The Experience of Wives/Female Companions of Aging Vietnam Veterans With Chronic Posttraumatic Stress Disorder: A Qualitative Replication Study

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Dedications

This dissertation is dedicated to my husband, Boatswain Mate Chief James L. Richardson, (United States Navy, retired) who proudly served his country serving two tours in the Vietnam War, for his support and assistance in this educational endeavor, and to my children, Stephanie A. Richardson and James G. Richardson. This is also dedicated to the strong, independent and determined women of my family, my mother Mary C. Benninger and my aunt, Mary E. Binninger. And lastly to friends, teachers, mentors and colleagues who have assisted me in this educational journey, especially Ann Townsend DrNP who was my guiding light and inspiration.

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Abstract

The Experience of Wives/Female Companions of Aging Vietnam Veterans With Chronic Posttraumatic Stress Disorder: A Qualitative Replication Study

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A plethora of information exists regarding Posttraumatic Stress Disorder (PTSD) in Vietnam veterans. What has not been exclusively researched is the effect of this illness on the aging wives and female companions of these veterans. The purpose of this phenomenologic qualitative replication study was to describe the experiences of wives and female companions living with aging Vietnam veterans with chronic PTSD and to compare/contrast findings to the 2001 parent study conducted by Lyons. A purposive sample of wives/female companions living with aging Vietnam veterans with chronic PTSD was recruited from various geographical areas of the United States using snowball sampling, recruitment flyers and direct contact. The 10 participants ranged in age from mid-fifties to the late sixties and had been in a cohabitating relationship with aging Vietnam veterans diagnosed with PTSD for more than six months over the last fifteen years. The data collection approach for this phenomenological study used semi-structured interview questions, with four participants interviewed in person and the remaining six participants interviewed by telephone; all interviews were audio recorded. Participants were also asked to complete a demographic questionnaire and the Cohen perceived stress scale, which measured the level of perceived stress within the past month. Data was analyzed using Colaizzi's systematic method and the qualitative analytical program Nvivo 10 was used to code data and extract themes. Themes that emerged were

similar to the findings of Lyons and a fourth phase was added that was termed the epilogue.

Chapter 1: Introduction

What determines the cost of war? Is it reflected monetarily or via the toll it has taken on those who served in the war arena? For some, war does not end when the combat stops; as returning heroes, veterans affected with Posttraumatic Stress Disorder (PTSD) face an ongoing battle with this disorder that may represent a lifetime of pain, suffering and anguish. Thus, the cost and casualties of war extend far beyond the war zones and battlefields and into the personal lives of veterans and their families. Wives/female companions of Vietnam veterans with chronic PTSD may become enmeshed in the PTSD pathology and express a secondary form of PTSD (Lyons, 2001). Few studies have examined the experiences of wives/female companions living with an aging Vietnam veteran with chronic PTSD. However, one study by Lyons has explored what it was like for wives/female partners to live with Vietnam veterans with PTSD. Lyons identified three relationship phases where specific themes emerged during each phase. The early phase, known as the adjustment period, was characterized as a "honeymoon phase" (p.72), where feelings experienced during this time were similar to a honeymoon period. In the middle phase or enmeshment period, the wives/female companions came to the realization that PTSD symptomology was a pervasive factor in all aspects of their relationship. In this phase, physical and emotional abuse emerged as a major theme. Lastly, in the later phase of "resolution and healing" the wives/female companions experienced stress symptoms similar to PTSD pathology and ultimately decided to maintain or terminate their relationship (Lyons, 2001, p.74). The central theme that emerged from Lyon's study was that the wives/female partners moved through these

phases towards resolution and healing, while minimizing the impact of PTSD on self and family.

Subsequent to Lyon's research, limited studies on the effects of wives/female companions of Vietnam veterans with PTSD have been completed. In view of this underrepresentation of aging woman in long-term relationships, a knowledge gap exists with respect to the meaning of what it is like for wives/female companions who live in a long-term relationship with an aging Vietnam veteran who suffers from chronic PTSD. Thirteen years have elapsed since the publication of the original study. This qualitative replication study will seek to compare/contrast findings to the 2001 parent study conducted by Lyons. Although this study replicated a similar cohort of dyads, many of the participants have now reached their mid to late sixties, and thus reflects an aging dyad that was less pronounced in Lyons' study. Qualitative replication studies are not common in the nursing literature (Polit & Beck, 2008) and so this study seeks to not only advance knowledge about aging Vietnam Veteran couples who are living with chronic PTSD, but also to add to the body of literature on the methodological challenges of qualitative replication studies.

Background

Historically, the psychological effects of war on servicemen and women were rarely acknowledged as a mental disorder. The physical injuries that were realized for centuries as a consequence of battle, but a change in the mental and emotional state was rarely acknowledged by the injured serviceperson or the medical community. It was not until 1980 that PTSD was officially recognized as a psychiatric disorder/diagnosis by the

medical and psychiatric community and placed in the Diagnostic and Statistical Manual III (DSM, III), Freidman (2013).

Although it is difficult to put a price on the personal cost of war, there has been an exponential rise in the funds allocated for disabled. Historically, providing care for war veterans increases for several decades and peaks 30 to 40 years or more after a conflict. Due to the earlier recognition of service-related disabilities, it is estimated that the cost of care for Operation Iraqi Freedom veterans over the next 40 years may range from 600 billion to 1 trillion dollars (Bilmes, 2011). Additionally, the socioeconomic impact of war may affect the veteran's family, as employed spouses or parents relinquish their paid employment positions to care for the veteran (Calhoun, et al., 2002).

During the Vietnam War (August 5, 1965 through May 5, 1975), there were 9,087,000 military personnel who served on active duty (Vietnam War Statistics, 2013). Currently, there are 7.6 million aging Vietnam veterans living in the United States (U.S.Veteran Population, 2000) many of who suffer physically, emotionally, and socially from chronic PTSD. According to the National Vietnam Veterans' Readjustment Study (NVVRS), the lifetime prevalence of PTSD symptoms among male Vietnam veterans is estimated at 30.9% (Price, 2010). As many of these aging veterans advance into their seventh decade of life, each is at risk to become one of the million lifetime cases to suffer from chronic PTSD or develop late onset PTSD (Albrecht, 2010; Calhoun, Beckham & Bosworth, 2002). The general symptoms of PTSD that follow a traumatic event are flashbacks of the trauma, avoidance of events that are reminders of the trauma, and a chronic hyper-arousal state (Bobo & Warner 2007). PTSD can be defined along a temporal continuum of symptom onset. Initial exposure to a combat stressor is followed

by an acute stress reaction (ASR) that does not resolve within four days (VA/DOD Clinical Practice Guideline For Management of Post-Traumatic Stress, October, 2010) versus Progression to Acute Stress Disorder (ASD) occurs when symptoms such as numbness and detachment lasts more than two days but less than one month. PTSD occurs when the symptoms of increased arousal, trauma re-experiencing and situational avoidance have lasted longer than one month (acute PTSD), greater than three months (chronic), or have a delayed onset (greater than or equal to six months) (Viewag et al, 2006).

PTSD is associated with significant co-morbidities and a myriad of health complaints, such as alcoholism (39.2%), drug abuse/dependence (5.7%), and tobacco abuse/dependence (National Center for PTSD, 2012). Additionally, high rates of divorce (40%), marital difficulties (14.1%), parenting problems, and homelessness have been reported in this group (U.S. Department of Veteran Affairs Fact Sheet). As suggested by these figures, research has indicated that mental illness has detrimental effects on those who care for affected individuals. Specifically, family members of individuals with depression, schizophrenia, and PTSD have been shown to report caregiver burden and poor psychological adjustment (Calhoun, et al., 2002; Manguno et al., 2007). Other studies have found that wives/female companions of PTSD sufferers experience distress as a result of a disruption in the family environment due to anger, violence, a lack of shared family/marital responsibilities, and may experience a secondary form of PTSD (Frederikson, Chamberlain & Long 1996). Therefore, a knowledge gap exists with respect to the meaning of what it is like for women/female companions who live in a long-term relationship with an aging Vietnam veteran who suffers from chronic PTSD.

This knowledge gap has precluded recognition, treatment, and psychosocial support for wives/female companions of aging Vietnam veterans with chronic PTSD. An understanding of this phenomenon of living with an aging Vietnam veteran may enhance stability within the relationship dyad and may alter family dynamics (Lyons, 2001). Information gained from this study may benefit the wives/female companions of veterans of past conflicts, as well as those returning from current conflicts.

As Vietnam veterans are reaching retirement age, the Veterans Administration hospitals have noted a significant increase in the number of veterans seeking care for medical conditions and PTSD (Somes, 2013). The number of veterans seeking treatment has increased from 272,000 in 2006 to 476,000 in 2012, more than half of the new cases served in prior wars (Somes). Life changes and looming retirement trigger delayed stress reactions hence the increase of cases at VA hospitals (Somes).

The goal of this qualitative replication study was to describe the experience of living with an aging Vietnam veteran with chronic PTSD as narrated through the personal reflections and stories of their wives/female companions. The long-term goal was to understand the secondary effects of prolonged exposure on women who live with aging Vietnam with chronic PTSD, thereby promoting health through effective coping. The objective of this study was to bridge the knowledge gap that exists as to what it is like for wives/female companions who live in a long-term relationship with an aging Vietnam veteran who suffers from chronic PTSD.

Purpose

The purpose of this study was to describe the experiences of wives/female companions living with aging Vietnam veterans who suffer from chronic post-traumatic stress disorder using a phenomenological methodology and to compare/contrast findings to the 2001 parent study conducted by Lyons. This research replicated a qualitative study by Lyons (2001) titled "Living with Post-traumatic Stress Disorder: The Wives'/Female Companions' Perspective". The present study applied Lyon's research in the context of the aging process of the wives and female companions and the chronicity of PTSD symptoms in the aging Vietnam veteran. Since Lyon's study, the wives, female companions, and veterans are more than a decade older, thus this replication study will not only contribute to the original research findings, but also add to the body of knowledge on the aging adult. Additionally, since Lyon's study), there has been limited research on the wives'/female companions' perspectives despite the fact that there is an increased number of aging Vietnam veterans diagnosed with chronic PTSD. In replicating Lyon's study, this current research employed an operational replication format, yet utilized a different method of data analysis. Operational replication duplicates the sampling process and data collection of the original study but utilizes a different method of analysis to substantiate or disprove the reliability and validity of the original findings (Gould, 2002) Although both studies were descriptive phenomenological approaches that were designed to uncover aspects of phenomenon never conceptualized or incompletely conceptualized in previous research, the present study validated themes and established trustworthiness through methods that included a return to participants to incorporate feedback. Through the shared experiences of these women, ongoing research has the

capability to influence health policies that improve mental health services for veterans and their dependents. This research has global significance since the subsequent conflicts in Iraq and Afghanistan have contributed to an escalating number of veterans with mental health disorders, such as PTSD and major depression, who are returning home to their wives and families. Interestingly, today's war wounded are surviving injuries they would have succumbed to in Vietnam, and so an additional number of surviving injured soldiers are presenting with PTSD alongside their often horrific injuries that they will now live with for the rest of their lives (News 21, 2013).

Research Question

The research question central to this phenomenological inquiry is: What is the experience of wives/female companions living with aging Vietnam veterans with chronic post-traumatic stress disorder?

The specific aims of this phenomenological inquiry are:

1. To explore the meaning of wives/female companions experiences when living with aging Vietnam veterans who chronically suffer with PTSD.
2. To understand the effects of long-term exposure to PTSD symptomatology in wives/female companions living with aging Vietnam veterans and to explore the impact of this long-term exposure on family relationships.
3. To make direct comparisons and contrasts to the parent study by Lyons and to increase the level of evidence on the topic of the effects of PTSD, on wives/female companions.

Definition of Terms

American Psychiatric Association (APA). The national medical specialty society of

physicians who focus on the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders (APA, 2014).

Diagnostic and Statistical Manual of Mental Disorders (DSM). A manual used by clinicians and researchers to diagnose and classify mental disorders (APA, 2015).

Dyads of Analysis for this study. The couples in this study were married couples that have lived together at least six months in the last 15 years. The husband must have served in Vietnam during the Vietnam War era and must be diagnosed with chronic Post Traumatic Stress Disorder.

Post Traumatic Stress Disorder (PTSD):

PTSD DSM -5. Posttraumatic stress disorder is a psychiatric disorder that can occur in people who have experienced (directly or indirectly) or "witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or other violent personal assault. PTSD is a real illness that causes real suffering" (American Psychiatric Association, 2015).

PTSD DSM IV-TR. Posttraumatic stress disorder (PTSD) is an anxiety disorder that can occur when an individual has a history of exposure to a traumatic event. In order to meet the criteria for a diagnosis of PTSD, one must experience a traumatic stressor, "and meet two criteria from each of three symptom clusters: intrusive recollections, numbing/avoidance and hyper-arousal symptoms" (http://DSM-IV-TR-criteria for PTSD –NATIONAL CENTER for PTSD).

PTSD DSM IV. "Posttraumatic stress disorder (PTSD) as defined by the DSM-IV as an anxiety disorder that can occur when an individual has witnessed or experienced a traumatic event. In order to meet the criteria for a diagnosis of PTSD, one must

experience a traumatic stressor, which is accompanied by re-experiencing, numbing/avoidance and hyper-arousal symptoms" (http://apa practice central.org/update/2012/09-13/ptsd).

Prevalence is defined as the percentage of people in a population who have a particular disease at a identified point in time, or over a specified period of time

(Prevalence Rates, 2015).

Vietnam Veteran:veterans of the Vietnam era means "a person who:
(1) Served on active duty for a period of more than 180 days, and was discharged or released therefrom with other than a dishonorable discharge, if any part of such active duty occurred:

(i) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or

(ii) Between August 5, 1964, and May 7, 1975, in all other cases; or

(2) Was discharged or released from active duty for a service-connected disability if any part of such active duty was performed:

(i) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or

(ii) Between August 5, 1964, and May 7, 1975, in all other cases."(US Legal, 2001-2015).

SUMMARY

The current study is a replication of an original study by Lyons (2001) entitled "Living with Posttraumatic Stress Disorder: The Wives'/Female Companions

Perspective". The researcher for the present study applied Lyon's research in the context of the aging process of the wives and female companions and the chronicity of PTSD symptoms in the aging Vietnam veteran.

In replicating the parent study, the purpose of this research was**:**

1. To explore the meaning of wives/female companions' experiences when living with aging Vietnamveterans who chronically suffer with PTSD;
2. To understand the effects of long-term exposure to PTSD symptomatology in wives/female companions living with aging Vietnamveterans; to explore the impact of this long-term exposure on family relationships;
3. To make direct comparisons and contrasts to the parent study by Lyons; and lastly, to increase the level of evidence on the topic of the effects of PTSD on wives/female companions.

Chapter 2: Review of the Literature

What is Chronic PTSD?

PTSD was first described as an anxiety disorder in the *DSM Manual of Mental Disorders,* third edition, 1980, (Freidman, 2013). Unlike other anxiety disorders, with PTSD one must experience a traumatic event prior to the onset of PTSD. The stress reaction at the time of the traumatic event may be the only factor that will determine who develops PTSD (McFarlane, 2000). Following the traumatic exposure, the stress response may be mitigated or the reaction may become chronically dysfunctional and cyclical due to progressive stress (McFarlane,).

When a traumatic event occurs, the body responds to the threat via direct visual and auditory pathway activation to the thalamus. Olfactory and tactile stimuli travel directly to the amygdala where the emotion center of the brain is located. The amygdala alerts other brain structures such as the hypothalamus, which produces the" fight or flight response". The amygdala stimulates the hippocampus to form memories of the traumatic event. Once the fear response is activated, the thalamus sends information to the cortex for higher level processing (Vieweg, Julius, Fernandez, Beatty-Brooks, Hettema, & Pandurangi, 2006). In PTSD, these mechanisms are responsible for the immediate and continued responses associated with the major PTSD symptomatology of avoidance/numbing, hyper arousal, and flashbacks. Recently, research using neuro-imaging studies has supported the role of the amygdala and cortical regions as significant structures in the pathophysiology of PTSD (Shin et al., 2004). Further neurobiological research conducted by Milad et al., (2009) supported their hypotheses that fear extinction is compromised in PTSD. They also propose that dysfunctional stimulation in brain structure that is responsible for fear extinction learning, and especially its recall underlies

the impairment (Milad et al. 2009).

Since the initial classification, the term PTSD has been further defined with specific diagnostic criteria to include the following dimensions; 1) exposure to a traumatic event where the person has experienced, witnessed or was confronted with an incident that involved actual or threatened death or serious injury to self or another, followed by feelings of intense fear, helplessness, or horror; 2) The traumatic event is re-experienced in distressing thoughts, images, and/or dreams; the individual experiences feelings or exhibits actions as though the traumatic event is reoccurring; intense physiologic or psychological responses occur in response to events that symbolize the initial trauma; 3) Persistent avoidance of traumatic event reminders and overall numbing of response that may be expressed as detachment, estrangement, and limited interests or involvement in present and future activities; and 4) Persistent increased arousal state that results in anger, exaggerated startle response, hyper vigilance, and lack of concentration (Vieweg et al., 2006). This definition is consistent with the DSM-IV Text Revision (APA, DSM-IV TR, 2000) criteria (Appendix B). Included in the current (APA, DSM-IV TR, 2000) PTSD diagnostic criteria is the temporal component that symptomatology is required to last longer than one month and causes functional impairment of the affected individual. Acute PTSD occurs when symptoms last less than three months; Chronic PTSD occurs when symptoms last 3 months or longer. Finally, symptom onset that is delayed for at least 6 months after the initial trauma, meets criteria for delayed onset PTSD (Vieweg et al.,).

In the newest edition of the Diagnostic Statistical Manual of Mental Disorders (APA DSM-V 2013**),** the evolution of the diagnosis of PTSD has undergone some

changes (Appendix J). In May of 2013, the American Psychiatric Association (APA) published the DSM-5, classifying PTSD as a "Trauma and Stress Related Disorder" (APA, 2013). Based on a common etiology of a traumatic or stress related event, symptomatology is no longer accepted as criteria for PTSD. In the previous versions of the DSM, (DSM III, IV and IV-TR), PTSD was considered an anxiety disorder and often shared similar symptoms with other types of anxiety disorders (Houston, Murphy and Delaney, 2014).

The most recent changes in PTSD criteria included modifications in the language that now presents a clearer version of what constitutes a traumatic event. Intrusion symptoms, previously re-experiencing, and alterations in arousal and reactivity, previously arousal, remain as individual clusters. Avoidance and numbing have been divided into two clusters, avoidance (Criterion C) and negative alterations in cognition and mood (Criterion D)(Houston, Murphy, & Delaney, 2014).

The timeframe and classification of acute or chronic PTSD has also been eliminated in the DSM-V (APA, 2013). When PTSD symptoms last longer than a month, a diagnosis of PTSD may be established, thereby eradicating the longer timeframe for diagnosis and differentiation of acute or chronic PTSD. The six-month timeframe for a full diagnosis of delayed onset PTSD, now termed delayed expression, has not changed (Houston, Murphy &Delaney, 2014).

As researchers and practitioners transition to the changes in the DSM-5 it is likely to take some time before it is reflected in assessments and practices. As a result of the diagnostic changes in the DSM 5, PTSD assessment scales are undergoing modification and validation (Houston, Murphy, & Delaney, 2014). Although changes in the DSM-5

are reflected in PTSD classification and criteria, prevalence rates are not expected to change significantly. Additional research will need to be conducted to better understand the effects of change in the DSM, research needs to be conducted to ascertain whether the changes improve diagnostic accuracy (Houston, Murphy & Delaney, 2014). To maintain accuracy and consistency of the findings, the DSM IV-TR diagnostic criterion was the operational definition of PTSD used for the current study.

In summary**,** PTSD is a psychiatric disorder that may occur following a life threatening or traumatic experience such as combat events, terroristic incidents, natural disasters, or personal assaults (Nayback, 2009). Following a traumatic exposure, the symptom triad of avoidance/numbing, hyper-vigilance/hyper arousal, and flashbacks of the traumatic experiences may be so severe that these behaviors interfere with the individual's ability to perform their occupational, social and familial responsibilities (Nayback, 2009; Vieweg, et al., 2006). Despite the functional impairments that may occur with PTSD, the number of PTSD sufferers seeking treatment remains low. As a result, increased personal and societal costs are incurred as the PTSD sufferer fails to achieve their full potential and function as a productive member of society (Kessler, 2000). The financial burden of PTSD escalates as productivity decreases and associated health care costs rise (Kessler, 2000). The personal burden of PTSD affects the families and companions of these individuals, as many must assume the responsibility as primary caregivers.

How prevalent is Chronic PTSD in Vietnam Warveterans?

Since the medical community did not officially recognize PTSD until 1980 when the DSM III was published, reported prevalence estimates have varied greatly (Gardner, 2007). In the elderly population of bothveterans and non-veterans, PTSD symptoms can

develop or reappear later in life. Research on the older population of veterans has supported that combat veterans have higher rates of exposure to traumatic events and PTSD symptomatology than the general population (Norris, 1990). In a study of older wartime veterans, PTSD lifetime prevalence was estimated at 53%, while the point prevalence was 29%. Although not specific to Vietnam Veterans, the median age of the participants in this study was 71 years, the age at which many Vietnamveterans are currently approaching (Engdahl, Dike, Eberly, & Blank, 1997).

In 1988, PTSD prevalence for Vietnamveterans was estimated at a lifetime rate of 14.7%, while in 1990 the NVVRS calculated a much higher figure of 30.9% lifetime prevalence (Gardner, 2007). More recently published data reanalyzing the original NVVRS study reported the lifetime prevalence rate of PTSD for Vietnamveterans to be 18.7% with a current prevalence rate of 9.1 % (Dohrenwend, et al., 2006). The most current study, a critical review of combat-related literature on PTSD prevalence rates in veterans, estimates the point prevalence to be 2 -17% and the lifetime prevalence to be 6-31%. Point prevalence for Vietnam veterans ranges from 2.2% to 15.2% (Richardson, Frueh, & Acierno, 2010). As the diagnostic criterion becomes more refined, along with a greater understanding of combat-related PTSD in the older population of veterans, prevalence rates may be more accurately estimated.

What is the Current Health Status of Living Vietnam War Veterans?

The association between PTSD and poor health outcomes may be attributed to the neurochemical alterations in the brain that occur with trauma and the resultant effects on biological, psychological, and behavioral health (Jankowsi, 2007). Specific research on Vietnam Veterans and health status was reported in a CDC study completed in 1988. This

research evaluated the psychological and physical health status of 8000 Vietnam veterans and compared their health status to same number of non-Vietnam veterans. The results revealed greater rates of psychological adversities in the Vietnam veterans than the comparison group with regards to alcohol abuse (13.7% vs. 9.2 %), depression (4.5% vs. 2.3%, and anxiety (4.9% vs. 3.2%). However, no significant physiological differences were found between the two groups.

In the NVVRS (1990) study, depression, anxiety, and alcohol abuse/dependence were prevalent in the Vietnam veterans with high levels of combat exposure. This group also reported experiencing more physical problems, particularly in those veterans diagnosed with PTSD or with substance abuse problems. Readjustment problems reported in the NVVRS study by the Vietnam veterans with PTSD were occupational difficulties, marital discourse, and family conflicts at higher rates than non-PTSD veterans (Price, 2007).

In 2011, Congress commissioned a second study, the National Vietnam Veterans Longitudinal Study (NVVLS), as a follow-up to the National Vietnam Veterans Readjustment Study (NVVRS). Initial findings from the NVVLS study revealed that Vietnam veterans with PTSD were at a greater risk of developing heart disease and other chronic illnesses and had a higher death rate than veterans without PTSD (ABT Associates, 2014). Further findings from the study estimated that the prevalence of PTSD was 11.2%, which was noted as important by the DoD and VA, indicating that a subset of those who have PTSD will likely have it for a lifetime (U.S.Medicine, 2014)

As Vietnam veterans are reaching retirement age, the Veterans Administration hospitals have noted a significant increase in the number of Vietnam veterans seeking

care for medical conditions and PTSD (Somes, 2013). These cases have increased from 272,000 in 2006 to 476,000 in 2012, life changes and looming retirement trigger delayed stress reactions hence the increase of cases of aging Vietnam Veterans at VA hospitals (Somes). While veterans from the Gulf War were included in these numbers, more than half of the new cases had served in earlier wars (Somes,).

What is the Current Health Status of Wives/Female of Living Vietnam War Veterans?

There is increasing evidence that PTSD adversely affects wives/female companions living with veterans with chronic PTSD. Due to PTSD symptomatology and associated behaviors, interpersonal relationships are strained resulting in marital instability, relationship distress, and inability for intimacy (Manguno-Mire et al., 2007). A national representative sample (N=1200) of male Vietnam veterans with self-reported PTSD and their spouses/ companions (N=376) were queried to determine the presence of PTSD, family adjustment, parenting issues and violent behavior. The spouses or companions were specifically interviewed to assess their own mental health issues, substance abuse/dependency and the behavioral problems of dependent children. In comparison with those veterans without PTSD, the families of PTSD veterans had more severe marital and family problems, lacked parenting skills and exhibited more violent behavior (Jordon et al., 1992).

In a qualitative study by Frederickson, Chamberlain, and Long (1996), five women companions of Vietnam veterans with combat exposure contacted the researchers to participate in this study. From the interviews, common themes surfaced related to the caregiver's experience living with a Vietnam veteran exposed to combat. Experience,

meaning, and understanding were the three main concepts that emerged. The experiences of caregivers were similar to PTSD characteristics; anger and violence were prevalent in the family relationships and the veterans exhibited emotional distancing that affected overall family dynamics. Meaning was described as the accounts the women gave regarding life events, their roles and what it meant to be part of a veteran's family. The participants ascribed meaning to a lack of normal family functioning, concern for consequences of anger and violence, stress related to their peacekeeping role in the family and caregiving protector**.** There was a sense expressed by these women that despite their love for their spouses and families, there would be a point at which they would need to save themselves. Understanding was focused on the impact that the war had on the veteran, and how he was affected as well as the impact on the family. These findings helped clarify the emotions, and experiences that the companions of veterans attributed to their family and life experiences (Frederickson, Chamberlain, & Long, 1996). This study underscored the effects of the Vietnam veterans' combat experience on family functioning and spousal relationships.

Symptom severity of PTSD in Vietnam veterans, caregiver burden, and the psychological adjustment in female companions of Vietnam veterans were described in a quantitative study by Calhoun et al. (2002). The sample (N=71) included Vietnam veterans and their female companions who were recruited from a PTSD specialty clinic at a Veterans Administration Medical Center. Fifty-one of these participants were diagnosed with PTSD, while the remaining 20 veterans did not meet PTSD diagnostic criteria but had combat exposure. Several measures of the Vietnam veterans' behaviors were quantified, using scales for PTSD symptom severity (Mississippi Scale for Combat

Related PTSD), violent behaviors (Conflict Tactic Scale), and hostility (Cook-Medley Hostility Scale). Companions were surveyed for demographics, caregiver burden (Burden Interview Scale) and psychological symptoms (Global Severity Index and the SCL 90). The results demonstrated that the companions of the veterans who were diagnosed with PTSD experienced more caregiver burden and had poorer psychological adjustments than the companions of the veterans who did not suffer from PTSD ($p <. 05$) (Calhoun, Beckham, & Bosworth, 2002).

Similar to the findings of the previously cited research, Mangino-Mire et al. (2007) conducted a cross-sectional study using a convenience sample of female companions (N=89) cohabitating with combat veterans with PTSD who were recruited from the New Orleans and Jackson Mississippi Veterans Administration Medical Center (VAMC). The purpose of the study was to describe the relationship between psychological distress and partner burden in the context of family and treatment factors. Through a structured telephone interview, the Partner Experiences with PTSD Survey (PEPS) was administered to the female companions/spouses of combat veterans with PTSD. The PEPS was developed as a collective tool to measure information about the psychological health of companions, their mental health treatment, as well as the involvement in the veterans' mental health treatment. Findings indicated that partners had an increase in psychological distress when perceived threat was imminent. Despite the limitations that this study was completed on a convenience sample of individuals living with veterans receiving mental health treatment, the findings support that companions of veterans with PTSD are a distressed group that receive only limited mental health care.

Similarly, the impact of PTSD on family relationships and the effect of these relationships on the recovery course were examined in a phenomenological study. Two major themes emerged as a result of this phenomenological inquiry: emotional numbing and anger negatively impact family relationships, and emotional withdrawal from family support adversely affects recovery (Ray & Vanstone, 2009). Unlike the previous studies, this study interviewed 10 participants with combat experience not limited to Vietnam. However, the researchers concluded that there needed to be further research to explore the impact of PTSD on familial relationships.

In summary, it is known that women living with veterans who have PTSD exhibit high levels of stress that may affect physical and psychological well-being (Calhoun et al., 2002, Manguno-Mire et al., 2007; Fredrickson, Chamberlain, & Long,1996). Consequently, there is a change in the female partner/spouse in the caregiver role, within the marital /relationship dyad and on family dynamics. Although the qualitative studies have shown that there is a negative effect on women who live with these men, the researchers have concluded that these women may suffer from a secondary form of traumatic stress in their attempts to provide support to their companions (Lyons, 2001).

What Findings did Lyon's Report and What Needs Further Exploration?

In 2001, Lyons examined the experience of wives/female companions living with Vietnam veterans in a phenomenological study. In this study, 10 wives/female companions who lived with Vietnam veterans diagnosed with PTSD were interviewed. The participants described three phases of the relationship: adjustment, enmeshment, and resolution/healing. The phases are gradual, incremental and have ongoing resolution. The central theme that described the experience of wives/female companions was one of

becoming gradually engaged in the PTSD pathology. As the women moved through resolution towards healing, a significant amount of their energy was directed at minimizing the negative effects of the situation on self and family. The researcher concluded that the wives/female companions of these Vietnam veterans may suffer a secondary form of traumatic stress disorder as a result of their attempts to provide social support to their companions and recommended further research to address the experiences of those who deal with the trauma of others be explored.

As women age, physical, psychosocial, interpersonal and functional role changes occur**,** which may make coping with PTSD more difficult than in earlier years. For example, with aging, stressors such as retirement, declining physical health, reduced income, limited social network and cognitive changes may occur that make aging adults more likely to experience symptoms of PTSD (Kaiser, Wachen, Potter, Moye, & Davison, 2013). In view of the dyadic relationship discord associated with the PTSD experience, many women have encountered interpersonal violence over the course of the relationship. Despite this ongoing trauma, older women are more likely to stay in violent relationships than their younger counterparts (Kaiser et al, 2013). In the parent study, Lyons identified that women often chose to stay in long-term relationships with the PTSD spouse despite these difficulties. Since limited research has been conducted on wives/female companions of Vietnam veterans with chronic PTSD in the years since Lyon's original study, further exploration of the psychological sequelae in this cohort needs to be described in the context of the aging process. Additionally, due to PTSD symptomology, findings from the parent study anticipated an increase in the need for medical, financial and social support services for both the aging Vietnam veteran and their significant other.

In view of contemporary governmental budgetary constraints, evidence based on research findings related to the aging Vietnam veterans with chronic PTSD and their wives/female companions would support resource allocations for this group.

Chapter 3: Design and Methodology

Research Design and Method

Phenomenology, historically rooted in philosophy and psychology, is considered both a philosophical approach and a research method (Flood, 2010). Although the initial description of phenomenology was first credited to German philosopher Immanuel Kant in 1764, Edmund Husserl (1859-1938) is acknowledged to be the founding father of phenomenology, which he considered "the universal foundation of philosophy and science" (Jasper, 1993, p. 310). The philosophical tradition of phenomenology was developed by Edmund Husserl and Martin Heidegger to explore and understand life experiences. According to Husserl, phenomena "cannot be separated from the experience of them" (Jasper, p. 310) thus, the knowledge of what has occurred must be described from the individual's perspective and reality. The basic tenets of phenomenology were expanded by philosophers Martin Heidegger, Maurice Merleau-Ponty and Jean Paul Sartre to include the fundamental beliefs of phenomena, reality, subjectivity and truth (Jasper),. Phenomenology, the research method, integrates these beliefs as a way to understand the subjective "essence of the phenomenon" (Jasper, p. 310).

Phenomenological research emphasizes "the meaning of the lived experience" (Beck, 1994, p.499) with the goal to "describe the human experience as it is lived" (Beck, p.500). The objective of phenomenology is to provide a description of everyday occurrences in an effort to understand the central structure (Sanders, 2003). According to Dahnke (2011), "for phenomenologists, the only world that matters is the world as it appears to us, a world composed of phenomena-things which appear directly to our mind or consciousness" (p.255). Phenomenological research is both inductive and descriptive;

the researcher seeks to understand the perceptions of the person who has had the experience and the effect of this experience on the individual (Flood, 2010). Thus, meaning is constructed through the interactions between the researcher and the participant (Beck, 1994). The ascribed meaning of the experiences of the participants will provide "a universal description of a phenomenon... [where] the quality of a descriptive phenomenological investigation…would be testimony from the participants themselves that the investigator's universal description of the phenomenon captured their personal experiences" (Wojnar & Swanson, 2007, p.174). Therefore, phenomenology is a qualitative method of research that seeks to "more deeply understand human experiences" (Munhall, 2007, p.163). The phenomenological approach is useful in nursing research as it reflects the core concepts of nurse caring and holistic understanding of the whole person (Connelly, 2010**).** The purpose of this study was to describe the experiences of wives/female companions living with aging Vietnam veterans who suffer from chronic post-traumatic stress disorder using a phenomenological method.

Setting

The setting of this study occurred in the Northeast, Northwest and Western United States. Four of the interviews were conducted either in the participants' homes or the researcher's home. The other six interviews were completed via telephone. The interviewer recorded discussions with participants, later transcribed the discussions verbatim, and clarified questions about content using emails. Upon completion of data analysis, the interviewer contacted the participants by telephone to confirm the participants' responses**.** Of the 10 participants interviewed, nine of the husbands were

aware that their wives were participating in this study. The tenth participant chose not to share this information with her husband, as his PTSD diagnosis was a sensitive issue.

Sample

This study utilized a purposive sample of 10 wives/female companions of aging Vietnam veterans diagnosed with chronic PTSD. As in Lyon's original study, participants were not required to produce documentation of their partners' PTSD diagnosis. Of the 10 participants, two were known by the researcher, two were referred by their friends, two were referred by a licensed family therapist on the west coast, and another was referred by a member of a Vietnam Veterans' wives organization. Two east coast participants contacted the researcher when friends gave them a flyer and lastly, one woman overheard the investigator describe the study to a colleague, requested information, and subsequently chose to become a participant**.** Participants varied in age from 54 to 68 years old, nine participants were Caucasian and one was Hispanic. Participants religious affiliations were varied and included Roman Catholic, Jewish, Christian, Baptist, Pentecostal and one participant chose not to answer the question. All ten participants were legally married to their spouses and had been married from two and a half years to 48 years. Of the 10 female participants, three of the wives and five of the husbands were previously married to other people. At the time of the first interview, one participant is contemplating divorce. Educational levels of the participants varied from a vocational technical school to a doctorate (PhD). Two participants had completed associates degrees, three had bachelor's degrees one had a master's degree and another a PhD. Of the other three participants, two had some college and one completed technical school. Three participants were retired, one participant was active with military affairs while her

husband was in the army for 29 years, two are educators, two are authors, one is an administrative assistant and the last participant is self-employed.

Participants who were living on the East Coast were recruited via email, fax, and flyer or in person by the co-investigator; participants living on the West Coast were recruited via e-mail, fax, and flyer or in person by a licensed family therapist. A letter of endorsement (Appendix F) explaining the study was provided to interested participants on the West Coast**.** Interested potential participants replied to a secure Internet address or via telephone with their contact information. The co-investigator contacted the potential participant to explain the purpose of the study and determine participant eligibility. Eligibility was based on a short series of general questions regarding their relationship status with a Vietnam veteran with PTSD (Appendix C). Participants were contacted through U.S. mail or fax with a letter reviewing the rationale of the study, ensuring that the data would be kept confidential, as well as provided with information regarding their right to withdraw from the study at any time without penalty through the culmination of data analysis. Consent was issued via U.S. mail, email, and fax or in person whichever was most convenient to the research participant. Two copies of the consent were sent with a stamped self-addressed envelope to the participant. One copy of the consent was for the participant to keep. The consent was returned to the co-investigator via U.S. mail, fax or in person. Inclusion criteria for the study consisted of the following conditions, the participants were wives, former wives or female companions who lived for more than six months over the past 15 years with a Vietnam veteran diagnosed with chronic PTSD. Participants had to read, write, speak and understand English. The co-investigator explained to participants that the interview could be recorded via Skype (video via

computer), or in the event that interested participants did not have a computer, information was audiotaped over the telephone or in person. Participants not willing to be interviewed and audiotaped were excluded from this study as well as those participants who did not meet the relationship duration of more than six months over the past 15 years. The participants understood that the interview would last approximately one hour with a follow up telephone call to confirm the researcher's interpretation of their statements

Data Collection Procedures

Prior to participant interviews, a co-investigator developed demographic questionnaire was completed (Appendix D); included as part of the demographic data, the Perceived Stress Scale (PSS) was also completed by the participants (Appendix E). The PSS measures perceived levels of stress over the last month (Cohen, 1994). Following the completion of the demographic data, an in-depth individual interview was conducted with each participant. The expected timeframe for this component of study was three months. The interviews were recorded, transcribed verbatim, and analyzed in combination with field notes. Data requiring content clarification by the co-investigator was validated by telephone follow-up or email with the participant. Data was coded to protect the participants' identity. Initial interviews with each participant lasted approximately one hour and followed an open ended format of the original five questions utilized in Lyon's study, and three additional questions developed by the co-investigator (Appendix A). Confidentiality was maintained by the co-investigator and the research participant. When in-person, the co-investigator met with the participant in a mutually convenient location, either my home or theirs where the conversation could not overheard.

When the interview was conducted via telephone or Skype, the co-investigator conducted the interview from her office with the door closed and no other person in the room. The participants were advised to receive the interviewer's call in a private area at a safe convenient location such as their home or office. The tapes of these interviews were kept at the co-investigators home office in a locked cabinet specifically designed for this research project. To promote rigor in this descriptive phenomenological research, the co-investigator bracketed using a reflective journal throughout the research process to control bias and preconceived assumptions about the phenomena.

Data Management Analysis

The methodology, an approach that links methods to outcomes (Creswell, 2009) in this study was phenomenology. The method or techniques and procedures used for data collection and analysis (Creswell) were based upon the Colaizzi method. With the Colaizzi method, "the phenomenologist employs descriptive methods to investigate human experience and communicate results" (Knaack, 1984, p.111). Colaizzi, a second-generation phenomenologist, based his method of data analysis on Husserl's work of descriptive phenomenology. Colaizzi's method of data analysis allows the researcher to work in a systematic manner when compiling information for data analysis. The seven steps, according to Colaizzi (1978) are:

1) Acquiring a sense of each protocol (transcript)
2) Extract significant statements,
3) Formulate meanings,
4) Organize formulated meanings into clusters of themes,
5) Exhaustively describe the investigated topic,
6) Describe the fundamental structure of the phenomenon,

7) Return to the participants for validation of interviews.

(Colaizzi, 1978, p 59-62).

Lyons' utilized Giorgi's method of data analysis, which is similar to Colaizi's with differences in terminology and analysis categories (Knaack, 1984). Giorgi's analysis eliminates the final step of validation of findings from the participants (Reiners, 2012). In this replication study, the researcher used the Colaizzi method to allow for validation of the researcher's interpretation with and meaning of the phenomena with the participants.

Data analysis will be presented within the context of the Double ABCX Model, a family stress theory. The Double ABCX model, a longitudinal model of family stress and adaptation, is based upon the initial ABCX formula developed in 1949 by "the father of family stress theory", Reuben Hill (Weber, 2011, p.82). The conceptual framework of the ABCX formula focuses on the pre-crisis variables of families. Based on Hills ABCX formula, McCubbin and Patterson (1983) added five variables to the model to create the Double ABCX Model. These five variables were added to explain how families recover from crisis and why recovery from crisis varies among families. Analysis of this concept will be reviewed in Chapter 5.

In qualitative studies it is necessary to utilize thorough techniques to generate rich and clear descriptions of a particular characteristic of human experience (Vivar, McQueen, Whyte, Armayor, 2007). Four approaches to determine rigor have been identified to evaluate trustworthiness in qualitative studies, credibility, transferability, dependability and confirmability. Credibility pertains to the validity of the data, which can be verified by review of the data in the final interview with the participant. Transferability refers to the generalizability of the study, can it be utilized on another

population with a different demographic status, such as age, sex or marital status. Dependability refers to the level of consistency should the research be replicated and lastly confirmability concerns the impartiality of the data. (Vivar et al., 2007).
A qualitative analytical program (Nvivo 10, 2012) was used to manage data analysis.

The study commenced following proposal defense and IRB approval. Recruitment notices were placed in the office of Mary Tendall, Licensed Family Therapist, in libraries, Veteran of Foreign Wars and American Legion Halls, and in the Vietnam Veterans memorial at a rest stop in Vermont.

Protection of Human Subjects

Prior to the start of the study, the principal investigator Dr. K. K. Anselmi and the co-investigator met with the Drexel University Institutional Review Board (IRB) for review of the study and non-medical informed consent. All participants were apprised of their rights of voluntary participation in the study, there was no coercion or penalty for withdrawing from the study. Protection of human subjects was evidenced by the maintenance of confidentiality at all times. Each participant was identified by a fictitious proper name provided by the Co-investigator. The code sheet with this information was kept separate from the data collection sheet; the code sheets were kept in a locked cabinet with access only to the PI and co-PI. Skype and audiotapes were kept in a separate locked cabinet in the home office of the co-investigator. The line of questioning could elicit emotional responses; in the event that this had occurred all participants were encouraged to contact their own health care provider, physician or support group. If any participant was removed without consent from the study for psychiatric reasons they were

encouraged to contact their own health care provider, physician or support group for follow up care.

Benefits to participating in this study were: to expand the body of knowledge as to the meaning and experiences of long-term partners/wives of chronic PTSD sufferers from a physical, psychological and emotional standpoint; to advance PTSD research and assist others in similar situations to be cognizant of their own experience**;** to add to the body of knowledge related to the long term relationships in the PTSD dyad; and to assist the participant in understanding the behaviors of her partner as well as provide avenues of support for the wife or female companion. Lastly, an additional benefit of participating in this study may be that information obtained through this study may add to the body of nursing knowledge on the shared experiences of women in long term relationships with partners who have PTSD.

Risks of participating in this research may be related to embarrassment of dialoging about her life, becoming emotional about the situation and not being able to continue to participate in the study.

Chapter IV: Findings/Results

4.1 Overview of Study

The purpose of this phenomenological qualitative study was to describe the experiences of wives/female companions living with aging Vietnam veterans who suffer from chronic post-traumatic stress disorder. The present study applied prior research findings by Lyons (2001) on "Living with Post Traumatic Stress Disorder: The Wives'/Female Partners' Perspective" in the present context of the aging process of the wives and female companions and the chronicity of PTSD symptoms. Since Lyon's study, the wives, female companions, and veterans are more than a decade older. Additionally, since Lyons study, there has been limited research on the wives'/female companions' perspectives despite the fact that there is an increased number of aging Vietnam veterans diagnosed with chronic PTSD. This chapter will present demographics, an assessment of participants stress level using Cohen's perceived stress scale obtained prior to the interview, and presentation of themes guided by using Nvivo software 10 for data analysis. Similar to the parent study by Lyons, results of this study indicated that while the participants transitioned through parallel phases, in the early and middle phases, ultimately in the later phase those who decided to stay in the relationship experienced not only resolution/healing but also resignation/acquiescence and resilience. In this study, the addition of resignation/acquiescence and resilience into the later phases of the relationship adds new insight into the experiences of the wives/female companions related to the chronicity of PTSD symptoms within the aging process and the effects of this disorder on long-term relationships.

4.2 Demographic Characteristics of Participants

The sample included 10 female participants recruited throughout the United States; seven interviews were obtained from east coast participants and three were obtained from west coast participants. All ten participants had met the criteria of living with a Vietnam veteran with PTSD for more than six months in the last 15 years, the range of relationship time in years spanned from 9-48 years, and the mean relationship time was 28.5 years. To maintain anonymity each participant was identified by initials that designated their geographic region, such as East Coast (EC) or West Coast (WC) followed by their numerical sequence in interview series. For example, EC #-1, refers to East Coast participant # 1. Demographics of the study participants in regards to their age, marital status, religious preference, socioeconomic status and education are provided in Table 2. Mental health history and substance use are provided in Table 3.

Table 1

Summary of Participant Demographics East Coast

	EC #1	**EC #2**	**EC #3**	**EC #4**	**EC #5**	**EC #6**	**EC #7**
Age in years	54	68	62	59	68	63	62
Occupation	Education	Home-maker	Retired	Administrative	Writer	Artist	Retired
Marital status	Married	Married	Married	Married	Married	Married	Married
Number of marriages	1	1	2	2	1	1	2
Spouse number of marriages	2	1	2	2	2	1	2
Race	White	White	White	White	White	White	Hispanic/ Latino
Number of Children	3	3	2	1	2	5	0
Income level	$41-$60,000	$20 - $40,000	$61-100,000	$61 - 100,000	$61-100,000	$20-40,000	$61-100,000
Religion	Christian	Catholic	Roman Catholic	Non-Believer	Christian	Christian	Catholic
Education	Graduate School	Some College	College Degree	College Degree	College Degree	Some College	College Degree

Summary of Participant Demographics West Coast

	WC #1	WC #2	WC #3
Age in years	67	64	66
Occupation	Riding Lessons	Writer	Retired
Marital status	Married	Married	Married
Number of Marriages	2	1	1
Spouse number of marriages	2	1	1
Race	White	White	White
Number of children	2	2	2
Religion	Roman Catholic	Jewish	Baptist
Education	Some College	Graduate School	College Degree

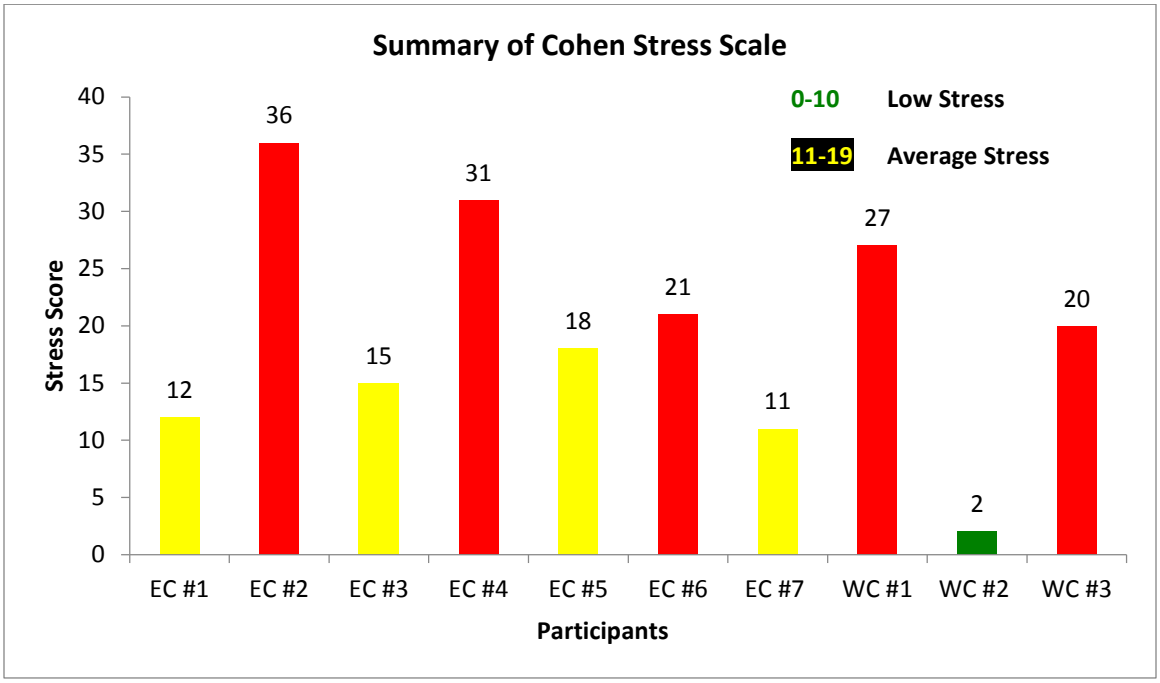
Table 2. Mental Health and Substance Use

Partici -pants	Current /prior smokers	Alcohol Use	Prescription medications for stress related disorders	Substance Use	Anxiety	Depression	Panic Attack	Other
EC # 1	No	No	No	No	No	No	No	No
EC # 2	No	No	Yes	No	Yes	Yes	Yes	No
EC # 3	Yes	No	Yes	No	Yes	Yes	No	No
EC # 4	No	Yes	No	No	No	No	No	No
EC # 5	No	No	No	No	No	No	No	No
EC # 6	No	Yes	No	No	No	Yes	No	No
EC # 7	No	Yes	Yes	No	Yes	Yes	No	No
WC #1	No	No	No	No	No	No	No	No
WC #2	No	Yes	No	No	No	No	No	No
WC #3	Yes	Yes	Yes	No	Yes	Yes	No	No

After completing the demographic data sheet, each participant completed Cohen's Perceived Stress Scale (PSS) questionnaire (Appendix E). The PSS provided a measurement of perceived stresses within the past month that are due to life situations and circumstances (Cohen, Kamarck, & Mermelstein, 1983). Total scores ranging from 0 to 10 indicate low stress, scores of 11-19 indicate average stress, and scores of 20 or above are considered high stress states. The range of scores for the ten participants in

this group was a 2-36 with a mean score of 19.3. Participants stress scores are illustrated in Figure 1.

Figure 1.



4.3 Participant Interview Responses

In reviewing each participant's transcripts, the Colaizzi (Colaizzi, 1978) method was used for data analysis. While acquiring an overall sense of each transcript, statements, meanings, and organizing themes clusters were derived from each interview. Overall emergent themes of the participants' experiences were categorized.

Question One: What was your early relationship like with your partner?

Eight of the 10 participants described their early relationships in a positive light. However, one participant (EC #7) felt like the relationship was "abnormal from the beginning" and another (EC # 5) recalled "…it was horrible…one of the worst years of my life." In answering the question, *What was your early relationship like with your*

partner, most of the participants described their early relationship as amicable supporting the emergent theme of happiness and compatibility as noted in Table 3.

Table 3. Question 1. What was your early relationship like with your partner?

Participant	Early phase: Lyon's Adjustment Phase Statements	Theme Clusters for the Early Phase	Richardson's Emergent Themes
EC #1	Happy, caring, energetic and fun	Happiness	Happiness and compatibility during early phase of relationship
EC #2	Laughed a lot and enjoyed life	Happiness	
EC # 3	Funny, nice, kind, caring and compassionate	Happiness, compatibility	
EC # 4	Love of my life…crazy about each other…active social and sexual life	Happiness, compatibility	
EC # 5	Worst year of my life	Unhappy	
EC # 6	Best friend, we did everything together	Compatibility	
EC # 7	Got along well in the beginning… very compatible…abnormal from the beginning	Some Compatibility	
WC # 1	Very strong, very good very compatible	Compatibility	
WC # 2	We had a lot of fun	Happiness	
WC # 3	Good, normal relationship	Compatibility	

Question two: What PTSD symptom does your partner experience? All of the participants responded that their husbands actively experienced PTSD symptoms throughout the relationship. Some of the participants initially recognized the abnormal behaviors but did not attribute them to PTSD. Recognizing, experiencing, and dealing with PTSD symptomatology emerged as the wives/female partners began to notice aberrant behaviors in their partners. The behaviors demonstrated were consistent with symptoms of PTSD: avoidance, hypervigilance, startle reflex, anger, flashbacks, paranoia and intrusive recollection. In one case, the participant sought medical assistance multiple times over an eight-year period and was told he did not have PTSD. Although he related experiences of chasing the Vietnamese children down the block because he felt they were "coming for him," medical professionals dismissed the symptoms. Due to the late onset

of symptoms, the lack of acknowledgement by medical professionals that these behaviors were manifestations of PTSD, and undefined PTSD diagnostic criteria until 1980, PTSD was not diagnosed in their spouse until later in the relationship. As the PTSD symptoms worsened, the behavior began to interfere not only with the core dyad relationship, but also with family and social relationships. As the spouses' PTSD behaviors became more consistent, the themes of recognizing, experiencing and dealing with spouses PTSD emerged as described in Table 4.

Table 4. Question 2. What PTSD symptoms does your partner experience?

Participant	Middle Phase: Lyon's Enmeshment Statements	Theme Clusters for the Middle Phase	Richardson's Emergent Themes
EC #1	Irritable, OCD, night tremors, hypervigilance, startle reflex…can't come up behind him, paranoia	Irritability Hypervigilence, Paranoia	Recognizing, experiencing, and dealing with spouses PTSD symptoms
EC #2	Outbursts, causes family arguments, hypervigilance, avoidance, not interested in the holidays, stopped socializing because of behavior, nightmares, startle response	Emotional outbursts, Hypervigilance. Avoidance	
EC # 3	Anxiety, panic attacks, hypervigilance, avoidance, flashbacks, he is reclusive…worse over the years, never spoke about Vietnam…holidays were horrible…he feels it is ok to behave in a certain way because he has PTSD	Hyper arousal, Intrusive recollection, Avoidance	
EC # 4	Rage outbursts…our son stepped in once; developed hearing problem…uses hearing aides…they pick up noise; he can't sit with his back to the door, more irritable, bypass surgery last summer has interfered…not sure if it is PTSD or health crisis; intolerant of having a civil conversation if you have a different opinion	Irritability, Emotional outbursts, Paranoia,	Recognizing, experiencing, and dealing with spouses PTSD symptoms
EC # 5	Anger, avoidance to social situations but he is fine once the situation occurs, startle reflex; put fist through a wall…fists through a door;	Emotional outbursts, Avoidance	
EC # 6	Angry, no friends, hypervigilance, anxious, suspicious, avoidance, startle reflex	Emotional outbursts, Hyperarousal, Avoidance, Paranoia	
EC # 7	Nightmares, startle reflex, irritable, anger, aggressive attitude, always on the alert, manipulative, always wants to make the decision; he screams, yells, and curses and I have to wake him up.	Hyperarousal, Emotional outbursts, Intrusive recollection	Recognizing, experiencing, and dealing with spouses PTSD symptoms.
WC # 1	Loses his temper fairly easily, road rage, difficulty in finishing anything he starts, avoidance, startle reflex, does not like to be in crowds for any length of time, very little patience with anyone	Emotional outbursts, Avoidance, Hyperarousal	

WC # 2	Hypervigilant, used to be very reactive; nightmares, emotional numbing, very OCD, has to be organizing whatever; he has a million projects going	Hyperarousal, Avoidance	Recognizing, experiencing, and dealing with spouses PTSD symptoms
WC # 3	He has to have his back to the wall; almost 99% of the time loud noises still bother him; if not scheduled or planned, don't change it…if there is no head's up on the order, it doesn't happen, if it does, it is very reluctantly. Dreams he is still in military…or back in Vietnam but he won't talk about it.	Intrusive recollections, Paranoia	

Question Three: How have these symptoms changed over time? Of the 10 participants interviewed, seven of the wives have stated the symptoms have worsened over time. Some women reported a temporal change in the symptoms but not necessarily an improvement. One participant did note that symptoms improved only if structure and routine were maintained in the household. In two of the relationships, age as a contributing factor surfaced. One spouse was unsure if the age related change in her husband was related to PTSD or organic brain changes such as Alzheimer's or dementia. As the spouses aged and behavioral symptoms worsened, the wives/female companions sought out therapy, medication, or hospitalization for their spouses; some of the women began taking medication or participating in therapy themselves. In reflecting upon the question how have these symptoms changed over time, a third theme of dealing with ongoing and worsening PTSD symptoms within the aging process emerged. As the spouses became cognizant of the chronic PTSD symptomology the themes of worsening of symptoms and age related changes became apparent as described in Table 5.

Table 5. Question 3. How have these symptoms changed over time?

Participant	Lyon's Middle Phase/ Later Phase Enmeshment / Resolution/healing Statements	Theme Clusters for the Middle Phase	Richardson's Emergent Themes
EC #1	Things have gotten worse over time, 1988 he was chasing the Vietnamese kids down the block, in 1990… we were told that he was not demonstrating … PTSD, so nothing was done. 1994 he threatened to kill someone…he was hospitalized in 1995 and has been hospitalized seven times since	Worsening of symptoms over time	Dealing with ongoing /worsening PTSD symptoms.

	then…		
EC #2	Extremely worse	Worsening of symptoms over time	Dealing with ongoing/worsening PTSD symptoms.
EC # 3	Gotten worse over the years, one night he had a bad dream and I jumped up and he smacked me in the eye, he freaked out and was upset about that, felt he needed help and started counseling.	Worsening of symptoms over time	
EC # 4	Numbing, depressed, withdrawn. Active in anti war activities during the Iraq war, joining antiwar and veterans groups, leadership roles. Unbearable at home, consumed by whole veteran thing, and he is still like that now. We are sick of it, it's a trigger for me if I hear the word Vietnam I want to crawl in a hole. Not like me, I am politically active.	Worsening of symptoms over time	Dealing with ongoing /worsening PTSD symptoms.
EC # 5	He did a lot of therapy…wasn't demonstrating road rage or putting his fist through walls, so that changed. It was a busy time for him as we had kids he was busy, I was busy …it was okay, except [the] outbursts of anger…he always blamed it on someone else. It got worse when he retired and ...when my mother died…lots of stuff was happening in our lives…he went to the Veterans Administration Hospital, he was afraid he was going to hurt someone.	Worsening of symptoms over time. Age Related Change	Age Related Changes
EC # 6	His PTSD symptoms were pretty consistent, " he was being completely crazy, his reactions to things were over the top, he became very religious, everything was a matter of rules nobody else's opinion mattered, this is how we are going to do it, I became one of the kids rather than a spouse, rather than an equal.	Consistent symptoms over time.	Dealing with ongoing /worsening PTSD symptoms.
EC # 7	They [PTSD symptoms] are getting worse…compulsive, controlling, manipulative and insecure…He is irritable… anger and aggression issues…It is his way or the highway…verbally abusive, and …at a later time he denies ever saying it. I think he might be getting Alzheimer's or Dementia.	Worsening of symptoms over time . Age Related Changes	
WC # 1	Worse, he is trying very hard, he knows a lot of these things are difficult for me…he is also a hoarder	Worsening of symptoms over time Age Related Changes	Dealing with ongoing /worsening PTSD symptoms.
WC # 2	Lots of therapy, anti-psychotic anti-depressants, he was a bomb defused, now not very reactive. Prior to medications there were times I thought he might kill somebody. I never knew what the trigger was, no bomb, no fuse. He had a breakdown… hospitalized for severe depression and anxiety. Better after that	Worsening of symptoms over time.	
WC # 3	Still sits with his back to the wall, tells me I had one of those dreams again and that's it. I don't worry I		Dealing with ongoing

	will awaken with his arm over my neck holding me down. Symptoms have gotten better, startle reflex remains. More laid back, I can make changes now if I don't spring it on him.	Age Related Changes	/worsening PTSD symptoms.

Question # 4: How have you coped with them?

Of the 10 participants interviewed, five attend therapy sessions; four of the participants found that ignoring the behaviors worked best for them. One woman confronts her spouse when his behavior changes, as she will not tolerate his behavior towards her. Another immerses herself in her painting as she feels she is able to fix the problems that surface in painting but not in her relationship. Others seek out work, friends, reading and compassion. One woman stated "foods is how I cope…I am 30-40 pounds overweight, and I read a lot, I immerse myself in someone else's life other than my own". Some of the women maintain an intact sense of self through positive activities. And lastly, one described her coping mechanism similar to the phases of grief, as she moved through the phases with resignation as the final outcome. She and her family also understand that this is an illness, and" they would never leave him if he had cancer, and PTSD is no different". In response to the question *how have you coped with them*, the themes of resignation, acquiescence and resilience were extracted from their statements as presented in Table 6.

Table 6. Question 4. How have you coped with them?

Participant	Lyon's Later Phase: Resolution and healing Statements	Theme Clusters for the Later Phase	Emergent Themes
EC #1	Sometimes good/bad, I've gone through phases, grief, anger, denial, reconciliation, sometimes I felt guilty that I wasn't doing enough, his mother told me it was my fault, I didn't love him or take care of him enough, sometimes he would say that. We prayed as a family, it is an illness, if he had cancer would we ask him to leave? You know you go through all the phases and come to resignation**.**	Resignation Compassion	Resignation/ Acquiescence

EC #2	Cry a lot, wait for it to pass, mental and verbal abuse (teary eyed) Take nerve pills if I need them	Ignore behavior	
EC # 3	"I don't like it but I try to understand it. I am not the enemy. I will stand by you; you're not going to treat me like this. He will look at me really strange and asks how am I treating you? You're brusque and bitchy. I am not afraid to tell him how I think and feel. I can't keep things inside. I'm very content to do things with out him.	Understanding the behavior but not tolerating it. Maintain a sense of self through positive activities.	Resilience
EC # 4	I try to ignore him. On Friday night on my way home from work, I stop at girlfriends house and we will have tea or wine and I avoid going home. If she has something to do and is not around I sometimes just pull off on the side of the road and just sit, because I don't want to go home.	Avoidance Ignore behaviors	Resilience
EC # 5	I went to therapy a lot longer than he did, I went to therapy for 25 years, I also just ignored him, I had to learn how not to take everything personally, cause everything was my fault when he was having these fits.	Therapy Ignore behaviors Maintain a sense of self through positive activities.	Resilience
EC # 6	When the kids became teenagers and began rebelling against this rigid lifestyle and you couldn't do anything about it, I became more involved in painting, I couldn't fix everyone's problems but I could fix a problem with a painting, and it made me feel good about myself.	Ignore behaviors. Maintain a sense of self through positive activities.	Resilience
EC # 7	It was easier to cope with his behavior when I worked, now we are retired. I am getting tired of it. He wakes me up constantly, I get so nervous, and it takes many hours to calm down. I lose sleep, he won't take his medications. I am tired and suffering from insomnia, I used to be very strong and independent, and in the past three years I no longer feel free, I am being submissive and I don't like that. I don't say a word because I want to avoid the outbursts.	Tolerate/ignore behaviors Won't take his medications Feels submissive Resolution	Resignation
WC # 1	Welcome Home Vets sessions, I attend a therapy session with other women. Individual and couple counseling with the same counselor as my husband it is apparent my husband says there are no problems, as the therapist is quite surprised at what I have to say.	Maintain a sense of self through activities and counseling, Resilience	Resilience
WC # 2	Work, friends, exercise, my dog, compassion, reading Buddhist literature, I have known him for many years and we are good partners we have separate bedrooms, it is complicated as our daughter moved home because she has Lyme's disease so we just play well together in the sandbox and deal with what is going on.	Maintain a sense of self through positive activities. Compassion, Therapy Resolution	Resilience
WC # 3	Food I am presently 30 to 40 pounds overweight, I read 3-4 books a week as I am in someone else's life not my own. I do that less now because of our activity level.	Stress behavior (overeating). Maintain a sense of self through positive activities. Resilience	

	I used to be a spender but I'm much better now as it is our money, not my money anymore.	

Question # 5. What feelings do you experience in your relationship with your partner? Six of the spouses experienced mixed emotions of frustration, anger and loss of patience. Of the six participants, three felt as though they were "walking on eggshells" and "…never knew when the eggshells would break," especially since their husbands would not take any medications. One of the participants described love, tenderness and contentment for her husband, although this was after her husband attended a ten-week PTSD therapy course at the Veterans Administration Hospital. Another loves her husband and realizes "he is not perfect". One wife describes feeling sadness for her husband, as she "just doesn't know how to help him, …although he does attend sessions with a counselor." Lastly, one spouse felt subservient and manipulated by her husband. Various themes have emerged related to the feelings and emotions that were elicited by this question, *what feelings do you experience in your relationship with your partner,* as evidenced by the responses of the participants in Table 7. From these participants' statements meanings were ascribed that further supported the emerging themes of resilience, resignation and acquiescence.

Table 7. Question 5. What feelings do you experience in your relationship with your partner?

Participant	Lyon's Middle/Later Phase: Enmeshment/Resolution/healing Statements	Theme Clusters for the Middle/ Later Phase	Richardson's Emergent Themes
EC # 1	Anger, lots of anger, he's frozen in time emotionally, like an 18 year old, I'm 54, I don't want to be with an 18 year old, it's frustrating, the emotional commitment he can make, and sometimes I'm angry because I didn't sign up for this. Every time we went to get help they wanted to drag the family into	Anger Frustration Won't take medication	Resignation

	it, and sometimes that made me angrier because its really not our problem, we live with the problem, and yes we need to know about PTSD…so we can help him. My husband can be as healthy as he wants and that is where I feel the anger the most, he won't take his medications. I am not a control freak, but I do want to control my life and we react a lot more to situations than control them,you know its like walking on eggshells when is it going to break?	It's like walking on eggshells.	Acquiescence
EC # 2	Extreme sadness, helpless, as I can't help him (teary eyed) I just don't know what to do.	Sadness	Resignation
EC # 3	I'm proud of him, what he did, and that he served, he is a hard worker, loyal and a good person. Is he perfect? No, but he has positive qualtities. I love him, but I don't always like him, especially when his sandwich is not perfectly even and he throws it out.	Loves him, not perfect.	
EC # 4	EC # 4 Frustration, anger when I am trying to have a conversation with him he dismisses me, if I say black he says white. This has been observed by our adult son who will comment to his dad "you just completely dismiss anything she says to you and she is usually right". He takes a complete a opposite stance, I'd rather not even talk to him.	Frustration Anger	
EC # 5	Actually it's interesting I feel tenderness now and before I couldn't be bothered about it. As I said I started ignoring him, now were talking a lot more because he was in a 10-week program in the VA for PTSD, I don't know I just feel content and happy.	Tenderness Contentment Happy	
EC # 6	Anger, I am mad when I feel like I am being manipulated and controlled. I leave and go visit my sister because I am not happy around someone that is not happy, mad and wants no part of life. It took me many	Anger Feels Manipulated and Subservient	

	years to say I am going with my friends and in my 50's I realized I didn't have to ask permission to do things I always felt subservient and I was stepping out of character and it felt wonderful.		
EC # 7	Sometimes mixed feelings sometimes he is very sweet and other times I feel like I am walking on eggshells, if he is argumentative I try to stay away from him, he makes me change my mood. I am very frustrated.	Frustration I feel like I am walking on eggshells.	
WC # 1	Frustration, I lose my patience and I cry a lot.	Frustration	
WC # 2	Frustration with circle talking, ruminations, discussions. Marijuana is legal here and is used for my husbands' pain issues. It helps with the pain and makes him way too chatty.	Frustration	
WC # 3	Sometimes frustration, I love him, I care about him and I want what is best for us and if that means I have to give up something, I give it up. I'm better now it used to hurt a lot, because that is what it felt like all I ever did was give up. Sometimes it still feels that way, but I don't dwell on it like I used to. I'm learning how to cope better.	Frustration Love Resentment	

Question # 6: Why did you stay: There were varying reasons for staying in the relationships. Some of the reasons stated were based on having "married for better or for worse," while two women "were financially dependent on their spouses." A few others described feelings of love and compassion for their spouses, and yet another felt family responsibilities were reasons for staying in the relationship. One conflicted participant "loved and didn't love her partner at any given time" and was pondering divorce at the time of the interview. In response to the question *Why did you stay,* participants'

statements supported themes such as resolution/healing, resilience, resignation and acquiescence emerged from this question, and are found in Table 8.

Table 8. Question 6. Why did you stay? Or why did you leave?

Participant	Lyon's Later Phase: Resolution and Healing Statements	Theme Clusters for the later Phase	Richardson's Emergent Themes
EC #1	Because it's an illness, because we love him and there is a good man trapped inside we have talked about it as a family, I have included my children in family decisions regarding their father since they were old enough to understand, you know when they get really frustrated or he gets really bad, we will have a family meeting without him and I talk to him and we sometimes give him ultimatums it's time to go back on your meds, it's time to go back in the hospital.	Good man, Illness Married for better or worse	Resolution Healing Resignation Acquiescence Resilience
EC #2	He is my husband, I love him, I told him we should live apart, sell the house. I did this for the shock value, so he would understand I don't have to tolerate his behavior.	Husband, I love him For better for worse Commitment to relationship	Resignation Acquiescence
EC # 3	I love him, sometimes he is thickheaded, and that comes with being human and a man. I can't imagine my life without him. We are devoted to each other. The good outweighs the bad.	Good man, Love	Resilience
EC # 4	Honestly I didn't make enough money to leave. I wanted to be financially independent, I worked very hard to get into a Masters program that was extremely difficult to get into and just as I was into it we hit bottom with money and we were using my student loan	Financially dependent on spouse	Acquiescence

	money to live on and I had to drop out, so that's mainly it, if I had money or the means to really support myself I would have left.		
EC # 5	I did think of leaving him a couple of times and I guess that is why I stayed in therapy for so long. I know what a good person he is, once you see that he is not covered over in rage or anger and everything, you know you don't stop loving them. You almost love them more, we were having a good enough time, I would just disappear when he got crazy.	Good person Love	Resilience
EC # 6	My kids ask me that question even now and I do ask myself why didn't I leave? I think because it was so drilled into that you don't divorce someone, you don't leave, then I felt sorry for him, is it our duty to leave every sad person? You do make these promises and then ask yourself how am I at keeping promises and so I stayed. My kids say "why don't you go? And I want to but can no longer afford to do it, so I take mini steps away. I have my own bedroom, we live together but we live our own separate lives in a lot of ways.	Financially unable to leave, Not right to divorce. Felt sorry for him. Familial commitment Married for better or worse	Resignation
EC # 7	I don't know why I stayed, I love him, I feel sorry for him, and it's not his fault. He has noticed a change in my behavior. It is a toxic insane relationship, not a healthy one. My personal life has changed also. I have been thinking about it for the last two months. I don't love him as much as I did, now he is only company. He has become worse; he is verbally abusive yet. Even though I am living with him, I feel lonely. I spoke with her in December and she is considering a divorce related to his verbal abuse and	Emotional turmoil, love versus no love Feel sorry for him.	Resignation

	aggressiveness.		
WC # 1	Because I love him, he is a good person and (teary sounding) I find it very hard to cope, when he is being difficult. We have different philosophies towards life, but I have changed with his severe onset of PTSD. He is very negative and pessimistic I am a spiritual and positive person and feel you must create your own joy. And once I figured it out and could understand it, it was ok. I could deal with it.	Love Understanding Coping mechanisms	Resignation
WC # 2	I stayed because we had kids and a family and I am committed to my family and it got me into my own personal growth, he is damaged from the war.	Familial commitments.	Resilience
WC # 3	Married about 16 yrs when I asked if he wanted a divorce, because if something wasn't clean on a daily basis I was a lousy mom, lousy housewife. He didn't want a divorce just a clean house, and I say those things to get your attention. So I decided to stay as I married him for better or worse, this was part of the worse and I was going to get through it and we would make it.	Married for better or worse	Resignation

Question # 7: Have you ever been placed in fear? Seven of the participants have never been placed in fear and three have experienced fear-producing events. Two of the events were physical and alcohol related and one event was "reactionary," where the mother and children had to lock themselves in a room until the spouse calmed down from the trigger. When asked the question *have you ever been placed in fear*, significant statements of trust that they would not be harmed and uncertainty that physical harm may occur and support the themes of resilience, resignation and acquiescence are noted in Table 9.

Table 9. Question 7, Have you ever been placed in fear?

Participant	Lyons Middle Phase, Enmeshment Statements	Theme Clusters for the Phase	Richardson's Emergent Themes
EC #1	Not physical fear that would be the last straw, we bounce back from emotional abuse but we would never allow physical abuse to occur.	Trust they would not be harmed.	Resilience
EC #2	Not really, he is a vey kind man.	Trust they would not be harmed.	Resilience
EC # 3	No	Trust they would not be harmed.	Resilience
EC # 4	No		
EC # 5	I never had any fear he would hurt me, but I did fear he would hurt somebody outside of the family. After awhile he stopped being so angry. When he did get angry it was more diffused. In the beginning it could have come to pass.	Uncertainty	Acquiescence Resignation
EC # 6	No, my husband is not that scary of a guy really.	Trust they would not be harmed.	Resilience
EC # 7	Once she was placed in fear when he drank too much and grabbed her by the throat, his son was there and prevented him from hurting her, but his father was also hitting his son who was attempting to protect his stepmother. He is not physically abusive and would never hit me, as that would be the last time he did. The next day he didn't even remember it all.		Resilience Acquiescence Resilience
WC # 1	No, he would never hurt me.	Trust they would not be harmed.	
WC # 2	All the time. I wanted to leave but then remembered I have kids it is not fair to them shuffling back and forth… My husband had EMDR about 10 years ago and one day thought he was back in Vietnam and began driving erratically on the twisty and windy roads, my son	Multiple events of fear/related to reactive behavior, but never any physical harm.	

	was in the back seat throwing up and my daughter was in the car as well. At a stop sign I told her to jump out and go to a friends house. I got my son a ride home from the game. Once home I called the psychiatric facility that he had been in and they talked him down. I was afraid he was suicidal and I called one of his friends who came and stayed with him for a few days until it was safe for us to come home. There are many times he would get really angry and the kids and I would have to lock ourselves in the bedroom, it was mostly reactivity and I was not raised around that. I was raised around a family that didn't talk to each other, but nobody yelled and screamed at each other, it was terrifying to me, it was a dark time.		Resilience
WC # 3	There was one time when he partied too much and he struck me, but I understood the condition he was in and when I told him about it the next day, he said I would never hit you, and I said but you did, and that was the last time he drank.	One event, which resolved in her husband, never drinking again. Trust they would not be harmed.	

Question # 8: How are you different now? As individuals, the women have grown and matured, shifting from the present relationship to finding ways for personal growth rather than relationship growth. Many have developed self-preservation and coping skills. At this point in their lives, the experience is about the women they have become, not the relationship. Seven of the women have found the strength within themselves to endure the relationship, one feels she has become used to the relationship and sees no change in the future and two women are contemplating divorce. When asked the question *You are older now how is this different*, the participants responses support

the themes of resilience, resignation, healing and acquiescence have emerged as noted in Table 10.

Table 10. Question 8, You are older now how is this different?

Participant	Lyon's Later Phase Resolution/Healing Statements	Theme Clusters for the Later Phase	Emergent Themes
EC #1	I've matured, I feel more secure in myself, "I don't allow it to devastate me anymore, my self esteem was wrecked for awhile, he was verbally abusive and said the meanest things and I used to believe him. Not anymore "I am making choices and taking care of me right now and that's good".	Come to terms with situation. Maintain an intact sense of self	Acquiescence Resilience
EC #2	I am wiser and know there is help out there. She stated she would be joining a group therapy session in 2015. Sometimes we grow into situations and adjust without knowing it, it's like a pain your body adjusts to, and you change your movement without knowing. He is going to counseling and I believe it has made things worse.	Acceptance	Acquiescence
EC # 3	Before I accepted him for the person he was, now I accept him for a person with an illness. I speak my mind		Acquiescence?
EC # 4	In some ways it has mellowed me a little bit, I am turning it inward because I would rather not deal with him. I have exploded twice within the last month and he looks at me and says "I love you, don't you love me" "I tell him I am going to work". And if I could pack a bag and leave I would. My son spoke to him that day about his behavior and when I got home he was more attentive, I felt he was placating me, you just can't get through to him. I came home on Friday and told him I was leaving for the weekend to go to a friends house and I left, that seems to have gotten through to him, it was much better after that.		Resignation Acquiescence
EC # 5	I am paying more attention and I'm more present myself, we still bicker, you know I have never been a pushover. Our relationship was volatile in the past, now its very caring and being older is not as bad as they make it out to be. I am present with both of us.	Age related changes. Attentive caring relationship Caring relationship	Resilience
EC # 6	I am braver than when I was younger and I am willing to do things on my own, um I have my own life and not just be an appendage sort of.	Independence	Acquiescence Resilience

EC # 7	I am anxious, there is no effective communication. I am unhappy very unhappy. It is very frustrating to live with him…I started noticing symptoms the first year of marriage, moody, argumentative. We can't make plans to go out because of his sleeping pattern, he is always tired and I can't enjoy myself knowing time is limited if we go out.	Unhappy	Resilience
WC # 1	I have made a life for myself here, I have made lots of friends, I have started teaching and riding and I love and have had great success with that. I get upset with myself I'm not patient anymore with him because he is negative about the future of our life together, he struggles, I'm sad most of the time	Happy Sad Mixed emotions	
WC # 2	W.C.# 2: I learned a lot, I've done a lot of personal growth, I made the decision not to leave. I always had a foot out the door you know I can't deal with this bullshit… blah blah blah I think once I made the decision I'm here for the duration, and I am not going anywhere and I will make it work for me without bringing anyone else down and I think my husband would say I'm a pretty good wife, I pick up the slack made sure my husband got his benefits, I'm here for the kids, I put everybody first, but I also took care of myself.	Personal growth, Maintain an intact sense of self.	Resilience Resilience
WC # 3	W.C.# 1: I have better coping skills, I know I can go to the coast to visit my family, I can get a girlfriend to go out to lunch with and talk. I have a sister who has been my release valve for all of our married life. She knows about every secret there is to know about in our life and has been there for me when I needed someone to uncork on.	Better coping skills.	

Summary

In this summary the data will be analyzed within the framework of Colaizzi's (Colaizzi, 1978) phenomenological method as it relates to the experiences of wives/female companions living with aging Vietnam veterans with chronic PTSD. Initially, the researcher conducted interviews to acquire a sense of each participant's experience; the interviews were then transcribed to "acquire a feeling for them" (Colaizzi, 1978, p.59). To gain a deeper understanding of the interviews, the researcher listened to the audiotaped sessions multiple times to extract significant statements and formulate

meaning from these narrations. Interview data was organized utilizing NVIVO 10 software and subsequently tabulated into significant statements, clusters and emergent themes as previously presented. The exhaustive phenomenon was organized according to the participants' responses to the eight questions in the study.

The fundamental structure of the phenomenon indicates that the wives/female companions living with aging Vietnam veterans with chronic PTSD have progressed through various phases over the years while attempting to adapt with the chronicity of PTSD symptoms. The effect of this long term PTSD relationship within the context of the aging process has revealed emerging themes that had not been previously described. Lyon's identified three phases of the relationship in her study; the early or adjustment phase, the middle or enmeshment phase, and the later phase of resolution and healing. Consistent with the parent study by Lyons, the participants of this study transitioned through various phases with similar overlapping themes in the early and middle phases. In the later phase Lyons defined the ongoing process of resolution and healing as "the point at which they chose to stay or leave in the relationship with veteran partners"(Lyons, 2001, p.75) However, while Lyons identified resolution and healing in the later phase, this study built upon those findings and discovered an epilogue phase in the relationship with additional themes of resilience, resignation and acquiescence. The latest phase to emerge was termed the epilogue phase since it describes an "event which reflects meaningfully on a recently ended conflict or struggle" (Free Dictionary, 2015). As the relationship experience changed, the participants transitioned through these stages in a non-linear and at times, concurrent patterns.

For the purpose of this study and based on the narrative accounts of the participants,

resilience is defined (Merriam Webster), 2015 "as the ability to become strong, healthy, or successful again after something bad happens". Acquiescence is "defined as the reluctant acceptance of something without protest" and resignation" defined is the acceptance of something undesirable but inevitable". Of the 10 participants, two women (E.C. # 7, & W.C. # 2) resolved to leave their relationships, consistent with Lyons later phase of resolution/healing. Two of the 10 participants (E.C.# 2, & #6) desired to maintain their marriage vows "for better or worse" and thus the theme of resignation emerged. One participant (E.C.# 4) is financially dependent upon her spouse and is resigned to the fact that she is unable to leave (resignation/acquiescence). Five of the participants (E.C. #1,3, 5 & W.C. # 1 & 3) moved from resignation/acquiescence into resilience during the course of the study.

The final validating step of Colaizzi's (Colaizzi) method of data analysis requires the researcher to return to the participants to authenticate interviews after the initial steps of data analysis are completed. Each participant was called and the interviews were reviewed. All of the re-interviewed participants (9/10) were in agreement that the findings represented their lived experiences. One participant did not wish to be contacted, as her husband was unaware of her participation in this study. The credibility of these interviews has been met as each participant agreed that the information they gave the co-investigator was verified in a return interview. While the data may be relevant in other contexts, transferability of the findings may not be generalizable to individuals with similar but not identical experiences. Dependability was obtained through replication of Lyons study with an older cohort who reported similar experiences 13 years later. Lastly, the researcher's interpretations of the phenomenon were confirmed through review of the

findings with the participants; conformability was also achieved through a review of narratives and themes by a doctoral prepared nurse colleague as well as a doctoral nurse candidate.

In Chapter 4, the results of this descriptive phenomenological study were presented. Demographic data of the criterion sample and results of the Cohen Perceived Stress Scale were tabulated. Themes were extracted from narrative data with new findings identified through Colaizzi's phenomenological method. These new findings added to the prior study by Lyons and provided further description of the phenomenon of living with aging Vietnam veterans with chronic PTSD. In Chapter 5, analyses of these findings will the presented within the context of the double ABCX model, a family stress model (Weber,) 2011. Significance to nursing, limitations to the study and areas for future research will also be discussed.

Chapter 5: Discussion, Conclusions and Recommendations

Research Question

The purpose of this study was to describe the experiences of wives/female companions living with aging Vietnam veterans who suffer from chronic post-traumatic stress disorder using a phenomenological methodology and to compare/contrast findings to the 2001 parent study conducted by Lyons titled "Living with Post-traumatic Stress Disorder: The Wives'/Female Companions' Perspective".

The research question central to this phenomenological inquiry was: What is the experience of wives/female companions living with aging Vietnam veterans with chronic post-traumatic stress disorder.

Specific Aim 1: *To explore the meaning of wives/female companions' experiences when living with aging Vietnam veterans who chronically suffer with PTSD.* The objective of phenomenological research is to provide a description of everyday occurrences in an effort to understand the central structure (Sanders, 2003). This specific aim was met as the researcher explored the meaning of the lived experience with the participants and the effects of these experiences on the wives'/ female companions living with aging Vietnam veterans.

Meaning was described as the accounts these women gave regarding life events, their roles and what it meant to be living with or married to an aging Vietnam veteran with chronic PTSD. These women describe the phenomenon as an inescapable emotional journey that invades their person, marital relationships, family dynamics, and social situations. The participants ascribed meaning to a lack of normal family functioning, concern for safety of children and self, increased stress related to worsening health and

PTSD symptoms as the women and spouses aged (Fredrickson, Chamberlain, & Long, 1996). Many of the wives had sought out medication and counseling for their spouses as well as themselves. Three of the women stated that despite their feelings for their spouses and family, they would eventually be seeking divorce. Other wives/companions felt that they had married for better or for worse and would remain in the marriage.

Specific Aim 2: *To understand the effects of long-term exposure to PTSD symptomatology in wives/female companions living with aging Vietnam veterans and to explore the impact of this long-term exposure on family relationships.* The impact of long-term exposure to PTSD was consistent among the wives/female companions. Many of the women voiced frustration and anger regarding their situations: one began therapy as early as 25 years ago, and some sought medical care and received antidepressants. Yet, they found some solace by immersing themselves in their work, families or hobbies despite their situation. However, not all marriages will remain intact, as the burden of long-term exposure has weighed heavily on some of the wives/female companions, and they will be seeking dissolution of their marriages. Another consequence of long-term exposure to PTSD for the wives/female companions is the effect that PTSD has had on these women. When questioned whether or not they felt as if they had secondary PTSD, there were immediate positive responses and one woman stated, "the thought never crossed my mind" (E.C.5, personal communication, April 14, 2015), this woman had been in therapy for 25 years since her husband's anger issues originated. This specific aim was met.

Specific Aim 3: *To make direct comparisons and contrasts to the parent study by Lyons and to increase the level of evidence on the topic of the effects of PTSD, on*

wives/female companions. Similar to the parent study by Lyons, results of this study demonstrated that while the participants transitioned through parallel phases in the early and middle phases, ultimately in the later phase, those who decided to stay in the relationship experienced not only resolution/ healing but also resignation/acquiescence and resilience. However, while Lyons identified resolution and healing in the later phase, this study built upon those findings and discovered an epilogue phase in the relationship with additional themes of resilience, resignation, and acquiescence. In this study, the addition of resignation/acquiescence and resilience into the later phases of the relationship adds new insight into the experience of wives/female companions related to the chronicity of PTSD symptoms and the effects of this disorder on long term relationships. This specific aim has been met.

Literature indicates that there is increasing evidence that PTSD adversely affects wives/female companions living with veterans with chronic PTSD. Due to PTSD symptomatology and associated behaviors, interpersonal relationships are strained resulting in marital instability, relationship distress, and inability for intimacy (Manguno-Mire et al., 2007). The women in this study have spent 6 to 48 years in a relationship that at times affected them physically and psychologically. They have experienced varying emotional reactions to or because of the effect of their spouses' PTSD and its evolution through the years. As the spouses aged and PTSD symptoms and behaviors became more consistent and began to interfere with personal, family and social relationships, the wives sought out therapy, medication or hospitalization for their spouses, and eventually began taking medication or attending therapy themselves.

Other studies have demonstrated that women living with veterans who have PTSD exhibit high levels of stress that may affect physical and psychological well being (Calhoun et al. 2002, Fredrickson, Chamberlain, & Long, 1996; Manguno-Mire et al., 2007). Consequently, there is a change in the female partner/spouse in the caregiver role, within the marital /relationship dyad and on family dynamics. Although the qualitative studies have shown that there is a negative effect on women who live with these men, the researchers have concluded that these women may suffer from a secondary form of traumatic stress disorder (TSD) in their attempts to provide support to their companions (Lyons, 2001). When validating the participants' initial interviews I asked each participant if she felt that she suffered from a secondary form of PTSD and 90% of the women stated yes. In 2007, Manguno and Mire, 2007 conducted a cross-sectional study using a convenience sample of female companions (N89) cohabitating with combat veterans with PTSD. The purpose of the study was to describe the relationship between psychological distress and partner burden in the context of family and treatment factors, utilizing the Partner Experiences with PTSD Survey (PEPS). Findings indicated that partners had an increase in psychological distress when perceived threat was imminent. Despite the limitations that this study was completed on a convenience sample of individuals living with veterans receiving mental health treatments, the findings support that companions of veterans with PTSD are a distressed group that receive only limited mental health care. To validate this point a participant in this study W.C.# 3, stated "Yes I have secondary PTSD, I look for a corner in a restaurant, I can do better coping…I'm not suicidal but I would like to run away sometimes. You know we wouldn't have these problems if we had just been included in the process, the outcome would have been

different, no one ever asked me…our lives would have been so different, the army might have some culpability…"(W.C.# 3, personal communication, March 29, 2015). The findings of the aforementioned studies parallel similar findings from this study that women living with aging Vietnam veterans who suffer from chronic PTSD may have greater psychological distress related to their partners disorder.

Analysis

Data analysis will be presented within the context of the Double ABCX Model, a family stress theory. The Double ABCX model, a longitudinal model of family stress and adaption, is based upon the initial ABCX formula developed in 1949 by "the father of family stress theory", Reuben Hill (Weber, 2011, p. 82). The conceptual framework of the ABCX formula focuses on the pre-crisis variables of families. In this model variable *A*. refers to the crisis-precipitating event or stressor; variable *B* is the family's crisis meeting resources or the family's ability t deal with the stressor; variable C is the definition the family makes of the event and the accompanying effects on the family; the interaction of variables A, B, and C, that produce variable X, the family crisis (Weber, 2011). In this formula, a family stressor occurs (A) that the family may not have been prepared for and is viewed by the family as a hardship. Depending upon the family's crisis-meeting resources (B), the stressor (A) either sends the family into a crisis (X) or the family is kept out of crisis (X) with available resources. The definition the family makes of the event (C) determines whether the family views the stressor as a challenge or a crisis (Weber, 2011).

Based on Hills ABCX formula, McCubbin and. Patterson (1983) added five variables to the model to create the Double ABCX Model. These five variables were

added to explain how families recover from crisis and why recovery from crisis varies among families. The five variables added were;"(1) additional life stressors and strains; (2) psychological, intrafamilial and social resources;(3) changes in the family definition ;(4) family coping strategies; and lastly a range of outcomes with family coping strategies..." (Weber, 2011, p.85). The three main parts of the Double ABCX Model are: precrisis, crisis, and postcrisis (Weber).

The precrisis includes the same variables (stressor, resource and definition) as the ABCX Formula up to the crisis. However, the authors changed the labels and the names of some of the variables and used lowercase letters to identify the changes. The lowercase (a) in the Double ABCX model represents the initial stressor. The lowercase (b) was labeled "existing resources" (page, 85) and changed from crisis-meeting resources (B). Additionally "psychological, individual and social/community resources as well as intrafamilial family resources" (p. 85) were included as resources. The label for (c) was changed to "perception of the stressor "as opposed to "the definition the family makes of the event"(p. 85). In the Double ABCX model, lowercase (x) is the label for crisis (Weber).

While Hills formula ends with the crisis (X), the Double ABCX model added postcrisis variables to the original formula (see Figure 2.). These variables were: (1) pileup, aA; (2) existing and new resources, bB; and (3) perception of the crisis, pileup, and resources, both new and existing, cC. (4) coping, and (5) adaptation. The variable pileup consists of the initial stressor and the cumulative hardships that persist over time to become chronic. During pileup, transitions occur within the family, along with

consequences within the family and society, as the family attempts to cope and adapt over time (Weber).

The emergent themes of the present study, along with the themes of the parent study by Lyons, are depicted in the Double ABCX Model in Table 12.

Table 11. Study Themes in the ABCX Model

Double ABCX Model	Lyon's Themes	Richardson's Themes
Precrisis	Early Phase begins with relationship and ends with awareness of Veteran's Illness	Recognizing and experiencing PTSD symptoms
Crisis	Middle Phase realization of severity of Veteran's symptoms and ended with decision to stay or leave	Dealing with PTSD symptoms
Post Crisis	Later Phase Ongoing Healing and Resolution	Pile-up of initial stressor (PTSD), hardships created within the relationship by the stressor (PTSD), transitions within the relationship, perceptions of the challenge
Coping	Later Phase Healing and Resolution	Resignation, Resilience, Acquiescence
Adaptation	Later Phase Healing and Resolution	Epilogue Phase: Bonadaptation- Resilience Maladaptation- Resignation, Acquiescence

PTSD is the initial stressor in the pileup phase of the Double ABCX Model, while this stressor was not identified for a number of years, the behaviors were identified by the participants as stressors to the relationship. Over time, the hardship of the initial stressor increased and became chronic, affecting both the wives and female companions as well as the spouses. The aberrant behaviors were consistent with the symptoms of PTSD, and as these symptoms worsened the behaviors began not only to interfere with the core dyad relationship, but also with family and social relationships, the themes of recognizing, experiencing and dealing with PTSD emerged and became part of everyday life. As the symptoms changed over time and worsened, it was noted by a few of the spouses that age seemed to be a contributing factor and it was difficult to determine if the changes were related to aging and co-morbidities or worsening PTSD. A third theme, dealing with

ongoing and worsening PTSD symptoms within the aging process emerged. However, the women sought out resources and started to attend counseling sessions, meetings for wives whose partners had PTSD, and some of the women began introspectively reflecting on their lives and making positive changes. This theme was termed resilience.

Coping in the Double ABCX Model interacts with all labels, aA, pileup, label bB, existing and new resources, label cC, perception of x + aA + bB, and with xX, Adaption, Bonadaptation, and Maladaptation. The responses from the participants varied regarding their coping skills and mechanisms for dealing with the behaviors. One woman described her coping mechanism similar to the phases of grief, as she moved through the phases with resignation as the outcome. Others immersed themselves in activities or counseling and attempted to maintain a positive outlook. Themes extracted from these responses were resignation, acquiescence, and resilience. Those who are resigned and acquiesce to the situation may utilize some positive coping methods but not nearly as many of those who are resilient and do not let the behaviors overwhelm them.

How the wives'/female companion adapt to their living situation, and whether or not it has a positive or negative outcome is determined through their ability to adapt to changes in the family systems (Weber). The balance of the family system is interrupted and has long-term effects on the family relationships, communications, interactions, rules, and perceptions (Weber).

A continuum of balance must be achieved at two levels to achieve bon adaptation. These levels are member-to-family and family to community levels (Weber). If the levels are in balance the outcome is positive for bonadaptation. Maladaptation (xX) is found on the negative end of the continuum when there is an imbalance in one or both

of the levels, or balance at the expense of the family's or a family member's integrity, development or autonomy (Weber).

Limitations

Limitations in this research study were: small sampling size, criterion sampling, researcher bias, non-generalizability, and "going native". In qualitative studies, where the sample is often smaller than quantitative studies, saturation occurs when the information starts to become redundant. Hence, a small sample size of 10 participants was sufficient for this study as saturation was met. Criterion sampling was utilized and was a limiting factor in the amount of participants that responded to recruitment posters or met the criteria for the study. As the co-investigator became immersed in the stories of the participants, researcher bias and "going native" (Polit & Beck, 2008, p.386) were also limitations. Researcher bias is a preconceived belief about the phenomenon and "going native " is when the researcher becomes actively involved in the situation and immersed in the stories of the participants. Due to personal experiences with the phenomenon, the co-investigator consistently found it difficult to bracket and became immersed in the stories of the participants. Another limitation is non-generalizability to populations without identical characteristics of the study population. This study cannot be generalized to presume that all wives of Vietnam veterans with chronic PTSD feel the same way or have had similar experiences. Lastly, the diagnosis of PTSD was purely by self report from the participants who took part in this study. Upon reflection, there may have been more risk to human subjects than first hypothesized, as there were more active emotional responses during the interview process than expected.

Delimitations

The research question central to this phenomenological inquiry is: What is the experience of wives/female companions living with aging Vietnam veterans with chronic post-traumatic stress disorder: A Qualitative Replication Study. The research study was delimited to wives and female companions living with aging Vietnam veterans diagnosed with chronic PTSD. In order to participate the women must have lived with or been married to an aging Vietnam veteran for at least six months within the past 15 years, agree to participate in the study and be audiotaped about their experience of living with an aging Vietnam veteran with chronic PTSD. This delimitation was chosen, as this was a replication study. The original study was published in 2001.

Implications for Nursing

Professional Nursing Practice

Much of the recent literature regarding the effects of war on veterans' health has focused on PTSD. However, a dearth of information exists that addresses the impact of PTSD on the wives/female companions of aging Vietnam veterans with chronic PTSD. The finding of this study describes the experiences of women living with these veterans. These women describe the phenomenon as an inescapable emotional journey that invades their person, marital relationships, family dynamics, and social situations. As these couples age, the symptomatology of PTSD may worsen and the wives/female companions attempt to cope with these changes while remaining intact.

Nurses in multiple settings may encounter Vietnam veterans and their wives and female companions. The findings of this study provide a richer description of this phenomenon than was previously described in the literature. An enhanced understanding

of the lived experiences of these women contributes to the body of nursing knowledge on this topic to better meet the needs of this group. Through the shared experiences of these women, ongoing research has the capability to influence health policies that improve mental health services for aging veterans and their dependents. In support of the increasing number of veterans and military families dealing with PTSD, nurses committed to national initiatives for increased training in mental health with an emphasis on veterans' issues can effect change.

Advanced and Doctoral Advanced Nursing Practice

Nurses in all settings may encounter Vietnam veterans and their wives/female companions and must understand the essence of the phenomenon of living within this situation, the chronicity of the symptoms, and the impact of PTSD on these relationships. An understanding of this phenomenon through the description of lived experiences of these women should provide them with a voice. A richer description and meaning of this phenomenon should promulgate further research of the effects of PTSD on wives/female companions living with aging Vietnam veterans. Through the shared experiences of these women, ongoing research has the capability to influence health policies that improve mental health services for veterans and their dependents.

Implications for Future Nursing Research

As Doctoral Advanced Practice Registered Nurses (DAPRN) develop greater advocacy roles, this research is significant as it is likely to enhance their knowledge base of the health issues affecting the vulnerable aging population of Vietnam veterans with chronic PTSD and their wives and female companions. Furthermore, by advancing the science of nursing knowledge, the DAPRN should utilize the findings of this study to influence the policy makers. DAPRNs have a responsibility to develop their political

expertise to represent their patients and their profession for political activism and social justice (Ward, 2011). The prevalence of post-traumatic stress disorder (PTSD) is increasing in both the military and general population. According to recent statistics 7-8% of Americans have experienced PTSD at some point and in any given year 5.2 million adults will experience PTSD (National Center for PTSD, 2012). The significance to nursing practice is that in all settings nurses may encounter patients and families who are affected by PTSD. The implication for nurses is that they must understand PTSD pathology, assess for a history of trauma, military or non-military, and symptoms of PTSD, inclusive of problems with sleep, insomnia and nightmares. Incessant nightmares interfere with rapid eye movement (REM) sleep and if not recognized as part of a sleep disorder may worsen and become a REM behavior disorder. Recognition of PTSD should prompt a multidisciplinary referral for support services, including a referral to a center for sleep disorders. Finally nurses as front line providers, researchers and educators, can respond to this PTSD crisis and effect health care policy change.

Summary

Similar to the parent study by Lyons, results of this study demonstrated that while the participants transitioned through parallel phases in the early and middle phases ultimately in the later phase those who decided to stay in the relationship experienced not only resolution/ healing but also resignation/acquiescence and resilience. However, while Lyons identified resolution and healing in the later phase, this study built upon those findings and discovered an epilogue phase in the relationship with additional themes of resilience, resignation, and acquiescence. In this study, the addition of resignation/acquiescience and resilience into the later phases of the relationship adds new insight into the experience of wives/female companions related to the chronicity of PTSD

symptoms and the effects of this disorder on long term relationships. While the epilogue phase builds upon Lyons findings, additional qualitative research must be completed to validate the findings of this present study.

The prevalence of PTSD is increasing in both the military and the general population. In light of the conflicts of the past 14 years, there will be many more spouses and companions both male and female who will be living with, or providing care for a veteran both in active duty or retired, suffering from PTSD and quite possibly other horrific injuries. Through the shared experience of these women, ongoing research has the capability to influence health policies that improve and expand mental health services for veterans and their dependents.

List of References

Abt Associates, (2014, August 08). Initial Findings: National Vietnam Veteran Study Reveals long-Term Course of PTSD and Link to Chronic Health Conditions. (http://abtassociates.com/NewsRelease/2014/Initial-Findings-National-Vietnam-Veteran-Study-Re.aspx).

Albrecht, B. (2010, February 07). Vietnam generation begins to fade as death rate rises for war's veterans. Retrieved from http//blog.cleveland.com/metro/Vietnam Vets fight final Battle.

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

American Psychiatric Association. (2000). Retrieved from :http://DSM-IV-TR-criteria for PTSD–NATIONAL CENTER FOR PTSD.

American Psychiatric Association. (2013). Retrieved from: http:// www.DSM5.org/Documents/PTSD

American Psychiatric Association, (21015) DSM: History of the Manual. Retrieved from www.psychiatry.org

American Psychiatric Association, (2015) Retrieved from http://.www.practicecentral.org/update/2012 /09-13/ptsd-dsm

American Psychiatric Association. (2015). Retrieved from http://www.Psychiatry.org/ptsd

Beck, C.T. (1994). Phenomenology: Its use in nursing research. *International Journal of Nursing Studies. 31 (6), 499-510*

Bilmes, L.J. (2011). Current and projected future costs of caring for veterans of the Iraq and Afghanistan Wars. Retrieved from http://www.Cost of war.org/sites/default/files…Bilmes%20veterans%20costs.pdf

Bobo, W. V., Warner, C.H., & Warner, C.M. (2007). The management of post traumatic stress disorder (PTSD) in the primary care setting. *Southern Medical Journal, 100* (8), 797.

Calhoun, P. S., Beckham, J. C., & Bosworth, H. B. (2002). Caregiver burden and psychological distress in companions of veterans with chronic posttraumatic stress disorder. *Journal of Traumatic Stress,15*(3), 205-212.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*, 386-396.

Colaizzi, P.F. (1978) Psychological Research as the Phenomenologist Views it. In Valle, R., King, M (Eds.) *Existential Phenomological Alternatives for Psychology*. pp(. 59-62). New York, NY:Oxford University Press.

Connelly, L.M. (2010). What is phenomenology?*Medsurg Nursing, 19(2),* 127-128.

Cresswell, J. (2009).The Selection of a Research Design. In J. Cresswell (ED.). *Research Design: Qualitative, Quantitive,and Mixed Methods Approaches (*pp. 3-21*)*. Los Angeles:Sage

Dahnke, M. (2011). Philosophies of Social Science. In M. Dahnke, & H.M.Dreher, *Philosophy of Science for Nursing Research: Concepts and Application* (pp.243-268). New York:Springer.

Dohrenwend,B.P.,Turner,J.B.,Tursi,N.A.,Adams,B.G.,Koenen,K.C., & Marshall, R.(2006).The psychological risks of vietnam for U.S. veteras: A revisit with new data and methods. *Science, 313,*979-982.

Engdahl, B., Dikel, T. N., Eberly, R., & Blank, A., Jr. (1997). Posttraumatic stress disorder in a community group of former prisoners of war: A normative response to severe trauma. *American Journal of Psychiatry, 154*, 1576-1581.

Flood, A.(2010). Understanding phenomenology. *Researcher,17(2),7-15.*

Frederickson, L. G., Chamberlain, K., & Long, N. (1996). Unacknowledged casualties of the Vietnam war: Experiences of companions of New Zealand veterans. *Qualitative Health Research, 6*(49), 49-70.

Free Dictionary. (2015). Retrieved from: https: www.freedictionary.com/

Friedman, M. J. (2013). Finalizing PTSD in DSM-5: Getting here from there and where to go next. *Journal of Traumatic Stress, 26,* 548-556.

Friedman, M. J.(2013). PTSD History and Overview. *National Center for PTSD* Retrieved from http://www.ptsd.va.gov/professional/PTSD-overview.asp

Gardner, A. (2007). Battle Continues over Vietnam PTSD Numbers. *U.S.News & World Report* Retrieved from http://health.usnews.com/usnews/health/healthday/070823/battle-continues-over-vietnam-ptsd-numbers.html

Gould, D. (2002). Using replication studies to enhance nursing research. *Nursing Standard, 16,(49),* 33-46. Time.health.mo.gov/training/epi/PrevalenceRates.html

Houston, A.A., Webb-Murphy, J., & Delaney, E. (2103). From DSM-IV-TR to DSM-5:Changes in Posttraumatic Stress Disorder. Naval Center for Combat & Operational

Control http://www.med.navy.mil/sites/nmcsd/nccosc/healthProfessionalsV2/reports white-paper-Documents from-dsm-iv-tr-to-dsm-5

Jankowsi, K. (2007). PTSD and Physical Health. National Center for PTSD. Retrieved from: http://www.ptsd.va.gov/professional/pages/ptsd-physical-health.asp

Jasper, M. A. (1994). Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing*, *19,* 309-314.

Jordan, K.B., Marmar, C., Fairbanks, J.A., Schlenger, W.E., Kulka, R.A., Hough, & R.L., Weiss. D.S. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 60(6) 916-926.

Kaiser, A.P., Wachen, J.S., Potter, C. Moye, J. & Davison, E. (2013) Posttraumatic stress symptoms among older adults: A review. Retrieved from: http//: www. Ptsd.va.gov.

Kessler, R.C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry, 61 (supplement 5),* 4-12.

Knaack, P. (1984). Phenomenological research. *Western Journal of Nursing Research, 6 (1),* 107-114.

Lyons, M. A. (2001). Living with post-traumatic stress disorder: The wives'/female companions' perspective. *Journal of Advanced Nursing, (1)* (34), 69-77.

Manguno-Mire, G., Sautter, F., Lyons, J., Myers, L., Perry, D., Sherman, M., & Sullivan, G. M. (2007). Psychological distress and burdena among female companions of combat veterans with PTSD. *The Journal of Nervous and Mental Disease 195*(2) 144-151.

McFarlane, A.(2000). Posttraumatic stress disorder: A model of the longitudinal course and the role of risk factors. *Journal of Clinical Psychiatry 61(supplement 5)15-20.*

Merriam Webster. (2015). Retrieved from:http://www.merriam-webster.com

Mliad, M.R., Pitman, R. K., Ellis, C. E., Gold, A. L., Shin, L. M., Lasko, N. B., Zeidan, M.A., Handwerger, K., Orr, S.P., & Rauch, S. L. (2009). Neurobiological basis of failure to recall extinction memory in posttraumatic stress disorder. *Biological Psychiatry,66,* 1075-1082.

Munhall, P. L. (2007) Nursing research, A qualitative perspective. In Munhall (Ed.) 4th edition. *A Phenomenological method*. Sudbury MA. Jones & Bartlett.

National Center for PTSD, (2012) United States Department of Veteran Affairs Factsheets. How common is PTSD? Retrieved from: www.ptsd.va.gov.

Nayback, A. M. (2009). PTSD in the Combat Veteran: Using Roy's adaptation model to examine the combat veteran as a human adaptive system. *Issues in Mental Health Nursing 30*, 304-310.

News 21. (2013) Veterans come home to unprepared nation. Retrieved from: http://www.news 21.

Norris F. H. (1990). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consult Clinical Psychology, 60,* 409–418.

Polit, D., & Beck, C.T. (Eds.). (2008). Developing an approch for a qualitative study. In *Nursing Research, Generating and Assessing Evidence for Nursing Practice (8th ed.).* 219-245 and 328.

Prevalence Rates, (2015). Retrieved from:http://www. health.mo.gov/training/epi/Prevelance Rates.html

Price, J. (2010). National Center for PTSD, United States Department of Veteran Affairs Factsheets. Retrieved from: www.ptsd.va.gov/professional/pages/vietnam-veterans-study.asp.

Price, J.L. (2007). Findings from the National Vietnam Veterans' Readjustment Study. Retrieved from: http://www.ptsd.va.gov/professional/pages/vietnam-vets-study.asp

Ray, S. L., & Vanstone, M. (2009). The impact of PTSD on veterans' family relationships: An interpretative phenomenological inquiry. *International Journal of Nursing Studies, 46*(6), 838-847.

Reiners, G.M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing Care, 1(119),*1-3.doi:10.4172/2167-1168.1000119

Richardson, L. K., Frueh, B.C., & Acierno,R. 2010. Prevalence estimates of combat-related PTSD: A critical review. *Australian New Zealand Journal of Psychiatry*, *44* (1), 4-19 doi: 10.3109/00048670903393597.

Sanders, C. (2003). Application of Colaizzi's method: Interpretation of an auditable trail by a novice researcher. *Contempory Nurse, 14(3),* 292-302.

Shin, L. M., Orr, S.P., Carson, M.A., Rauch, S,L., Macklin, M.L. Lasko, N.B., Peters, P.M., Metzger,L.J. Dougherty, D.D., Cannistraro, P.A., Alpert, N.M., Fischman, A.J & Pitman, R.K. (2004). Regional cerebral blood flow in the amygdala and medial prefrontal cortex during traumatic imagery in male and female Vietnam Veterans with PTSD. *Archives of General Psychiatry, 61*,168-176.

Somes, J.(2013). Vietnam veterans: Getting old,getting sick-is this service related. *Journal of Emergency Nursing, 39,(6),*640-643.

United States Department of Veterans Affairs Factsheet. Retreived from www.ptsd.va.gov

US Legal.com http://USLegal (2001-2015).

U.S. Medicine. (2014). U.S.Medicine.com/...veterans.../ptsd-still-plagues-more-than-1-in-10-...

U.S .Veteran Population Census (2000). Retrieved fromwww.infoplease.com.MilitaryAffairs.Veteran

VA DoD.(October 2010). Clinical Practice Guidelines for the Management of Post-Traumatic Stress, Core Module Algorithm,14.http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL- 201011612.pdf

Vietnam War Statistics (2013) Armed Forces Press.Com/www.veteranshour.com/vietnam_war /statistics.htm

Vieweg, W.V., Julius, D.A., Fernandez, A., Beatty-Brooks, M. Hettema, J.M., & Pandurangi, A.K. (2006). Posttraumatic Stress Disorder: Clinical features, pathophysiology, and treatment. *The American Journal of Medicine, 119*, 383-390.

Vivar, C.G., McQueen, A.,Whyte,D., & Armayor, N.C. (2007), Getting started with qualitative research :developing a research proposal. *Nurse Researcher, 14*, (3) 60-73.

Ward. L. (2011). A new level of advocacy for nurses in the doctoral advanced nursing practice role. In H.M. Dreher & M.E.Smith Glasgow (Eds.), *Role Development for Doctoral Advanced Nursing Practice* (pp. 357-367). New York: Springer.

Weber, J. G. (2011). The ABCX formula and the double ABCX model. In *Individual and family stress and crises.* (pp. 82-97). Thousand Oaks, CA: SAGE Publications, Inc. doi: http://dx.doi.org/10.4135/9781452274720.n4

Wojnar, D.M. & Swanson, K.M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing, 25,172*-179.

Appendix A: Data Collection Questions

1. What was your early relationship like?
2. What PTSD symptoms does your partner experience?
3. How have these symptoms changed over time?
4. How have you coped with them?
5. What feelings do you experience in your relationship with your partner?
6. Why did you stay or why did you leave?
7. Have you ever been placed in fear?
8. How are you different now? You are older now, how is this different?

Appendix B: DSM-IV TR Criteria for PTSD

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or Without delay onset: Onset of symptoms at least six months after the stressor

References

1. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th Ed.). Washington, DC: Author.

Appendix C: Inclusion Screening Questions

1. Are you living with an aging Vietnam veteran with a diagnosis of PTSD?
2. Have you lived with an aging Vietnam veteran diagnosed with chronic PTSD for more than six months within the last 15 years? _____
3. What type of health professional diagnosed your spouse/significant other with PTSD?
4. A. When did your partner's symptoms of PTSD begin? _____

   B. When was your partner *diagnosed* with PTSD? _____

   C. During or after separation from the military? _____

   D. Was it months or years after separation from the military? _____
5. Has your partner ever been diagnosed with Dementia or Alzheimer's? Yes No
6. Would you be willing to participate in a study and be willing to be audiotaped about your experience of living with a Vietnam veteran with chronic PTSD?

If participant answered, "yes" to all questions, then they are eligible for study inclusion.

Appendix D: Demographic Information

1. Age_____

2. Race: (NIH Categories):

A. White B. Black/ African-American C. Asian D. Hispanic/Latino

E. American Indian or Alaskan Native F. Hawaiian/Pacific Islander

3. Marital Status:

A. Married B. Co-Habitation C. Separate/Divorced D. Widow E. Single

Number of marriages_____

4. Number of Living Children in Family _____

Number no longer living_____

A. List ages of Children/Adult Children_____

5. Educational Level:

A. Graduate school B. College degree C. Some college D. High school diploma

E. Some high school.

6. Occupation:

A. Working full time B. Working Part time C. Retired D. Homemaker

E. Unemployed F. Other

7. Yearly Household Income Level:

A. Less than $20, 000 B. $20,000-$40,000 C. $41,000-$60,000 D. $61,000-$100,000

E. Over $100, 000 F. Over $200,000

8. Smoking History

A. Current smoker?

B. Yes. No.

C. If yes, describe: how long (years)_____ how many cigarettes per

day_____

9. Alcohol Consumption

A. Yes. B. No.

If yes, what type of alcohol? _____And for how long?_____

Ounces per day of liquor, wine, or number of days

Number of drinks per week? _____

10. Current recreational substances/drugs

A. Yes. If yes, what type of recreational substance/drugs? _____B. And when did

you start? _____C. How often do you use recreational substance/drugs? _____

D. No.

11. Mental health

A. Do you have a past or current history of any of the following? Check all that apply

1. Depression yes no

2. Anxiety yes no

3. Panic Attacks yes no

4. Other _____

12. Religion_____

Appendix E: Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month.**
In each case, you will be asked to indicate by **circling** *how often* you felt or thought a certain way.

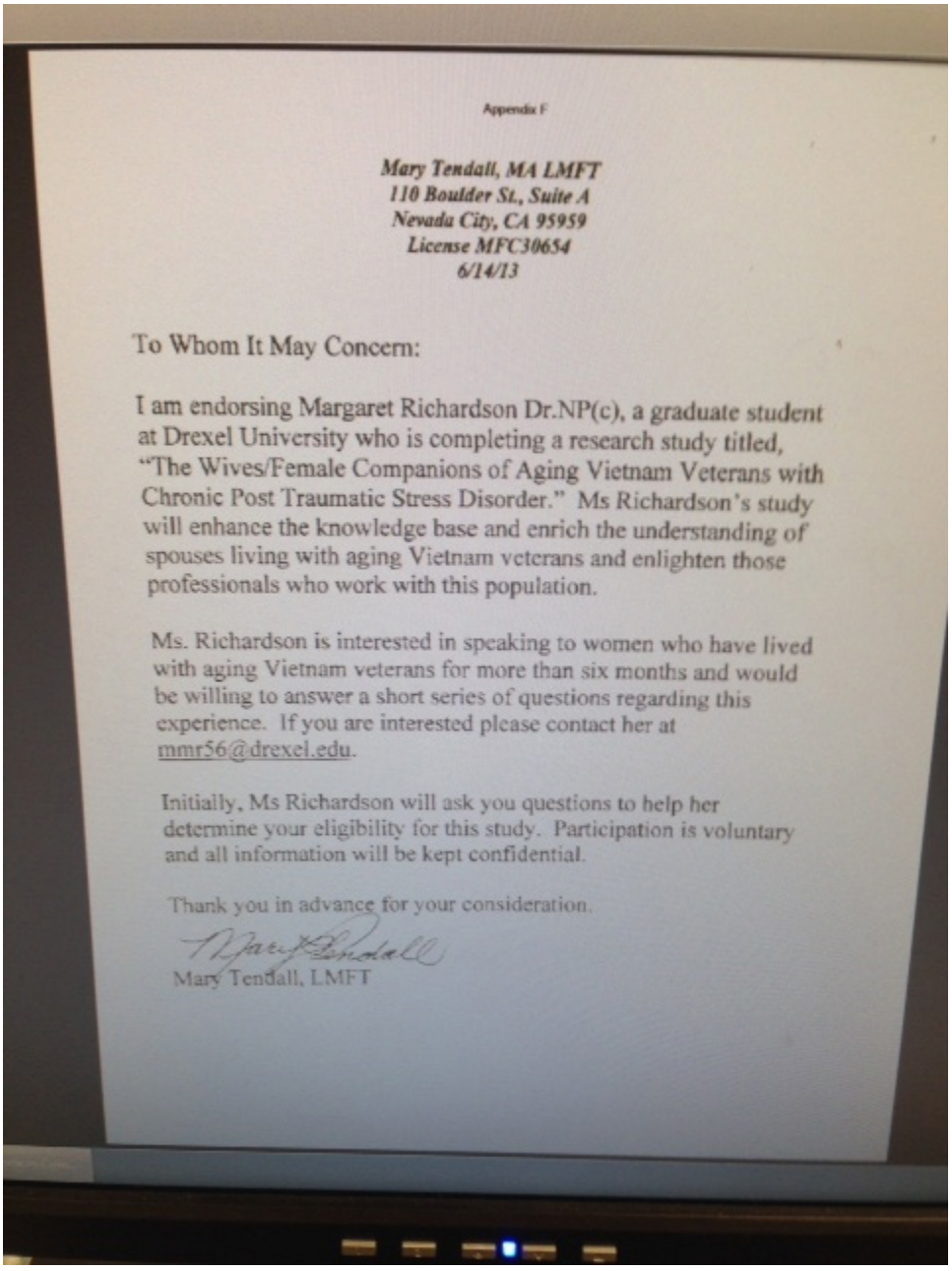
Identifier number_____
Date _____
Age _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?..... **0 1 2 3 4**
2. In the last month, how often have you felt that you were unable to control the important things in your life?..... **0 1 2 3 4**
3. In the last month, how often have you felt nervous and "stressed"? **0 1 2 3 4**
4. In the last month, how often have you felt confident about your ability to handle your personal problems?..... **0 1 2 3 4**
5. In the last month, how often have you felt that things were going your way?.....**0 1 2 3 4**
6. In the last month, how often have you found that you could not cope with all the things that you had to do? **0 1 2 3 4**
7. In the last month, how often have you been able to control irritations in your life?.....**0 1 2 3 4**
8. In the last month, how often have you felt that you were on top of things?..... **0 1 2 3 4**
9. In the last month, how often have you been angered because of things that were outside of your control? **0 1 2 3 4**
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?..... **0 1 2 3 4**

From: "A Global Measure of Perceived Stress" by. Cohen, S., Kamarck, T., & Mermelstein, R. (1983). *Journal of Health and Social Behavior, 24*, 386-396.

Appendix F: Endorsement Letter



Appendix F

Mary Tendall, MA LMFT
110 Boulder St., Suite A
Nevada City, CA 95959
License MFC30654
6/14/13

To Whom It May Concern:

I am endorsing Margaret Richardson Dr.NP(c), a graduate student at Drexel University who is completing a research study titled, "The Wives/Female Companions of Aging Vietnam Veterans with Chronic Post Traumatic Stress Disorder." Ms Richardson's study will enhance the knowledge base and enrich the understanding of spouses living with aging Vietnam veterans and enlighten those professionals who work with this population.

Ms. Richardson is interested in speaking to women who have lived with aging Vietnam veterans for more than six months and would be willing to answer a short series of questions regarding this experience. If you are interested please contact her at mmr56@drexel.edu.

Initially, Ms Richardson will ask you questions to help her determine your eligibility for this study. Participation is voluntary and all information will be kept confidential.

Thank you in advance for your consideration.

Mary Tendall, LMFT

Appendix G: Recruitment Poster

Drexel UNIVERSITY

Recruiting Volunteers for a Research Study

Research Title:
The Experience of Wives/Female Companions of Aging Vietnam Veterans with Chronic Post Traumatic Stress Disorder: A Qualitative Replication Study.

Research Objectives:
The purpose of this study is to describe the experiences of wives/female companions living with aging Vietnam veterans who suffer from Chronic Post-Traumatic Stress Disorder. We hope to understand the secondary effects of prolonged exposure on women who live with aging Vietnam veterans with chronic Post Traumatic Stress Disorder (PTSD), thereby promoting health through effective coping.

Information for Research Subjects Eligibility
To be eligible, the participants

- Wives, former wives, and female companions who have lived for more than six months over the past 15 years with Vietnam veterans diagnosed with chronic PTSD
- This research involves an in person telephone interview or via computer Skype interview lasting about one hour.

Location of the research and person to contact for further information
If you are interested in participating in this study, please contact:

Maggie Richardson at
609-206-8274 or mmr56@drexel.edu

This research is conducted by a researcher who is a member of Drexel University

APPROVED
Human Research Protection
Protocol # 1307002189
Approval Date: 10/28/13
Expiration Date: 10/27/14

HRP

Appendix H: Letter to Dr. Lyons Requesting Permission to Use Her Study Questions

Dear Dr. Lyons,

Good Afternoon and Happy Spring, I am a Doctoral student at Drexel University, a few years ago I wrote to you and we also spoke via telephone about your study, Living with post-traumatic stress disorder: the wives'/female partners' perspective. At that time I am uncertain if I asked for your permission to use your first five questions in the study. As this is a replication study I thought it important that I replicate your study as closely as possible.

May I have your permission to use the questions that you used for your data collection?

What was your early relationship like?

What PTSD symptoms does your partner experience and how do you cope with them?

What feelings do you experience in your relationship with your partner?

Why did you stay or why did you leave?

How are you different now?

Thank you and I hope this note finds you in the best of health and spirits.

Maggie Richardson DrNPc,

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From: **Margaret Lyons** <mlyons@bama.ua.edu>
Date: Sat, May 2, 2015 at 3:06 PM
To: Maggie Richardson <vietspousestudy@gmail.com>-

Hi Maggie, yes you may use the questions. Good luck and please share your findings with me.

Sincerely,
Peg

Appendix I: Letter Dr. Friedman Requesting Permission to Use Appendix J

Subject: **Finalizing PTSD in DSM -5**

From: **Maggie Richardson** <vietspousestudy@gmail.com>
Date: Sun, Jan 4, 2015 at 5:41 PM
To: Matthew.Friedman@dartmouth.edu

Good Evening Dr.Friedman,
I am a doctoral nursing student at Drexel University in Philadelphia, Pa. I am currently working on my dissertation titled "The Experience of Wives/Female Companions Living with Aging Vietnam Veterans with Chronic Post Traumatic Stress Disorder: A Qualitative Replication Study

I would like permission to use Table 1 in your article "Finalizing PTSD in DSM-5: Getting Here From There and Where to Go Next" as it outlines clearly the distinction between DSM-IV and DSM-5, a distinction that I am defining in my dissertation.

May I please have permission to use your table in my dissertation.

Thank you,

Maggie Richardson, DrNP(c)MSN,CRNP,
609-206-8274

- From: **Matthew J. Friedman** <Matthew.J.Friedman@dartmouth.edu>
  Date: Mon, Jan 5, 2015 at 1:30 PM
  To: Maggie Richardson <vietspousestudy@gmail.com>

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Dr. Richardson,

I just realized that since I work for the federal government, everything I do is in the public domain, even when it's published in a journal.
So feel free to use that table in your dissertation.

Best wishes,
Matt Friedman

Appendix J: Dr. Friedman

Table 1
Comparing PTSD Criteria for DSM-5 *(and* DSM-IV*) for Adults, Adolescents, and Children Older than 6*

Criterion	Symptom category	# Symptoms required	Specific symptoms
A	Exposure to a traumatic event (A_1)		1. Directly experiencing the event(s) 2. Witnessing the event(s) 3. Learning that the event(s) occurred to a close relative or close friend[a] 4. Experiencing repeated or extreme exposure to aversive details of the event(s)
A_2			Eliminated in *DSM-5* (i.e., fear, helplessness, or horror)
B[b]	Intrusion symptoms	1	1. Intrusive distressing memories of the traumatic event(s) (*DSM-IV* B_1) 2. Recurrent distressing trauma-related dreams (*DSM-IV* B_2) 3. Dissociative reactions (e.g., flashbacks) (*DSM-IV* B3) 4. Intense psychological distress when exposed to traumatic reminders (*DSM-IV* B_4) 5. Marked physiological reactions to reminders of the traumatic event(s) (*DSM-IV* B_5)
C[b]	Avoidance symptoms	1	1. Persistent avoidance of thoughts and memories (*DSM-IV* C_1) 2. Persistent avoidance of external reminders (*DSM-IV* C_2)
D[b]	Negative alterations in cognitions and mood	2	1. Dissociative amnesia of the traumatic event(s) (*DSM-IV* C_3) 2. Persistent negative expectations (*DSM-IV* C_7) 3. Persistent distorted blame of self or others about the traumatic event(s) (new) 4. Persistent negative emotional state (new) 5. Diminished interest or participation in significant activities (*DSM-IV* C_4) 6. Feeling of detachment or estrangement from others (*DSM-IV* C_5) 7. Persistent inability to experience positive emotions (*DSM-IV* C_6)
E[a]	Alterations in arousal and reactivity	2	1. Irritable behavior or angry outbursts (*DSM-IV* D_2) 2. Reckless or self-destructive behavior (new) 3. Hypervigilance (*DSM-IV* D_4) 4. Exaggerated startle response (*DSM-IV* D_5) 5. Problems with concentration (*DSM-IV* D_3) 6. Sleep disturbance (*DSM-IV* D_1)
F	Duration of symptoms is > 1 month		
G	Symptoms cause significant distress or functional impairment		
H	Symptoms are not due to alcohol, drugs, or medication		1. Specify if: dissociative subtype (full PTSD + derealization or depersonalization 2. Specify if: preschool subtype (1 B and 2 E, but only 1 C or D symptoms are needed)[c] 3. Specify if: with delayed expression of symptoms

Note. PTSD = posttraumatic stress disorder; *DSM = Diagnostic and Statistical Manual of Mental Disorders*.
[a]Does not include traumatic exposure through electronic media. [b]All B, C, D, and E symptoms began or worsened after exposure to the traumatic event(s). [c]Only four D symptoms are included (D_{4-7}); reckless behavior (E_2) is not included.