Freedom, and possibly Operation New Dawn, the current conflict in Iraq, Vietnam, Multiple wartime deployments, and one person who declined to state where they were in combat.

Figure 1 Conflicts
Participants included 18 veterans of military service, all male, and 12 spouses or significant others, all female. This was not by any method of selection; it is attributable to the random response from the surveys completed by respondents.

The survey design used for the research utilizes a five-page questionnaire that had five-point Likert-type items, plus some open-ended items. The 23 questions pertained to the experiences and challenges participants faced when returning to the home environment after combat, and included the specified areas of marital satisfaction, general contentment and peer interaction. Demographically, 37% (n=30) of respondents were under thirty, while 46% (n=30) were over the age of forty-three. This research involved 67% (n=30) Caucasians, and 33% (n=30) other ethnic groups, of these, 10% (n=30) were African American and 14% (n=30) were Hispanic. A full 78% (n=30) of participants are currently married, 60% (n=30) own their home, while 37% (n=30) rent and 67% (n=30) are currently employed. Finally, 27% (n=30) currently attend college, 16% (n=30) have never attended college, 43% (n=30) attended some college or graduated with a four-year degree and 13% (n=30) went beyond the four-year degree to earn a Masters, PhD or professional degree.

**Data Analysis and Findings**

There were a total of thirty surveys returned and analyzed using Statistical Package for Social Sciences (SPSS). Of the respondents, eighteen were veterans of military service and had experienced wartime, combat conditions. The conflicts in which participants served span a period of over four decades. The other twelve respondents were the spouses and/or significant others of the military combatants. Both
the veterans and the spouses had a page in the survey specifically designed to measure their individual experience. The data was gathered from both members of a couple at the same time, but on two individual surveys, one for each of them. While anonymity was assured from this researcher, it is not guaranteed that the two members of the dyad felt their partner would not see the information as they were filling out the survey, and that may have influenced the findings reported here. Other adverse influences may be the military code and culture, which teaches personal strength and resilience, and the limited access most civilians experience when questioning the areas of that strength as it may be tied to the military and issues of mental health.

In order to visually demonstrate the overall trends and patterns, certain ordinal level responses were quantified as interval level values for calculations, i.e., Never/Rarely (1 point), Occasionally (2 points), Sometimes (3 points), Often (4 points) and Most of the Time (5 points). The "mean" score for each of the items were calculated. Other mean average information, again separating the military member from the spouse, shows that as a group, the military member feels that 45% (n=18) of the time their military friends understand them and their concerns often or most of the time. This number leaves 55% (n=18) for those who state their civilian peers understand them and their concerns occasionally or never/rarely. Close to 44% (n=18) reported they sometimes or often feel left out when they are with their civilian peers, and 40% (n=18) stated they often or most of the time feel they would rather be with their combat buddies, that nothing here seems important to them. Spouses stated that 45% (n=12) sometimes or often civilian concerns seem petty to their military member and 54%
(n=12) indicated sometimes, often or most of the time their military friends are the only ones who understand their concerns.

In addition to the use of descriptive statistics, basic inferential statistical analyses, i.e., Chi Square were also employed to for differences. Most of the data did not yield significant difference or statistical significance. While the mean average states that 66% (n=30) of respondents often or most of the time like to be busy, when those responses are calculated using Chi Square after separating the military respondents from the spouse respondents, one see that those who like to stay busy are to a larger degree the spouses, not the veterans. This was reversed with the data on sleep, as the answer to “I do not sleep well at night” yielded 66% (n=30) who stated sleep was only sometimes or less often disrupted, but the Chi Square number showed the spouses slept better more often than the veteran. Using a one-tailed Chi Square to test the difference in regard to military members versus spouses reveals a statistically significance difference, (X² = 2.5, df = 1, p< .10). This indicates the former military members surveyed have a higher incidence of sleeping problems than their spouses, a statistic that is not apparent until the data is separated by those who have been in combat and those who have not.

Table 1 below shows the two statistically significant answers and a sample of two answers that one might expect would be significant but were not proven to be in this data. In the restless answer, to the statement I am restless and can’t keep still, replies indicate no significant difference is found between a combatant, a spouse/significant other and an average person’s response. This is a statement that the
responses actually showed a lower response than would be expected from the average
person in the United States. The average person’s response might be expected to state
sometimes, an answer rating of 3, while these respondents had a mean answer of 2.47,
below the 3 of an average answer. This indicates only rarely or occasionally does the
person feel restless. In the category of sleep well, as discussed above, in an answer to I
do not sleep well at night, there is a statistically significant answer, showing the combat
veteran does not sleep as well as his counterpart. The response to I feel that my partner
doesn’t understand me, yielded an average answer of 2.66, indicating an understanding
average again below the sometimes mark of 3, or that understanding one another is only
occasionally or rarely a problem in these relationships. Again in the last answer, be
active, the reply shows a significant difference between the spouse/significant other and
the veteran, indicating the spouse/significant other is more likely to state an answer of
often or most of the time to the statement I enjoy being active and busy. These answers
indicate an inconsistency between the hypothesis and the data, and is discussed below.

Table 1 Relationship Among Variables Between Military and Spouse

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<thead>
<tr>
<th>Category</th>
<th>X²</th>
<th>df</th>
<th>one-tailed Significance</th>
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<tbody>
<tr>
<td>Restless</td>
<td>1.09</td>
<td>1</td>
<td>None significant</td>
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<tr>
<td>Sleep Well</td>
<td>2.50</td>
<td>1</td>
<td>p&lt;.10, one-tailed</td>
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<tr>
<td>Not Understand</td>
<td>1.03</td>
<td>1</td>
<td>None significant</td>
</tr>
<tr>
<td>Be Active</td>
<td>2.50</td>
<td>1</td>
<td>p&lt;.10, one-tailed</td>
</tr>
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</table>
Discussion

In analyzing the data collected for this research, it appears these couples are doing well, in some cases, better than the average person in America might feel if asked these same questions. This was not a category in this study, as this researcher did not have a control group of non-combatants, although that is an interesting idea for someone who might want to work with this population in the future. The two statistically significant findings concern the difference in sleep patterns between the veteran and the spouse/significant other and the activity level each desire to achieve. The combat veterans, as a group, state they do not sleep as well at night as they would like and they do not find being active and busy a significant part of their life. Their spouse/significant other counterparts report sleeping better more often and that they want to be active and busy more often than the veteran.

These findings do not correspond to the literature review or to a common sense view of a response to a wartime deployment. This may be indicated due to the survey tool, possibly an interview method would have been a better data-collection tool for this population. Perhaps the participants who responded are more able to adjust to civilian life, maybe the decades between the war and the survey for some respondents have altered their remembrance of the incidents involved, or the persons who did not readjust as readily are the ones who did not fill out the surveys, even after indicating they would do so. This is impossible to tell at this point, indicating again that an interview could have created more realistic views of actual events that the survey could not capture.
When this project was begun, it was known to be one that would be difficult for this researcher to complete, as a non-military member, with enough significant data to prove specific areas of concern. Without sanctioned access to active military and their families, the data is almost impossible to acquire. Military facilities are closed to civilians. Commanders are protective of their troops, with good reason, and the military culture closes ranks when there is a perception of possible danger to the morale and safety of the members, be that possible threat physical or mental. While never my intention, the questions included in the survey were difficult for the participants to answer, as veterans, even without the thought of a possible re-deployment, an event faced by many current military members.

The ideas of remaining militarily strong, ready and resilient are things not easily surrendered once achieved through hard work and sacrifice. These ideals become family norms for those who live within the larger ethos of the military. This researcher understands the military culture, as the military has always been a part of my life and family. This comprehension and affinity was not enough to gain access to the closed ranks and break through the personal ideology of honor, courage, and commitment found in those connected to the military.

The topic is an important one, as the world is not becoming a more friendly or peaceful place, young men and now even older, experienced soldiers are still being sacrificed and dying on foreign soil. Everyone in the United States should realize the true cost of war is not only measured by the numbers reflecting the dead and the wounded, as horrific as those casualties are in a human toll. The other unseen and
unstated casualties are in the lives of all of those who sacrifice and all of those who love them. The research was done in order to attempt to bring part of that information to light. The lack of compelling data should in no way reflect on the topic, but instead on the inexperience of the researcher. The need for more research, and more counseling is true and these needs must be met for the future health of our troops and American families in general.
This study endeavored to show the need for mental health services to be provided to the couple when a military person returns home from a combat deployment. Merolla (2010) states increased anxiety, loneliness, and doubt combine with a decline in relationship areas such as intimacy, fulfillment and encouragement during a deployment situation, increasing the stress faced by military couples. Orthner and Rose, in a 2005 study on adjustment during a couple’s reunion, found that 47% of civilian spouses did not find the return of their spouse to be an easy transition.

In a systematic view of stress, one can assume the stressors that one half of a couple experience affects the other person in the couple, and both react accordingly. Often when help is sought it is at the behest of the spouse or significant other of the service personnel involved. Renshaw, in 2010, found that many spouses were the impetus for the military member seeking some adjustment counseling, and that when the couple attended therapy together, they are both more likely to finish. This further solidifies the need for joint counseling when a couple is reunited after a wartime separation.

**Summary and Conclusions**

There is an increasing need for information and education for the military spouse. This would give our nation an opportunity to retain these military marriages, intact and healthy. The United States needs their military to be battle-ready, their
soldiers to be dedicated, and the military family resilient. It is important to support the military, the veteran and the family who accept the challenge to diligently serve and tenaciously protect our country. In a non-draft environment, our military is dependent on civilians who want to enlist in one of the branches of the service and serve their country, often at great personal risk. As George Washington stated so long ago, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation" (American Veterans, n.d.). The information discovered through further research on the topic of armed forces mental health would aid the structures already in place to service our military members and veterans, while expanding these efforts to include the family members.

It is difficult, as discussed in chapter two, to break through the military mindset and the culture of power and resilience to convince the service member to seek help in their readjustment to a civilian environment. Weiss, Coll, Gerbauer, Smiley and Carillo (2010) discuss the impact of one’s military training, featuring physical and mental strength, courage, loyalty and a strong code of ethics to uphold the integrity of the particular branch of the service to which one belongs. Military code of conduct and the priority of the mission are first and foremost, limiting the willingness to break the code by seeking help for what is viewed as a weakness. Weiss, et al., also state the well being of the spouse can determine the family mental health status, so the plan to offer services to the spouse would improve the condition of interaction between all family members.
Implications for Social Work

With our increased understanding of how the brain works, how the fight or flight response influences a person, there is an improved opportunity to mitigate the issues that arise after combat. The brain actually creates areas of response to deal with the questions inspired by feelings of constant danger to self and one’s combat buddies. Pinel, 2006, states the cerebellum holds memories of learned skills, but the striatum is where the memories of stimuli and the learned response are stored. This is due to the long-term development of information over the course of time, through many instances of stimulus and response, such as might be seen in a wartime deployment. The act of learning changes the brain; and memory is related to the storage of the knowledge. Currently there is so much information related to the impact of trauma from anywhere, including that of combat, and the responsibility we as social workers have is to build on our ability to effectively utilize this knowledge.

As social workers who might be called on to provide mental health services for this population, it is important to have a working knowledge of the unique environment and coping skills necessary for survival in the military world. One cannot approach this population as one would approach a person from civilian society. There is a context to the military world that is not easily understood by an outsider, unless that person has a compelling reason to learn and understand this environment. The military is diverse in their ethnic and racial makeup, and the person’s perspective changes within each military branch as well. The hierarchy is sacrosanct, and the placement of one within the ranks brings a degree of responsibility and stress at each level. The importance of
experience within this milieu cannot be overly emphasized, in order for a therapist to be successful in their interaction with their client.

In the military, what is said may not be as important as what is left unsaid. The principles of belonging to a brotherhood, one exposed to demands and dangers not understood by those in a civilian environment, is not easily breached or exposed. The belief behind the ideal of protecting each other is what keeps each of them alive when the world explodes around them. This brother-in-arms relationship is sacred. Many times it is more compelling than extended family ties where one will probably not be called upon to give each other protective cover fire or man the machine gun so another soldier can work to clear wrecked vehicles from the road. What is truth and what a military member is willing to divulge, especially in an arena where silent and strong is prized, can be vastly different from each other.

Where an average civilian might easily answer they are sometimes restless, this survey found military members unwilling to state that possibility. According to much of the collected data in this survey, a wartime deployment might be a good thing for a person or a couple, while the vast majority of research quoted in chapter two states combat adversely affects the combatant, the spouse and the relationship. The dichotomy lies in the data collection tool, the respondents’ veteran status, or the unwillingness to divulge items not yet realized. Part of what was revealed appears to be an inability to articulate the experience or, since many respondents were four decades from their wartime experience, that these are no longer active issues for the person. Those subjects who chose to participate and are currently in a scholastic setting are
possibly not the ones who have experienced readjustment difficulties. All of these are possible scenarios, but my hypothesis that there are difficult challenges faced by a couple after a combat deployment was not supported by this research.

**Evaluation**

It is the opinion of this researcher that a survey was not the correct data-gathering tool for research with this population. An ethnographic participatory interview would have been a more appropriate tool for any researcher without access to current members of the military. A more culturally appropriate approach might have been qualitative in-depth interviews rather than a specific, standardized set of questions.

The anecdotal participant information observed by this researcher belies the story told by the survey data. At a meeting of Vietnam veterans, a Global War on Terror (GWOT) Army Sergeant, sitting next to his pregnant wife, allowed his head to sink lower and lower, while his wife lightly ran her hand over his back in a comforting manner. This was while the group asked questions about PTSD, combat stress and related experiences of war. Another gentleman, a Vietnam veteran pilot, with tears in his eyes asked how one was supposed to get rid of the images in his head, and a third related that life is just “so f---ing hard”, using this term over and over again in his story.

Written comments on the surveys included, “We were as happy as could be, under the circumstances. We loved each other. The injuries were a huge strain,” but the comment was not supported by this spouse’s survey responses. Or “I am blessed with amazing friends, they often did not understand why I stayed with him.” Another wife responded that she was no longer a wife immersed in PTSD problems, as “My husband
has gotten help and things are great now.” A veteran writes that he “sometimes feels guilty knowing others will never have that opportunity” in reference to his current ability to have a good time. Another veteran alludes to a difficult marriage after his return from combat, with the comment that it was all her issues, even though he has not been able to sustain another relationship in the ten years since his last tour. These comments and participant observations convince this researcher that the survey tool did not capture the information that possibly offered a different story.

An on-line survey tool could have been effective, and maybe been more accessible to younger military members who might have participated. The difficulty would be in assessing the correct questions needed to generate effective data. An online tool would have had the advantage of circumventing roadblocks imposed on this researcher. The military commanders and Vet Center therapists who were approached felt they could not allow their troops and clients to participate, due to this researcher’s inability to procure sanctioned approval from the Department of Defense or Veterans Administration. This researcher was twice denied access to potential subjects and in two other instances; the requests were ignored by commanding officers. If one is not in the military, does not have approved access to troops or is not formally endorsed by a legislative body, it will continue to be a difficult population to access.
APPENDIX A
Survey

HOMECOMING FOR THE MILITARY COUPLE: COPING WITH THE CHALLENGES

Read each question about your experience and circle your answer. Please expand your answers if you would like, and answer as accurately as possible. There are no right or wrong answers. You may skip any question you prefer not to answer. Please return survey to me within the week. Thanks You!

Conflict Served In ____________________________

General Contentment

1. I am restless and can’t keep still.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

2. I have a hard time getting started on things I need to do.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

3. I feel the future looks bright for me.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

4. I do not sleep well at night.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

5. I feel that others would be better off without me.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

6. I enjoy being active and busy.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

7. It is hard for me to have a good time.
   Never/Rarely Occasionally Sometimes Often Most of the Time
   1 2 3 4 5

Additional Comments:
______________________________________________________________________
______________________________________________________________________
**Relationship Satisfaction**

8. *I feel that my partner really cares for me.*
   
   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

9. *I feel the future looks bright for our relationship.*
   
   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

10. *I feel that ours is a very happy relationship.*

   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

11. *I feel that we manage disagreements and arguments very well.*

   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

12. *I feel that my partner doesn’t understand me.*

   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

13. *I feel that I can trust and rely on my partner.*

   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

14. *I feel we were happier together before the combat deployment.*

   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

15. *I feel that my partner does not understand me anymore.*

   Never/Rarely    Occasionally    Sometimes    Often    Most of the Time

**Additional Comments:**

______________________________________________

______________________________________________

______________________________________________
Peer Group Relationship Satisfaction—Military Only, Spouse go to pg 4 & 5

16. My military friends are the only ones who understand my concerns and me.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

17. My non-military peers regard my ideas and opinions highly.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

18. I really feel my peers who are non-military do not like me very much.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

19. Other than family, I really do not care for the non-military peers in my life.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

20. I really feel left out of my peer group, unless I am with my military peers.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

21. Civilian concerns seem petty and irrelevant to me.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

22. Nothing seems important to me here, I would rather be with my combat buddies.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

23. My civilian peers are a real source of pleasure to me.

Never/Rarely  Occasionally  Sometimes  Often  Most of the Time

Additional Comments:
Peer Group Relationship Satisfaction – Spouse Only, Military, go to page 5.

24.  My military friends are the only ones who understand my concerns and me.

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25.  My non-military peers regard my ideas and opinions highly

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26.  I really feel my peers who are non-military do not like the military or me very much.

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27.  Other than family, I really do not care for the non-military peers in my life.

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28.  I feel my peer group only includes other military spouses, not non-military friends.

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29.  Civilian concerns, including my own concerns, seem petty and irrelevant to my spouse.

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30.  Nothing seems important to my spouse, he/she would rather be with their combat buddies.

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31.  My civilian peers are a real source of pleasure to me.

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<th>Rating</th>
<th>Never/Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the Time</th>
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Additional Comments:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
**Background Information**

1. **My Age**
   - 18 to 23
   - 24 to 30
   - 31 to 36
   - 37 to 42
   - 43 to 49
   - 50+

2. **Race**
   - Black/African American
   - Hispanic
   - White/Caucasian
   - Native America/Alaskan
   - Asian/Pacific Islander
   - Multi-Ethnic
   - Other, please specify ______________________

3. **Gender**
   - Male
   - Female

4. **Current Marital Status**
   - Married
   - Significant Other
   - Remarried
   - Widow/Widower
   - Single

5. **Current residence**
   - House/Condo (owned)
   - Parent’s House
   - Renter
   - Relative or Friend’s House
   - Hotel/Boarding House
   - No regular residence (homeless)
   - Hospital/Therapeutic/Halfway House
   - Other, please specify ______________________
   - College Housing

6. **Are you currently employed?**
   - Yes
   - No
   - Active Military

7. **Highest Level of Education**
   - Current student for __________________ degree or:
     - Less than high school graduation
     - High school graduation/GED
     - Trade or technical training
     - Some college, no degree
     - 2 year college (AA)
     - 4 year college (BA or BS)
     - Masters or PhD Degree
     - Professional Degree

I am a Master of Social Work student at California State University, Sacramento, and the wife of a combat veteran of Vietnam, a man who still struggles with the issues of PTSD. I would like to invite you to participate in a study of the challenges faced by a military couple after a wartime deployment. This type of study has been done in other areas of the United States, but has not been done in Northern California. You were selected as a possible participant in this study because you are a member of a couple with one military member who has been in combat. The purpose of this study is to gain feedback from both members of the couple, after the homecoming. It is my hope to recruit you as collaborators who will complete these questionnaires thoughtfully and honestly. Your involvement is entirely voluntary; you may withdraw at any time without penalty.

If you decide to participate, I will ask you to complete a questionnaire that should take you approximately 15 to 20 minutes, depending on how much information you choose to disclose. A potential detriment in your participation in this study is a renewed awareness of the situations you may or may not like to think about, as well as anxiety related to these situations. The only benefit you will receive from your participation in this study, other than my gratitude, is the knowledge that your answers may help others in similar circumstances so that their homecoming is an easier transition.

All your answers will remain completely confidential and anonymous. Consent forms will be kept separately from any other information. Each couple will be asked to name the conflict in which the military member served. All data will be destroyed after the completion of the study and the processing of the data. You may skip any question you prefer not to answer. Should you decide, upon reading the questions, that you do not wish to participate, please do not turn in the survey, but discard it instead. Feel free to ask me if you have any questions about the survey.

We are interested in general statistical patterns, not the answers of individual participants. You are encouraged to share as much information as you are comfortable disclosing. Your participation is voluntary and confidential. The results of this study may be published. Thank you for your participation, I appreciate your assistance in this valuable research endeavor.

Jeri Wilson, MSW II student, California State University, Sacramento.

Participant Name (please print)  Participant Signature

Date

A copy of this consent is available for you to keep. Thank you for your participation.
Thank you for participating in my study. As the wife of a combat veteran from Vietnam, one who still struggles with the issues of PTSD, I appreciate your assistance. The purpose of the study is to explore the challenges faced by a military couple after a wartime deployment. This type of study has been done in other areas of the United States, but has not been done in Northern California. You were selected as a possible participant in this study because you are a member of a couple with one military member who has been in combat. The purpose of this study is to gain feedback from both members of the couple, after the homecoming. I appreciate that you completed the questionnaire thoughtfully and honestly.

During the study you were asked to complete a questionnaire to assess specific feeling about your current situation, or the situation in the months immediately following the military member’s return from combat. I asked questions which measured certain areas of your general contentment, marital satisfaction and peer group relationships, as well as collecting limited, non-identifying demographic information. Your answers will be used to compare homecoming experiences for different couples and to potentially uncover specific feelings or circumstances that may not be apparent at a surface level. All answers are confidential and anonymous, all data is collected using your personally selected code name, not identifiable with your actual name.

If you have any further comments, suggestions, concerns or questions, please let me know. Your feedback can be very helpful and improve our research outcome. If you have any troubling concerns, please discuss them with your Chaplin. Alternatively, a counselor is available at your local Vet Center or at the Mental Health Facility for your County. Those phone numbers are listed below.

Thank you again for your participation,

Jeri Wilson, MSW II, email: jlw262@saclink.csus.edu
Dr. Francis Yuen, DSW, ACSW, email: fyuen@scsus.edu
Division of Social Work
California State University, Sacramento

Counseling and Veteran Support Services (additional resources may be found at www.va.gov)
• Sacramento Vet Center, 1111 Howe Avenue, Suite #390, Sacramento, CA (916) 566-7430
• Sacramento County Mental Health Treatment Center 2150 Stockton Blvd, Sacramento, CA, Adult Access Team: (916) 875-1055
REFERENCES


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The International Society For Traumatic Stress Studies. (2005). *When a friend of loved one has been traumatized.* Retrieved June 22, 2009 from [http://www.istss.org/resources/when_a_friend_has_been_traumatized.cfm](http://www.istss.org/resources/when_a_friend_has_been_traumatized.cfm)

