

Mount Saint Vincent University
Department of Family Studies and Gerontology

The experience of the female partners of Canadian Military Veterans
diagnosed with post traumatic stress disorder

by

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Dedication

This thesis is dedicated to my husband and partner Rick Baker.
With his endless support and encouragement, this project was completed.
Thank you Rick.

Abstract

Military members and first responders to catastrophic events directly experience the impact of trauma. This may lead to the development of posttraumatic stress disorder (PTSD), or other types of secondary stress response. PTSD often brings complications such as personality and behavioural changes. Previous research has demonstrated there is a need to be concerned with treating the primary sufferers of PTSD. However, there is also a chain reaction in the relationship dynamics of the family. The family unit themselves develop symptoms of PTSD, and manifest their own secondary traumatic stress response. The primary question for this study was: What are the lived experiences of the female partners of Canadian military veterans diagnosed with PTSD? Secondary questions addressed the relationship between the experience of the diagnosis of PTSD and daily life. Specifically, what coping strategies and supportive resources did these women utilize? This study was situated within an interpretive/constructivist framework.

In this study we read about women, who while dealing with ambiguous loss, must adjust and adapt their lives around the needs of their partner, who is struggling with the symptoms of PTSD. The complications of this change in relationship led women to de-self and face the difficulties of secondary traumatic stress, such as depression and hyper vigilance.

There is a need for future and more in depth research into family functioning when faced with this phenomenon. Specifically, does the adjusting and adapting actually enable the veteran to stay ill and remain defined by his diagnosis? What are the long-term implications for the children who are being reared in these circumstances. How can these women be enabled to gain meaningful support in order to cope with daily life?

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Shalom,

Sandra Pickrell Baker

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Chapter One: Introduction

“Our Families live the missions with us, and they suffer similar trauma, before during and after.”

General Romeo Dallaire (2004), *Shake Hands With the Devil*

According to the Department of National Defence (DND) website, there are approximately 8000 Canadian Forces members, who represent one third of the deployable force, preparing for, engaged in, or returning from an overseas mission every day (DND, 2007). The frequency and tempo of these missions has increased dramatically since the 1990s, as global unrest has become more widespread (Standing committee on National Defence and Security (2006) Conventional peace-keeping missions involved less risk of exposure to traumatic events than the current missions of peace-making (Barabe, 2001). Peace-making, also known as peace-building, involves interaction in political and diplomatic circles. Peace-making may involve negotiation, arbitration and reconciliation. Peace-keeping may require a more physical engagement involving the use of violence (Ryan, 1995). However, both peace-keepers and peace-makers experience a great degree of stress, from not only by being in a combat zone, but also by the pace and frequency of moving from a peace setting in to a war zone (Wessells, 1998).

The mission in Afghanistan has substantially increased the level and intensity of combat operations, and a significant number of soldiers are returning from overseas deployments with mental health issues (McFadyen, 2008). According to Harris Macleod of the *Hill Times*, the Department of National Defence reports 14.1% of soldiers returning from Afghanistan have an operational stress injury and posttraumatic stress disorder. This number does not however reflect members who may develop symptoms at some point in the ensuing years. Nor does it reflect the number of soldiers or veterans yet

to make their way through the process of being diagnosed and having that diagnosis recognized by the military system.

Media Coverage

North Americans are besieged, as never before, with media images of war, natural disasters, and human suffering throughout the world. Advancements in media quickly bring the battles and their consequences into our everyday lives. (I can still recall staying up all night watching the bombing of Iraq in the early 1990's). September 11, 2001 brought the reality of global unrest very close to home. This increased exposure to information is perhaps responsible for the growing sense that war and its related trauma have an impact on individuals who are our neighbours and society as a whole.

Operational Stress

Trauma changes how we perceive and make sense of the world around us in three ways (McCann & Pearlman, 1992). First, it changes the way in which, and the extent to which, we recognize our vulnerability. Second, it can make us believe the world is no longer a safe place. Finally, trauma can cause us to feel we are not worthy of living; as a result, the meaning and orderliness of daily events no longer make sense to us (McCann & Pearlman, 1992).

Military members and first responders (such as police or paramedics) to catastrophic events directly experience the impact of trauma. According to the *Diagnostic and Statistical Manual (DSM- IV, 1994)*, posttraumatic stress disorder (PTSD) is characterized by the development of an ongoing set of defined symptoms, which follow the involvement in, or the witnessing of, an extraordinarily traumatic event. Symptoms include anxiety, depression, feelings of isolation and difficulty sleeping, among others.

Global events and our increased awareness of them, together with an increasing interaction with technology, and an increasing pace of life, have created an environment where, for many, being in a state of stress has become a way of life (McEwen, 2002).

Family Stress

PTSD often brings complications such as personality and behavioral changes, which may lead to difficulties for the family members (Galoski & Lyons, 2003). When struggling with the complications of this illness, there is a chain reaction in the relationship dynamics in the family (Lyons, 2001). The family may also manifest symptoms of PTSD or secondary traumatic stress response. Therefore, the nature of the trauma can potentially influence the listener's thoughts and beliefs and change how the listener perceives the world (Pearlman & Saakvitne, 1995). While research indicates the need to be concerned with treating the primary sufferer of PTSD and those professionals who care for them, there is little research regarding the effect on family members who engage regularly with trauma survivors. Pearlman and Saakvitne describe secondary traumatic stress response as the unconscious transfer of a client's trauma to the therapist's own mental schema while engaging empathically with a trauma survivor. If this transference of trauma occurs in a therapeutic relationship where the listener has the skill and training to protect their boundaries, how is a family member going to fare?

The military culture asks more of its personnel and their families than most other employers. In the military family, in the event of the service person's deployment, the non-military partner is often required to take on all family responsibilities, and institutional demands. These requirements are in response to the military need for combat-ready members while they are keeping the peace or are involved in acts of war.

Indeed “military families are regularly challenged by conditions that test their capacity for healthy functioning” (Norris, 2001, p. 55).

“Our families are inextricably linked to our missions, and they must be supported accordingly” (Dallaire, 2004, p. xvii). The interim ombudsman for the Department of National Defence, Mary MacFadyen (2008) published a review of the department of National Defence and Canadian Forces Action on Operational Stress Injuries (post traumatic stress is an operational stress injury). In this review, she acknowledged the dramatic impact the challenges associated with an operational stress injury could have on military families.

The area of particular interest for this study is the traumatic effect on the female partner of the male military veterans affected with PTSD. When an individual cares for traumatized people, s/he is exposed to their trauma and may experience pain as a result of the interaction (Figley, 1995). The number of military members being diagnosed with PTSD is increasing (Canadian Press, 2005); therefore, the number of partners of military members and veterans coping with the challenges of this phenomenon may also be on the rise. In light of this, I have chosen to explore the experience of the female partners of Canadian military veterans experiencing PTSD.

Previous Studies

The literature review for this study revealed little research that addressed the experiences of the intimate partners of persons dealing with the challenges of PTSD; none of the research included Canadian participants. The few studies that were conducted were from a medical model and mostly included work with spouses of returning Vietnam veterans and focused on deficits in the family (Figley, 1993, 1995, 1998; Galoski &

Lyons, 2003; Lyons, 2001). This lens, although relevant, held out little in the way of resources for those interested in how to create healthier functioning within the family unit. Although a clinical understanding of this phenomenon is important, it does not lead to an understanding of the daily challenges faced by these individuals or their families. An exploration of the experiences of the female partners of Canadian military veterans diagnosed with PTSD will offer insight and understanding of the women's daily reality.

All of the studies reviewed for this paper cited the importance of social and familial support for the well-being and eventual healing of persons involved with the challenge of dealing with a family member diagnosed with PTSD. In his book *Family Burnout*, Figley (1998) references the need to support the intimate partners so that they, in turn, are able to support the primary sufferer. Figley states that without spousal support, the likelihood of the primary sufferer finding healing and the family surviving is minimal. He theorizes the way to accomplish this is through teaching the female partners how to maintain firm boundaries and giving them the skills to maintain their sense of self in the act of caring for their ill partner. With the ever-increasing numbers of persons being diagnosed with PTSD and the documented effects on the family, we are obligated to explore and discover as much as we can to aid and support their recovery process (Figley, 1998; Galoski & Lyons, 2003; Lyons, 2001).

Military Support Systems

The Canadian military now has a Directorate of Quality of Life (DQOL) and subsequently there has been great effort on the part of the military to implement family support. DQOL sets policy for members and families that are implemented through programs at the Military Family Resource Centers (MFRC). Family policies and

programs are designed, in part, to enhance member recruitment and retention. Through the Canadian military, family members have available to them a free, confidential, twenty four hour/seven day a week hot-line for short term support, known as Canadian Forces Military Assistance Program (CFMAP). If long-term support is required referrals may be made at no cost. This voluntary and confidential service is meant to enable families to garner the support they may need in times of difficulty.

Primary Questions under Study

The primary question for this study is: What are the experiences of the female partners of Canadian military veterans diagnosed with posttraumatic stress disorder (PTSD)? Sub-questions for this study include: What meaning do the female partners ascribe to this experience? What is the relationship between the experience of the diagnosis and daily life? What coping strategies and supportive resources do these women use?

Personal Viewpoint

I did not understand, until recent years, the impact of trauma on daily life nor the relationship between primary and secondary trauma. When trauma happened in my own family, I was taken aback at the repercussions it had on the whole family. Our family unit - not just the traumatized individual - was deeply affected. Relationships that had been uncomplicated became strained and entangled. I found myself trying to control the household environment so the family member in question would not have a reaction, such as an emotional outburst. A television show or an innocent conversation could cause or trigger a response. I became vigilant about her safety. Where was she? Who was she with? Did she take her medication? I constantly was fretting; was I going to help her pick

up the emotional pieces again? Throughout her treatment process, the most difficult aspect for me, as her primary care giver, has been to trust her to manage her own life and deal with the day-to-day stressors. While we continue to make our way through this process with the aid of trained professionals and family support, I have been left with many questions about the nature of trauma and its impact on the family; I have gained more objective understanding through research.

In the process of interviewing participants, my experience provided a point of reference, a place to begin. Boundaries are an important aspect of partner and family relations. Has the female partner been able to navigate meeting of her needs while managing the day-to-day requirements of the family? All relationships have internal rules for transformation; have there been changes in the relationship and how has she dealt with these? For couples, the rule may be: when things get tough, they pull together to overcome the hardship. Alternatively, the rule may be: when things get tough, the couple goes into isolation in order to determine a solution on their own. These themes were explored through in-depth interviews with the female partners.

Chapter Two: Review of the Literature

Three themes are explored in the literature review: the military family, post-traumatic stress disorder (PTSD), and secondary traumatic stress response. These themes were chosen to support the focus of the study, which involves an exploration of experiences of female partners of military members who have been diagnosed with PTSD. The placement of the family within the military institution is relevant due to the interdependent relationship between family functioning and the functioning of the military institution. Veterans and their families remain tied to the military in the case of supports and benefits. In addition, a working knowledge of PTSD is necessary to explore the potential familial risks when a member is diagnosed with the illness. Finally, I explore secondary traumatic stress response and the possibility of it manifesting in the lives of the female partners of the Canadian military veterans.

Before examining the military family, a functional understanding of military culture is necessary; the military institution, as an entity, demands membership in a specific culture with its own rules and ideologies (Enloe, 1983; Harrison, 2002; Norris, 2001; Segal, 1986). These ideologies are reportedly maintained for reasons of national safety and are identified as imperative to having an effective and ready defence force. Military ideologies can and do, according to some researchers, create unique stress on the family unit (Enloe, 1983; Harrison, 2002; Norris, 2001; Segal, 1986).

The Military Family

Military families are like all families; they must deal with all the day-to-day challenges such as childcare, elder care, education, parenting concerns, and career choices. In addition to these daily requirements, military families must also deal with

extraordinary stressors, which may not be present in civilian life. Military families are exposed to stressors, such as a diagnosis of PTSD, specifically related to the occupational requirements of the military member. When a soldier is diagnosed with PTSD, he/she can seek help at one of the trauma treatment centers located at various military bases across the country. The family members can access support through the Canadian Forces Military Assistance Program (CFMAP).

Military Culture

Department of National Defence document 5044-1 states the first mission of a military member is to be combat ready at all times (DND, 2002). Being combat ready is directly related to meeting the three mandates of the Canadian Forces: to defend Canada, defend Canada's interests and values, and to contribute to international peace and security. Due to the involvement of military operations, this imperative of combat readiness has the potential to create an environment of secrecy and control. The soldier must be under the leadership and control of his/her superiors and ready to obey orders at any cost. In turn, he/she expects the same from those members who are under his/her command. Combat readiness and the culture it creates are aspects of military training that soldiers receive from the beginning of their military careers.

Unit cohesion is a fundamental part of military operations. It unites the members of a unit to fight for each other and obey orders without question. The military fosters the development of social relationships that help to sustain and maintain the building of unit cohesion, even among the partners and families of the members. This is accomplished through mess and family activities. A valuable partner is one who understands and supports the cohesion of the unit. Knowing this means the military system comes first

and much of the family's socialization takes place in conjunction with other military families (Harrison, 2002; Norris, 2001).

Cohesion is imperative to the combat readiness of a unit; members must be ready at all times to stand side by side in whatever way the military requires. This creates a culture that requires an environment of consistency and control; where each soldier is reliant on and has implicit trust in, the members of his/her squadron in order to keep them safe and alive during the operation of a mission. Cohesion is necessary for the solidarity of the unit, where a member may be mobilized, not by ideological imperatives, but in answer to a desire to protect his team member. In war, second place can mean death for you or a member of your unit (Harrison, 2002). A soldier must always trust his/her unit and have the well being of the unit as the first goal on any combat mission. The readiness to act and react may be one of the contributing factors in the development of PTSD among soldiers (Figley, 1995).

Deployment

Members of military families are expected to have a partner and/or parent ready to leave for a period of time to serve where required. This practice is referred to as deployment and is supported by the combat ready designation required of military members. This may create an environment of fear for the military family as they worry about their loved one being sent to serve in a field of operation. Deployment is acknowledged as having the potential to create stress and hardship on the family unit (Black, 1993).

Maintenance of family relationships is complicated by deployment and the challenges inherent with time spent apart. This is reported to be the greatest source of

dissatisfaction with military life for family members (Black, 1993). Military members can be gone for months, or even over a year at a time. This, in itself, can create undue hardship for the family at home. The partner left behind is expected to be able to become self-reliant and self-sufficient while the military member is away on deployment, not burdening the military member with family challenges. Some women work very hard to achieve the status of an independent wife; this means they will not need to distract their partner from their military duties while he/she is away on a mission (Harrison & Laliberte, 1994; Norris, 2001). With the member's return, some partners may be expected to become dependent once again (Norris, 2001). This process is seen as a part of the everyday life of military families and is fundamental to the survival of the military system, without the partners support, the military member would not be able to readily able to deploy. This creates a constant state of alertness that could be detrimental to a feeling of security and safety for the family. The possibility of not knowing when the military member may be required to leave home for a mission may create anxiety in the household. For the partners left behind to manage the family and household, this is an added challenge.

Relocation

Another stressor is frequent geographical moves (called postings) a part of normal life for a military family. In order to advance within the military system, members must frequently relocate. Postings can serve to keep the non-military partner and the entire family dependent on the income of the military member; frequent relocation affects the female partner's capacity to maintain equitable employment and gain seniority. Many employers do not want to spend time and money training an employee who may be

moving within a short period of time. In other circumstances, the family may be posted to a site where a woman working outside the home is not encouraged (Segal, 1986). What does appear to be of concern is the concentration of demands placed on military families. Not only are they moving away from friends and family networks, but for many, the new base may be located in a national or international location where language and culture can further segregate the family. Added to this is the very real possibility of a military parent being deployed to a field of operation shortly after relocation (Black, 1993), leaving the family on a military base with unfamiliar or insufficient support in place. For the adult family members, this can be a time of stress, both physically and emotionally, due to the logistics of moving (Pollari & Bullock, 1998). This can lead to isolation of family members and the children acting out at home or in school (Wertsch, 1991).

Family Rank

The family's socioeconomic status is dependent on the member's rank within the military. The family is treated in reference to this rank and expected to behave accordingly or the military member may be sanctioned for the family's behavior. It is as though the family members themselves carry the rank of the military member; this includes a pressure to conform to a predetermined behavior (Albano, 2002). Members may have a fear of reprisal that family behavior will reflect on their career and further prevent or impede their advancement within the military system. A military family is a part of the military system willingly or unwillingly (Wertsch, 1991). A military member, particularly one in a command position, who is perceived to be unable to handle family difficulties, is viewed and questioned as to whether he/she can successfully manage or lead their unit (Harrison, 2002; Segal, 1986). Women and children may be expected to

form close relationships with the other female partners and families of military members who belong to their husband's unit, as long as rank is considered (Wertsch, 1991). A male officer's female partner would be expected to form relationships with the other officer's partners and not the non-commissioned officer's partners (Wertsch, 1991).

Female Partners of Military Members

Women who are the partners of military members may soon feel they are second to the military system, or third behind the combat unit (Harrison & Laliberte, 1994).

Women are expected to complete the invisible work of running the family on a daily basis without complaint (Norris, 2001). Living on a base may be a foreign experience for many women, especially if the posting has taken them to a part of or out of the country to a place where language or culture is not familiar. Unit cohesion can infiltrate into the family system and the intimate relationship by creating a bond from which women often find themselves excluded (Norris, 2001).

The creation of Military Family Resource Centers (MFRC) and the development of programming for support during deployment and postings have, for some, been an asset. Through the MFRC partners and families have access to many support and social networks. The covenant for the Military family service center includes the phrase "Military Families: Strength Behind the Uniform" However; the military is still primarily an employer and an institution and secondarily a compassionate parent, concerned about the quality of life of its members.

Posttraumatic Stress Disorder

In the past, war related symptoms of mental stress and illness were referred to as shell shock, battle fatigue, and later as posttraumatic stress disorder (PTSD). With the

recent global unrest there has been a significant increase in the numbers of soldiers diagnosed with stress related illnesses (Canadian Press, 2005). Persons who have a diagnosis and symptoms for more than three months may be pensioned out of the military, as they are not considered deployable or combat ready. According to the Canadian Press article, more than 5000 Canadian ex-soldiers are now receiving disability pensions related to their diagnosis of PTSD. In 2004, “1141 pensions were activated, for soldiers deemed to be suffering with PTSD symptoms, compared with 25 in 1995” (p. A8). Soldiers are especially at risk for developing PTSD, according to Janice Summerby, Veterans Affairs, as they are witnesses to, or confronted with death, serious injury, and threats to the personal integrity of themselves and others by being deployed to various fields of unrest (thestar.com, April 2009). The response may be one of intense fear, helplessness or horror and addiction. These alterations in the veteran’s behavior have the potential to affect family wellness. Family members are often left to cope with the consequences of these changes. As family members are exposed to these symptoms, they often feel they are responsible for the difficulties that arise (Prefontaine, 2004). A result for the coping and caregiving the family offer may lead to the family members experiencing compassion fatigue (Figley, 1995). All of these aspects may limit the veterans’ ability to regain health and recover (Prefontaine, 2004, 2004).

The history of machismo within the military institution has contributed to an environment where seeking help for PTSD in the past was seen as a weakness on the part of the soldier. Due to recent efforts of high-ranking military officials, such as General Romeo Dallaire, much more attention is being given to the ill effects of military service. In writing the book *Shake Hands with the Devil: The Failure of Humanity in Rwanda*,

General Dallaire (2004) prays Canadians will understand the national duty they have to the soldiers and their families who have served in the military.

Diagnosis of PTSD

PTSD is the result of the ‘psychological fallout’ following an overwhelmingly stressful event (Figley, 1993). The diagnosis of posttraumatic stress disorder was not included in the *Diagnostic and Statistical Manual of Mental Disorders*, until 1980 (*DSM-II, 1980*). This inclusion came about as the result of extensive research with veterans and survivors of catastrophic events. In the *DSM-IV (1994)*, there is a description of persons who could be diagnosed with PTSD. According to Figley (1995), the diagnosis includes persons who are traumatized either directly or indirectly. Learning of a loved one’s violent death, unexpected harm, or even the threat of harm can create symptoms of PTSD.

Symptoms vary from person to person, depending upon the initiating traumatic event. Common themes are recurrent intrusive recollections of the event, including images, thoughts, nightmares, flashbacks, hallucinations, and dissociated behaviors. Daily life becomes a chore for these individuals and relationships can become strained. Symptoms may include sleeping difficulties, anger issues as well as an exaggerated startle response. Depression and addiction are not uncommon companions to PTSD (*DSM-IV, 1994*). Added to challenges (of the diagnosis of PTSD) are the life-long changes in body and brain chemistry that predispose the person to many systemic illnesses such as type II diabetes and heart disease (McEwen, 2002).

Treatment of PTSD

A PTSD sufferer, referred to as “G” shared with me a conversation she had with her therapist. She had come across a picture of herself before her engagement in a field of operation. She told her therapist “I want to go back to become that person again” (personal communication, 2005). The therapist informed her she could never go back as she now knows too much. “G” understood this statement; however, she wished it were not true, as she has witnessed not only how battle changed her forever, but her family as well. According to researchers this feeling of isolation is common (Figley, 1998; Lyons, 2001).

In December of 2008, the interim ombudsman, Mary McFadyen tabled her report entitled: *A Long Road to Recovery Battling Operational Stress Injuries*. In this report she expresses concern that some soldiers and veterans are not receiving the support they require. Mental illnesses, including PTSD, still have stigma attached to them and in an institution that is proud of its machismo, the members of the military may be reluctant to seek help. One difficulty in deciding to seek help for PTSD may lie in the fact that the symptoms do not always manifest immediately after the traumatic event (Figley, 1998). In recent years, trauma researchers have recognized that stress and symptomatology may not be solely the product of a single precipitating event (Figley, 1998). What is observed, as a stress reaction may be the consequence of a series of highly stressful life events extending to one’s personal history prior to the focal traumatic experience or present event.

Secondary Traumatic Stress Response

As a result of his research with the families of returning veterans from World War 11, Hill (1949) was the first to introduce the concept of family stress. A similar pattern of dysfunction emerged in studies involving returning Vietnam veterans and their families long after the war was over (Figley, 1995; Figley & Kleber, 1997). Vietnam veterans and their families were among the first studied in an attempt to understand the experiences of the female partners of military members diagnosed with PTSD (Mataskis, 1988; Williams, 1987). McCann and Pearlman (1990) developed a conceptual framework of 'vicarious traumatization,' defining it as a process of change resulting from empathic engagement with trauma survivors. Bloom (1995) wrote that trauma is contagious, similar to a virus, and theorized that the veterans' traumatic memories of veterans infected their partners and became integrated into all of the family's processes, especially relationships.

In a study of US families where war-related PTSD is an issue, the veteran is more likely to be married, but for fewer years (Gimbel & Booth, 1994). There is a lower rate of life functioning and a higher rate of marital problems, more family violence, and children tend to have behavioral issues (Lyons, 2001). Members of these families have lower scores on a subjective well-being scale and a higher rate of demoralization and vulnerability to nervous breakdowns (Kulka et al, 1980).

Relationships

It is important to understand that PTSD does not exist in a vacuum. The challenges associated with it manifest in all relationships, especially intimate partner relationships. The intimate partner may not be aware that he/she has been affected by the

trauma until it is too late to prevent it from occurring. The infectiousness of the trauma seems to be found in the close connection between intimate partners (Bloom, 1995). The act of caring deeply and wanting to come to the aid of a loved one potentially leaves the door open for the contagious trauma to find a new place to take root. The primary sufferer may not even be aware of the transference (of the partner taking on their symptoms), as they are absorbed in their own process. Transference can be viewed as a caregiving response where the intimate partner begins to anticipate any event, which may bring about anxiety on the part of the primary sufferer (Bloom, 1995). A partner may spend a lot of time attempting to make certain there are no extraordinary stressors for the military member by keeping outside distraction to a minimum for fear of the reaction of the primary sufferer (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005). This is done in the hope of lessening the struggles of the primary sufferer thereby making the family less chaotic; yet, the result is usually the opposite. The result of the families attempt to care give and support their love one may result in their manifesting symptoms of secondary traumatic stress disorder and begin to exhibit health challenges of their own related to this (Figley, 1998). Symptoms such as the lack of sleep and depression may not be seen as having originated in the transmission of trauma but rather as a response to the changes in the intimate relationship. Communication is often a challenge and may lead to introspection and the feeling of a personal deficit being the cause of the difficulties (Bloom, 1995). However, when these symptoms are coexistent with nightmares, heightened startle response, and flashbacks, it is believed the PTSD has intensified (Bloom, 1995). When these symptoms manifest, the challenges of daily life may become exponentially more difficult.

We become emotionally drained by [caring so much]; we are adversely affected by our efforts. Indeed, simply being a member of a family and caring deeply about its members makes us emotionally vulnerable to the catastrophes, which impact them. We become “victims”, because of our emotional connection with the victimized family member. (Figley, 1995, p.12)

Key aspects of the research reviewed for this study focused on the manifestation of secondary traumatic stress response, which may arise from female partner’s view of her role as rescuer and caregiver for the military member. Female partners may find themselves anticipating feelings and events that may trigger a response from the member diagnosed with PTSD, often speaking in the first person about such challenges of the primary trauma. In researching the partners of Vietnam veterans with PTSD, Lyons (2001) found many seemed to mimic some of the symptoms of the primary sufferer. Examples of this would be lack of self-care; hostility and/or withdrawal with emotional episodes; difficulty concentrating, and the presence of stress-related symptoms such as frequent headaches, sleep disturbance, increased heart rate, and sexual dysfunction.

Coping styles and strategies are thought to affect the development and resolution of secondary trauma in the families that were studied (Dekel et al., 2005; Figley, 1998; Lyons, 2001). The women who were interviewed and were able to navigate this phenomenon and remain healthy were not in the majority (Dekel et al., 2005). The female partners all struggled to maintain their separateness from the veteran to preserve their sanity and autonomy. Managing to maintain personal space and identity along with meeting the needs of their partner required many compromises. One of the first compromises to take place is around family organization; many veterans find they are no

longer able to work to support the household or may have been relieved from duty without financial supports. If this is the case this may necessitate the female partner increasing or seeking out employment. How the family manages household duties also involved adjusting around the needs of the veteran. Depending on his level of wellness, the family may need to perform duties previously taken care of by the veteran, such as household maintenance. The veteran may also no longer be able to help support the family with childcare. Stories of women who were afraid to leave their children with the veteran were not uncommon. Concerns around whether he would remember to care for them or attempt to take his own life while he was supposed to be caring for them led some women to seek out alternate childcare while they went to work. The women spoke of changes in their social support systems. They were no longer able to be spontaneous such as invite a friend over for a cup of coffee to have a talk and gain informal support. Community support such as having a group of people over to entertain was not a possibility. Every aspect of their social lives no had to be planned out in finite detail and be prepared to change to do nothing with little or no notice depending on the veteran's state at any given moment. Some women interviewed by Dekel et al. stated they had denied the role of caregiver, as it was just too overwhelming to think this would be their way of life from now on. In one case, a female partner said she persisted in treating him as her equal partner until one day she realized she was his caregiver. After this insight, she struggled with a sense of failure for not being able to separate from him. Lerner referred to an over investment as 'de-selfing', "a manifestation of what occurs when one participates in relationship patterns that block one's own growth or when too much of the self, (one's beliefs, values, wants, priorities, ambitions) become negotiable under relationship

pressures” (1998, p. 227). The women in the Dekel et al. study reinforced this contention through their expression of the struggle to not get lost themselves in the care and management of their husband’s illness.

Avoidance of the symptoms manifesting and their origin could potentially cause the symptoms to escalate and the situation to become aggressive (Dekel et al., 2005). If aggression does occur, the family may not seek outside resources for fear of legal intervention. An external source may diligently seek out support and resources from military services or friends, in an attempt to find aid for the situation in which the partners find themselves. The depression that can result from secondary traumatic stress response may cause isolation and vice versa. This then becomes a factor for the family unit. Women who often found themselves in the role of central caregiver to a partner who was depressed and isolated due to the PTSD were left with little room for her own self-expression (Dekel et al., 2005; Lyons 2001). Daily life became a dance around the needs of the sufferer for some of the female partners in an attempt to maintain some control over the uncontrollable. For many women this was a very real and life altering challenge. Work may have previously been an outlet for personal interest, but now became important for family economic survival if the member was unable to work and had been pensioned out of the military. However, leaving the house to work created new problems for the partner since the veteran was left at home without support. Would the children be safe with their partner? Would he remember to care for them or worse would he become distraught and attempt suicide?

In the study completed by Dekel et al. (2005), many women felt they had lost the man they had married and struggled with an obligation to the man that he had become.

For some, religious beliefs were helpful. These women reported feelings of giving service to a higher good. For others, there was no help, only a sense of desperation and isolation for themselves and their families. For most there was a sense of loss of the dreams that were shared and now shattered, and an ambiguous sense of loss (Boss, 1987). Dekel et al., quotes one woman: "...we have all disappeared – our dreams are over, our desires erased" (p.30). For some of these women, all sense of self and independence has been lost and now they only live for their husbands. In other instances, women spoke of their husbands as giving them strength to cope and carry on with the challenges of daily life. "I draw a lot of strength from him. He learns and participates; he fights and gives me encouragement...If he doesn't break down, who am I to break down? (p. 31)." In both of these examples the female partner's experience of self appears to be held in the reflection of the member with PTSD. There is an ongoing struggle to maintain an identity separate from her partner and his illness (Dekel et al., 2005).

Research conducted with individuals involved in the Civil War in Lebanon and later diagnosed with PTSD and their partners, suggests social isolation is associated with PTSD (Solomon et al., 1992). The partners tended to blame themselves for their husbands' symptoms. They felt unable to cure their husbands as a result of their own ineffective coping skills, which at times caused a distancing from social support (Rabin & Nardi, 1991).

One of the symptoms of PTSD that is a challenge to couples is the isolation, both by choice and by default; this can be the result of family and friends their reducing attempts to support the couple. Substance abuse and violence, both emotional and physical, can also exacerbate the already difficult relationship. Many of the household

responsibilities, which were shared before the onset of the illness, may now fall to the female partner. If the member has been pensioned out of the military, it can become necessary for the female partner to seek employment, which may pose another challenge. There appears to be an enmeshment (a lack of clear definable boundaries) that occurs during the coping phases of dealing with this diagnosis (Johnson, Feldman, & Lubin, 1995). The female partner often speaks about the needs of their partner as if they are not separate from their own. These women tend to organize their lives around their husband's traumatic experience and his needs (Johnson et al., 1995). This reorganization and the stress it creates have the potential to initiate the breakdown of the family unit (Figley, 1998).

Conversely, returning veterans can be viewed as heroes fulfilling important missions. Where this is so, the female partners may feel that it is their duty, morally and ethically, to care for these men who have been off fighting for their country and their family's freedom. This permits some women to find positive meaning in a burdensome marriage (Dekel et. al, 2005). If PTSD is an issue, the sense of mission is vital to the construction and maintaining of a positive outlook.

Conclusion

As explored in the review of the literature, the female partners of Canadian military members face the unique challenge of being a part of a system with its own ideology and culture. Articulated throughout this literature review is the need for research into how the female partners of Canadian military members are managing daily life when their partners are diagnosed with a potentially life altering illness, PTSD; an illness which may create secondary stress response in the female partner. Has the relationship changed

due to the symptoms of PTSD? Have the roles in the relationship been altered? Is there a sense of ambiguous loss? Do these women alter their behavior to accommodate the needs of their partner to the point of de-selfing? If so, how do they do it and what does it mean to them and others? Is there evidence of the transference of trauma as documented by the presence of depression and hyper-vigilance? Are they able to find balance between the needs of the partner and themselves/ are healthy boundaries maintained? Are they able to become resilient in light of the challenges they are coping with? What does this resilience mean to them and how does it manifest? How is the military responding in terms of diagnosis, treatment and support?

Chapter Three: Theoretical Framework

An interpretive/constructivist framework was used for this research project to gain an understanding of the experiences of the female partners of military veterans diagnosed with PTSD. This framework was chosen in light of my desire to retrieve multiple first voice accounts, to not impose an outside interpretation of their experiences and to hear the way in which these women were making sense of daily life. What meaning did the women attribute to the experience they were living? What was their lived reality? As stories were told and I interpreted the multiple meanings, I looked for common experiences, or evidence of coping strategies in the partners' reflections.

Interpretive/Constructivist Framework

Interpretive/constructivist research proceeds from the epistemological position that multiple truths are created through individual action in daily life and the corresponding ontological position that there is no single shared social reality, but a series of social constructions (Ritchie & Lewis, 2003). Within this framework, cultural and historical contexts provide the environment for individual interpretations of experience known as "verstehen" (Schutz, 1967). Interpretive/constructivist researchers strive to understand and interpret these meanings through an understanding of the individual's life view of their situation.

Epistemological and Ontological Implications

Epistemologically, the interpretive/constructivist approach places importance on the phenomenon of study and sees both data and analysis as created by the shared experience of the researcher, the participant and the relationship that develops between them (Charmaz, 2000; Charmaz & Mitchell, 1996). When appropriate, the sharing of my

story, being the parent of a trauma survivor, aided in creating an environment of understanding and support. This emic (insider) perspective enabled the participant and me, as researcher, to interpret and construct meaning about the event under study. This was relevant in order to achieve an understanding of the lived reality of the female partners of military veterans diagnosed with PTSD.

I attempted to examine the nature of the lived reality of the female partners of military veterans experiencing PTSD and determine what can be discovered and interpreted about their daily experiences. Understanding reality is a relative concept entered into by the knower (female partner of military veteran) and the would-be knower (myself as researcher), (Lincoln & Guba, 1985). The knower's lived experience is the topic of interest. There is no truth, no right or wrong, only the value given by the participants, the knower and the would-be knower. Reality is not what is, but what the knower perceives it to be (Ritchie & Lewis, 2003). All of this is important to keep in mind as the participant allows their story to be told and recorded without judgment in keeping with the interpretive constructivist paradigm there is no single truth only a shared reality embodied within the experience.

The reason for choosing the interpretive/constructivist paradigm lies in the desire for a research process that allows for the weaving together of personal stories to create a tapestry of meaning. I used interviews to retrieve the stories of the participants, in the hope of gaining an understanding of how the participants construct meanings about the event under examination. According to the constructivist theory of self-development, human beings actively create and construe their personal realities and representational models of the world (McCann & Pearlman, 1992). This becomes the framework used to

make sense of a new or challenging experience. Therefore, the stressful event takes on meaning and is understood in relation to the construct developed by the individual (McCann & Pearlman, 1992).

Although stress does influence interaction, many families survive because they are able to counterbalance their vulnerabilities with strengths (Boss, 1987). My plan was to learn the implicit meaning of the lived experience to gain insight into their daily reality. Most people have experiences of grief and loss and have had their lives disrupted because of unforeseen events. My goal was to look at persons with a similar stressor to see what can be learned. Another goal was to strive for a balance between telling the participant's story and to search for an understanding of the process entered into by the participants as they have constructed meaning for their lived experiences.

Two models were used to view the experiences of the participants and how the experience of post traumatic stress influences family and personal relations. The first is the ABC/X model (Hill, 1949) and the second is the Circumplex Model (Olson, 2000). Using the ABC/X and Circumplex models of family interaction to examine how the female partners constructed meaning and made sense of their circumstances allowed for insight into family and individual functioning. Both of these models were useful in framing the experience under study.

ABC/X Model

The ABC/X model (Hill, 1949) outlines the interaction between (A) the stressor or the event (B) family resources (C) the definition the family gives the event producing (X) the crisis or the use of present resources to avoid crisis. Hill developed this model as a way to study the experience of the families of the veterans returning from World War

11. Hill proposed that the event (A) could be buffered by two things (B) the resources the family has available to them to prevent isolation (Hill defined these as primarily social relationships) and (C) the interpretation the family gives the event. Hill included the range of interpretation to include cognition and attitude, hope personal effectiveness vs. despair and helplessness. This model provides a way to map the experiences a family goes through coping with a crisis, as they move through disorganization to reorganization following the event (Norris & Dunn, 2005).

A stressor is whatever the family determines it to be. It could be the loss of employment, job relocation, or the diagnosis of an illness. In this study the stressor (A) is the manifestation of symptoms and the eventual diagnosis of PTSD in the male partner. Family resources (B) were explored through the interview process to explicate from where, from whom and what kind of support the female partner was receiving. Was there evidence of isolation? In exploring the meaning the female partner has given this event (C) will be of interest as it is the individual interpretation of the event that is under study. Were these women hopeful for the future or in a state of despair? Of further interest is whether or not crisis (X) occurred due to the interaction of (A) (B) and (C). What one family perceives as a stressor may for another be an opportunity to change the family's direction or focus. The functionality of the family is the determinate factor for the outcome of the family. The ABC/X model suggests stress is not inherent in an event, but occurs in relation to how the family constructs meaning in its response to the occurrence (Norris & Dunn, 2005). Therefore, not all families will experience the same event as stressful. Nor will the same incident necessarily cause crisis in all families.

One factor determining the outcome for a family is its available resources. The resources the family may have are both internal and external. The family may belong to a faith community that could be perceived as an external system where members can receive support in a time of need. The Canadian military provide resources in the form of spousal support programming and counseling services. Internal resources, such as good communication skills, can be a part of the family system, and influence whether or not the family interacts with each other and adapts to the event. Crisis occurs when the family perceives a lack of internal or external resources (Hill, 1949).

Circumplex Model

In the Circumplex Model, the focus is on the adaptation and cohesion of the family unit (Olson, 2000). In this model balance is the key, a balance of cohesion and adaptability. The Circumplex Model of family systems is perceived as flexible/separate, flexible/connected, structured/connected, or structured/separate. Excessive cohesion can result in rigid boundaries in the entanglement known as enmeshment. Too little cohesion may create a sense of chaos (Norris & Dunn, 2005). How a female partner copes with the stressor is dependent on what resources are available and how she perceives the event: is it a challenge or opportunity?

Understanding that there are normative events that are expected to occur in the natural course of life (a new baby, children going through developmentally difficult times, job relocation, etc.) and non-normative stressors such as catastrophes (an untimely death of a loved one, severe illness, the loss of a job, etc.) furthers the understanding of how these systems may become complicated by the actions of daily living in a family. Families that are more flexible and less rigid (Boss, 1987) are more likely to be able to

adapt to obstacles with less difficulty. Well-organized families continue to be organized during times of stress while disorganized families tend to become more disorganized. Being a part of a family system is stressful in itself without the added demands that occur during a crisis. Stressful events threaten the status quo and hold potential as a stimulus for crisis (Sussman & Steinmetz, 1987). The events do not in themselves have to be positive or negative. For example, the birth of a child may be seen as a blessed event or a drain on the family's limited resources. The stress is dependent on how the family perceives the event. Even normal developmental stressors may cause a reorganization of family and personal boundaries.

The stressors can also be seen as acute or chronic depending on their origin and long term implications. A family member having a broken leg may be the cause of acute stress in that the family will need to reorganize for a short time to care for and support the member. However, if a family member is diagnosed with PTSD, the stress may be ongoing for a long period of time where the demands on the family may cause strain. If the resources are not present to deal with the need this is likely to cause a fracture in the family system (Sussman & Steinmetz, 1987).

Another factor impacting personal and family stress/coping is the visibility of the cause of the stress. A broken leg is an obvious challenge that is impossible to deny. A family member diagnosed with mental illness however, can still look normal. The choice may be to use denial as a coping mechanism, especially if the other family member cannot come up with a solution to meet the added demands (Sussman & Steinmetz, 1987).

Conclusion

This interpretive study provided the opportunity to bring to light much regarding the lived experiences of the participant(s) involved in the study. In using the ABC/X and Circumplex Models, I had a framework for exploring meanings the participant has given to the phenomenon of interest, the resources being utilized and the consequences of the choices into which they entered. The ABC/X and the Circumplex Model merged to present a cycle of experience that manifests during a stressful time.

Chapter Four: Methodology

Theory and Method

In keeping with the interpretive/constructivist framework, this qualitative study involved working with a knowledge base that arose through the constant comparing of data, collected through an interviewing process, asking significant questions and allowing for spontaneous responses. This study was interactive and reflexive, as I was engaged with the participants and the data at every stage of the research. For this study the women self-identified as possible participants. The most important aspect of this study was to gain an understanding of the lives these women were living and to explore the meaning given to their unique experiences. There was no expected outcome going into this project, only the desire to hear the stories and allow themes, if there were any, to emerge.

First Voice Accounts

Participating women were interviewed in depth, which allowed for the gathering of detailed data and first person accounts of their experiences as female partners of military veterans diagnosed with PTSD. The interviews were semi-structured using a question guideline (appendix A). The questions were open ended and neutral to allow for responses that made it possible for the participant to share to the extent she was comfortable. Retrieving first voice accounts enabled the examination of experience including the construction of meaning, the coping strategies, and the resources utilized by the female partners of military veterans diagnosed with PTSD. The interview questions explored how these women viewed the situation in which they found themselves. They were also asked about the process of diagnosis and treatment. Were they able to access

support while making their way through this stage? The women were asked to reflect on whether this event had changed how the family functioned on a daily basis, or if it altered the roles in the family, if so how.

Reflexivity

As the researcher, I kept a field journal of my personal reactions to the research and any feelings of a personal nature that arose. Maintaining a reflexive practice served two purposes. First, it provided a mechanism through which personal reflections and perceptions were recorded and bracketed to be sure they did not unduly influence the interpretation of the data. Secondly, journaling also helped to highlight the areas that needed further exploration. Although there was no attempt at objectivity, the constant reflection of my own experience and the keeping of a reflexive journal held subjectivity in check. Prior to the research process, the interview was piloted to make sure the questions and the methods were successful in attaining the desired information.

Epistemologically, the inquired and the inquired into, the participant and I formed an epistemic relationship; therefore, the data was highly subjective and inductive. As an insider having a child with PTSD and the researcher, I was the instrument in this emic process. This facilitated the development of a research process and yielded significant epistemic outcomes.

Recruitment

The participants for this study were located in two ways. First, through a snowball method where a friend, who is the partner of a military veteran with PTSD, told her friends about the study and invited them to contact me if they were interested in taking part in the study. In turn they invited their friends to do the same. The second method was

through the use of contacts and caregivers at the Department of National Defence treatment facility, Veterans Affairs and the Operational Stress and Injury Support Services, located in Halifax (OSSIS). Prospective participants contacted me through a private e-mail or phone number accessed only by myself in order to keep their contact confidential. At that time I answered any questions they had regarding the study and set up an interview if they wished to take part in the project. My goal was to interview eight to ten female partners who have been co-habiting with their partner for a period of at least five years in the hope that they were established in their relationship with their partner before the onset of PTSD. I was successful in completing seven interviews that met the above criteria.

Interviews

Personal interviews were chosen over a focus group due to the nature of the study and the desire to create a safe and comfortable environment for each participant to share her personal experiences. Individual interviews offered the best method of retrieving the meaning these women ascribed to their experiences. Data collection began with setting up interviews with the female partners of military veterans who had been diagnosed with PTSD. The interviews took place in private settings of the participants choosing. Questions were arranged in a way to always end on the strength building the participant had experienced as a result of her experience in order to finish on a positive note. Upon completion of the interview, the participant was also provided information about the counseling services offered through the Military Family Resource Center (MFRC) and the Canadian Forces Member Assistance Program (CFMAP). As well, they were provided the contact information for OSSIS and the support group offered at the Halifax

Trauma Treatment Facility, in case they felt a need to debrief any issue that may have come to light through the interview process.

The interviews took place over a six-month period. Field notes and a reflexive journal were kept throughout the process to supplement the interviews. The interviewing process continued until saturation was achieved and individual findings did not identify new significant data or themes.

Procedure

Potential participants were given my confidential e-mail and phone number. They then contacted me to express their interest in finding out more about the study. Once I provided them with an overview of the project, they decided whether or not they wished to take part. We then would decide on an agreeable time and place to meet. At the onset of the interview, I introduced myself and shared a little of my own story including the reason for my interest in this topic and my plans for the research. As required by the University Research Ethics Board, a signed informed consent was obtained from each participant prior to taking part in the research. This ensured that she understood her right to stop the interview at any time and withdraw from the study completely with no fear of reprisal from anyone. I began the interview with general demographic questions such as name, age, and employment status before moving on to the more in-depth questions. The interviews, with the participant's permission, were recorded and transcribed. After transcription the participant was mailed a copy to review and alter if she wished. Each participant was interviewed once. No participant chose to alter her interview transcript. The complete interview guide can be found in Appendix A.

Coding

Managing the data and the coding process was aided with the use of a computer program designed for qualitative data analysis, MAXQDA. Using open coding (Corbin & Strauss, 1996), I read through each interview transcript line by line writing memos and determined initial themes or categories that emerged. First, I noticed the redefining of roles in the relationship and the presence of secondary trauma. Next, axial coding was completed (Corbin & Strauss, 1996). This involved the rereading of each transcript to determine if there were categories or subcategories in the text that could be linked to each other. For example, identifying the female partners sense of ambiguous loss due the changes in the relationship and the adjusting that took place in order to accommodate those changes. Finally, the themes and categories were integrated to provide the basis for the initial interpretation.

Analysis

Through analysis, the goal was to become aware of emergent themes and theories by constantly comparing the new data obtained from the interviews to the existing data and the literature review. “Working up from data is often presented as what qualitative research is especially about” (Denzin & Lincoln, 1994). In this study working “up” from the data was the goal. The linking of thoughts and reflections of the participants from the beginning created a rich study of first voice accounts. Coding was completed after each interview and was an ongoing part of the research. Using key words to group data together was helpful in determining similar experiences. Although identifying the lived experience of the female partners of military veterans diagnosed with PTSD was a foundational question, many other questions were required to answer this one. Each

person's experience is unique to them and needed to be viewed from that vantage point. This was the rationale for using the interpretive/constructivist framework. The coding process was completed with the use of a qualitative software program. When the interviews stopped presenting any new categories or properties, I judged that saturation has been attained. At that time, the interviewed women's experiences were documented and the themes retrieved.

Ethical Considerations

Through the written consent process permission was obtained to record and transcribe each interview (see Appendix B). Each participant was aware that they could choose not to be taped or to stop the recorder and/or the interview at any time, although no one made this choice. The individual who transcribed the interviews and me, along with my thesis advisor, were the only people to listen to the recordings. The tapes and transcriptions were secured in a locked filing cabinet in my home. These steps provided confidentiality. Electronic files were password protected. Files and tapes will be destroyed upon completion of the study.

Participants were assured that confidentiality would be maintained through the use of pseudonyms. In addition, any potentially identifying information in the interview was altered, such as the rank of the partner or employment status. Member checking was achieved by giving all participants a copy of their transcribed interview to review for accuracy. If they had any discomfort with all, or a part of the interview, that section, or the interview would have been excluded from the study. This could have been accomplished through the participant informing me in writing or in person. In light of the fact that this interview process may have brought to mind some unresolved emotions

regarding their partner's diagnosis and the changes it may have brought about in the family unit, it was important for participants to understand they are taking part in a research project and not a therapeutic process, nor were they entering into a therapeutic relationship.

The preceding safeguards were clearly articulated in the letter of consent each participant was required to sign. At the beginning of the interview session, these safeguards were verbally reviewed to insure that the participants were giving informed consent.

Conclusion

Completing this study using the interpretive/constructivist lens enabled the stories of the participants to unfold without attempting to make them fit into a fixed model. This allowed for an organic process of research. The stories were told and themes emerged that were examined using the ABC/X and circumplex models.

Chapter 5: Findings

Veteran - whether active duty, retired, or reserve is someone who, at one point in his/her life, signed a blank check made payable to "The People of Canada," for an amount up to and including my life. Author unknown

This chapter presents the experiences of seven women who were the partners of military veterans diagnosed with posttraumatic stress disorder (PTSD). The stories presented represent the participant's attempts to understand and to make sense of the situation in which they find themselves now living. Similar themes emerge from all of the narratives and will be described in this chapter. In keeping with the interpretive/constructivist framework, first voice accounts are used to present the stories and the struggle for meaning in the daily lives of these participants (Schutz, 1967). Participants were not required to prove their husbands pathology but rather stated his diagnosis.

Demographics

In order to protect the anonymity of the participants, potentially identifying information will not be presented. Participants ranged in age from thirty to sixty. Two women were no longer co-habiting with the veteran, although they are both co-parenting with their partners. All but one woman was formally married to the veteran. The duration of these relationships was between seven and forty years. The veterans held the ranks of enlisted infantrymen to that of commanding officers in charge of large regiments of soldiers. All of the veterans had served in "hot spots" at some time in their careers. A "hot spot" is a location where there is an active military engagement. All the women were Caucasian and had grown up in Canada. The education level of the women was varied, as was their employment status. One participant was now retired, but all had

been or were currently the primary provider for the family. One woman was presently on maternity leave. The children of these families varied in age from newborn to adult. Three of the families have one child, two families have two children, one has three and one has five children. Two of the participants had grown up in a military family. None of the women expressed a religious practice or faith community as being important in their daily lives.

The Participants

As this is an interpretive/constructivist study that has its focus on first voice accounts I felt it would be helpful to present a brief introduction to each of the participants. This will enable the reader to gain to a sense of each woman as her story unfolds.

‘Carol’ was a woman in her fifties who has been married to her partner for more than thirty years. At the time of the interview she worked fulltime in the health care field. They have three children aged from early to late twenties. Carol was open and honest about the challenges she and her partner face. I was struck by how much laughing she did during the interview when speaking about the various adjustments she has been required to make.

‘Sherry’ was a woman in her sixties. She has been married to her partner for over forty years. She was now retired from a position in the health care field. They have one adult daughter, in her middle thirties. Sherry was a quiet woman. She spoke openly of the difficulties she and her partner face daily. Sherry reported she has stayed in the relationship with her partner due to a sense of duty. She came across as being very sad.

'Tammy' was in her forties. She has known her partner all of her life but has cohabitated with him for a little more than five years. She worked full time in the health care field. They shared the responsibility for five children. Three are her children from a previous relationship and two are her partner's. The children range in age from pre-adolescent to their early twenties. Tammy was very emotional and talkative during her interview. She expressed feeling overwhelmed by the challenges she faced on a daily basis and her frustration at not being able to access sufficient supports for her partner and their children.

'Denise' was in her thirties. She and her partner were married for over fifteen years although they no longer cohabit. She worked full time in a counseling position. They have two children in their teen years. Denise was talkative and had a great desire to be helpful.

'Janet' was in her fifties. She was a stay at home mother taking care of her one child, a daughter, now in her teens. Her husband of sixteen years recently lapsed in his treatment for an alcohol addiction and left the relationship when it came to light he had gambled away all of the family assets. Now she was required to work at a minimum wage job in an attempt to keep her family home. Much of Janet's interview was expressed with a great deal of emotion (anger and tears).

'Natalie' was in her late forties. She and her partner have been married for almost thirty years. She has held various jobs over the years from store clerk to presently part-time home care worker. She was the stepparent of two adult sons. Over the term of their marriage Natalie and her partner have fostered almost thirty hard-to-place children.

Natalie was very talkative and spoke often of her husband and herself in the first person using the term “we” when talking about his specific symptoms and challenges.

‘Katie’ was in her thirties. She has been married to her partner for about ten years. Presently Katie was on maternity leave from full time employment. They have one newborn child. Katie was the youngest participant and the least talkative. She was also the most optimistic about the future outcomes.

There are many themes that emerged in this study. I will begin by speaking of the veterans’ service, the origin of where the PTSD had its beginning. Some of the partners knew exactly what the precipitating event was for others it was an accumulation of events.

Veteran’s Service

The veterans who are the partners of the participants of this study represent collectively close to one hundred and fifty years of military service. They served all over the world in various capacities with the common denominator being that they at some point in their career they faced a work-related trauma or event which forever altered who they were in profound ways.

Carol’s partner served in the military for over thirty years as a technician on submarines. Throughout his career he spent time in various hot spots (locations where the military was actively engaged in peace making or peacekeeping) including Cambodia and the Falklands. After these deployments, Carol noticed some behavioral changes and now, in retrospect, believes this was the beginning of his struggle with the operational stress injuries. She notes: “...when he had come back from Cambodia, he was stationed there

for one year, things kind of fell apart”. Her partner was released with a disability pension in place, although Carol works to provide necessary financial support for the family.

Sherry’s partner was a fighter pilot and was unable to discuss the details of his missions due to national security requirements. Therefore, she did not have advance knowledge of whether he was going to serve in hotspots or just completing exercises for training purposes. He flew missions for over twenty years prior to his release from the military due to having become aero phobic (a fear of flying). He received his diagnosis of PTSD after his release from service. He was released without the benefit of a disability pension. Subsequently, Sherry was retrained and entered the work force to provide for the family.

Tammy’s partner served in the military for twenty years and was deployed to Bosnia twice with six months between deployments and was also deployed to Africa. He was an infantry soldier. He was diagnosed with depression and released from the military with no benefits. He was still attempting to receive proper recognition for a diagnosis of PTSD, which came after his release from the military.

Denise’s partner served in the military for twenty years with eight tours served in Bosnia and Afghanistan. Denise stated her partner has an ongoing challenge with an alcohol addiction as well as flashbacks, which made it dangerous to cohabitate with him. They have since divorced. Denise retrained and has been the primary financial support for herself and her children. Her partner was diagnosed with PTSD prior to his release from the military. He had served in the army tanker and as a firefighter. Due to complication brought about by his PTSD he was medically discharged without a treatment plan in place.

Natalie's partner was a cook who served in many spots where peacekeeping and recovery missions took place. He served for two separate periods of time totaling over twenty years. When she was dating her husband, he showed evidence of PTSD. Natalie was familiar with PTSD as her father had been diagnosed with battle fatigue and had struggled with the symptoms and personality difficulties all of her life. She felt she recognized the symptoms in her husband and was instrumental in his receiving support. Natalie's husband remustered (i.e., returned to cob) in an effort to keep his career. He was able to stay for another eleven years as a 'runner' (couriering important documents from one person to another) but was eventually unable to cope away from her support. His diagnosis came after his release and support was achieved after legal action took place.

Janet's partner was a commanding officer who had served in several hot spots prior to and during the years of their relationship. He had a military career of over twenty years. Her partner had shown signs of being hyper-vigilant and controlling during their relationship. At the time Janet had thought of these behaviors as nothing more than odd. When he was released from the military Janet's husband held a high-rank as an officer. He was released with the diagnosis of PTSD, no therapeutic supports were put in place for him to utilize upon his leaving.

Katie's partner served in the military for just short of ten years as an infantry soldier with numerous deployments in Bosnia. He was discharged from the military, without a medical diagnosis of PTSD when his symptoms made it impossible for him to do his work. He has no benefits in place and was working to have this rectified. He has been unable to be employed anywhere else after being discharged from the military.

As the stories of the women and the veteran's unfold, we hear of men who went away in service to their country and were deployed to fields of operation where they had experiences that fundamentally changed who they were. The veterans returned with much altered personalities and dysfunctional coping strategies. Some became violent, while others engaged in addictive behaviors and some withdrew into themselves. What is evident from these women's stories is the result of the trauma their partner experienced also altered the family unit. Some families were able to adjust and find a new normal; understandably others became fragmented and fell apart

The Military Wife (Partner)

Harrison and Laliberte (1994) and Norris (2001) speak to the role of the military wife and the particular challenges these women face. For Denise, following her familial example of military life was what she knew. Only two women participating on this study, Denise and Natalie were raised in military families. Natalie felt having a father who acted out due to the symptoms he suffered as a result of his PTSD prepared her for her role as a supportive partner. Sherry was the only other woman who identified her role as the wife of a military officer although she had not been raised in a military family she sought out and married a military member.

Denise and her partner lived on base when they were together and were housed in the same area as most of the other members of his unit. Often, socializing was done in conjunction with the other members and their partners and families. This unit cohesion; however, did not extend to nurturing support between the families, in fact, Denise reflects on how it was actually more destructive. Due to her neighbours also being her partner's

co-workers, relationships were enmeshed. Managing daily life was supported through her adherence to the ideology of the strong military wife.

Yeah, it was like and nobody's - you know, it's insanity, and you don't know, you know. I mean now I went back through counseling and learned stuff. But when you're young, you know and don't talk about stuff because it's a military family and it's not a bad thing. I grew up with a military family and my parents never discussed anything. I'm the wife, he gets the paycheque, you know, we're part of the military...I am sure nobody ever sat me down - but I mean I was - here I was with my neighbours, and I would say to them "you guys need to suck it up". You know, I was out there shoveling my driveway, you know, like I was eight months pregnant, I didn't have to (chuckle) and being hard on my neighbours because they were hurting. That's very sad, you know. But I should have been saying, "Sit down. Let's talk." But I'm like okay, "suck it up, I don't want to hear your problems". (Denise)

Whether they lived on or off base these women express how they worked to keep the veteran functioning and an active member of the Canadian Forces.

Veteran's Diagnosis

For the women who took part in this study, their partner's diagnosis with PTSD was the formal part of naming what had happened to their partner. It brought some a sense of relief knowing they were correct in their layman's diagnosis. For others there was a deeper level of understanding about the challenges facing them and the family unit. Three of the seven participant's partners were diagnosed prior to leaving the military; only one of those had a treatment plan in place. One couple successfully litigated in order

to achieve veteran status and compensation. Three families are still attempting to receive Veterans Affairs (VA) recognition and support from the military for the injury acquired during their service.

Sherry returned to school after her partner's release from the military pursuing studies in the field of mental health. This helped her to understand her partner's behavior as being a possible PTSD injury. This led them to seek out a formal investigation and eventually a medical diagnosis. Due to the diagnosis following his release, Sherry and her partner are involved in an ongoing review process to have his PTSD recognized by Veterans Affairs. A successful review will entitle him to receive compensation for his work related injuries. In addition to having PTSD, he has a spinal disease, which is thought to be the result of flying jet aircraft on and off of naval vessels. This also was not formally diagnosed prior to his leaving the military. Sherry had retrained in order to provide for her family. At the time of the interview she had recently retired from active work.

A physician and a psychologist, both of whom work in conjunction with Operational Stress Injury Support Services (OSISS), diagnosed Sherry's partner. This diagnosis has not yet been acknowledged by Veterans Affairs. Due to his other health challenges (spinal deterioration) he is unable to be active in any physical way and is unemployable.

The psychologist confirmed, I mean by this time we were pretty sure, we were actually really sure, but we needed it confirmed medically right, and so the psychologist was able to do that, you know when he started sleep walking, I mean, like it's way over the top now. So, it was so much easier I think to know,

yeah. And if we could have sent him back to work, we probably would have because it might have been easier for him, that way, just to keep working and keep busy to not have to deal with it, right? (Sherry)

Sherry's partner is now in the maintenance phase of his treatment. He is attempting to gain recognition and support for his injury from the military. Sherry shared some of the struggles they are having navigating the military medical system.

We finally got his medical records and you know they're not all there which is generally the case but it's - ah, when he was released from the Canadian Armed Forces, he was released without any supports in place, without being told that he had PTSD and you so on and so on. And, that he didn't have this and he didn't have that but in his medical records we found before he was released, there are things written in there that clearly indicate he was released with PTSD and no appropriate supports. He wasn't even told you know. That was back in 1978. (Sherry)

Here Carol expresses her belief about the support he received being in part due to the public nature of the event and injury, which resulted in the onset of his symptoms. Carol and her partner were open with family and friends about his diagnosis or the reason for his eventual discharge.

He was deployed and injured on a submarine that caught on fire and with this episode the Armed Forces were smacked in the face in that they had to watch these people because it was so blatant. It wasn't subtle. (Carol)

Tammy's partner sought out support from his military physician in 1998 with symptoms of what they now understand to have been depression brought on by his

PTSD. At the time they just knew something was wrong. Prior to his release from the military he attempted suicide and was treated for depression. This diagnosis led to his discharge from the military, as he was not considered to be deployable. The depression was not identified as a part of the PTSD spectrum of symptoms. Tammy expressed her frustration with the process of obtaining a Veterans Card (VA); veteran recognition would entitle her partner and their family to access the supports of the military system.

The last year he was in the military he was not doing his job and so since he got out it's been five years of limbo [trying to get a medical diagnosis documented and then complete the paper work necessary for VA]. So that Veterans Affairs will recognize him as a Veteran, You're not recognized as a Veteran until you have your VA card, which is really hard. So everybody assumes we're okay. And that he got out with a medical pension and - and basically the only reason that we're going through this now [getting a formal diagnosis] is that my Mom passed away last year and there was a little money left and we could afford the weekly fee for him to see a psychologist so that this process can get done [the diagnosis]. And if it weren't for that money from my mother's death we would still be waiting. (Tammy)

Denise's partner, after serving in the Army in Bosnia as part of the army assigned to a tank, attempted to remuster (change his formal military designation) into the Navy as a way to save his military career. He retrained as a firefighter, however due to his symptoms he was unable to be deployed.

He remustered in '99 - then he finally got diagnosed he couldn't go on ship and that's part of his job to be a firefighter you have to go on ship and he wanted to go

on ship but because he had a category, [diagnosis with PTSD] it doesn't let you go on ship. – so he became an administrative burden and that sort of thing, you know, when you're fighting everything [the military administration]. He didn't have a dishonorable discharge but he was helped out [of the military]. (Denise)

The following episode took place during the time after Natalie's partner was first discharged from the military. Even though Natalie's husband had his first episode with PTSD symptoms almost thirty years ago, his diagnosis took place in 2000.

I came back, he was standing in the living room looking at her TV just frozen, could - wasn't really breathing just - and I'm oh here we go cause I have lived with it with my father - So here I am eighteen years old and I said, okay, sit down. And I said what were you watching? And then they - they were - they were doing the clip again. It was a boy - two boys had been killed by their father - this - this image of this child with the dark hair the dark eyes was the same image as he saw back in '76'. And that was the trigger. So I called my brother and I said, okay you need to take him to the hospital. So he took him to the hospital he was just a shade - just white by this point and they said, oh he's having an anxiety attack here's some Valium. We took him home, I said come with me, took him into the bathroom, and took the pills and flushed them down the toilet. I said we are going to get through this. What I didn't realize is for the next four months I was not going to be out of his sight. Not even having a shower. The shower curtain had to be open. I couldn't leave - (Natalie)

After months of acting as the sole care giver and provider for her partner, he began to show signs of improving and eventually decided to return to his military career.

Although he had enjoyed his military career he had taken a discharge at the request of his first wife. He had been out of the military for five years. They both also felt the routine would facilitate his recovery. He retired from his military career in 1993. In 2000 Natalie felt her partner required formal supports and they successfully sought out medical diagnosis and compensation through the military system.

I realized that it was time to do something so he went to a psychologist and sure enough he was diagnosed when he came here to Halifax. But it was eighteen-months; he had to come down for interviews and that type of thing. (Natalie)

Katie and her partner's life changed quickly when he returned from his last deployment to Bosnia. Katie's partner struggled with symptoms of depression and was not considered able to be deployed and was therefore released from military service. He accessed support in the form of therapy and acquiring a medical diagnosis of PTSD through the OSISS site close to where they reside. Katie's partner has regular therapy session and as a couple they have attended therapy. He has yet to receive his VA card or compensation benefits for his injury.

As we read above, a medical diagnosis of PTSD in the military system does not always translate into a medical discharge for a work related injury. In one case the Veteran was released without being informed of his PTSD diagnosis, even though his file reflected that diagnosis. For most a formal medical diagnosis did not bring with it automatic access to the military system, a Veteran Affairs (VA) card which would entitle them to financial support and access to therapy for themselves and their families. For some this struggle for recognition and aid is still ongoing.

Response to the Diagnosis

The response to the formal diagnosis of a traumatic illness and injury provided a name for the symptoms experienced by the partners. For some of the women it was a relief to realize there was a name for what they were experiencing. However, there also came the awareness of the challenges that would lie ahead.

Here Sherry expresses some of her challenges and her response to the formal diagnosis of PTSD. For her there was also the awareness of personality changes on the part of her husband and the man whom she had married.

I think it's very helpful to - I mean it validates your experience. You're no longer feeling crazy (laughing). You know. Really, because some of the behavior and some of the responses can be kind of crazy making and, um, and when you don't have that formal diagnosis, you sort of question. His formal diagnosis did, in fact, come after his release, actually just in the last two years. Although I knew something over the years wasn't - was off, I didn't really know for sure for many years. And then I started doing some work, my own work and working in a field, which led me to learn quite a bit about PTSD, and, kind of, ah hah, um, you know. It started you know, it kind of clicks here and there in a certain amount but it wasn't until we came back here that it clicked like really big. (Sherry)

For Sherry's daughter, the formal diagnosis of her father's PTSD was enlightening and helpful in understanding his controlling behaviors as she was growing up in what she felt was a household full of secrecy. A household that functioned around keeping secret the symptoms her father was experiencing.

It was a like a big wow. It's like ohhh, now so many things make sense, that didn't make sense before. His behaviors, you know, he could be a - he could be excessive; he could be over protective, like to the point - well, being controlling because he was trying to protect his family. (Sherry)

Denise expressed her frustration with the lack of support in the system when they were going through this difficult phase. At the time she blamed herself and their young ages for the difficulties they were experiencing, as well as their lack of coping skills.

It explains a lot of things especially now. I have an understanding. When you're young and you know there's so many reasons you think of why people aren't happy, right, it's - you're not a good wife, he's not a good husband or maybe you got together too young, you change, you know, we had all those different things, so - if we had a diagnosis, [earlier], I mean you don't know right. Hindsight is 20/20. Maybe we could have got therapy, you know the kids, there's all that stuff we all live with now today which I think we could have got help for. But - and when you divorce, there's no support through the military through Veteran's right, there's nothing. (Denise)

For Katie and her partner receiving the diagnosis was very helpful. Katie had no idea what was going on with her partner. She was blaming herself for the difficulties they were experiencing.

When he returned from over there I knew things were different but I thought it was about me. He tried to tell me it wasn't but I didn't believe him. He would be helping with dinner cutting the meat and stuff and all of a sudden he would storm off and I would think what did I do? What did I say? Cause he would be really

quiet and withdrawn. After he got out we went to counseling and then I understood he was having flash backs and stuff and just needed time to get his head together. So the diagnosis helped in that way I know it's not about me it about him trying to make sense of stuff. (Katie)

Although the diagnosis brought some relief in the naming of the illness and injury, which allowed for some understanding of past behaviors, it also brought the awareness of a lifetime ahead full of challenges.

Treatment

The partners of the women who took part in this study had made their way through the initial treatment phase for PTSD. The initial phase of treatment involves individual and group therapy, a regimen of medication and, for some, retraining. The maintenance phase of treatment is entered into after having made their way through the intensive steps of the initial phase and reaching the highest level of wellness that can be expected. Some veterans continued with maintenance care either within the military system through OSISS or the VA. One of the veterans sought out support in the private sector. This maintenance phase usually included the continued use of medication and for some continued therapy. Just because a veteran is in the maintenance phase one should not assume this could be equated with a return to the previous level of functioning previously did not enjoy nor does it infer that he is symptom free

Recently Denise's partner made his way through treatment and has been able to take a more active role in parenting their children.

Just because you get treatment, it doesn't fix all the damage that's been done. And there's a lot of guilt and it - I find guilt, it's - and it's not even - it's the soldier,

the spouse - okay they're just an army guy, they're hard core they don't care and it's not, it's the guilt that eats them up. You, know, I mean either they get help or it will just spiral because you know - and it's - you see the suffering that they feel. I mean, their job - they're in the military and they do their job and this came about because of their job. I'm not saying being a soldier is a bad thing but if you're broken then someone needs to help fix you and not just toss you to the side, you just can't do your job anymore.... He's not nearly as angry. He still gets angry, he has a short fuse, but he's aware of it and he'll do things to not blow up, I guess, he knows the things that irritate him. But it's a big thing for him to go out in crowds.

(Denise)

Carol speaks about her partner's whole life changing due to his illness and injury. Although he has received treatment, she recognizes that to some extent, the changes will always be there.

Our whole life changed (laughing). And everything changed. Um, the whole world revolved around him. - There are still days when the whole world revolves around him. He has completed treatment and is in the maintenance phase Yeah; I think that is what they call it (chuckling). The treatment gave him coping skills and that was the big thing. Cause it's not something that's going to go away, it's not something you're going to get over. (Carol)

Janet expressed her struggle to understand all that has happened in her relationship with her partner since his diagnosis and release from the military.

He also went through some sort of um secret - he went through a secret alcoholism treatment because in the military, the problem is if you admit to

having something wrong and needing treatment, your chances of promotions were kibosh. He would over react to being startled - he would jump but he would jump a mile so much. But it happened always. So it happened so frequently it seemed a huge over-exaggeration. He was doing fairly well and until probably the last three or four years of his serving and he started to get really angry about a lot of things. So he started seeing a psychiatrist on a weekly basis. He was always walking around like a bundle of stress. And that was always very fun. So, he kept – he would do things around the house, um as a - as a favor to me almost with it has a – I always figured it had a – it seemed to have a checklist, you know, look what I did. I did his now are you going to thank me and appreciate me and that sort of thing. And this sort of personified. He was then – he was diagnosed with PTSD, and he was on pain-killers [for a knee surgery] antidepressants, and sleeping pills. And he would get - he would have sort of different mood swings and he became – he just became more and more emotionally disconnected from me.... So, it was becoming, um, quite difficult. (Janet)

For Natalie's partner accessing the VA system enabled him to receive his formal diagnosis but the support in the form of therapy he did not find helpful.

He came home and he'd say, "I feel worse when I go to therapy." He says I know it's - I know when it happened, I know the day that I had my breakdown, I know what's causing my post traumatic stress. He says lots of people don't
Yeah, I just knew. I knew what I had to do. And like he says, what would have happened, he said I would have been dead. He said, "I would have probably just walked out into traffic just in a daze." Yeah, I just I don't know, I just knew

exactly what it was and all these years it's like I've always been the person like when he's having horrible asthma attack in the hospital, the nurse when he was here in, in - this is an example. He was - came down here for an interview for his posttraumatic stress, he was having an anxiety asthma attack and the nurse remembered me and called me in Fredericton and said, "He just needs to hear your voice." As soon as he heard my voice he was fine. But I'm definitely - like he says, God help me if you ever died or anything cause where would I be. Yeah, you're a caregiver. You really - I mean you're - you're wife but your also like a caregiver of a special needs child. You really are. I was his saviour. I'm the one who saved him. (Natalie)

Treatment, as previously noted is not a panacea. There appears to be no full recovery; only a learning to deal with the symptoms brought about by this injury. Similarly, access to support groups is limited by knowing where and from whom support is available as most of the women expressed not being able to afford to access private therapy. Others had no interest in taking part in therapy put on by the system they see as having failed them and their partner. For Natalie and her partner treatment was not helpful and they have found a way of functioning together to manage the symptoms and challenges faced on a daily basis.

The Stigma of Mental Illness and Injury

Like society as a whole the military is attempting to deal with the stigma surrounding psychological illness. A social worker at the trauma treatment facility in Halifax explained to me a change in protocol surrounding the naming of diagnosis and treatment of soldiers with PTSD. The military health care system has begun to refer to

stress related trauma as an injury replacing the term illness. For example, the language has shifted from...a soldier now suffers with an operational stress injury instead of an operational stress illness. This was thought to be helpful in terms of validating the diagnosis of symptoms due to a stress related incident and thus reducing the stigma. She also stated that over eighty percent of soldiers diagnosed with PTSD are relieved from active duty; some are remustered but most are unable to continue functioning within the military system. With this documented diagnosis they are released and given a disability pension.

The participants in this study had not experienced this new protocol. For those whose partner's onset of symptoms was many years ago, keeping the secret of the symptoms and struggles with daily functioning was imperative in order to remain employed by the military. Although there are many years between Sherry and Denise's stories we hear the same sentiment and concern for not disclosing the challenges they and their partner are facing. For Sherry it was from her neighbours and friends Denise from the Padre but both with the same motive to keep their partner employed.

During her partner's military career, Sherry was a stay-at-home mother. She and her partner lived on the base and interacted socially with the members of her partner's unit so routine activities became fraught with anxiety because they were reliant on her partner's income to maintain their way of life. She expressed their understanding of the military motto "If you are not deployable, you are not employable" (The meaning taken to be if he could no longer fly he would loss his job and they would be left with no income or support).

Well first off, you don't feel safe. You don't trust the same way, and when you're in the military, you want to keep that hidden. If you're having a problem, you're not talking about it because that means you're going to lose your job, right.

(Sherry)

Denise grew up in a military family and of all the participants was the one who most expressed the ethos of the strong military wife. Here she talked about having to be debriefed by the Padre before her partner was deployed for another period of time in Bosnia.

You sat in front of the Padre, "and it was are you okay with him to go?" You know I was pregnant, I didn't want to say no, I don't want him to - you didn't do that... I mean you didn't tell him, he's not sleeping, and he's having nightmares, like he's drinking all the time. - It was not real right. So you're not going to say in front of the Padre, who is going to be debriefed by the superior, no I don't want him to go. You know that - you're screwing your husband's career....

There's that stigma and mental illness, period, you're not supposed to talk about it right. Well, it is a mental illness. And there is help out there, but if you're taught - I mean look at his side, right, you can't - and he was Army. And it's not to say Army is tougher but the army guys, I mean he was in the field right. Like he's, you know, in a tank. I mean you can't - you'd never - anyone that wasn't there was sick, lame and lazy. That is wrong. But I mean as an Army guy you wouldn't say, oh man, I'm having nightmares or you know like I woke up and I was, you know, I had my wife pinned down on the ground because I thought she was somebody else. He didn't talk about stuff like that. (Denise)

Here Denise speaks about her partner seeking help for the symptoms he was experiencing, nightmares, flashbacks and uncontrolled anger. When her partner eventually did seek help, his superior officer was not supportive.

And when he - he had people tell him and it was a sergeant and I won't use a specific reference but it had to do with the facts that the idiots that can't sort their heads out. And it's an excuse and what an excuse. If you're a soldier, you should do your job. You know, and he wanted to do his job but just couldn't. (Denise)

For Tammy and her partner the stigma of her partner's injury was part of their daily life.

Within my family, they think he is a loser. They honestly think he's just sitting at home doing nothing, living off me, and that's really hurtful and it's hard to have relationships with people that won't listen and can't see it for what it is. If he had his legs blown off, they'd all love him. Isn't that sad? He would be a hero - he's our hero (Tammy)

The stigma of mental illness and injury is not isolated to the military system.

However, as we have read the role of machismo coupled with the lack of understanding of a non-visible injury impeded getting proper support and recognition. These veterans strongly identify with their role as strong military members and being seen as "sick, lame or lazy" is not easy for any of them.

Adjusting and Adapting

For these women even after their partner received treatment and help on how to manage his challenges, the family was still required to alter previous patterns. The partners of these veterans expended a great amount of energy adapting and adjusting to meet the needs of their partner, in light of his symptoms. Daily life has for all changed

dramatically for all and for some roles have been reversed. For all of the participants, daily life and routines changed with the onset of the symptoms of their husband's injury. Some of those changes were blatant such as the veteran's inability to be in an open space or a crowded room. Other symptoms were subtler such as withdrawing from the relationship or lack of communication. External social relationships for all the participants and their families became strained. In some cases, relationships were terminated thus isolating the participants and their families in a time of great need of support. For some participants, there seemed to be a lack of awareness of how through their coping they had isolated themselves from family and friends.

Carol laughs as she speaks about the changes in their daily life. She stated that one of the most challenging adjustments she has had to make is in their social life.

Social relationships changed big time, he was always a do anything go anywhere kind of guy, now he's not. I mean we were very upfront that he had PTSD, A lot of people I know aren't, but this is not something we kept a secret but um - socially we don't go out a lot anymore. Um, (sigh) we have to plan to go to children's graduations because he has to sit at the very back by a door. We don't go to concerts. If we go to a restaurant, he has to sit with his back to the thing, so he doesn't - he doesn't really enjoy going out with a lot of people anymore and doesn't really enjoy going out much period, so - Yeah, that, that part of it is really changed which I was surprised because he's always been an active social person. We occasionally go to the movies in the afternoon when there's nobody in the theatre and he can sit in the back. But is can bit of a pain in the ass where I have to do all the planning. I have to scout everything out and say ok, this is where

we'll go, this is where we'll sit and, you know the exit is right there if you need to leave so - (Carol)

Denise spoke of the way life was in between deployments to Bosnia for her partner and his unit. They all lived on the same cul-de-sac and shared back gardens. Socializing became a series of "drunk fests" and she took care of the running of all the day-to-day activities involved with running the household.

They didn't want to go anywhere, or he didn't want to go anywhere, right? Their select group, you know, the guys that - they would get together. But then it's just a big drunk fest, right. And we couldn't be involved so you know it was women here, the men, here, we didn't go places. And I didn't know that you know so and so that lives in the PMQ beside me, I didn't know what was going on in her house. Because you didn't talk about stuff that - you could about everything but - so I had no idea that you know just - I mean when the guys got together, they'd just drink.... I take the kids everywhere. I do everything. Guys would get together if you were having a barbecue in the yard or whatever, but you didn't do - you didn't go out and go places and do things together anymore. (Denise)

Tammy expressed her struggles with the burden of daily life and her responsibilities. She works shift work as a health care provider in a veteran's hospital. She often picks up overtime shifts when she is asked due to her income being required to financially support the household.

Because people don't understand - I'm the one who pick up - all every piece. It's like - I don't want to say it's like having another child but when you have somebody that's disabled and not capable, basically all the responsibilities fall on

me. I pay the bills, I worry about the bills, I make all the doctor's appointments, you know. I was filling out his Veteran's Affairs papers because they come in and sit on the desk for weeks and weeks because he wasn't even capable of even filling them out. And, just the day-to-day things, you know. Laundry, I work 40 hours a week and then I come home and have to do it all, so I'm being a single parent even though we're in a relationship. So it's really hard. (Tammy)

For these women, the adjusting they did on a daily basis appears to have been an unconscious response to the need to keep the family functioning. All of the women who took part in this project reported that their social and support relationships had changed with the onset of their partner's injury. Both couple and individual interactions had been altered. Many expressed a lack of understanding not only from society as a whole but even on the part of family and friends. Not only did their partner's no longer wish to be social for some the survival of the family income was reliant on keeping the secret of his struggles and injury. The adjusting created hardships for these families and the burden of carrying these fell on the backs of the women.

Secondary Traumatic Stress

All of the participants reported struggling with depressive thoughts and wondering how much of the difficulties were theirs and not due to their partner's illness. What is evident is that these women struggle with many of the same symptoms as their partner.

Carol speaks about her struggles with drawing the line as she calls it between her and her husband's injury, separating her from his symptoms.

The only thing, I mean like I said, things have settled down now, but you still – you still think, is that because of PTSD that he’s doing that or is that just because he’s [partner’s name]. Like I mean you wonder sometimes where the line is. I will tell you the doctor swears I have PTSD. I have some of the same symptoms, so – it’s kind of a little weird.... Not so much that as, you know, you have to take care of yourself or you’ll get really tired. But, I - you kind of – osmosis because you’re tired of dealing with everything, you do get kind of shell-shocked and –. (Carol)

Denise shared her understanding of her challenges with secondary traumatic stress.

I’ m very high functioning but you don’t realize the little – why do I jump all the time? I kind of have an idea now, before I’m just like oh I’m a nervous person. But there’s stuff I don’t - I don’t do well with anger.... You know you can’t live on what ifs but it - for me it was painful because it opened it; I mean you recognize a lot of things. Like startling or whatever – like I’m okay, I’m fine. It’s similar nightmares, um waking up and being unable to run. I still don’t sleep, but I can sleep when I’m dead right? (Denise)

Sherry and her husband lived on a military base and socialized with members of her partner’s squadron therefore they were very secretive about the challenges he was facing before a flight. Sherry felt this need for secrecy led to her experiencing feelings of isolation and depression.

It all drives you deeper within yourself; right, to pull from within to be able to support yourself. But, you know, I’ve also struggled at times with feeling of anxiety and depression and you’re - and sometimes I’m confused as to - how

much is that playing a part in it? How much is my own stuff playing a part in it?
(Sherry)

All of the women expressed questioning their own sanity and spoke of struggles including times of feeling overwhelmed by the expectations they place upon themselves. They often reported questioning themselves and the behavior of their partner wondering if it was the PTSD or a personality quirk. What is evident is that these women all experienced the effects of their partner's illness.

Hyper vigilance

Many of these women spend their days attempting to ensure the possible triggers which could escalate the symptoms, be kept to a minimum. This led some of the women to feel they too had become hyper vigilant. Dealing with the impact of the events that traumatized their partners irrevocably changed their lives and their families. What is unclear is whether or not these women are cognizant of the extent to which they have adjusted their lives to fit the new relationship dynamics.

For Tammy, symptoms of depression and anxiety add to an already challenging existence. Tammy reports even when she is working, she is concerned about what is happening at home.

I call a couple of times [a day]. It's on my mind. I've been trying to back away from calling – but it's tough because I worry about him.... I know I'm depressed.... It's been Hell. Really. There's some days I don't want to get out of bed myself, you know, I know that I'm going to work and we're still not going to have enough money to pay the bills, and that I'm going to come home and do the housework, and have to deal with the children. And I find that really stressful.

There's going to be times when I'm going to be angry with him but I can't be. I don't feel that I can be - I can't be - I can't be normal. You have to walk on eggshells, you know - I can't have a shitty day either; I'm going to tell you that. No way. I have a shitty day and he's thinking it's because I want to leave. You've had enough of this shit haven't you? Sometimes I'm thinking in my mind, oh yeah (laughing). (Tammy)

Natalie has spent the last thirty plus years managing her partner's illness and his environment, this in an attempt to lessen his symptoms and create a stable life for them both.

It's - it's - it's non-stop. You're always watching but you don't even really think about it. It just becomes a way of life. I watch for triggers, like too much news on bombings and earthquakes and it's like, oh you know what dear, it's a really nice day, let's go for a car ride and we really don't need the satellite radio on, you know. Because he becomes like when there's an earthquake or something like that, he's just transfixed. And he watches the military channel. And I said, that's great dear, but you really don't need to be watching bombings. He says, well, it doesn't really bother me. And I said, you don't probably think it does, but I said, there's a reason you are drawn to that. You know. (Natalie)

Ambiguous Loss

Ambiguous loss in this context is the loss of persons with whom the women had entered into relationship. The man appears the same physically, but is inherently different. Boss (1987) refers to this phenomenon as ambiguous loss. The person they knew is physically present, but is psychologically different. The women speak of changes

in personality, and in the appearance of unhealthy coping strategies, such as difficulties with addictions and violence. The loss of the support their partner had previously brought to the relationship further led to the experience of ambiguous loss for many of the women.

Carol expresses her loss by describing the person she married being replaced by another; she has had to come to know and adjust to being with the new “version” of her partner.

The above normal anger was a little hard to deal with. A lot of the personalities he had which were, you know, in normal amounts became huge, with the drinking which was - kind of - goes with the territory for a lot of it. Um, Like I said - very jumpy, very skittish - I lit a candle in the house one day and it was like he came out of nowhere, - God, just almost magnified, all the personality traits just totally magnified, out of control, um the personality that really would change that was disturbing as was his lack of wanting to be social. That’s totally out of character. That wasn’t a magnification of him that’s complete turnaround of normal. Um, things have kind of shrunk back to normal to a certain extent, but yeah, that, that - you’re looking at the total person, you can see the pieces of the person from before but it’s totally different. And just way out of proportion. It’s like ah - applying for a job as a cook and going in and discovering that you’re the floor washer. It’s like, you know, this is my job. This is what I signed up for. What happened here? Why am I in something totally foreign and - It wasn’t a gradual thing; it like he went to the store and came back a totally different person -And

that's hard. Some of the things he says, you kind of look and say, yeah, okay, just go away and leave me alone (sotto voice). (Carol)

For Sherry and her husband, his constant physical pain is a daily reminder of his PTSD and prevents him from having any distraction from the challenges he is living with.

It's in his face, daily and mine, daily. And I'm thinking, you know - it's been hard to adjust to, you, know you feel you've lost your life. He feels that, I feel that like for him and I as a couple, we've basically lost that. It's like you married one person and days, months, later you find this person and start all over again. And I think I'm sure I did anyway, found myself adjusting me - adjusting myself to fit in there to make it work, to have it continue to work. I mean the things that initially attracted me to my husband was the fact that he was a member of our Canadian Armed Forces and that he was willing to sacrifice his quality of life so that I, our children, and our families and friends, and everybody else who is Canadian, would hopefully have a safe life. Right. That they could go to bed at night and not be worrying about their children maybe being bombed during the night and those kinds of things, right. Ah, so even though sometimes you feel like running, um I wasn't going to abandon this man who was injured doing what I thought was a honourable thing. You know? I'm sure I did sometimes look behind a book or watching a good movie, no question about it but that was as far as it was going to go, right (laughing). And like I say, you find yourself adapting yourself to do your best to keep everybody together and to keep ah - keep it working. (Sherry)

Tammy also witnessed personality changes. Here she expresses the loss of the partner she had known.

He has always been outgoing. Well, that's it in a nutshell. He's very intelligent, very compassionate, all the things you'd want in a partner and those were easy for him too. In the beginning of our relationship, and then as we settled in, I noticed that. It's like where did he go? He's gone. And I've said that to him, I miss you, I'd like to have you back. I find it very, very, very lonely. And that's - I think the grief if that is, is something that's harder than the physicality, like if he wasn't physically there. And I know myself, suffering from depression; I know that - it's human to want what you want - I want it now (laugh)! And that gets him upset too because he feels he's not getting better fast enough so everything just bounces back and forth and it's like, oh honey, I don't mean that, but it's been so long. I have to be careful what I say all the time. One lady said once, well, at least he came back alive. And I said, no, don't you realize, it would have been easier if he would have died. You guys don't get it. (Tammy)

For Janet the loss of the person she married has been devastating for her relationship.

When I got married and part of the reason I said yes was that I, I thought he is a great guy that is an honorable man and will always do the right thing, and will treat me well. Every...everything that I thought he is now gone. The respectful, wonderful guy is gone. (Janet)

The ambiguous loss reported was difficult for the women to express. It was for many a new concept and some felt guilt at not being happy their partner had returned

alive. Some were angry that due to his injury being mental in nature and essentially invisible family and friends did not understand and offer more support. For all of the women the loss of what they had previously had with their partner was significant, but also the loss of the hopes, dreams and plans they had for the future.

Formal and Informal Support Systems

Carol was the only individual who had been invited to attend a peer support group put on by the staff at the Halifax Trauma Treatment Facility. She found attending the support group was helping her come to terms with the stages of grief and adjustment she was experiencing.

I found it extremely helpful seeing women in different stages and knowing that was what I was going through at that time is not unusual. And that, okay, I'm not going nuts, that this is - I think I've gotten the point where, um, I think we're set at where we were going to be. I feel comfortable knowing what's - what's normal is not normal, with this PTSD deal. (Carol)

The majority of the women who took part in this study were not aware they could access support through OSSIS or for those whose partner had a VA card through the Trauma Treatment Center in Halifax. The difficulty with the Halifax trauma treatment center is that a referral is required from the veteran's psychologist in order for the women to be invited to attend. The mandate of the trauma treatment team is to treat military members and veterans with a stress injury - not their partners. However, they do periodically offer peer support groups for the partners of military members and veterans with PTSD. Ready access to these resources was an issue for some of the women; Tammy would have to commute an hour in each direction.

Janet and her partner never lived on base, nor did they socialize with other military members. She felt he liked to keep things very separate. She did not have a familial or social support system. Shortly before being interviewed they began to attend couples' counseling as Janet felt they had communication challenges. She recalls a pivotal conversation they recently had.

He came home he had found a new therapist that specialized in post traumatic stress disorder and he had two or three meetings with him and he came home from one of those meetings on - So I said to him - my counselor has suggested that I let him know that I was there for him, and I said to him, you know, I love you and now you're going through this new counselor with the PTSD, I want you to know that you can talk to me about whatever is happening or you don't have to talk to me. Whatever makes you feel better. And he turned around and he said, well, I don't love you anymore and I'm leaving. And, um, so my response was, on the Friday, I took an overdose of drugs. I tried to kill myself. But I knew that he was coming home and figured that he would probably save me. And then somehow, then things would be better (crying). Three days later my father died. When I phoned his sister and his cousin who were friends of mine, they didn't want to have anything to do with me. (Janet)

Sherry came from an abusive family and was unable to access support from them. With the lack of openness in the military community she was left with no support, and felt she supported herself alone.

So, who's supporting me? Me? (laughing) Me. That's about it. Me. Because, you know, how can other people in your life support you, your friends and your family because they don't understand it. They just don't understand it. (Sherry)

Sherry had no prior knowledge of the support groups offered by OSSIS or Veterans Affairs. I was able to pass along to her the information on two places she would be able to access support for herself and her daughter if she chose to do so.

Tammy's mother had been her main source of support but her premature death last year has left Tammy feeling bereft and isolated. Her siblings believe her partner is lazy and just needs to get a job. Her partner comes from a family with many challenges so there is no support from them either.

I was thinking about starting one up [support group] in the area because I've been so tired of the - a lot of things are held only on military bases and you have to travel. And there's tons of people in the community that suffer that were either in the reserves or the military and now they live back home again, and um, you know I've gone to counseling myself for support and made huge strides because I took a lot of this stuff personal. You know. I need someone that's actually living it, that understands the .. that they're taking care of everything too and that there's.. there's no bonus at the end of the week where you're going to go on a date and be loving and caring, blah, blah, blah.. There's just another week another day. And that's the hardest part. And when you have those.. like I said, happy moments where you're really connected and you can tell that he's not thinking about anything else, you don't want to let go, you know, and it almost makes you.. It's like you start fortune telling, oh it's not going to last very long so you

ruin the moment yourself. Sometimes I just need a hug. I feel that a lot. Yeah. I said I wish it were like AA's and I had a buddy. I need a hug tonight, how are you doing with your PTSD fool there? (laughing) Cause mine is pissing me off, you know, cause you know it's natural. He's human. (Tammy)

Although Denise is now divorced from her partner she still has a supportive role in his life as they share custody of their two children. Denise, similar to Sherry, expressed self-reliance in coping with her partner's PTSD

I was involved with the family resource center but it wasn't support. I stayed busy. I didn't go to a therapist. This is what life was. I didn't talk to my neighbour and say, hey, I'm having a really bad day. I mean the girls may sit outside and have glass of wine, that what we would do. You'd have a glass, go back in to your retreat, and do your own little thing, right? So it wasn't - you just moved on, you didn't - (Denise)

Natalie and her partner formed helping relationships with other people. Often, the people she cares for professionally are in need of some extra support, such as being taken to do errands or in need of some minor maintenance around their home. These are things her partner will do so he is able to be close to her while she is working. They do not have a social network of friends. She stated her family is not interested in hearing about her challenges. Natalie asserted that her family is not interested in hearing about her challenges. Her family feel they had enough dealing with their father's battle fatigue growing up and are not interested in hearing about her and her partners struggles, so she is on her own now. Natalie and her partner have created a life that revolves around the two of them alone.

Yeah, it's always been basically the two of us. I mean we have, a friend here, we're always helping her out feeding her and taking care of her. It's just one of those things where you take care of somebody and she was our next-door neighbour before we moved. But it's always been the two of us. Um, he's very friendly. I mean he'll stop and talk to anybody but he doesn't want them intruding into our space. It's a life sentence. Really, it's like having a handicapped child, are you going to keep the child or are you going to commit yourself to it. And it's a handicap. Like I said to - years ago, I said I - I think I understand what you are feeling. I said do you feel like you're sitting here talking to me but the real you are over there watching? He says, yeah. I said, and when you look in the mirror, there's not the image of you. I said, I'd love to have written a book: A mirror without an image. Because I think that would really describe it because you - you lost yourself. It's like a cancer of the personality. And people when they look at somebody with post traumatic stress say, well he looks normal. (Natalie)

Absence of Resources

Janet felt she had no support, either familial or social. When her husband left the marriage and Janet discovered his gambling addiction and the level of debt due to this addiction, she was devastated; subsequently she attempted suicide. She was then referred to a psychiatrist and has been receiving therapy. She was able to access this support due to her employment benefits, which entitled her to six sessions through her employee assistance plan.

I lost thirty pounds and I only had about ten to lose (laugh). Um, I was on tranquilizers every day and sleeping pills at night. And I was still working

because I had a job that if I don't work, I don't get paid. And, um, I just suck it up and carry on. And I had to feed our daughter so that was good because I'd have to- try to cover it up and act as normally as possible. I feel like I'm in - I feel like, um I've had very - very little, no support from the military other than I discovered, um, from the Family Resources Centre that, my daughter and I were entitled to some counseling, so we had six visits of counseling for the two of us. Um, but they only, they only provide the six sessions then you have to come up with something on your own. The military hung me out to dry. (Janet)

For Tammy and her partner, the lack of support turned out, in her opinion, to be a positive event.

We went through a time of abuse. Our neighbour called, it was probably a year a year and a half ago, the neighbour heard us fighting and she called the RCMP [Royal Canadian Mounted Police]. . It was the best thing anybody ever did for us. Cause we were yelling for help. Help us; we don't know what to do. And, Um, it was one hell of a way to get help for us because they march your partner who I know is sick, who had taken, um - he doesn't do well o some meds too which we didn't know, but he taken Ativan or something that doesn't work well with him and - he gets even more upset.

So anyways the police come into the home and they took him out, and of course - that was the first time I felt like someone understood - police, one of them had a military background and he took his meds. He let me talk and gather (partners) stuff up and he - and I thought for the first time that maybe now we were going to get - it was a relief even though it was - you know, now it's public, it's in the

newspaper, court report, blah, blah, blah, had to go through all of that. He had to leave for six months because we were investigated by Family and Children's Services, but you know what? They paid for our counseling. (Tammy)

Conclusion

What is evident from the stories of these women is the use of internal resources to make sense of and adjust to a new way of being in relationship with their partner. The changes in their partner's personality, as well as some of the destructive behaviors, put stress on the relationship and for one woman it resulted in an unsafe living environment for her and her children. For some, there were expressions of feeling inadequate which resulted in feeling guilt for not being able to correct or fix this situation.

None of the women expressed external supports as the place where they got their strength or support. All responded to the question of, Who supports you? with "Myself". The women often responded with emotion when talking about support or, in some instances, the lack of support. They appeared to be an appreciation of how alone they were on the road they were walking. For some, crisis occurred when their internal resources were unable to meet the demands placed upon them by the situation in which they found themselves.

Chapter 6: Discussion

Throughout my research into the experiences of the female partners of male military veterans diagnosed with PTSD, I sought insight into their everyday lives by posing the following questions: What meaning did these women ascribe to their experience? What coping strategies were utilized by the women to make sense of the everyday?

I paid particular attention to places where the women compromise and adjust their own needs to meet the needs of their partner and the family. My interest was in the telling of first person stories, in finding meaning in a situation that, according to the literature review, was challenging at best and catastrophic at worst. It was important to document the voices of the women on the front lines of this issue and hear what they have to say about how they are coping and finding meaning in their day-to-day lives in order to achieve a deeper understanding of this phenomenon.

What I heard were stories of varying degrees of hardship and struggle. In fact, the stories did not present the level of hope and resilience I had expected to uncover. Many of the women spoke about the absence of understanding on the part of family and friends. More pointedly, they spoke of the military system's failure to meet their needs and those of their partner, specifically, fighting to receive the disability pension they believed they were entitled to collect. This conflict with the very system that was supposed to protect their interests increased the hardship on the family unit, especially for the female partner. Financial need often forced the female partner to become the sole provider for the family unit. Although the focus of this study was not the primary sufferer, it is important to note that the interim ombudsman for the Department of National Defence reported military

members who suffer with operational stress injuries are not being diagnosed, or getting adequate treatment that allows them to continue to be contributing members of Canadian society (McFadyen, 2008).

I will present five summative statements as a way to pull together the themes brought to light in Chapter 5. Then I will discuss my observations using the interpretive/constructivist lens in a search for understanding. I will also explore the meaning of the stories and the themes that emerged using the frameworks of the ABC/X and circumplex models. To review the ABC/X model (Hill, 1949), 'A' is the event or the stressor. For these families, it is the onset of the military member's PTSD symptoms, not the diagnosis that is the central stressor, since the diagnosis for many veterans did not occur until many years after the onset of symptoms. 'B' is the interpretation of this event. What meaning, if any, did the partner ascribe to this event? 'C' represents resources the woman has available to meet the needs this event has brought forth. 'X' is the crisis that occurred when resources were not sufficient to meet the needs of the woman and her family. For some, this crisis was profound and resulted in the dissolution of the family unit. For others, it became a new way of functioning that includes daily monitoring of external stimuli and symptoms.

Using the circumplex model (Olson, 2000), I explored the intersections where the partner adjusted and accommodated by becoming more cohesive in an attempt to maintain a new normal, a new level of functioning. I also examined where the partner relationship fractured and fell apart due to the lack of coping strategies and or the lack of internal and external resources.

Summative Statements

Redefining the relationship

The couples were required to redefine their relationship in light of the challenge they face. The women who took part in this study expressed how the relationship with their partner changed, once he had experienced the traumatic injury. Caring for someone with a traumatic injury has a cost (Figley, 1995). Many women found themselves struggling to come to terms with a new way of being in relationship. A partner who has always been 'the life of the party', no longer wanted to leave the house. Other veterans engaged in addictive behaviours that isolated them from their partners. Some men who had no history of violent behaviour began to have dangerous outbursts. Men, who had been proud members of a military unit, were no longer able to go to work, felt too ashamed that they were injured, and too ashamed to seek help. Others were afraid that seeking help would mean losing employment. Both examples led to isolation for the couple and, for some, isolated the individuals in the relationship. These changes in the relationship took place for some over a period of time, increasing the stress on the family and how it functioned, prior to the onset on symptoms. In the beginning stages, the women questioned what was happening: why had their partners behavior changed so dramatically? They made excuses in an attempt to rationalize his behaviour such as: he must be stressed about work or he's tired or that's just him being 'crazy'. This interpretation of the events led to accommodating behaviours by the female partner, in the hope that he would return to his 'usual self'. For short periods of time, denial may be used as a resource (Hill, 1949). The struggle for these women became to redefine the dyadic relationship into a workable stable one in light of their partners traumatic event

(Gilbert, 1998). At this stage none of the women were aware of how much their life was about to change and to what extent they would need to adapt their way of functioning to maintain the family unit.

In some instances, the veteran was released or pushed out of the military due to his symptoms, as he was no longer able to carry out his duties. The women in these families who had stayed at home to manage the house while the veteran was deployed were now required to seek employment to support the family. Some of these women had never worked outside of the home and found this a difficult adjustment. They found they were no longer able to rely on the veteran to be present in the relationship or as a helpmate in the household; this created feelings of frustration, which resulted in further isolation.

The women expressing the loss of what had been their life prior to the onset of symptoms held the most resonance. Boss (1987) refers to this phenomenon as ambiguous loss, referring to the person who is physically present but psychologically absent or altered. They spoke of the loss of the person they had loved and the loss of the imagined future to be shared with a partner who reciprocated the love and caring they felt and gave. For all, this was now only a memory. One woman spoke of how the process of adapting to PTSD was like coming to love another person who looked like the partner she had married. Another woman spoke of her hope the person she remembered and loved would make his way back to her. It was difficult to hear the story of the woman who dreamt of leaving and finding a new life, but felt obligated to stay and care for her partner who was struggling with both a mental injury and a debilitating physical one. This overcaring is of concern due to the potential onset of the loss of the self (Learner, 1988) but the

possibility of the complications associated with a secondary traumatic stress disorder (Figley, 1998). A number of the women compared the care they were asked to provide and the adjusting they were required to make to caring for a child with special needs. The women all expressed a great sense of loss; ambiguous loss was a difficult emotion for these women who struggled with feeling guilty for wanting things to go back to the way they were. For all of the women taking part in this study, there was an acknowledgement that life, as they had known it, had changed forever. The relationship they had with their partner was forever redefined and few were aware of the level of grief this created.

Accommodation

Accommodating became a way of functioning for these women as they struggle to find a new normal in their daily lives. Many participants spoke of the changes in the intimate relationship, leaving them feeling even more isolated and alone. In certain situations, the partner retreated into his room for days on end, leaving her responsible for all the family care giving and the daily organization of the family. A troublesome aspect to the level of accommodation taking place is the presence of hyper vigilance that became a part of the daily management of the household. As often the women took on the responsibility of her partner's well being in addition to caring for the children and herself. (Lyons, 1999).

The home environment needed to be carefully managed. The children could not be too loud or bring friends over because no one knew how the veteran would present himself. These women spoke of being on guard at all times. There had to be a constant monitoring of the environment, to watch for possible triggers, because they never knew when a flashback or an anxiety attack might manifest. The television had to be carefully

supervised, to be sure no provocative images float across the screen, if they do, the channel is changed quickly and a distraction statement used to alter the focus and hopefully avoid any symptoms. Food preparation was another activity that was entered into carefully because it could also bring about unwanted images.

The women reported becoming hyper vigilant in regard to external stimuli. Stories of family outings where the female partner would go to the location ahead of time to pick out a safe place to sit were not uncommon. Safe was defined as not too open or too confined, in view of the doors, not too crowded, and there must always be an exit strategy, in case of some unforeseen situation. This controlling behavior is engaged in an attempt to reduce the chaos created by the symptoms of PTSD (Figley, 1995). Being away from home where it is not as easy to control the environment created other challenges. Many expressed feelings of stress and guilt around not being able to control all of the contributing factors in dealing with this situation. When they are at work they are concerned about what is happening at home; when they are home, they are over whelmed by the expectations they place on themselves around household management and childcare, in addition to caring for the veteran. All of the women expressed their own struggles with depressive thoughts and feelings. This created additional stress and in some cases acted as an accelerant in an already volatile family dynamic. One incident resulted in a crisis, where the police were required to intervene. Another family just disintegrated under the pressure and their inability to adapt.

The women chose to enter into this accommodation for different reasons: some for the love they felt for who their partner had been and the desire to maintain a cohesive relationship, and others felt it was their duty. The resources utilized here to make these

accommodations are internal and require a de-selfing (Lerner, 1998). The women over invest in the relationship (Figley, 1995) and put their own needs on hold in order to meet the needs of their partner and family. They now managed their life around their husbands PTSD. Many spoke of lost dreams for the future they had imagined for themselves and their partner. The most significant compromise was where the women actually chose to relinquish personal hopes and needs by staying in a relationship, which required self-denial.

According to Figley (1995), the most important aspect in achieving the male partner's recovery is his female partner being able to maintain a sense of self and strong personal boundaries. Therefore the question brought to light by the level of accommodating and adjusting by the female partner is: Does this accommodating and adjusting behaviour actually enable the veteran to stay in his symptoms and not require his stretching himself to reach a higher level of wellness?

The struggle for balance

With all of the changes brought about by the redefinition in the relationship and the level of accommodation the women struggled to find balance in their lives, not always successfully. For some the dramatic change in their partner's personality and functioning, prior to deployment and upon returning home caused them to doubt themselves and their judgment. For others the change was more gradual with an accumulation of symptoms and triggers. One woman, who had a parent who lived with PTSD, recognized the onset of symptoms for what they were: a life-altering event. Functioning from a place of hyper vigilance led these women to anticipate their partner's reaction to certain stimuli, imagined or real (Lyons, 1999, Figley, 1998). The symptoms

and challenges were often spoken about in the first person, as though cohesion had created another personality. For example: We have been struggling to receive a proper diagnosis and recognition of the PTSD. The women also spoke of becoming sensitive to the same stimuli that their partner would react to, anticipating his reaction had created in them the same response. This manifestation of secondary trauma led many of the participants to require treatment for anxiety and depression. Questions around whether this is in response to becoming hyper vigilant have been posed by many of the researchers in this field (Bloom, 1995; Figley, 1995; Lyons, 2001).

Many of the women were conversant with some degree of hardship: they had endured and managed the households during lengthy deployments, frequent moves and being second after the military system. They had adjusted and adapted to the needs of the military that was required as a part of being the partner of a military member. However, none felt they were prepared for what came about with the symptoms presented by PTSD. All of the women expressed the awareness of great change in their partnership and their family functioning.

What became evident in the interviews was the fact that these women were 'military wives' who had become proficient at putting the needs of the military system and their partner ahead of their own, a seemingly necessary part of being a military partner (Harrison & Laliberte, 1994; Norris, 2001). Many expressed a sense of duty to their husband as he struggled with his symptoms and attempted to regain equilibrium. Some entered into collusion with their partner in an attempt to keep his symptoms a secret; all this in order to retain his employment status. Every participant felt a great pride in the service their partner had given to the military and the country, and felt their partner

should be viewed a hero. Even the woman, who left the marriage relationship due to her partner's violent outbursts, felt he was wounded in an act of great bravery and deserved better treatment by the military system and society as a whole. All of the participants had felt the sting of the stigma around psychological illnesses, from not only military peers but from family and friends. Some of the women entered into therapy independently in an attempt to reclaim themselves and come to terms with the depressive thoughts and moods. Others seemed oblivious of the enmeshed boundaries and appeared content to struggle with their partner as one. These families created a new normal and appeared to stay at the level of functioning they had come to during the onset of symptoms and had never gone back to the previous patterns. For some many years of this kind of behaviour had transpired: Would some form of family therapy around family functioning and accommodation be helpful and aid in coming to a more even level of functioning?

Redefining resilience

Resilience is defined as: the capacity of a strained body to recover its size and shape quickly after deformation caused especially compressive stress; an ability to recover quickly from or adjust easily to misfortune or change. (Merriam-Webster Dictionary, 2009). The participating families did not present this exact definition. There was no quick recovery or easy adjustment. However, I would argue they manifested a different kind of resilience. These families were not able to overcome the challenge they were facing instead it became a part of who they were and how they defined themselves. They had an innate ability to adjust and adapt in order to meet the needs of the veteran. Maybe this innate ability was fostered by the years of military service, the adjusting and adapting required of the family, by the military system in order to function around

lengthy deployments and frequent postings (Norris & Dunn, 2005). Even if the intimate relationship was not able to stay intact, all but one couple remained supportive and in a reported positive relationship.

The women spoke of feeling isolated and alone in dealing with the day-to-day needs of this situation, and yet they continued. In the beginning these women blamed themselves for their partner's symptoms; they felt they should be able to control the environment enough so he would not have an outburst, or that they may have done something to precipitate the behaviour. Lyons (2001) expressed this as a common occurrence and speculated that this belief added to the challenge of asking for outside support. When asked the question: Who supports you? all of the women reflected that they received support from their own internal source first; few were able to say a friend or family member offered support. These women appeared to go within themselves and find an inner strength they did not know they possessed. Some spoke of taking it one step at a time dealing only with what was necessary at that particular moment. Others spoke of lowering personal standards around the care of the house and their own being. One woman, who from first appearances was the most enmeshed with her partner, said her daily practice of time alone reading and writing was what enabled her to continue to deal with her partner and not lose her sense of self; which seemed to be a contradiction to the rest of her interview. The only woman who had been invited to take part in a peer support group was able to say the military had been a resource. All the others felt they and their partners had been abandoned by the military system and by society on the whole. They were changed forever, and some would now deal with the complications of secondary trauma and hyper vigilance. Yet these women were able to navigate a difficult time and

survive, although they had not returned to the level or same functioning as prior to their partners' injury they were finding a new normal.

Military Response

If the veteran was still in active duty when the onset of symptoms occurred, the stress was intensified as the military is still struggling with the stigma of stress-related injuries. Ombudsman investigators found myths and stereotypes associated with post-traumatic stress disorder and other operational stress injuries remain a real problem. In fact, mental health caregivers from virtually every military establishment in Canada raised the issue of stigma as one of the biggest challenges facing the Canadian Forces (McFadyen, 2008).

For the families who were attempting to remain in active duty even after the symptoms of PTSD began to manifest, secrecy and collusion became a way of life. This intensified the stress response of the female partner, who found she must not only manage the household, but also keep all possible triggers to a minimum, while not sharing with her peers. For one couple, the threat of the potential loss of employment manifested in her words "a house full of secrecy". This same response was seen in the struggles with the stigma from family and co workers who thought of mental illness as a weakness, often referred to as "if you are not over there (deployed) you must sick, lame or lazy". When secrecy is the case, accessing outside resources was out of the question.

Some who had left the military before receiving a formal diagnosis were left with no medical pension and were required to litigate in order to achieve proper compensation. This again added stress to an already stressful situation. The struggle for pension recognition appeared to provide a common enemy, which seemed to have a positive

cohesive effect in the relationship. Although having a diagnosis did not bring any great onset of support, the women did feel empowered by having a name to give to the collection of behaviors many were afraid they were exaggerating. One partner, who had to leave the relationship due to safety issues for herself and her children, expressed relief at her partner's formal diagnosis. Diagnosis appeared to be a positive occurrence in the interpretation of the event. Moving the blame from the family to an individual or an external stimulus that was beyond the control of the individuals involved, provided some relief.

What became obvious in hearing the stories of these women's lives was treatment for PTSD is not a panacea. There is no recovery. Access to support and services is dependant on where you live and if you have recognition by the military of the operational stress or PTSD injury. The ombudsman reported that depending on where you live affected the timeliness of mental health care as well as the quality of care offered by the military establishment (McFadyen, 2008). Treatment protocol consists of the veteran learning coping strategies to manage his symptoms as well as he is able. Once he has achieved the level of wellness he enters into what is referred to as the maintenance phase, the majority of the symptom management, however, appears to fall to the female partner.

Resources in the form of support as expressed earlier in this study appeared to be internal on the part of the female partners. One participant was able to take part in a support group offered for the peers of women whose partner was diagnosed with PTSD. However most of the women did not know there was such a group and spoke of feeling isolated and alone in dealing with the day-to-day needs of this situation. Given that the

resources (Hill, 1949) and the part of the female partner in managing illness (Figley, 1995) are fundamental in the goal of a higher functioning and wellness on the part of the veteran this appears to be a great deficit.

When a Canadian Forces member has a stress injury, it is a significant challenge for the whole family, not just the member. Given the sacrifices that military families make for their loved ones and their country, the Canadian Forces has a moral responsibility to ensure that they, too, have access to appropriate health care in order to support an injured military loved one. (McFadyen, 2008)

Although McFadyen is speaking about active members and their families it is easy to extend this sentiment to those who are no longer able to serve due to their traumatic injury.

ABC/X and Circumplex Model

In viewing the stories of these women using the ABC/X and circumplex models, it becomes evident that these are families whose continued healthy functioning is challenged. With 'A', being the onset of symptoms, in their interpretation 'B' participants claimed that everything changed. This is evidenced by the places where the women were able to adapt and adjust and make use of internal resources (C). This was done to maintain family functioning avoid possible crises (X). Achieving this is reflective of a high cohesion model of functioning (Lavee & Olson, 1991). According to the circumplex model this level of enmeshment, made the women so highly adaptable it lead to their de-selfing (Lerner, 1988) and creating a chaotic family system, potentially resulting in the female partner accommodating and becoming excessively cohesive with the veteran (Lavee & Olson, 1991). Some women found meaning in this struggle to navigate this

situation to the point that, for some, their identity was attached to this struggle. This is seen in the stories where the veteran's symptoms and challenges are spoken about in the first person as though the female partner is the primary sufferer of PTSD. Conversely, this level of cohesion is also, according to some literature, the way in which healthy families are able to maintain functioning in the face of a challenge (Lavee, McCubbin, & Olson, 1987). For example, the female partner stood by her veteran, seeing he was wronged and in some cases became the advocate he needed to achieve compensation. Although there was an increase in stress, the adaptation of the female partner created an opportunity for a re-balancing of the relationship (Olson, 2000). In these cases, it is the female partner adjusting her needs to accommodate those of her partner and the utilization of her internal resources, which enabled the couples to remain flexible/connected. However, as the veteran often reacted by becoming more rigid, all of the accommodating and adjusting was on the female partner's side. For one couple, the low adaptability and rigidity of the family system did not allow for the accommodation the female partner desired and ultimately led to the veteran entering into a destructive addictive phase and the dissolution of the relationship. The question arises are all of the adaptation and the over responsible and overfunctioning behaviours by the female partners leaving them open to develop secondary traumatic stress (Gilbert, 1998)?

Summary

Both the ABC/X and the circumplex models speak of the need for internal and external resources in the face of extraordinary challenges. Hill, (1949) stated the importance of the interpretation, the family gives to these stressors being foundational in the avoidance of crisis. In this study one main resource these families had was the ability

of the female partner to adjust her needs and adapt to meet the needs of the veteran and the family. However, from the outside these families are functioning to the best of their ability, with limited financial and social resources. It would appear in the light of this that they should be commended for being able to remain functional at all. From a family studies perspective there are long term implications and questions for study around for personal and family well being. Families need to be taught new ways of functioning and be given ways of thinking and interaction to aid in the recovery and sustainability of a healthy family unit (Gilbert, 1998).

From a personal perspective living with a family member who has PTSD is a daily struggle between meeting their needs and the needs of the family. This field is understudied and has implications for many aspects of family support. Not only for families with members diagnosed with PTSD, but with any life altering diagnosis. There is an expectation the family will step in as care giver and support person, often with no training and little understanding of what to expect or anticipate. This is an intolerable situation and requires immediate attention or we are going to have a population of burnout care givers who were pressed into that role without anyone their permission.

Limitations

Being limited by the scope of a Masters thesis only seven participants were interviewed for this study. A larger sample may bring to light a broader perspective. Although the focus of this study was to hear first voice accounts of the female partners of male veterans diagnosed with PTSD, this created limitations on the data retrieved. Only hearing the women's stories was hearing one side of the equation. The veteran's side of the story would add a richer understanding of where and when he was aware of the

adjusting and accommodating that took place. Also, the whole of the family may have insights the woman herself was not able to bring to the discussion. There were no male partners of female veterans with PTSD interviewed for this study, which would add another point of interest. If male partners accommodated and adjusted in different ways than the female partners it would be significant to explore the gender differences. Due to the limitations to access through the military system no active members of the military or their partners were interviewed. This may have produced a model with a more evident traditional resilience, especially, if the member was able to remain in active duty. A study of locations where availability of resources varied may have produced different results.

Although, Halifax has a trauma treatment facility many of the partners I interviewed were not aware of that resource. Interviewing women who took part in these support groups may have altered the findings. There may have been more evidence of peer support and a richer understanding of the challenges of PTSD and family functioning.

Recommendations

This research project brought to light many questions that I have no answers for. First and foremost to me is the need to determine of how many CF members are suffering with operational stress injuries and PTSD. At present there is no national body or officer charged with ensuring that these CF members, veterans and their families are cared for. Through this study I heard many alarming stories of families and veterans who are lost in a struggle for recognition of the service they gave and the injuries that ensued during that service. Many are falling through the cracks and not receiving the care they require; the Canadian Forces needs to address this deficit (McFadyen, 2008). Also, the stigma

attached to psychological injuries must be addressed in a more aggressive manner; many families are facing hardship brought on by the soldier's service to this country and its people, only to be abandoned with no support. The ombudsman acknowledged that we have a moral obligation to the families who have given so much in the service for their country (McFadyen, 2008).

Avenues of prevention need to be investigated. There needs to be training in recognizing the symptoms, at the first onset, in order for them not become as entrenched, and therefore infiltrate into the family system. The families also need to be supported in developing awareness of the signs and symptoms of PTSD. Neither of these initiatives will be accomplished if the family is in fear of the losing position and employment if the illness comes to light and support sought. Families need to be aware of the supports that are in place for them and the stigma associated with seeking support must be eradicated. Most importantly, these families must be allowed to express what it is they require, as each family will find its own way through the challenges of PTSD. For some, there may be a need for help with childcare or respite, for others it may be the intervention of family therapy to learn strategies for maintaining healthy boundaries and relationships. Each family must be enabled to express what they need and have that need met. A grief process for these families needs to be developed in order to enable them to acknowledge what and whom they have lost. In doing so, they will be given the resources to embrace the "new normal" in which they now find themselves.

Future Research

Future research into this phenomenon is ongoing. Some of the areas where I see a need are: What is the military protocol in the situation of a psychological injury and what

is the actual experience of the member or the veteran diagnosed with an operational stress injury? Exploring the experience of active military members, how they are able to manage their symptoms? How are their families functioning? The partners of women who have a psychological injury need to be researched as well as the female military members themselves. I uncovered no research that explored the perspective of women veterans with PTSD or their partners or the experience of same sex couples. The experience of the divorced or separated partners of male veterans or soldiers with PTSD would bring other topics to light. Also, an investigation into the experience of ambiguous loss and may be helpful in coming up with strategies for others dealing with this challenge.

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Appendix A: Interview Guide Interview Guide

1. Participants name.
2. Date of Birth
3. How long have you lived with the military member?
4. Do you have children?
5. How many/ages?
6. How long did or has your partner serve (d) in the military?
7. What is the nature of your partner's work? (Probe: What does his work involve, deployment to hot spots for peace making.)
8. Describe your partner's diagnoses with PTSD.
9. Is he presently in treatment? What has been the impact of the treatment?
10. Did the diagnosis have an affect on you?
11. Has your daily routine changed? In what way? (Probe: For example childcare, or other daily responsibilities.)
12. Have your social relationships changed? Do you still have the same routine with friends and family?
13. Who supports you? (What are the internal and external resources are available)
probe: family, friends, military family services.
14. What does this support mean to you?
15. What have you learned about your support system(s)?
16. Have you or would you availed yourself of the treatment offered through the trauma treatment center or other services?
17. If yes, what was that experience like for you?

18. What have you found to be most helpful for you?
19. What have you learned about yourself? eg. I am stronger than I thought I was.
20. Is there anything else you feel I should know, or that you would like to tell me?

Appendix B: Informed Consent

MSVU Letterhead
Informed Consent

Title of Study: The experiences of the female partners of Canadian military members who have been diagnosed with post traumatic stress disorder (PTSD).

Sandra Pickrell Baker

I am a graduate student at the Department of Family Studies and Gerontology at Mount Saint Vincent University. As a part of my Master of Family Studies and Gerontology thesis, I am conducting research under the supervision of Dr. Deborah Norris, and I am inviting you to participate in my study entitled: The experiences of the female partners of Canadian military members who have been diagnosed with post traumatic stress disorder (PTSD). The purpose of this study is to document and gain further understanding of how the female partners of Canadian military members are managing this phenomenon.

This study involves interviewing 8 -10 female partners of male military members who have been diagnosed with PTSD. Each interview will take place at a location of the participants choosing. The interview will last approximately two hours. Participants will be interviewed (one time) and the interview will be recorded and transcribed with the participant's permission. During the interview if you become uncomfortable with the questions or any part of the process you can stop the interview and reschedule or withdraw from the study completely. Your participation in this study is completely voluntary. You may withdraw from this study at any time without penalty.

Confidentiality will be maintained at all times. The person who transcribes the interviews and myself, along with my thesis advisor will be the only persons to listen to the tape recordings. The tapes and transcriptions will be secured in a locked filing cabinet in my home. As well, any computer data will be password protected and all identifying information such as name and address will be coded for my use only. Confidentiality will be maintained through the use of pseudonyms. In addition, any potentially identifying information in the interview will be altered, such as the rank of the partner or employment status. Upon completion of the study all tapes and identifying data will be destroyed.

If you have any questions about this study, please contact:

Sandra Pickrell Baker
902-401-7936
spb@accesswave.ca

And

Dr. Deborah Norris
902-457-6100
deborah.norris@msvu.ca

This research activity has met the ethical standards of the University Research and Ethics Board at Mount Saint Vincent University. If you have any questions or concerns about this study and wish to speak with someone who is not directly involved with this study, you may contact the University Research Ethics Board, by phone at 902-457-6350 or by e-mail at research@msvu.ca.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study.

Participant's signature

Date

Researcher's signature

Date

One signed copy to be kept by the researcher, one signed copy to the participant