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An Educational Group Therapy Program for Female Partners of Veterans Diagnosed with PTSD

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An Educational Group Therapy Program for Female Partners of Veterans Diagnosed with PTSD

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy

in

Clinical Psychology

by

Heather Marie Sones

Committee in charge:

University of California, San Diego

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San Diego State University

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Professor Joseph Price

2014
The Dissertation of Heather Marie Sones is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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Co-Chair

Chair

University of California, San Diego

San Diego State University

2014
DEDICATION

To my Mother, for her unwavering love, support, and encouragement. Marion C. Garretty got it right when she said “Mother love is the fuel that enables a normal human being to do the impossible.” Having you in my corner has given me the strength to stand up to seemingly insurmountable obstacles. You have instilled in me the courage and confidence to pursue my dreams and have believed in me from the start, even when I have doubted myself. I love you!
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To my family – thank you for always encouraging me to follow my dreams, even when that meant moving far away from home. And to my closest friends, Ashley, Naju, and Janel - you each have offered so much love and support over the years, and have been a shoulder to lean on and an ear to vent to during the more difficult times. Although the past six years have moved me many miles away from you as well, there are few who are closer to my heart.

To Jessica and Ursula, my co-therapists for this project – you are both brilliant therapists with whom I felt extremely lucky to have worked. Thank you for your wonderful contributions to these groups and this project as a whole.

And finally, a special thank you to the women who participated in this study. You each taught me so much during our short time together, and continue to inspire me every day.

The Introduction, Methods, Results, and Discussion chapters were co-authored, in part, by Joshua Madsen, Matthew Jakupcak, and Steven Thorp and
together have been submitted for publication. Heather Sones is the principal author of this material.
VITA

Education

2008-2014  Ph.D. in Clinical Psychology (APA Accredited)  
San Diego State University/University of California, San Diego  
Faculty Mentor: Steven Thorp, Ph.D.  
Doctoral Dissertation: Evaluation of a group therapy program for the female partners of veterans with PTSD

2008-2012  M.S. in Clinical Psychology  
Degree earned during Doctoral Training  
San Diego State University/University of California, San Diego  
Faculty Mentor: Steven Thorp, Ph.D.  
Master’s Thesis: Ethnocultural differences in PTSD and anger in Hawaiian Island veterans

2004-2008  B.S. in Psychology with Neuroscience option  
Schreyer Honors College, The Pennsylvania State University  
Faculty Mentors: Kevin Murphy, Ph.D., and Amy Marshall, Ph.D.  
Honors Thesis: Future military leaders’ perceptions of males versus females with posttraumatic stress disorder

Academic Awards

2013  Association for Women in Science (AWIS) Scholarship  
2007  Class of 1922 Scholarship  
2006  Tracy Winfree McCourtney Scholarship in the College of Liberal Arts  
2004  Veterans of Foreign Wars Scholarship

Scholarly Honors

2008  Summa Cum Laude and Honors in Psychology, Penn State University  
2007  Psi Chi National Honor Society in Psychology  
2006  Phi Kappa Phi Honor Society  
2005  Phi Eta Sigma National Honor Society  
2004-2008  Deans List, Penn State University

Professional Affiliations

American Psychological Association (APA)  
APA Division 18: Psychology in Public Service  
APA Division 19: Military Psychology
Clinical Positions

2013-Present  **Psychology Intern, Puget Sound VA Healthcare System, Seattle Division (APA Accredited)**  
First Rotation: Primary Care Mental Health Integration  
Supervisors: Autumn Del Fierro, Ph.D., and Matthew Jakupcak, Ph.D.  
- Deliver integrated mental and behavioral health care services to Veterans within an interprofessional primary care setting  
Second Rotation: PTSD Outpatient Clinic and Family Therapy Program  
Supervisors: David Tarver, Ph.D., and Peter Fehrenbach, Ph.D.  
Third Rotation: Rehabilitation Care Services/Polytrauma Clinic

2013  **Study Therapist, Telemnede for Improved Delivery of Psychosocial Treatments for Post-Traumatic Stress Disorder**  
San Diego VA Healthcare System, PTSD Clinical Team  
Supervisor: Steven Thorp, Ph.D.  
- Provided Prolonged Exposure therapy via telemmedicine and in-person for Veterans diagnosed with PTSD

2012-2013  **Practicum Student, OEF/OIF/OND PTSD Clinic**  
San Diego VA Healthcare System  
Supervisor: Abigail Goldsmith, Ph.D.  
- Conducted diagnostic evaluations and treatment planning for Veterans diagnosed with PTSD  
- Provided evidence-based treatments, including Prolonged Exposure and Cognitive Processing Therapy, in both group and individual therapy settings

2009-2013  **Independent Clinical Evaluator, Treatment of Older Veterans with Chronic Posttraumatic Stress Disorder**  
Posttraumatic Stress Disorder Clinical Research Laboratory  
San Diego VA Healthcare System  
Supervisor: Steven Thorp, Ph.D.  
- Conducted diagnostic assessments at baseline and post-treatment using the Structured Clinical Interview for DSM Disorders (SCID), Clinician Administered PTSD Scale (CAPS), and a neuropsychological test battery  
- Trained research assistants on the administration and scoring of all clinical interviews and neuropsychological tests used in the study assessments
2011-2012  **Practicum Student, Substance Abuse and Mental Illness Program**  
San Diego VA Healthcare System  
**Supervisors:** Martha Diaz, Ph.D., and Ryan Trim, Ph.D.  
- Provided individual and group-based clinical services for Veterans diagnosed with co-morbid mental illness and substance use disorder  
- Developed a group therapy protocol for co-morbid chronic pain, substance use disorders, and mood/anxiety disorders

2011  **Study Therapist, Veterans Telemedicine Outreach for PTSD Services**  
San Diego VA Healthcare System, PTSD Clinical Team  
**Supervisors:** Carie Rodgers, Ph.D., and Steven Thorp, Ph.D.  
- Provided Cognitive Processing Therapy via telemedicine and in-person for Veterans diagnosed with PTSD

2010-2011  **Practicum Student, Family Mental Health Program**  
San Diego VA Healthcare System  
**Faculty Supervisor:** Joshua Madsen, Ph.D.  
- Provided Emotionally Focused Couple Therapy and other evidence-based clinical interventions for couples presenting to the clinic with relationship distress, with an emphasis on couples in which the Veteran was diagnosed with PTSD

2010-2011  **Study Therapist, Depression, Substance Dependence, and Trauma**  
San Diego VA Healthcare System  
**Supervisor:** Carolyn Allard, Ph.D.  
- Provided Cognitive Processing Therapy for Veterans diagnosed with co-morbid PTSD, depression, and substance use disorder

2009-2010  **Student Therapist, Psychology Clinic**  
San Diego State University  
**Supervisors:** Nader Amir, Ph.D., and Vanessa Malcarne, Ph.D.  
- Provided clinical services for a range of clients, including both children and adults  
- Implemented manualized cognitive-behavioral interventions for various mental health concerns, including depression, anxiety, panic disorder, and PTSD

**Research Experience**

2013-Present  **Psychology Intern, Puget Sound VA Healthcare System, Seattle Division**  
**Supervisor:** Matthew Jakupcak, Ph.D.
- Assist with research and Quality Improvement projects examining utilization of family services by both Veterans and caregivers, barriers to seeking treatment, and provider awareness of family services and potential barriers to referral
- Pilot and evaluate the utility of a “Relationship Check-up” as a consultation and assessment service within the Family Therapy Program

2008-2013  
**Research Study Coordinator, Treatment of Chronic PTSD in Older Male Combat Veterans**
Posttraumatic Stress Disorder Clinical Research Laboratory  
San Diego VA Healthcare System  
**Supervisor:** Steven Thorp, Ph.D.
- Recruited and screened study participants, scheduled and maintained records for assessment and therapy sessions, monitored participant progression through study, compiled and entered assessment and therapy data
- Trained and supervised undergraduate research assistants helping with recruitment, screening, and data entry

2012-2013  
**Research Study Coordinator, The SAGE Study: Successful Aging Evaluation Computerized Testing**
Posttraumatic Stress Disorder Clinical Research Laboratory  
San Diego VA Healthcare System  
**Supervisor:** Steven Thorp, Ph.D.
- Developed and maintained a web-based survey using Zoomerang.com software and monitored data collection

2007-2008  
**Undergraduate Research Assistant, Scientific Study of Social Justice Laboratory**
The Pennsylvania State University  
**Supervisor:** Theresa Vescio, Ph.D.
- Assisted with study using electroencephalograph to examine sexual objectification of women
- Conducted experimental sessions examining implicit attitudes toward gay men and lesbian women and feelings of disgust toward same-sex male behavior

2006  
**Undergraduate Research Assistant, Personality, Psychopathology and Psychotherapy Laboratory**
The Pennsylvania State University  
**Supervisor:** Kenneth Levy, Ph.D.
- Analyzed longitudinal data for a study Adult Attachment Theory and a study testing three psychotherapy techniques for treating Borderline Personality Disorder.

### Teaching Experience

**2010-2012**  
**Graduate Teaching Assistant, Clinical Interventions Course**  
San Diego State University  
**Supervisor:** Nader Amir, Ph.D.

- Assisted in teaching clinical interventions course by conducting weekly labs to teach first year clinical psychology doctoral students fundamental clinical skills including diagnostic interviews, treatment planning, interventions, and documentation
- Consulted with students on clinical cases they were following in the San Diego State University Psychology Clinic
- Evaluated and graded the performance of 10-15 students throughout the semester

**2007**  
**Undergraduate Teaching Assistant, Biological Science Course**  
The Pennsylvania State University  
**Supervisor:** Chris Uhl, Ph.D.

- Conducted two 50 minute lessons every week
- Evaluated and graded the performance of 25 students throughout the semester

### Professional Activities

**2013**  
Family Therapy Program Workgroup  
Goal: To develop and implement a plan for restructuring the Family Therapy Program utilizing “best practices” from other VA couple and/or family services across the country.  
Puget Sound VA Healthcare System, Seattle Division

**2013**  
Intern Class Representative, Psychology Training Committee  
Puget Sound VA Healthcare System, Seattle Division

**2013**  
Internship Seminar Committee  
Puget Sound VA Healthcare System, Seattle Division

**2013**  
Attended Prolonged Exposure Therapy Training  
University of California, San Diego/San Diego Veterans Administration  
Presenters: Peter Tuerk, Ph.D., and Sheila Rauch, Ph.D.
2010  Joint Doctoral Program Student Selection Committee  
Experimental Psychopathology Track  
University of California, San Diego/San Diego State University

2009, 2012  Attended Cognitive Processing Therapy Training Workshop  
University of California, San Diego/San Diego Veterans Administration  
Presenter: Carie Rodgers, Ph.D.

Community Service

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<td>Jan 2012</td>
<td>Travelled to Haiti to help rebuild a home damaged by the January 2010 earthquake</td>
<td>Port-au-Prince, Haiti</td>
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<tr>
<td>Jan 2011</td>
<td>Travelled to Haiti to help rebuild homes and volunteer at orphanages damaged by the January 2010 earthquake</td>
<td>Port-au-Prince, Haiti</td>
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<tr>
<td>Nov 2010</td>
<td>Raised $4,000 through a fundraiser to help support building construction in Haiti</td>
<td>San Diego, CA</td>
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<td>Jul 2010</td>
<td>Volunteered in the Mental Health tent at Stand Down</td>
<td>San Diego, CA</td>
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Publications

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<tr>
<td>2011-2013</td>
<td>Journal of Traumatic Stress</td>
</tr>
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<td>2012</td>
<td>Behaviour Research and Therapy</td>
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<td>2010</td>
<td>Cognitive Therapy and Research</td>
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Peer-Reviewed Publications


**Book Chapters and Invited Publications**


**Newsletter Publications**


**Manuscripts Under Review**


**Manuscripts in Preparation**


Stress. Book proposal submitted to literary agent for submission to potential publishers.


Conference Presentations


Invited Presentations

**Sones, H.M.** (May 2013). *Understanding and Treating Posttraumatic Guilt.* Presentation at West LA VA Evidence Based Practices Seminar, Los Angeles, CA.


ABSTRACT OF THE DISSERTATION

An Educational Group Therapy Program for Female Partners of Veterans Diagnosed with PTSD

by

Heather Marie Sones

Doctor of Philosophy in Clinical Psychology

University of California, San Diego, 2014
San Diego State University, 2014

Professor Steven Thorp, Chair
Professor Ariel Lang, Co-Chair

As researchers continue to explore the consequences of posttraumatic stress disorder (PTSD) within the military population, there has been increased focus on the negative impact PTSD can have on intimate relationship functioning and the psychological health of both partners. Despite the development of conjoint couples therapy programs designed to address PTSD and relationship functioning, very few
programs have been developed to address the unique needs of the female partners of veterans diagnosed with PTSD. The current study evaluated a 10-week group therapy protocol aimed to increase partners’ PTSD knowledge, self-care, and relationship-focused skills as a means to improve both the psychological health of the female partner and overall relationship functioning and satisfaction. Twenty-three female partners were randomized to either the intervention group or waitlist control condition, and completed measures of relationship satisfaction and psychological distress at baseline and post-treatment. Although no significant difference was found on changes in relationship satisfaction for the intervention or waitlist control group, the female partners participating in the intervention reported a significant decrease in their own psychological distress when compared to the waitlist control condition. In addition, participants who completed the intervention found it to be beneficial, and the women provided helpful feedback to help improve future iterations of the treatment. The results of the intervention are reviewed, limitations are presented, and future directions for research are discussed.
Introduction

Posttraumatic Stress Disorder within the Military

Posttraumatic stress disorder (PTSD) is one of the most debilitating mental health problems affecting military veterans. Previously given such labels as "shell shock" and "combat fatigue," PTSD was first introduced into the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) as an official diagnosis in 1980 (American Psychiatric Association [APA], 1980). A key feature of PTSD is the experiencing of a traumatic event that involves either actual or threatened death or serious injury to oneself or others. The symptoms of PTSD are divided into four clusters: intrusion symptoms (e.g., nightmares, intrusive thoughts or images, flashbacks), avoidance symptoms (e.g., avoiding reminders of the event), negative changes in thoughts and mood (e.g., persistent negative beliefs about oneself or others, persistent negative trauma-related emotions, feeling disconnected from others), and hyperarousal symptoms (e.g., hypervigilance, irritability/aggressive behavior, difficulty concentrating, sleep problems; APA, 2013). To meet criteria for PTSD according to the Fifth Edition of the DSM, an individual must endorse a minimum of one intrusion symptom, one avoidance symptom, two negative changes in thoughts and mood symptoms, and two hyperarousal symptoms for at least one month, and these symptoms must cause a clinically significant level of distress.

The lifetime prevalence rates of PTSD within the general population have been estimated at 8%, but the rate is as high as 30% in some combat veteran groups (Kessler et al., 2005). Among veterans, the rates of current PTSD vary across studies,
but have been estimated to be between 2-15% in Vietnam War veterans, 2-13% in Persian Gulf War veterans, and 4-17% in veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF; for a review of PTSD prevalence rates from combat, see Richardson, Freuh, & Acieno, 2010).

**Impact of PTSD on Intimate Relationships**

As researchers continue to study the impact of PTSD within the veteran population, an increasing awareness has been focused on the negative impact of PTSD on intimate relationship functioning (for reviews, see Galovski & Lyons, 2004, and Link & Palinkas, 2013). PTSD can negatively affect many facets of an intimate relationship, including overall relationship functioning, the veteran’s mental health (including PTSD symptoms), and the mental health of the veteran's partner.

**The impact of PTSD on overall relationship functioning**  Several studies have demonstrated the detrimental impact of PTSD on overall relationship satisfaction. A recent meta-analysis examining the correlation between PTSD and relationship quality found a small to moderate effect size ($r = -.24$), and found that military status was a significant moderator of this relationship in that military samples demonstrated a larger effect of PTSD on relationship quality ($r = -.26$) than civilian samples ($r = -.15$; Lambert, Engh, Hasbun, & Holzer, 2012). Utilizing data from the National Vietnam Veterans Readjustment Survey, Jorden et al. (1992) found that over 60% of the female partners of veterans diagnosed with PTSD reported medium to high levels of marital distress, compare to 36% of significant others of veterans who were not diagnosed with PTSD. Similarly, Riggs and colleagues (1998) found that 70% of
couples in which the veteran was diagnosed with PTSD reported significant relationship distress, as compared to 30% of couples in which the Veteran was not diagnosed with PTSD. The severity of the veteran’s PTSD symptoms has also been found to be inversely related to both the veteran and partner’s self-reported relationship satisfaction. In other words, the more severe the veteran’s PTSD symptoms, the more relationship difficulties were endorsed by both partners (Nelson Goff, Crow, Reisbig, & Hamilton, 2007). The negative impact of PTSD on relationship functioning could potentially contribute to veterans with PTSD reporting divorce rates that are twice as high as their counterparts without a PTSD diagnosis (Jordan et al., 1992).

Several consequences of the PTSD diagnosis could be contributing to the elevated levels of relationship distress. Within the PTSD symptoms, the avoidance cluster, emotional numbing, and PTSD-related anger appear to be most strongly related to relationship distress and poor family functioning (Cook et al., 2004; Evans, McHugh, Hopwood, & Watt, 2003; Ray & Vanstone, 2009). Furthermore, veterans with PTSD report lower levels of self-disclosure and cohesion in intimate relationships, as well as higher levels of conflict and physical aggression (Carroll, Rueger, Foy, & Donahue, 1985). Relatedly, PTSD symptom severity has been consistently associated with higher rates of intimate partner violence within the veteran population (Marshall, Panuzio, & Taft, 2005).

**Negative effects of poor relationship functioning on recovery from PTSD.**

The negative impact PTSD often has on intimate relationship functioning can in turn
detrimentally affect the veteran’s recovery from the disorder. Social support has been consistently identified as a key protective factor against the development of PTSD, and a lack of social support has been shown to influence the maintenance of the disorder (Schnurr, Lunney, & Sengupta, 2004). The family environment, and intimate relationships in particular, are critical in the recovery from PTSD (Beach, Martin, Blum, & Roman, 1993; Schnurr et al., 2004). For instance, higher levels of family support and adaptive communication styles within the relationship are related to better PTSD treatment outcomes for the partner diagnosed with the disorder (Byrne & Riggs, 2002). Although this support serves as a resiliency factor in protecting against the development and persistence of PTSD, a bidirectional relationship has been found in which the presence of PTSD symptoms may serve to erode these protective social support networks (e.g., Benotsch et al., 2000). Within the context of an intimate relationship, the emotional distancing as well as increased irritability and anger commonly found in PTSD can have a detrimental impact on the perceived support the veteran receives from his significant other. This reduction in social support can serve to perpetuate, or even exacerbate, existing PTSD symptomatology. For example, a longitudinal study examining the impact of family functioning on veterans’ recovery from PTSD found that poor family functioning predicted an increase in PTSD symptoms following a course of PTSD treatment, even when a majority of the veterans experienced a symptom decrease over the course of therapy (Evans et al., 2010). Furthermore, high levels of criticism and hostility within the relationship and less social support, have been associated with poorer treatment outcomes in a non-
veteran sample with PTSD (Tarrier, Sommerfield, & Pilgrim, 1999). Therefore the marital distress that often results from PTSD can in turn negatively influence recovery and perpetuate the disorder, leading to a negative cycle of symptom maintenance and relationship distress.

**Impact of PTSD on the mental health of the significant other.** Not only does PTSD have clear negative consequences for the veteran, it also can have a detrimental impact on the mental health of the veteran’s romantic partner. Studies have consistently demonstrated a relationship between PTSD and partner psychological distress. In the previously mentioned meta-analysis by Lambert and colleagues (2012), a medium effect size was found for this relationship ($r = .30$) and all 25 studies included in the analysis demonstrated a positive correlation between PTSD symptom severity and partner psychological distress. Furthermore, military status was a significant moderator of this relationship in that the effect size in military samples ($r = .33$) was much larger than that in civilian samples ($r = .14$). Similarly, higher levels of psychological distress (Manguno-Mire et al., 2007) and poorer psychological adjustment (Calhoun, Beckham, Bosworth, 2002) have been found in the partners of veterans with PTSD when compared to the partners of veterans without PTSD. When compared to wives of non-veterans with PTSD, the wives of veterans diagnosed with PTSD have been found to report significantly higher levels of anxiety and depression, even decades after the veteran’s military service (O’Toole, Outram, Catts, & Pierse, 2010). Taken together, these studies indicate that the increased level of psychological distress is due to PTSD and not exclusively due to veteran status.
The higher level of partner psychological distress as a result of PTSD within the relationship context has been characterized in various ways throughout the literature. Several studies have used various terms to label the distress seen in the spouses of individuals with PTSD, including “secondary traumatic stress (STS)” or compassion fatigue (Figley, 1995). The symptoms of STS are similar to those of PTSD, and include re-experiencing symptoms, avoidance of triggers, and hyperarousal related to the significant other’s traumatic event. Although several studies have found evidence of such secondary PTSD symptoms in the significant others of military personnel with PTSD (e.g., Dirkwager, Bramsen, Ade’r, & van der Ploeg, 2005; Nelson Goff, Crow, Reisbig, & Hamilton, 2009), controversy exists around the validity of this concept. Namely, it is difficult to determine whether these PTSD-like symptoms are a direct consequence of the partner’s trauma, are resulting from the individual’s own traumatic experiences, or are better characterized as general psychological distress (Renshaw et al., 2011).

In addition to secondary traumatic stress symptoms, studies have found the significant others of veterans with PTSD report higher levels of depression, anxiety, sleep difficulties, somatic complaints, social isolation, and demoralization, and lower levels of family connectedness, self-esteem, happiness, and overall life satisfaction (Jordan et al., 1992; Link & Palinkas, 2013; Westerlink & Giarratano, 1999). PTSD has also been associated with higher rates of caregiver burden in significant others (Calhoun et al., 2002). Furthermore, significantly more partners of Vietnam veterans with PTSD reported feeling as if they were going to have a “nervous breakdown” at
some point in the future as compared to partners of veterans without PTSD (Jordan et al., 1992). In one study examining the effectiveness of behavioral family therapy for couples in which the male was a veteran with PTSD, the authors stated that female spouses were particularly difficult to engage in treatment because they “were clearly angry and burdened and had limited psychological resources available to support the veteran” (pg. 249, Glynn et al., 1999).

Taken together, these studies highlight the vicious cycle that can ensue within the intimate relationships of veterans diagnosed with PTSD. The presence of PTSD within a relationship can decrease emotional connectedness, increase tension and conflict, and increase levels of psychological distress for the significant others, leading to a decrease in overall relationship satisfaction. This strain on both partners and the relationship can then diminish the support felt by the veteran, which can serve to maintain or exacerbate his or her PTSD symptoms. Although distress in the relationship and both partners individually has been well-documented, few studies have empirically examined the possible mechanisms that lead to this distress. Several theories, however, have been suggested to explain the negative impact PTSD has on a relationship.

**Theoretical Understanding of PTSD within Relationships**

Several theories have been implicated in the explanation of the relationship between PTSD, intimate relationship dissatisfaction, and partner psychological distress (for a review, see Dekel & Monson, 2010). One theoretical model for understanding the impact of trauma on intimate relationships is described in Johnson’s
Bowlby's (1969) attachment theory is utilized as a means for describing the negative effects one partner's trauma can have on relationship functioning and the other partner's individual distress. Oftentimes when one partner has experienced a traumatic event, it can impair healthy attachment within interpersonal relationships. Several symptoms of PTSD, including emotional numbing, interpersonal detachment, and heightened anger/irritability can result in negative affect and distance within the relationship, which detracts from the attachment that is necessary in healthy intimate relationships (Johnson & Williams-Keeler, 1998). Furthermore, the distance and isolation that often result from PTSD prevent the traumatized partner from adequately meeting their partner’s attachment needs, which perpetuates the distress felt by the untraumatized partner (Johnson, 2002).

A second theory, entitled the Couple Adaptation to Traumatic Stress (CATS) Model, has been proposed by Nelson Goff and Smith (2005). The developers of this theory suggest that the PTSD symptoms experienced by the traumatized partner negatively affect the significant other, causing a secondary stress reaction. This reaction in the significant other can then serve to exacerbate the distress experienced by the traumatized partner. Both partners’ distress impacts the overall functioning of the couple. The influence of each partners’ distress on the relationship is moderated by predisposing factors (e.g., previous traumas, pre-existing stress in the relationship) and current resources (e.g., coping abilities, social support). A more recent study has proposed a modification of this model to include the potential role of resilience as a
moderator of the relationship between PTSD and couple distress (Melvin, Gross, Hayat, Jennings, & Campbell, 2012). Melvin and colleagues found that higher levels of resiliency within the couple were related to higher levels of relationship satisfaction, regardless of PTSD symptom severity. This addition to the CATS model may provide important direction for interventions directed at preventing the systemic effects of PTSD in relationships, and requires additional investigation.

A third model is the cognitive-behavioral interpersonal model, which identifies both inter- and intrapersonal cognitive and behavioral processes that are involved in the development of PTSD symptoms and related relationship distress (Dekel & Monson, 2010). Behaviorally, the avoidance of both internal and external triggers as well as avoidance of emotional experiences associated with PTSD has been identified as a primary source of relationship difficulties (e.g., Cook et al., 2004; Evans et al., 2003; Fredman, Monson, & Adair, 2011; Hendrix, Erdmann, & Briggs, 1998; Riggs, Byrne, Weathers, & Litz, 1998). This avoidance not only maintains PTSD symptoms, but also creates physical and emotional distance in the relationship as a result of diminished enjoyable activities shared within the couple. Several cognitive processes are also involved in the development and maintenance of PTSD and relationship distress. For example, the presence of PTSD often creates an attentional bias for detecting threat in the environment, including perceptions of significant others’ actions as untrustworthy, hostile, or threatening. This cognitive distortion, as well as those around other common areas affected by trauma (including trust, intimacy, and
esteem), further contribute to the distance and distress within the relationship (Dekel & Monson, 2010).

Although not theoretical models, several other possible explanatory factors should be considered in the relationship between PTSD and intimate relationship distress. For example, it is possible that the significant others of traumatized individuals can unknowingly act as "enablers" for their partner by encouraging and even assisting with their avoidance of potential triggers, and making excuses for their partner’s PTSD-related behaviors (e.g., angry outbursts, avoidance of social activities; Fredman, Monson, & Adair, 2011). In addition, Renshaw, Rodrigues, and Jones (2008) have illustrated that the distress experienced by the spouses of combat veterans with PTSD is dependent on their perceptions of their husband’s level of combat exposure. The veteran’s reported PTSD symptoms were negatively associated with the spouses’ marital satisfaction only when the spouse believed their husband experienced low levels of combat. If she perceived high levels of combat, PTSD symptoms were unrelated to spouses’ relationships satisfaction. This suggests that marital satisfaction and relationship distress depend on whether the spouse perceives their husband’s PTSD symptoms to be ‘justified’ by their level of combat exposure. Finally, disclosure of combat-related thoughts and experiences has been found to be positively correlated with partner support and negatively correlated with PTSD symptom severity, suggesting that combat disclosure may be a protective factor against PTSD and its systemic effects (Balderrama-Durbin et al., 2013). These findings imply that lack of communication about thoughts and feelings related to
combat within an intimate relationship may be related to more severe PTSD symptoms and relationship distress. Although the exact mechanisms are unknown, the distress found in both the spouses of individuals with PTSD and the relationship as a whole has been heavily documented and warrants further attention in the treatment literature.

**Interventions focusing on Relationship and/or Partner Distress**

Given the systemic negative effects of PTSD within intimate relationships, researchers have begun to evaluate both patient and partner desire for and utility of the involvement of significant others in the treatment of PTSD, as well as the need for interventions targeting the psychological distress of the partner. A phone survey of the female partners of Vietnam veterans with PTSD found that over 60% desired individual therapy, over 75% desired conjoint therapy, and more than half of the partners requested a women only group (Sherman et al., 2005). Despite these desires, only 28% of them had recently received any sort of mental health care, with almost half of these women only receiving one or two sessions within the past six months. Furthermore, a recent study surveyed veterans within a PTSD Outpatient Clinic and found that 90% of participants felt their partners desired to be involved in their treatment, and 78% reported they desired their significant other to be more involved in their care (Meis et al., 2013). This sample expressed an interest in more broad partner involvement (e.g., partners attending veteran’s individual therapy sessions) than couple therapy. Despite this desire, and also the Department of Veteran’s Affairs (VA) initiative to include family members in the mental health treatment of veterans
(Department of Veterans Affairs, 2011), only a small number of programs that address this need have been established in the literature.

**Conjoint therapy addressing veteran’s PTSD.** Studies have begun to examine the integration of spouses into PTSD-focused conjoint therapy in hopes of improving veteran’s PTSD symptoms and relationship satisfaction. One of the first attempts at addressing PTSD within the context of a dyadic relationship was through behavioral family therapy (BFT). A randomized controlled trial was conducted by Glynn and colleagues (1999), utilizing a sample of Vietnam veterans diagnosed with PTSD and their significant others. When comparing a waitlist control group, an exposure therapy only group (for the veteran), and a third group that received exposure therapy (for the veteran) followed by BFT, there were no statistically significant differences between the exposure only and exposure plus BFT group. The effect sizes for the exposure plus BFT group, however, were larger than the exposure only group.

Couple-based interventions targeting PTSD in the relationship context have been developed. Cognitive-Behavioral Conjoint Therapy (CBCT) for PTSD was developed to target both relationship functioning and PTSD symptoms simultaneously (Monson & Fredman, 2012). This treatment typically consists of 15 sessions and is divided into three parts: 1) psychoeducation for PTSD and its impact on the relationship and both partners, and tools for conflict management and promoting safety within the relationship; 2) behavioral skills that encourage approach behaviors from each partner and improve communication; and 3) cognitive restructuring skills
for challenging and amending those negative cognitions that serve to maintain PTSD and relationship distress. Several studies have found this treatment to be effective in not only improving relationship functioning, but also decreasing PTSD symptoms in the patient and decreasing general psychological distress in the partners. These findings have been replicated across the Vietnam veteran population (Monson, Schnurr, Stevens, & Guthrie, 2004), OEF/OIF veterans (Fredman et al., 2011; Schumm, Fredman, Monson, & Chard, 2013), and a broader, more diverse community sample (Monson et al., 2011). Although the aforementioned studies were uncontrolled trials of CBCT, a recent randomized controlled trial found CBCT to result in significantly greater improvements in PTSD symptoms, PTSD diagnosis, and relationship satisfaction when compared to a waitlist control condition (Monson et al., 2012).

Strategic Approach Therapy (SAT) is a manualized couples-based intervention targeting relationship functioning and patient PTSD symptoms, with a focus on addressing avoidance and numbing symptoms that likely serve to maintain relationship distress (Sautter, Armelie, & Glynn, 2010). This 10-session treatment also consists of three phases, including 1) a psychoeducation phase, focusing on PTSD and the impact it can have on the relationship, as well as a rationale for SAT; 2) a skills training phase, in which the couple learns communication and emotional regulation skills; and 3) an application phase, during which the couple is encouraged to apply the skills they have learned while increasing their behaviors together and confronting avoided internal and external triggers of the trauma. This treatment has
been piloted and was found to decrease clinician, veteran, and spouse reports of PTSD symptoms in a sample of Vietnam veterans, with a notable decrease in avoidance/numbing symptoms (Sautter, Glynn, Thompson, & Franklin, 2009). Unfortunately, no studies to date have examined the impact of SAT on relationship satisfaction and/or the mental health of the partner.

Emotionally focused couple therapy (EFT) has been adapted for use with couples in which one partner has experienced a trauma (Greenman & Johnson, 2012; Johnson, 2002). This treatment uses the experiential and systemic approaches of traditional EFT as a way to re-establish the secure attachment that is necessary in intimate relationships, especially those in which the detachment and emotional numbing of PTSD has compromised the relationship foundation. This treatment approach has been found to be successful across a range of clinical case studies (Greenman & Johnson, 2012; Johnson, 2002; Johnson & Williams-Keeler, 1998; MacIntosh & Johnson, 2008), although no randomized controlled trials have been conducted to evaluate its efficacy.

**Therapy for wives of veterans with PTSD.** Despite the increase in programs addressing PTSD and relationship functioning through conjoint couples therapy, very few programs have addressed the needs of the spouse/significant other directly. Self-help resources for the wives of veterans have been published (Mason, 1990; Matsakis, 1996; Matsakis, 1998), and women’s support groups have been described (Williams, 1980; Williams & Williams, 1985). Williams and Williams (1985) described the qualities they believed to be necessary in a group for wives of Vietnam veterans.
They stated that these groups should consist solely of women (including the facilitators), because the presence of a male may disrupt the cohesion of the group and may lead to the women becoming more inhibited and less assertive within the group. They also recommended specific phases and strategies that should be included: the first stage should consist of rapport-building, orientation to the group, and psychoeducation, followed by the second stage, which should be designed to re-establish wives’ assertiveness to assure their needs are being met. Through communication and assertiveness training, the women can begin to understand their veteran partner and decrease defensiveness, which can allow the couple to confront PTSD (or other psychological repercussions of combat) as a unified front.

Despite the effort invested in developing self-help resources and outlining the ideal content for a group designed for the female partners of veterans with PTSD, no published empirical study to date has examined the utility of such resources. One doctoral dissertation was found that examined the effectiveness of a group for the wives of veterans with PTSD, but this study had a small sample size (n = 19 wives) with no substantial control condition, limiting the interpretability of the findings (Reck-Gordy, 2011). The current study aims to address this dearth of research by evaluating the efficacy of an education and skills-based therapy group for the female significant others (i.e., wives, fiancées, long-term partners) of veterans currently diagnosed with PTSD as compared to a waitlist control condition.
Research Support for Topics Addressed in Wives Group

The topic areas included in the group manual for the current study were chosen based on the relevant current literature. The rationale for including the various topics within the current therapy protocol are discussed below.

Psychoeducation. Several authors have pointed to psychoeducation as a critical element in helping the significant others of individuals with PTSD to cope with the effects of the disorder. Remer and Ferguson (1998) stated that psychoeducation is crucial for several reasons. It helps to dispel any potential myths or misunderstandings about PTSD, and can help significant others to understand why their loved one cannot simply ‘move on’ and put the traumatic event behind them. Having a more thorough understanding of PTSD and the symptoms can also help them to delineate between PTSD and other mental health problems, and can promote understanding and cooperation within the relationship (Remer & Ferguson). Finally, delivering psychoeducation within the group setting can allow for women to bond over common experiences, which may help normalize their own struggles and increase group cohesion. Given that studies have shown that a significant other’s attitudes and perceptions of their loved ones are also associated with PTSD treatment outcomes (e.g., Tarrier et al., 1999), developing a thorough understanding of PTSD is necessary in a group for the female partners of veterans with PTSD.

Based on this literature, the therapy protocol developed as part of the current project includes extensive psychoeducation comprised of PTSD education, a discussion of the effects of PTSD within a relationship, common PTSD co-
morbidities, and the various empirically supported treatments for PTSD. Through this knowledge, we hope to increase the female partners’ awareness and understanding of PTSD and its treatment as a way to increase understanding and supportiveness within the relationship.

**Developing a unified front.** As a way to further increase the female partner’s understanding and supportiveness, an effort has been made to include material that focuses on removing the veteran from the “identified patient” role and establishing a shared, unified front in addressing the problem of PTSD within the relationship. When a veteran with PTSD becomes the identified patient in a family unit or relationship, negative consequences often result. Labeling the veteran in this way may lead the female partner to reduce her significant other’s responsibilities within the family, creating an underfunctioning-overfunctioning dynamic within the relationship (Rabin & Nardi, 1991). This pattern often results in increased burden on the female partner, and increased psychological distress for both partners. In addition, as the “identified patient” the expectation is that the veteran is the one that must do the changing in order to overcome the current distress in the relationship (Williams & Williams, 1985). It is therefore important for the female partner to understand how the “PTSD” label can place the veteran in the identified patient role, which will only leave their relationship stuck in the current state of distress. After developing this understanding, the female partner should explore the role she plays in maintaining the distress in the relationship (Williams and Williams, 1985), and begin to explore how addressing the issue of PTSD as a shared problem within the relationship (as opposed
to solely the veteran’s responsibility) is a more productive approach to resolving the negative effects it has on the relationship.

One skill that is included in the current manual that addresses this concept of a “unified front” for addressing PTSD is the use of “we” versus “you” talk. Rohrbaugh and colleagues (2008) found that the process of “communal coping” as evidenced by “we” versus “you” talk in couples coping with one partner’s heart failure, was related to more positive health outcomes for the patient over a six month time period. In other words, patient health outcomes favored those couples in which partners were viewing the heart failure as a shared problem to be tackled together (e.g., our problem), as opposed to a responsibility solely held by one partner or the other (e.g., his problem, my problem).

**Self-care.** Studies have found high levels of caregiver burden in the partners of combat veterans with PTSD (Beckham, Lytle, & Feldman, 1996; Calhoun et al., 2002; Manguno-Mire et al., 2007). These studies have also directly linked this physical and mental strain on the partners to greater levels of partner psychological distress. In addition, the avoidance symptoms of PTSD that often lead veterans to isolate can eventually lead to the female partners isolating with their veteran (Sherman, Zanotti, & Jones, 2005). This decrease in pleasant activities and social support often exacerbates the partner’s existing distress. In order to lessen this burden, female partners must learn to balance their needs with the needs of their partner to ensure that they are taking proper care of themselves. This need is addressed in the
manual through several self-care practices, including psychoeducation on secondary traumatization, suggested self-care practices and assignments, and relaxation skills.

**Communication skills.** Communication skills, such as active and empathic listening and assertiveness, can be extremely useful tools for the female partners of veterans with PTSD. These skills can help bridge the communication gap that may have developed within their relationship as a result of PTSD, while also asserting their boundaries and need for self-care. As previously mentioned, the increased anger/irritability, mistrust, isolation, and emotional numbing associated with PTSD can create a significant disconnect within an intimate relationship. These factors oftentimes result in negative communication patterns in which the partner with PTSD reacts with irritability or angry outbursts, creating a defensive reaction in their partner. This creates a rift in relationship communication. Shehan (1987) labeled this “communication apprehension,” which results from the fear of communication non-PTSD partners develop as a result of their significant other’s potential reactions towards them. She also suggests that ways to minimize this ineffective communication pattern could include psychoeducation and active/empathic listening. Furthermore, assertiveness communication skills may help the female partner better communicate her needs within the relationship, which could decrease caregiver burden and promote better self-care.

**Relationship enhancing exercises.** Specific homework assignments were included throughout the manual that were intended to be completed with the veteran as a means to improve relationship quality and satisfaction for both partners. These
exercises included the following: Catch and Tell, a standard behavioral couple therapy exercise encouraging each partner to ‘catch’ their partner doing something nice each day and telling them about it; Relationship Enhancing Thoughts, a series of questions prompting each partner to reflect on positive qualities of their partner and positive moments shared together; and the Five Love Languages (Chapman, 1992), a theory of the different ways in which people communicate love that was reviewed and each group participant was encouraged to reflect on and share their love languages with their partner. These activities specifically focus on increasing the amount of positive interaction that takes place within the relationship dynamic, which is perhaps lacking as a result of avoidance and emotional numbing related to PTSD. Furthermore, an increase in positive sentiments and interactions within a relationship may help to not only improve relationship satisfaction, but may also help to buffer against the effects of future negative interactions.

**Present Study**

Based on the aforementioned lack of services available for the female partners of veterans diagnosed with PTSD, the current study evaluated the utility of a 10-week group-based therapy program designed for this population. The primary aims of this study were as follows:

**Primary Aim 1:** To evaluate the impact of group therapy participation on relationship functioning and satisfaction.
**Hypothesis 1.1:** The female partners randomly assigned to the group therapy program will report significantly greater improvement in relationship functioning and satisfaction from pre- to post-treatment than those in the waitlist control group.

**Primary Aim 2:** To evaluate the impact of group participation on the female partner’s psychological distress.

**Hypothesis 2.1:** The female partners assigned to the group therapy program will report significantly greater improvements in psychological distress from pre- to post-treatment than those assigned to the waitlist control group.

**Exploratory Aim 3:** To evaluate the female partners’ perceptions of the acceptability, relevance, and usefulness of the group therapy content in order to refine the intervention for larger scale studies.

The Introduction, Methods, Results, and Discussion chapters were co-authored, in part, by Joshua Madsen, Matthew Jakupcak, and Steven Thorp and together have been submitted for publication. Heather Sones is the principal author of this material.
Methods

Participants

Given that approximately 92% of veterans are male (National Center for Veterans Analysis and Statistics, 2011) and the majority are heterosexual, this group was exclusively for the female partners of male veterans. As previously mentioned, males were not included in the group as either participants or group facilitators because the presence of a male in a predominantly female group could disrupt group cohesion and result in the women being less assertive and open to sharing their experiences (Williams & Williams, 1985). These women were recruited from the VA San Diego Healthcare System (VASDHS) via flyer-based advertisement and provider referrals, and included female partners from several war eras. Flyers were posted in the various mental health waiting rooms, and were also given to mental health providers to pass on to their veteran patients who were diagnosed with PTSD, identified as being in a committed relationship, and expressed interest in the study. In addition, the Study Coordinator visited several treatment groups and treatment team meetings to increase awareness of the current study and distribute flyers. She also mailed over 150 flyers to veterans who had participated in PTSD treatment research and had indicated interest in being contacted for future studies.

Inclusion Criteria. In order to qualify for participation in the study, (a) the couple must have been cohabitating and identify themselves as being in a serious committed relationship (two exceptions were made for couples who previously had lived together, but were currently not cohabitating due to PTSD-related relationship
problems), (b) the veteran must have had a current military-related PTSD diagnosis (verified by the referring provider), and (c) the female partner must be proficient in English.

**Exclusion Criteria.** Exclusion criteria included (a) unmanaged psychosis or manic episodes in the past year for the female partner; (b) alcohol or substance dependence within the past three months for either partner; (c) concurrent couple-based psychotherapy, or individual psychotherapy for the female partner; or (d) physical abuse within the past three months of the relationship.

**Procedure**

The current study was conducted in accordance with the standards approved by the University of California, San Diego Human Research Protections Program (UCSD HRPP; Protocol 120924) as well as by the Veterans Association Research and Development Office.

Interested female partners were contacted via telephone in order to further assess interest and eligibility. The study was described, and a phone screen was completed with the female partner in order to determine study eligibility and establish a time for the baseline assessment meeting.

During the baseline assessment meeting, the female partner and Study Coordinator met to complete the consent forms and the baseline self-report questionnaires. Female partners were then randomly assigned to either the Immediate Intervention (INT; \( n = 12 \)) or Delayed Intervention Waitlist (WL; \( n = 11 \)). Those assigned to the INT group began the 10-session group protocol within two weeks of
the baseline assessment. The INT group members were given their post-treatment questionnaire packet during the final session along with a stamped envelope and were asked to complete the questionnaires and return them within the next week; the WL group members were mailed the same packet at this time and asked to complete it immediately and bring it to the first group session. The WL group began the intervention one week after the INT group completed the protocol. The WL group was then given this same questionnaire packet a third time during their final session to take home, complete, and return in the addressed and stamped envelope. See Figure 1 for participant flow.

**Immediate intervention (INT): Group therapy for partners of veterans with PTSD.** This protocol was designed to include 10 weekly group therapy sessions, each 90 minutes in length. The manual was developed by the candidate and her supervisors and focuses on PTSD psychoeducation, skills-based interventions, and relationship-enhancing exercises. The manual alternates between psychoeducation sessions and skills-focused sessions in order to balance educational information related to the veteran and PTSD with skills they could begin to implement in their daily lives. Specifically, the protocol includes the following content areas:

Introduction and overview of the group (Session 1), definition of PTSD and its impact on intimate relationships (Session 2), the importance of self-care (Session 3), other post-war reactions including substance abuse and depression, and the impact of overidentifying or underidentifying with the veteran’s mental health problems (Session 4), communication skills (Session 5), an overview of available PTSD
treatments (Session 6), challenging negative thoughts (Session 7), relaxation skills for both the partner and the veteran (Session 8), the “we” versus “you” approach to PTSD recovery and the importance of communal coping (Session 9), and a final review session (Session 10). Each session included a weekly homework assignment, several of which were relationship-enhancing exercises intended to be shared and completed with the veteran (for a list of session titles and paired homework assignments, please see Table . During the final session, female partners were also given additional resources, including bibliotherapy references and information about the VA Caregivers Program as well as the National Alliance on Mental Illness (NAMI) Family-to-Family program. For a copy of the group therapy manual, please see Appendix H.

Delayed intervention waitlist (WL). The WL group was chosen as the control condition because currently there are no alternative treatment options specifically for the significant others of veterans with PTSD within the VA. While the INT group completed the intervention, the WL group members were contacted once a month to check in, and were invited to contact the Study Coordinator as needed. As previously mentioned, the WL group members were offered the intervention beginning one week after the INT group completed, so approximately 12 weeks after the baseline assessment. The waitlist group completed the same questionnaires at pre-treatment, post-treatment, and throughout the intervention, and their responses to the weekly questionnaires and post-treatment feedback regarding the intervention were
included in this study in order to provide the maximum amount of feedback regarding the intervention.

**Assessment Overview**

Three primary sets of assessments were included in this study: a telephone screen, the questionnaire packet administered at pre-treatment and post-treatment, and weekly questionnaires administered during the sessions.

**Telephone screen.** The Manic Episode and Psychotic Episode modules of the *Mini-International Neuropsychiatric Interview* (M.I.N.I.; Sheehan et al., 1998) were administered through a phone screen in order to determine the presence of psychotic or manic episodes in the past year (for potential study exclusion).

In the 10-15 minute telephone screen, the Study Coordinator briefly described the study and obtained oral consent for the phone screening. To determine study eligibility, female partners were asked about (a) the veteran’s PTSD status, as well as the clinic through which he is receiving treatment (this information was confirmed if already provided by the referring provider), (b) current engagement in psychotherapy, including either couple-based counseling or individual counseling for the female partner, (c) lifetime psychotic disorders or Bipolar Disorder (assessed using the M.I.N.I.), and (d) alcohol and/or substance dependence in the past three months for either partner. During this screen, relationship status was determined by asking if the couple was currently engaged, married, or living together as if married. Interpersonal violence was also assessed by asking the female partner a series of questions about the presence of physical violence in her relationship during times of conflict (e.g.,
pushing, hitting, fear of her partner becoming physically violent). If the female partner qualified for the study based on the phone screen, she was scheduled for an in-person meeting with the Study Coordinator to complete consent forms and pre-treatment questionnaires, and to receive her randomization.

**Pre-treatment and post-treatment measures.** This questionnaire packet evaluated the female partners’ relationship satisfaction, relationship closeness, confidence in the relationship, and current psychological distress. The INT group completed this packet at two time points (pre-treatment and post-treatment). Because the WL group was offered the intervention after the INT group completed, the WL group completed this questionnaire packet at three time points (pre-treatment, post-12 week wait, and post-treatment), with the post-12 week wait packet serving as their pre-treatment measures.

To assess overall relationship quality, female partners completed the *Dyadic Adjustment Scale* (DAS; Spanier, 1976). The DAS is a 32-item self-report measure designed to assess overall relationship satisfaction. The measure yields a total score ranging from 0-151, as well as scores on four subscales: Dyadic Satisfaction, Dyadic Cohesion, Dyadic Consensus, and Affectional Expression. A higher score on this measure indicates more relationship satisfaction, with a score of 97 or lower indicating relationship distress. The internal consistency ($\alpha = .70-.95$) and test-retest reliability for all subscales and the total score are high and test-rest reliability is also high (Carey, Spector, Lantinga, & Krauss, 1993).
The *Relationship Closeness Inventory* (RCI; Berscheid, Snyder, & Omoto, 1989; See Appendix A) was used to assess relationship closeness. This self-report questionnaire provides an index of overall relationship closeness, as well as subscales measuring the frequency of contact, diversity of activities shared together, and degree of mutual influence within the relationship. Total scores range from 3-30, with higher scores indicating higher levels of closeness in the relationship. This measure has acceptable internal consistency ($\alpha = .64$) and test-retest reliability ($r = .82$; Berscheid, Snyder, & Omoto, 1989).

The *Confidence Scale* (CS; Stanley, Hoyer, & Trathen, 1994; See Appendix B) was administered to assess the female partner’s confidence in the relationship and their ability to stay together in the future (e.g., “I believe we can handle whatever conflicts will arise in the future”). This 10-item self-report measure has a total score ranging from 10-70, and has been found to have acceptable internal consistency and construct validity (Whitton et al., 2007).

The female partner also completed the *Brief Symptom Inventory – 53* (*BSI-53*; Derogatis, 1993) in order to assess for general psychiatric distress. This self-report measure is made up of 53 items to which participants respond on a 0 (not at all) to 4 (extremely) scale, and the total score is then translated into a Global Severity Index (GSI). In addition, this measure consists of nine additional subscales – Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Each participant’s GSI score and subscale scores were then converted into a T-score based on normative data from
adult non-patient females, with a GSI T-score of 63 representing cases that exceed normative levels of psychological distress. This measure has demonstrated good internal consistency and convergent validity (Derogatis, 1993).

During the first session, female partners were asked to complete the Demographics Form (See Appendix C) and the Background Information Form (See Appendix D). The Background Information Form has been adapted with permission from the original author from a similar form used in the Support and Family Education (SAFE) Program, an educational program for the families and caregivers of mental health patients within the VA (Sherman, 2008). This form evaluated the female partners’ baseline understanding of PTSD and ability to manage her own needs and the needs of the veteran.

Finally, as part of the post-treatment questionnaire packet, female partners were asked to complete the Participant Satisfaction and Feedback Form (See Appendix E). This brief questionnaire included several of the questions from the Background Information Form administered during the first session, and was intended to evaluate the female partner’s understanding of PTSD and confidence in meeting her needs and those of her significant other after having participated in the group. This form also asked for specific feedback on the group content and structure, including what they liked most and least about the group, what they feel they gained from the group, and if/how they would change the order and/or content of the ten sessions.

Weekly measures. The female partners were asked to complete weekly measures during their group therapy participation. These included the Weekly
Satisfaction Measure (WSM; Whitton, Stanley, Markman, & Baucom, 2008; See Appendix F) and CS to measure partners’ weekly satisfaction and confidence within their relationship, as well as the BSI-18 (Derogatis, 2001), a briefer version of the BSI-53 that measures psychological distress. In addition, each week participants completed the PTSD Partners Group Session Evaluation Form (See Appendix G), which was adapted with permission from a similar SAFE Program form for use in this study (Sherman, 2008). This measure was used to evaluate the utility of the content covered in each session.

Preliminary Analyses

Power. Prior to beginning study recruitment, the minimum sample size necessary to detect significant effects in this study was estimated using Cohen (1992) and the G*Power 3 Software (Faul, Erdfelder, Lang, & Buchner, 2007). Because these calculations were conducted a priori and effect sizes for the current study were unknown, sample size was estimated based on the effect sizes of similar studies. Although no published studies have examined the impact of a group solely for the partners of veterans with PTSD, several studies have evaluated the influence of couple-based interventions for PTSD on relationship satisfaction. These studies have consistently reported large effect sizes. For example, in one study examining the effects of cognitive-behavioral conjoint therapy for PTSD, the effect size was large ($d = 0.93$) for improvement in relationship satisfaction ($N = 7$ couples; Monson et al., 2005). A power analysis was conducted for ANOVA repeated measures, between factors using the G*Power 3 software. In order to have sufficient power (i.e., at least
.80) to detect a large effect size ($d = .80$; Cohen, 1992) at a two-tailed significance level of $\alpha = .05$, the analyses require a minimum sample size of 40 participants.

Despite extensive recruitment efforts, only 23 participants were randomized in the current study. As a result, analyses were conducted using G*Power 3 to determine if this study sample provided sufficient power for examining the proposed hypotheses. At a two-tailed significance level of $\alpha = .05$, the current study would have sufficient power (i.e., at least .80) to detect effects of $d = 1.06$ or larger. For each hypothesis, Cohen’s $d$ effect size was calculated to determine the magnitude of differences both between and within groups. The limitations of the current sample size are considered further in the discussion section below.

**Missing values.** Prior to conducting the main analyses, the data were checked for missing values. Every effort was made during data collection to ensure each participant’s pre- and post-treatment questionnaires were complete, and participants who dropped out of the study were also contacted to complete post-treatment questionnaires. All baseline measures for the 23 participants were complete. Post-treatment measures were missing for one participant who dropped out of the INT group. Also, WL group post-treatment questionnaires were not completed by two participants who dropped out of the WL during the intervention period (i.e., they did not drop out during the waitlist portion of the study, and did complete their pre-treatment questionnaires). Two additional participants (one INT, one WL) who completed the study were missing seven and nineteen items on the post-treatment RCI, respectively. For study completers, the maximum amount of missing data was 4.0%
on the RCI. The results of Little’s missing completely at random (MCAR) test indicated that missing data was randomly distributed on the RCI ($X^2=.000[124]$, $p = 1.00$). Although several strategies exist for estimating missing data points, none of these methods were implemented in the current study given the minimal amount of missing data and that the small sample size greatly reduces the accuracy of missing data estimation (Tabachnick & Fidell, 2001). Because missing values were not estimated, true intention-to-treat analyses could not be completed. Analyses were therefore limited to completers only (i.e., participants in the INT group who completed the intervention and post-treatment questionnaires, and those in the WL group who completed the post-INT treatment questionnaires following the waitlist portion of the study). Fortunately, with the exception of the two incomplete RCI scores, all participants who completed the INT or WL groups had complete data (i.e., missing data points were otherwise only for study non-completers). Given these limitations, other more complex analytic strategies that utilize all existing data points (e.g., hierarchical linear modeling) were not used.

**Baseline characteristics.** The sample for the current study consisted of 23 female partners who were randomly assigned to either the INT group ($n = 12$) or delayed intervention WL group ($n = 11$). The mean age for the total sample of female partners was 50.6 (SD = 15.6, range 25-70), and the mean age for their veteran partner was 52.7 (SD = 16.7, range 27-70). The length of relationship ranged from 3 years to 53 years, with a mean length of 26 years (SD = 17.2). The majority of the female partners were Caucasian (65.2%), reported having some college education (52.6%),
and were either working full-time (34.8%) or retired (43.5%). A breakdown of demographic information by randomization group is available in Table 2.

Potential differences in demographic and baseline clinical variables between the INT and WL groups were evaluated. Baseline characteristics were compared using \( \chi^2 \) or t-tests. No significant differences existed between the two groups for female partner age, veteran age, length of relationship, marital status, ethnicity, and years of education. Additionally, the two groups did not differ significantly on any of the four baseline clinical variables. Given that the current study examined completers only, the baseline clinical variables were also examined for this sub-sample. INT and WL completers did not differ significantly from each other, and study completers did not differ significantly from the total randomized sample on baseline clinical variables (all \( ps > .40 \)).

**Statistical assumptions.** Before conducting the main analyses, the statistical assumptions of univariate analysis of variance (ANOVA) were examined. The assumptions of ANOVA are that the errors (\( \varepsilon \)) are normally distributed, independent, have equal variances, and are expected to have a mean of zero. The normality of the baseline data was evaluated using the Shapiro-Wilk’s statistic. Using an alpha of .05 to evaluate the normality assumption, this statistic was significant for the DAS \( (p = .003) \) and CS \( (p = .01) \); the BSI-53 and RCI distributions were within normal limits \( (p = .56 \text{ and } .75, \text{ respectively}) \). The kurtosis and skewness values for the DAS and CS were examined to determine the extent of non-normality of the data and to select appropriate transformations. The distribution for the DAS was found to be negatively
skewed (-1.74, SE = .48) and leptokurtic (3.93, SE = .94), and the distribution for the CS was found to be negatively skewed (-1.16, SE = .48). To correct these non-normal distributions, the participant scores on the DAS and CS were square root transformed. Because these data points on these measures were negatively skewed, the formula \( \text{SQRT}(K - X) \), where \( K \) is an integer from which each participant score is subtracted so that the smallest score is equal to 1, was used to transform the scores (Tabachnick & Fidell, 2007). These transformations normalized the distributions for the baseline variables (DAS \( p = .50 \); CS \( p = .48 \)). The transformed data was used to complete the main analyses. Because the transformed data is no longer in an easily understood metric, and back-transformation cannot be used for certain statistics like standard deviations and confidence intervals (Bland & Altman, 1996), the original values are also used for reporting results of the analyses (see Table 3 for original and transformed means).

In addition, potential multicollinearity was evaluated by examining the correlations between the four baseline dependent variables and using a correlation of .70 or stronger as an indicator of redundancy between variables (Tabachnick & Fidell, 2007). The correlations were weak to moderate in strength (see Table 4). Of note, the relationship satisfaction variables (i.e., DAS, RCI, and CI) were all positively and moderately correlated with each other, and the measure of psychological distress (i.e., BSI-53) was negatively correlated with all three measure of relationship satisfaction.

**Analyses**

All analyses were conducted in IBM SPSS Version 20.
**Hypothesis 1.1.** The female partners randomly assigned to the group therapy program will report significantly greater improvement in relationship functioning and satisfaction from pre- to post-treatment than those in the waitlist control group.

The construct ‘relationship satisfaction’ was measured using three self-report questionnaires: the DAS (overall relationship quality), RCI (relationship closeness), and CS (relationship confidence). Given that these constructs are conceptually related, the original analytic plan was to conduct a multivariate analysis of variance (MANOVA). This plan was changed to conducting a series of univariate ANOVAs due to the small sample size that would likely not provide sufficient power for conducting a MANOVA. Three 2 (group: intervention, waitlist) X 2 (time: pre-, post-treatment) mixed model ANOVAs were conducted separately for overall relationship quality (DAS), relationship closeness (RCI), and relationship confidence (CS) as the dependent variables. If a significant omnibus interaction was detected, follow-up paired-sample t-tests were conducted in order to determine changes in that specific outcome variable within each group.

In addition, the session means on the WSM and CS for those who completed the INT group were calculated. Given the very small sample size for each session \((n = 9 \text{ or fewer})\), statistical tests were not conducted to evaluate for significant differences. Rather, the session means were plotted in order to illustrate the weekly change in relationship satisfaction and confidence over the course of the ten-week intervention.
**Hypothesis 2.1.** The female partners assigned to the group therapy program will report significantly greater improvements in psychological distress from pre- to post-treatment than those assigned to the waitlist control group.

Female partner’s psychological distress was measured using the GSI T-Score that was derived from the BSI-53. This hypothesis was examined using a 2 (group: intervention, waitlist) X 2 (time: pre-, post-treatment) mixed model analysis of variance (ANOVA) with repeated measures on the second factor. If a significant omnibus interaction was detected, follow-up paired-sample t-tests were conducted in order to determine changes in partner psychological distress within each group.

In addition, the session means on the BSI-18 for those who completed the INT group were calculated. Given the very small sample size for each session ($n = 9$ or fewer), statistical tests were not conducted to evaluate for significant differences. Rather, the session means were plotted in order to illustrate the weekly change in psychological distress over the course of the ten-week intervention.

**Exploratory Aim 3.** To evaluate the female partners’ perceptions of the acceptability, relevance, and usefulness of the group therapy content in order to refine the intervention for larger scale studies.

Given that the INT and WL groups did not differ at baseline on any demographics or clinical variables and they both received the same intervention by the end of the study, their data were combined in order to provide the maximum amount of feedback regarding the content of the intervention.
In order to determine the overall acceptability of the intervention, dropout rate and average number of sessions attended were calculated.

Using the Session Evaluation Form and Participant Satisfaction and Feedback Form, the relevance and usefulness of each session and the intervention as a whole were explored in several ways. The Session Evaluation Form contained several questions that inquired about the overall quality of the session, the style of the group leaders, the relevance of the topic, the usefulness of the information provided, and the amount of new information they gained from the session (See Appendix G). Each item was rated on a 1-5 point scale. First, means and standard deviations were calculated for ratings of relevance and usefulness for each of the sessions. Additionally, the scores on these five items were averaged across all participants for each of the eight content sessions (excluding the introductory session and final wrap-up session) in order to determine the overall quality of each group session.

Second, participants were asked to rank the sessions in order from most helpful (1) to least helpful (8) in the post-treatment Participant Satisfaction and Feedback Form (See Appendix E). The average ranking for each session was calculated in order to determine which sessions participants found to be the most and least helpful after having completed the group.

Third, as part of the Session Evaluation Form, participants were asked after each session to reflect on how the session was helpful by indicating from a list of nine items those that best describe their needs that were met during the session. These data were summed and collapsed across sessions and participants to determine the
percentage of participants who felt these specific needs were met through participation in the group intervention. In addition, participants’ feedback regarding the aspects of the group they liked the most/least, and benefits they feel they gained from participating in the group was reviewed and themes were extracted.

Finally, one of the important goals of this intervention was to provide significant others with the skills and knowledge necessary to increase their confidence in handling their partner’s PTSD. In order to measure this, several questions were included in the Background Information Form (See Appendix D) and Participant Satisfaction and Feedback Form that inquired about confidence in dealing with PTSD, understanding of PTSD, anxiety about veteran’s well-being, knowledge of VA resources, and self-care. The scores on these items were compared between pre-treatment and post-treatment using paired sample t-tests.

The Introduction, Methods, Results, and Discussion chapters were co-authored, in part, by Joshua Madsen, Matthew Jakupcak, and Steven Thorp and together have been submitted for publication. Heather Sones is the principal author of this material.
**Results**

**Hypothesis 1.1:** The female partners randomly assigned to the group therapy program will report significantly greater improvement in relationship functioning and satisfaction from pre- to post-treatment than those in the waitlist control group.

Using an alpha level of .05 to evaluate homogeneity assumptions, Levene’s statistic was found to be non-significant for each dependent variable (all ps > .24). The Time X Group interaction effects were not significant for the DAS \([F(1,16) = .32, p = .58, d = .28]\), the RCI \([F(1,16) = .02, p = .89, d = .07]\), or CS \([F(1,16) = 2.72, p = .12, d = .83]\). In other words, the intervention and waitlist control groups did not differ significantly in their changes on the relationship satisfaction measures from pre- to post-treatment (see Table 3 and Figures 2-7 for group means and change in individual participant scores), although there was a large effect size for the CS.

Similar results are found when examining the session means on the WSM and CS (see Figures 8 and 9). The scores on these two measures appear to stay relatively consistent across the intervention.

**Hypothesis 2.1:** The female partners assigned to the immediate intervention group will report significantly greater improvements in psychological distress from pre- to post-treatment than those assigned to the waitlist control group.

Female partner’s psychological distress was measured using GSI T-scores derived from the BSI-53. This hypothesis was examined using a 2 (group: intervention, waitlist) X 2 (time: pre-, post-treatment) mixed model analysis of variance (ANOVA) with repeated measures on the second factor. The interaction
effect was also significant \([F(1,16) = 8.17 \, p = .012, \, d = 1.43]\). Paired samples t-tests were used to follow-up this significant interaction effect, which indicated that the INT group had a statistically significant \([t(8) = 2.84, \, p = .022]\) decrease on the BSI-53 from pre-treatment to post-treatment, while the WL group did not \([t(8) = -0.93, \, p = .38]\).

This indicates that the changes in GSI T-scores from pre- to post-treatment were significantly different between the intervention and waitlist control groups (see Table 3 for group means). Specifically, the scores for the intervention group decreased from pre-treatment to post-treatment, while the waitlist control group showed no significant change in scores (see Figure 10 for group means, and Figure 11 for change in individual participant scores).

In order to determine which subscales of the BSI-53 were driving the significant decrease in GSI T-scores from pre- to post-treatment in the intervention group, paired sample t-tests were used to compare the ten subscale T-scores for those participants in the intervention. Significant decreases in T-scores were found for the Hostility \([t(8) = 3.10, \, p = .015]\) and Paranoid Ideation \([t(8) = 2.41, \, p = .043]\) Subscales. Average T-scores across all subscales decreased between 1.89 points (Psychoticism) and 8.22 points (Hostility) from pre- to post-treatment for the intervention group.

A similar trend is found when examining INT group scores on the weekly BSI-18 questionnaire (see Figure 12). Due to limited power for repeated measures analyses, formal statistical analyses were not used to evaluate differences between the
sessions, there appears to be a trend towards a reduction in scores across the ten sessions.

**Exploratory Aim 3:** To evaluate the female partners’ perceptions of the relevance and usefulness of the group therapy content in order to refine the intervention for larger scale studies.

Given that both the intervention group and waitlist control did not differ at baseline on any demographics or clinical variables and they both received the same intervention by the end of the study, their data were combined in order to evaluate the content of the intervention. Looking at the sample as a whole who participated in the intervention (i.e., attended at least one session; \( n = 21 \)), the average number of sessions attended by both completers and non-completers was 6.30 (\( SD = 3.54 \)). Of those participants who completed the intervention (\( n = 15 \)), the average number of sessions attended was 8.53 (\( SD = 1.25 \)). Three of the women who dropped out never attended the group (one due to lack of childcare, one went on an extended vacation, and one was not reachable by phone), and two additional women dropped out after the first and second session due to extenuating family circumstances (i.e., family member admitted to psychiatric inpatient unit and family member with a medical emergency, respectively). The three other women who discontinued their participation did so after Sessions 5 (\( n = 2 \), both with work obligations that conflicted with the group time) and 6 (\( n = 1 \), moved out of state). With a dropout rate of 28%, and many of the women who ended their participation needing to do so for factors beyond their control as
opposed to lack of interest in the intervention, it appears the protocol was very well received as a whole.

In terms of overall quality of the sessions, all session means reported on the Session Evaluation Form were above a 4.0, with Session 4 (Other Common Post-War Reactions), Session 7 (CBT Basics – Challenging Negative Thoughts), and Session 9 (“We” versus “You” approach to PTSD) having the highest overall means. Furthermore, when participants were asked to rank the sessions on the Participant Satisfaction and Feedback Form (where a smaller number indicates a higher rank), no session received an average ranking lower than 5.0. Among the highest ranked sessions were Session 2 (PTSD in Relationships), Session 3 (Taking Care of Yourself), and Session 5 (Communication Skills). Table 5 provides overall quality means and rankings for each session.

In addition, participants were asked after each session to reflect on how the session was helpful by indicating from a list of nine items those that best describe their needs that were met by that session. These data were then summed and collapsed across sessions and participants (See Table 6). The most frequently met needs were having the opportunity to talk with other partners who face similar issues (87.5%), feeling as if their role as a partner of a veteran was valued within the VA (64.6%), and learning new ways to help their significant other (64.6%).

Furthermore, on the Participant Satisfaction and Feedback Form, female partners were asked to report what they liked most about the group and describe the top three things they gained from participating, in their own words. By far the most
frequently reported aspect of the group that was liked the most by group members was
the opportunity to interact with other women who shared similar experiences (reported
by 14 out of 19 women who completed the *Participant Satisfaction and Feedback
Form*). Each participant’s feedback regarding the top three things they gained from
participation were reviewed and grouped based by theme (see Table 7). The most
commonly reported themes were improved communication skills and a better
understanding of their Veteran’s experience with PTSD. Other commonly cited
benefits were increased confidence/assertiveness, increased knowledge of PTSD, and
improved self-care.

Participants were also invited to provide constructive feedback on which
content areas they found to be the most/least helpful, as well as ways to improve the
session content and/or ordering. Although the feedback was quite varied across
participants, and a large number of female partners approved of the intervention in its
current form, a few themes emerged. These included the following: 1) Move
relaxation skills to an earlier session and combine with self-care. One woman
suggested practicing a brief relaxation skill at the beginning of each session as
opposed to dedicating an entire session to relaxation exercises. 2) Move
communication skills to an earlier session to allow for more practice across sessions.
3) Spend less time in session focused on “technical detail” of PTSD and more time
dedicated to coping with PTSD in the relationship and how to apply the knowledge
gained within their relationships.
In order to gain additional constructive feedback to help improve future iterations of the group, female partners were also asked to report what they found to be their least favorite aspect of the group. The most frequently cited aspect of the group that participants liked least was the size of the group, stating they “would like to see more spouses/partners participating” (cited by 6 out of 19 participants). Four participants would have liked to have a longer group or some kind of follow-up program. Notably, six participants reported there was “nothing” they liked least about the group.

Finally, paired sample t-tests were used to compare pre- to post-treatment scores on several items measuring female partners’ confidence in dealing with PTSD, understanding of PTSD, anxiety about veteran’s well-being, knowledge of VA resources, and self-care (see Table 8). Female partners who completed the intervention reported a significant increase in their confidence in dealing with PTSD ($p = .02$), their understanding of PTSD ($p = .002$), and their knowledge of VA resources ($p < .001$).

The Introduction, Methods, Results, and Discussion chapters were co-authored, in part, by Joshua Madsen, Matthew Jakupcak, and Steven Thorp and together have been submitted for publication. Heather Sones is the principal author of this material.
Discussion

The goal of the present study was to evaluate the utility of a 10-week group therapy protocol for the female partners of veterans diagnosed with PTSD. This included determining the impact of group therapy participation on relationship functioning and satisfaction (Aim 1) and female participants’ psychological distress (Aim 2), while also eliciting feedback about the intervention from participants in order to determine the acceptability, usefulness, and relevance of the protocol to inform future revisions of the intervention (Aim 3). In order to evaluate these aims, participants were randomized to either an immediate intervention group (INT) or delayed intervention waitlist control group (WL). Pre-treatment to post-treatment changes on several measures were determined.

The first study hypothesis postulated that participation in the group therapy treatment would result in a significant increase in relationship functioning and satisfaction. Although improvement in certain areas of relationship functioning were observed in the group context and reported anecdotally by participants, participation in the group intervention did not result in a significant increase in relationship closeness, satisfaction, or confidence per the self-report measures.

Several potential explanations exist for this non-significant finding. First, it could be that the intervention truly did not have a significant impact on relationship satisfaction, closeness, or confidence. In a group therapy protocol focused on the female partners only, it may be that the positive impact of the intervention would be primarily on their own psychological health. Additionally, given the significant
emphasis on self-care and the female partner’s psychological well-being, it could be that the content of this intervention that focused on enhancing relationship satisfaction was insufficient to change these constructs. Furthermore, creating a significant and immediate change in relationship functioning with just one partner present may be difficult, especially in an intervention that only runs for 10 weeks and does not include any interaction with or participation from the veteran partner.

Alternatively, it is possible that the relationship measures used did not accurately capture the facets of participants’ relationships that were impacted by the intervention. Given that this study was one of the first to empirically evaluate an intervention for the female partners of veterans with PTSD, the authors chose measures based on the available literature and relationship factors that they felt would be impacted by the intervention. It may be, however, that the areas affected are not accurately represented by these measures. This explanation is substantiated by the fact that qualitative feedback from participants indicate positive impacts on their relationship and communication with their partner. Future evaluations of this intervention will include a measure of effective communication or willingness to openly communicate in the relationship.

A third potential explanation is that the small study sample size only provided sufficient power to detect effect sizes of $d = 1.06$ or larger. In other words, it is possible that meaningful differences could not be detected because of insufficient power as a result of the small sample.
A final possible explanation for the lack of significant findings in regards to changes in relationship satisfaction may be that the female partners were already reporting moderate to high levels of relationship satisfaction at the beginning of the intervention, so there was not much room for improvement. When inspecting Figures 3, 5, and 7 which depict changes in individual participants scores, it is clear that most participants scored highly on relationship satisfaction at both pre-treatment and post-treatment/post-12 week wait. For example, the majority of participants scored above the clinical cut-off for relationship distress on the DAS (i.e., a score of 97; Figure 3), and many participants scored near the maximum possible score on the CS (i.e., a score of 70; Figure 7). The quantitative and anecdotal qualitative reports of relationship distress were discrepant at the onset of the intervention, so these high scores could at least partially be due to a positive reporting bias when the researchers were less well known to the subjects at the start of the study. Regardless of the explanation, the baseline scores on the relationship measures were already in the average to high range, so this could also partially explain the lack of significant change on these measures.

The second hypothesis evaluated in this study predicted that participation in the group intervention would result in a significant reduction in psychological distress for the female partners. This hypothesis was supported in both the quantitative data and anecdotal reports by participants. These results imply that the facets of the intervention content that were designed to improve the female partners’ psychological health, including the emphasis placed on self-care, inclusion of communication and assertiveness skills, and instruction around tools for challenging negative thoughts,
likely helped to buffer against the negative effects of PTSD and relationship distress on their own mental health. In addition, several elements of the intervention that were not written in the manual, including the social support gained from the other women in the group and the development of a greater understanding and empathy for their veteran’s experience of PTSD, were rated by female partners as some of the most beneficial aspects of the group. These factors likely served to reduce their own psychological distress.

The third aim of this study was exploratory in nature and sought to evaluate the female partners’ perceptions of the intervention and to garner their feedback about the group in order to improve future iterations of the manual. Based on the feedback, the intervention was very well received and the participants generally approved of the content. Notably, participants most frequently reported that their favorite aspects of the group were not related to any specific content, but rather related to the social support gained from other women with similar experiences within the group, and feeling as if their role was valued within the VA. Furthermore, the majority of participants stated that the main facet of the group they would change if possible was the size of the group to include more participants.

Similar to how some of the most impactful elements of the intervention were not related to the written content of the group, some of the most helpful information and “feedback” was not captured on the weekly or post-treatment questionnaires, but rather was observed and experienced through the process of implementing the group. These informal findings will be helpful in both refining the current intervention and
guiding the development of future interventions, and are therefore summarized in the following “Lessons Learned” section.

Lessons Learned

Group content. 1. A continuous discussion of the importance of self-care appeared to be a central strength of the intervention. The women participating in the group often reported taking the role of caretaker for other family members while neglecting their own personal care. Self-care was introduced in Session 2, and the homework assignment asked participants to make a list of several potential self-care exercises, and to pick one and practice it for the week. They were then encouraged every week to continue their self-care practices. Revisiting this topic was very important because several of the women reported feeling guilt for doing things for themselves rather than for their partner or family. These feelings were normalized, and the long-term consequences of neglecting one’s own well-being, including having fewer resources to care for others, was reiterated. At the conclusion of the group, several participants gave feedback that the concept of self-care was one of the most important lessons taught in the group. For example, one woman saw significant change within herself simply by taking time every morning to go for a run with her dogs. She reflected that this allowed her to feel much better about herself and gave her time to clear her head, which in turn allowed her to be more patient with her husband.

2. Relationship enhancing exercises were reported to be one the most efficacious assignments in terms of improving relationships, and therefore additional
exercises will be included in future revisions of the intervention. These exercises included “Catch and Tell,” relationship enhancing thoughts, and exploring the Five Love Languages (Chapman, 1992). Female partners were asked to share the exercises with their partner. One participant reported that after sharing the Catch and Tell exercise with her husband, he made an extra effort to do nice things for her throughout the week. Another participant reported that while completing the relationship enhancing thoughts exercise with her husband, she had a difficult time identifying a romantic occasion in their relationship. Her husband then planned a surprise dinner and movie night for the two of them in order to increase the romantic moments shared in their relationship. Given that these exercises explicitly requested the participation of the veteran partner, it is likely that additional similar exercises could allow for more improvement in relationship satisfaction for both partners.

The Five Love Languages was included as a discussion in the Session 7, but will likely be moved to an earlier session in future iterations of the manual. This exercise explores the five most common ways people give and receive love, and female partners were asked to reflect on their love languages as well as that of their partner. This concept sparked a lot of interesting conversation within the group and within the participants’ relationships, and it would likely enhance several of the other exercises in the manual (e.g., Catch and Tell, practicing communication skills). For example, one female partner stated that she and her husband realized that they feel most loved when spending time together, especially traveling, and were able to
pinpoint that the lack of recent travel together was likely one source of their current distress.

3. Although not directly tied to a specific content area of the intervention, the female partner’s participation in the group and knowledge gained from the content appeared to lift communication barriers in some relationships. Several women commented that participating in the group created more of an open dialogue around PTSD with their partner. It seemed that, since the participants were encouraged to take the information covered in session home each week and share it with their partner, this may have demonstrated to the veteran that their significant other was trying to learn more about what he was experiencing. This, in turn, may have made the veteran feel more open and willing to discuss his experience with PTSD.

Several anecdotal reports throughout the group corroborate this hypothesis. Several participants spoke about how their husbands began to spontaneously offer more information about their experiences with PTSD than they had before. For example, one veteran expressed to his wife that a specific situation they experienced made him feel “unsafe,” which was a trauma trigger for him. The veteran’s disclosure of a “softer” emotion had not previously happened within their relationship. Another husband opened up as to why sitting with his back to other diners in a restaurant made him uncomfortable, and he also began to share more about his Vietnam experiences with her. Finally, another veteran stopped the Study Coordinator in the hall after a session and thanked her for developing the group, stating that it has become much easier to talk about PTSD with his wife since she began attending the group. Future
investigations of this intervention will include pre- and post-treatment questionnaire items to assess veteran willingness to talk about his PTSD.

4. One topic that was not addressed in the content of the group but will be included in future iterations of the manual was the impact of PTSD on physical intimacy and sexual health in relationships. On the Weekly Satisfaction Questionnaire collected at the beginning of each session, the first item inquired about the participant’s weekly satisfaction with her “sex life.” This was by far the lowest rated item across the 10 weeks - the mean rating for this item was a 2.8 out of 7, with higher scores indicating more satisfaction (the second lowest ranking item had an average rating of 4, which inquired about satisfaction with the way arguments were resolved). Of note, the highest rated satisfaction item across the 10 weeks was “your partner’s physical appearance,” which had an average rating of 5.0 out of 7. This topic was more frequently broached by female partners during one-on-one conversations with group facilitators than in the group setting, and communicated a similar struggle; despite physical attraction, there was a significant discrepancy in desire for and frequency of physical intimacy, typically with the female partner desiring more connection of this nature.

Future iterations of the manual will dedicate at least half of a session to discussing the impact of PTSD on sexual intimacy. This will include the direct effect of PTSD in intimacy (e.g., those with PTSD feeling vulnerable during sex) and the detrimental impact of some psychotropic medications on sexual desire and performance. Although changing the sexual health of a relationship may be beyond
the scope of a group with only one partner present, it may be beneficial to normalize this issue and provide the space for an open discussion.

**Group dynamics.** 1. Consistent attendance is a critical element of group cohesion. Many participants in the first round of the group struggled with the fact that other group members did not seem as committed to the group or dedicated to regular attendance. As was cited in both the quantitative and qualitative feedback, group participants reflected that they learned as much from each other as they did the group facilitators, so having as many people present as possible was important. Given that this feedback came up consistently throughout the groups, the importance of consistent attendance will be stressed at the beginning of future groups.

2. The ideal number of participants for this group is between five to eight women. Group size and attendance varied greatly across the sessions, ranging from two to eight women. Although the smaller groups allowed for each participant to receive more individual attention, many group members gave the feedback that more participants in the groups would have made for a better experience. Given that group members reported learning just as much from the other participants, the information shared by the women often enhanced the session content, and absences often occur, a minimum group size should be five women. On the other hand, too many participants would make it difficult to cover all of the session content and allow for each woman to have the opportunity to share personal experiences. Eight women in the group would be the ideal maximum for balancing the review of session material with sufficient time for discussing the application of the material and sharing of personal experiences.
3. The inclusion of female partners across several war eras created a unique and supportive environment in which these differences were embraced. Before beginning recruitment, the developers discussed whether to limit the group to a specific era (e.g., Vietnam era) or to include all interested participants without era restriction. It was decided that this group would be open to all participants given that there were no other similar options for female partners, and this approach maximized recruitment of eligible participants. The groups consisted of female partners of veterans from the Vietnam War, Desert Storm, and OEF/OIF. The first session included a discussion of the importance of respecting and embracing differences, and not using the group as a place to vent frustrations towards those who have not experienced similar life events or circumstances.

The women appeared very understanding of generational and war era discrepancies from the beginning, and the inclusion of several war eras led to unexpected supportive dynamics within the group setting. For example, the older female partners often stated that they felt as if they could offer guidance and insight to the younger partners, given that they had often been in similar situations before. The younger partners, on the other hand, often offered a “fresh perspective” on coping with PTSD in relationships for the older generation who sometimes expressed hesitation toward considering new ways of coping.

Group members varied greatly in age, socioeconomic status, occupation, closeness with their significant others, commitment to the relationship, length of relationship, level of knowledge about veteran’s war experiences, their own traumas or
mental health concerns, and number of children. Despite these differences, the groups were able to bond over the common element of PTSD impacting their relationship, and continuously supported one another irrespective of differences.

4. The groups were overall very supportive environments, with female partners often reporting more comfort focusing on others instead of themselves. To the facilitators, these groups exclusively for female partners had a much different level of engagement than the traditional veteran treatment group. These women appeared genuinely interested in the material, were engaged throughout group, and more frequently completed the homework assignments.

The participants often focused on helping other group members and appeared uncomfortable when asked to reflect on themselves and their own struggles. Although offering support and suggestions to other group members is often a benefit of group-based interventions, facilitators must be mindful of when this technique can serve as avoidance of dealing with uncomfortable personal struggles or issues. For example, one of the group participants frequently asked thoughtful questions of other group members, and listened thoughtfully before offering support or advice. However, when discussing the topic of self-care she expressed difficulty articulating activities she enjoyed alone or ideas for improving self-care. The woman was able to identify that her awareness of her lack of self-care was upsetting, but she voiced guilt about taking time away from caring for her husband and apprehension around changing the relationship dynamic by spending more time alone.
5. As in any other group setting, disruptive group members can begin to weaken the cohesion within the group and should be addressed in a respectful but firm manner by the facilitators. In order to minimize the amount of disruptive behavior in the group, ground rules were clearly outlined in the first session. Although these groups were generally respectful and supportive, there were several occasions when a participant discussed explicit details of her partner’s traumatic events, or discussed her frustrations towards her partner in an unproductive and derogatory manner. These situations were addressed by reviewing group rules as needed as well as mid-way through the group protocol (i.e., beginning of Session 6). Everyone was reminded that stories that are salient to the session topic should be shared in a constructive way that respects the privacy of others.

**Difficult Topics.** 1. Some group members presented with significant distress in their relationship, and entered the group with ambivalence around their commitment to the relationship. The group facilitators remained neutral and supportive of the female partner as she weighed her decision. Although a few participants reported incidences of interpersonal violence in their relationship history, none reported violence occurring during their participation in the group. If an incident of interpersonal violence were to occur, the group facilitators would have provided the female partner additional support as needed, placing an emphasis on the importance of self-care. She would also be provided with additional resources and contact information for therapy and shelter options.
Two group members who were in difficult relationships decided to end their relationship during the course of the group. This was not an anticipated outcome given that one of the inclusion criteria for the study was being in a committed relationship. However, ending of romantic relationships should be considered given the significant distress reported by the women seeing such a group for support. The group facilitators and supervisors had to decide how this situation would be handled, given that these women were no longer in relationships and at least half of the group material was relationship- or PTSD-focused. The women were invited to remain in the group, with the understanding that some of the group topics may be challenging given the recent ending of their relationship. Surprisingly, both women decided to stay in the group after the ending of their relationships because of the connection they felt with the other group members. It is noteworthy that both female partners reported significant improvements in their own mental health and well-being from pre-treatment to post-treatment.

2. Several of the women expressed concerns about whether their partners were being completely truthful with their providers about their suicidal thoughts. These women asked the group facilitators how they should go about relaying that information to the provider. While several other group members suggested calling the provider directly, group facilitators reminded them that, for confidentiality purposes, the provider can not confirm or deny that the veteran is in fact their patient without a written release of information from the veteran. However, the facilitators noted that a
female partner could call and disclose her safety-related concerns, and the provider can then choose what he or she does with that information.

3. Some of the female partners struggled with their veteran partner’s unwillingness to engage in his own treatment for PTSD. Some veterans had completed full courses of evidence-based therapy while others were not currently interested in engaging in PTSD-related interventions. The participants suggested that one of the best times to enroll women in the intervention would be when their veteran partners were also either just beginning or currently engaged in a course of treatment. Contacting women at that stage of their partner’s treatment seemed to contribute to both partners feeling that they were addressing their own needs and equally sharing the responsibility of addressing their relationship distress.

Some female partners expressed that their significant others were currently not interested or willing to participate in PTSD treatment. Participation in the group made some group members eager to return to their partner and share the information they learned about PTSD and available treatment options. However, it was clear that other group members were growing resentful that they were engaging in a PTSD-related intervention while their partner was not. Group facilitators discussed some of the common reasons why veterans choose to not engage in treatment or may not feel ready for treatment. Group members were reminded that PTSD treatment is very challenging and that the reason for this group was mainly for their own psychological health. They were encouraged to continue sharing what they were learning in group with their partners to foster open dialogue about PTSD within their relationship.
Limitations

The current study has several limitations. First, the findings of this pilot study should be interpreted with caution due to the small sample size. Only 23 women were enrolled and randomized in the study despite extensive recruitment efforts. This small sample size limits the ability to detect significant group differences. Although the current study did find a significant reduction in psychological distress in female partners who completed the intervention, the intervention should be replicated using larger samples. Furthermore, many of the clinical findings were anecdotal and therefore may not accurately represent the benefits of the intervention in different clinical settings.

Additionally, the small sample size limited the use of more advanced statistical analyses to evaluate treatment outcomes. Although the initial plan was to use multivariate analyses of variance (MANOVA) to account for the shared variance between the measures (DAS, RCI, CS) in Hypothesis 1.1, the small sample size precluded the use of that approach. This hypothesis was evaluated using a series of ANOVAs, which does not account for the shared variance and increases the likelihood of committing a Type I Error. In addition, the current study did not use intention-to-treat (ITT) analyses. Missing data points were not imputed because small samples reduce the accuracy of missing data estimation (Tabachnick & Fidell, 2001). Not utilizing ITT analyses can result in biased findings due to the exclusion of data from non-completers. Additionally, more advanced statistical tests that allow for the use of
all data collected regardless of completion status (e.g., hierarchical linear modeling) were not used because of the small sample size.

As noted, it is possible that the relationship satisfaction measures chosen for this study did not accurately capture the domains in which the intervention would have impacted the relationship. In addition, the study relied solely on self-report measures, which do not provide an objective representation of personal distress or relationship satisfaction. Many of the women identified that they were not accustomed to focusing on themselves, which may have made it difficult to accurately report their own psychological distress or dissatisfaction.

Although this intervention was open to partners of male veterans from several war eras, it was limited to the female partners of veterans with combat-related PTSD who were recruited largely through VA-based mental health clinics. This greatly limits the generalizability of the findings. Combat-related trauma is just one of many trauma types that can affect the veteran population and lead to the development of PTSD. Future implementations of this intervention should evaluate its usefulness in samples consisting of all male partners and various trauma types.

Finally, a follow-up assessment was not included in the current study because of its time-limited nature. Although no significant changes were seen in female partner relationship satisfaction immediately following completion of the intervention, a follow-up assessment would have elucidated possible improvements in relationship functioning that may have occurred as a result of the female partner’s improved psychological health and social support. Future implementations of this protocol
should include a follow-up assessment to determine whether any changes are maintained after the group has ended.

**Future Directions**

The intervention developed for the present study resulted in a significant decrease in the female partner’s psychological distress, which has implications for the health of the relationship. Based on the participant feedback, this intervention will be revised to include 1) moving relaxation skills to an earlier session and combining it with self-care, 2) moving communication skills to an earlier session to allow for more practice across sessions, 3) including an additional session focused on communication skills, 4) providing a discussion around the impact of PTSD on physical intimacy, and 5) emphasizing the application of PTSD-related knowledge to the relationship context.

Given the anecdotal reports of more frequent and open communication within the relationship, it may also be helpful to include a measure of openness to communication for both the veteran and partner. For example, the veteran could complete the Combat Disclosure Scale (Balderrama-Durbin et al., 2011), a self-report measure of his willingness to discuss his deployment-related thoughts and feelings. This measure could also be adapted for the female partner to complete based on her perspective of the veteran. Alternatively, more general measures could be adapted for completion by both partners. This could include the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1978), which measures relational empathy, expressivity, and overall regard for one another, or the Marital Communication Inventory (Schumm et al., 1983), which measures patterns of communication within a marriage. In
addition, a measure of social desirability should be included to illuminate potential reporting biases. Future studies would also benefit from assessing the veteran’s perspective on the intervention, as well as his view on potential changes in both his partner and the relationship dynamic. Finally, future studies should include a post-treatment follow-up assessment in order to determine whether the effects of the intervention were sustained after the completion of the group.

An additional area for future research is evaluating the needs, stigma, and barriers to care faced by the partners of veterans with PTSD. Despite partners expressing an interest in services, the programs that are developed for this population often go underutilized when compared to the reported need (Sherman, Blevins, Kirchner, Ridener, & Jackson, 2008). Before continuing to dedicate resources to the development of new interventions in this area, a qualitative assessment should be conducted to develop a better understanding of what would constitute an appealing and effective intervention for this population. A more thorough assessment of potential stigma and barriers to care, as well as the partners’ ideas as to what an ideal intervention or resource would entail, would assist in the development of future intervention for this population.

The current intervention could be further adapted to address the common barriers to care for this population, including providing the treatment on the weekends or weekday evenings to accommodate busy work schedules or condensing the group material into a one- or two-day workshop. Given the VA’s increasing use of telehealth technologies to overcome travel distance and other barriers for the veteran
population, this technology could be used to transform this protocol into a home-based group intervention. This would allow the female partners to attend the group from home, which would eliminate several of the common barriers to participating.

If additional studies support the intervention, it could be expanded to include the male partners of female veterans with PTSD as well as same-sex partners. As the combat veteran population continues to diversify and include more females and individuals who identify as gay or lesbian, it is important to develop resources to target the unique needs of significant others of all combat veterans. Important questions to evaluate include whether this intervention is as effective for male partners or same-sex partners, and what impact a coed group may have on group dynamics. Furthermore, the current study did not include any female partners who were also veterans or female partners also diagnosed with PTSD, but the differences in effectiveness of the group intervention for these different sub-populations is important to understand as well.

The Introduction, Methods, Results, and Discussion chapters were co-authored, in part, by Joshua Madsen, Matthew Jakupcak, and Steven Thorp and together have been submitted for publication. Heather Sones is the principal author of this material.
References


Figures

Assessed for eligibility ($n=47$)

Excluded ($n=24$)
- Not meeting eligibility criteria ($n=3$)
- Unable to reach ($n=10$)
- Scheduling conflicts ($n=5$)
- Not interested ($n=7$)

Randomized ($n=23$)

Randomized to receive immediate intervention ($n=12$)
- Withdrew ($n=3$)
  - Moved out of state ($n=1$)
  - Lack of childcare ($n=1$)
  - Family emergency ($n=1$)
- Included in analysis ($n=9$)

Randomized to delayed intervention waitlist ($n=11$)
- Withdrew ($n=2$)
  - Extended vacation ($n=1$)
  - Unable to reach ($n=1$)
- Included in analysis ($n=9$)

Included in analysis ($n=9$)

Offered intervention ($n=9$)

Withdraw ($n=3$)
- Work conflicts ($n=2$)
- Family emergency ($n=1$)
- Completed intervention ($n=6$)

Figure 1. Participant flow
Figure 2. Changes from pre-treatment to post-treatment/post-12 week wait in relationship satisfaction for INT versus WL groups
Figure 3. Individual participant DAS scores at pre-treatment and post-treatment/post-12 week wait
Figure 4. Changes from pre-treatment to post-treatment/post-12 week wait in relationship closeness for INT versus WL groups.
Figure 5. Individual participant RCI scores at pre-treatment and post-treatment/post-12 week wait
Figure 6. Changes from pre-treatment to post-treatment/post-12 week wait in relationship confidence for INT versus WL groups.
Figure 7. Individual participant CS scores at pre-treatment and post-treatment/post-12 week wait
Figure 8. INT group session means for relationship satisfaction
Figure 9. INT group session means for relationship confidence
Figure 10. Changes from pre-treatment to post-treatment/post-12 week wait in psychological distress for INT versus WL groups
Figure 11. Individual participant BSI-53 GSI T-scores at pre-treatment and post-treatment/post-12 week wait
Figure 12. INT group session means for psychological distress
### Table 1. Session content and homework assignments

<table>
<thead>
<tr>
<th>Session Content</th>
<th>Homework Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: <em>Introduction to the Group</em></td>
<td>Share group information and manual with partner</td>
</tr>
<tr>
<td>2: <em>PTSD in Relationships</em></td>
<td>“Impact of PTSD on Relationships” worksheet</td>
</tr>
<tr>
<td>3: <em>Taking Care of Yourself</em></td>
<td>“Taking Care of Yourself” worksheet</td>
</tr>
<tr>
<td>4: <em>Other Post-War Reactions</em></td>
<td>Practice “Catch and Tell” with your partner</td>
</tr>
<tr>
<td>5: <em>Communication Skills</em></td>
<td>Practice communication skills with partner</td>
</tr>
<tr>
<td>6: <em>PTSD Treatments</em></td>
<td>Complete “Relationship Enhancing Thoughts” worksheet</td>
</tr>
<tr>
<td>7: <em>CBT Basics</em></td>
<td>Practice identifying and challenging negative thoughts</td>
</tr>
<tr>
<td>8: <em>Relaxation Skills</em></td>
<td>Practice relaxation skills daily</td>
</tr>
<tr>
<td>9: ‘We’ versus ‘You’ Approach to PTSD</td>
<td>Complete “Coping Styles” worksheet</td>
</tr>
<tr>
<td>10: <em>Review and Wrap-Up</em></td>
<td>Continue implementing learned skills</td>
</tr>
</tbody>
</table>
Table 2. Sample characteristics

<table>
<thead>
<tr>
<th></th>
<th>INT Group $(n=12)$</th>
<th>WL Group $(n=11)$</th>
<th>Total Sample $(N=23)$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>$M=46.3, SD=14.3$</td>
<td>$M=55.3, SD=16.3$</td>
<td>$M=50.6, SD=15.6$</td>
</tr>
<tr>
<td><strong>Veteran Age</strong></td>
<td>$M=49.2, SD=16.6$</td>
<td>$M=56.5, SD=16.8$</td>
<td>$M=52.7, SD=16.7$</td>
</tr>
<tr>
<td><strong>Relationship length</strong></td>
<td>$M=23.0, SD=18.7$</td>
<td>$M=29.0, SD=16.0$</td>
<td>$M=26.0, SD=17.2$</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>75.0%</td>
<td>54.5%</td>
<td>65.2%</td>
</tr>
<tr>
<td>African American</td>
<td>8.3%</td>
<td>9.1%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>8.3%</td>
<td>27.3%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Native Hawaiian/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>8.3%</td>
<td>9.1%</td>
<td>8.7%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some high school</td>
<td>---</td>
<td>12.5%</td>
<td>5.3%</td>
</tr>
<tr>
<td>High school</td>
<td></td>
<td>25.0%</td>
<td>10.5%</td>
</tr>
<tr>
<td>diploma/GED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>63.6%</td>
<td>37.5%</td>
<td>52.6%</td>
</tr>
<tr>
<td>College degree or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>higher</td>
<td>36.4%</td>
<td>25.0%</td>
<td>31.6%</td>
</tr>
<tr>
<td><strong>Work Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full or part-time</td>
<td>50.0%</td>
<td>36.4%</td>
<td>43.4%</td>
</tr>
<tr>
<td>Retired</td>
<td>25.0%</td>
<td>63.6%</td>
<td>43.5%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>8.3%</td>
<td>---</td>
<td>4.3%</td>
</tr>
<tr>
<td>Student</td>
<td>16.6%</td>
<td>---</td>
<td>8.6%</td>
</tr>
</tbody>
</table>
Table 3. Original and transformed means for clinical variables

<table>
<thead>
<tr>
<th>Clinical Variable Scores</th>
<th>Pre-treatment</th>
<th>Post-treatment or 12-week wait</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Means (SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original</td>
<td>97.2 (14.1)</td>
<td>97.6 (14.0)</td>
</tr>
<tr>
<td>Transformed</td>
<td>5.0 (1.3)</td>
<td>5.6 (1.2)</td>
</tr>
<tr>
<td>WL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original</td>
<td>99.3 (24.9)</td>
<td>93.2 (33.8)</td>
</tr>
<tr>
<td>Transformed</td>
<td>4.5 (2.3)</td>
<td>5.4 (2.8)</td>
</tr>
<tr>
<td><strong>RCI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT Original</td>
<td>17.2 (5.0)</td>
<td>16.3 (3.3)</td>
</tr>
<tr>
<td>WL Original</td>
<td>17.7 (3.6)</td>
<td>17.4 (4.2)</td>
</tr>
<tr>
<td><strong>CS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original</td>
<td>49.0 (16.9)</td>
<td>51.1 (16.4)</td>
</tr>
<tr>
<td>Transformed</td>
<td>4.3 (1.9)</td>
<td>4.0 (2.0)</td>
</tr>
<tr>
<td>WL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original</td>
<td>59.6 (10.4)</td>
<td>51.9 (15.6)</td>
</tr>
<tr>
<td>Transformed</td>
<td>3.1 (1.5)</td>
<td>3.9 (2.1)</td>
</tr>
<tr>
<td><strong>BSI-53 (GSI T-Score)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT Original</td>
<td>59.0 (10.0)*</td>
<td>52.9 (12.2)*</td>
</tr>
<tr>
<td>WL Original</td>
<td>59.3 (7.6)</td>
<td>60.8 (6.8)</td>
</tr>
</tbody>
</table>

*Note. BSI-53 = Brief Symptom Inventory-53; CS = Confidence Scale; DAS = Dyadic Adjustment Scale; INT = Immediate Intervention; RCI = Relationship Closeness Inventory; WL = Waitlist Control; *p < .05
Table 4. Correlations between baseline dependent variables

<table>
<thead>
<tr>
<th></th>
<th>DAS</th>
<th>RCI</th>
<th>CS</th>
<th>BSI-53</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAS</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>.479</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS</td>
<td>.489</td>
<td>.526</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>BSI-53</td>
<td>-.168</td>
<td>-.277</td>
<td>-.571</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Note. BSI-53 = Brief Symptom Inventory-53; CS = Confidence Scale; DAS = Dyadic Adjustment Scale; RCI = Relationship Closeness Inventory*
Table 5. Feedback regarding quality of sessions

<table>
<thead>
<tr>
<th>Session (n)</th>
<th>Overall Quality Mean ($SD^a$)</th>
<th>Session Rank ($SD^b$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2: PTSD in Relationships (16)</td>
<td>4.6 (.59)</td>
<td>2.7 (2.4)</td>
</tr>
<tr>
<td>3: Taking Care of Yourself (15)</td>
<td>4.4 (.60)</td>
<td>3.3 (2.3)</td>
</tr>
<tr>
<td>4: Other Post-War Reactions (14)</td>
<td>4.7 (.38)</td>
<td>4.3 (2.3)</td>
</tr>
<tr>
<td>5: Communication Skills (16)</td>
<td>4.7 (.48)</td>
<td>2.2 (1.2)</td>
</tr>
<tr>
<td>6: PTSD Treatments (12)</td>
<td>4.6 (.64)</td>
<td>3.8 (2.2)</td>
</tr>
<tr>
<td>7: CBT Basics (11)</td>
<td>4.8 (.36)</td>
<td>3.5 (2.3)</td>
</tr>
<tr>
<td>8: Relaxation Skills (14)</td>
<td>4.6 (.64)</td>
<td>4.8 (3.0)</td>
</tr>
<tr>
<td>9: ‘We’ versus ‘You’ Approach to PTSD</td>
<td>4.7 (.48)</td>
<td>3.8 (2.8)</td>
</tr>
</tbody>
</table>

Note. CBT = Cognitive Behavioral Therapy; PTSD = Posttraumatic stress disorder

$^a$Higher number indicates better overall quality (range 1-5)

$^b$Lower number indicates higher rank (range 1-9)
Table 6. Female partners’ needs met through the intervention

<table>
<thead>
<tr>
<th>Partner Need</th>
<th>Percentage Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had the opportunity to talk to other partners who face similar issues</td>
<td>87.5</td>
</tr>
<tr>
<td>Felt that my role as a significant other of a veteran is recognized and</td>
<td>64.6</td>
</tr>
<tr>
<td>valued by the VA</td>
<td></td>
</tr>
<tr>
<td>Learned new ideas about how to help my significant other</td>
<td>64.6</td>
</tr>
<tr>
<td>Learned new ideas about how to better care for myself</td>
<td>63.9</td>
</tr>
<tr>
<td>Learned more about the definition of PTSD/other post-war reactions.</td>
<td>46.5</td>
</tr>
<tr>
<td>Learned more about the treatments for PTSD</td>
<td>45.8</td>
</tr>
<tr>
<td>Had the opportunity to ask questions about mental illness</td>
<td>40.3</td>
</tr>
<tr>
<td>Increased my awareness of various resources at the VA Medical Center</td>
<td>37.5</td>
</tr>
<tr>
<td>Learned more about the causes of PTSD</td>
<td>33.3</td>
</tr>
</tbody>
</table>

Note. PTSD = Posttraumatic stress disorder; VA = Veterans Affairs
Table 7. Top five reported benefits gained from group participation

| Themes with Related Quotes |  |
|----------------------------|  |
| **Improved Communication** |  |
| “More communication with my husband” |  |
| “Effective ways to communicate during PTSD-triggered behavior.” |  |
| “Spouse and I talked about the sessions. It helped to share recommendations with him.” |  |
|  |
| **Increased Understanding of Veteran’s Experience with PTSD** |  |
| “More compassion for what he is struggling with” |  |
| “Patience and a clearer understanding of how my husband thinks and acts” |  |
| “Deeper appreciation for my partner” |  |
|  |
| **Increased confidence/assertiveness** |  |
| “I have the confidence to communicate with [veteran name] even while his PTSD is triggered” |  |
| “Reduced fear of openness with my partner” |  |
|  |
| **Expanded PTSD Knowledge** |  |
| “Understanding of avoidance mechanisms and behavior” |  |
| “Knowing the facts of PTSD.” |  |
|  |
| **Improved Self-Care** |  |
| “Ways to avoid stress on myself due to partner's issues” |  |
| “Better at balancing my needs and my partners” |  |

*Note. PTSD = Posttraumatic Stress Disorder*
Table 8. Changes in confidence and knowledge related to PTSD

<table>
<thead>
<tr>
<th>Construct</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>95% CI of the Difference</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence in handling PTSD</td>
<td>3.07 (1.03)</td>
<td>3.80 (0.68)</td>
<td>(-1.31, -0.16)</td>
<td>-2.75</td>
<td>.02</td>
</tr>
<tr>
<td>Anxiety about veteran’s well-being</td>
<td>3.27 (1.22)</td>
<td>2.87 (2.87)</td>
<td>(-0.15, 0.95)</td>
<td>1.57</td>
<td>.14</td>
</tr>
<tr>
<td>Understand PTSD</td>
<td>3.07 (1.03)</td>
<td>4.27 (0.59)</td>
<td>(-1.87, -0.53)</td>
<td>-3.85</td>
<td>.002</td>
</tr>
<tr>
<td>Knowledge of VA PTSD resources</td>
<td>2.87 (0.83)</td>
<td>4.33 (0.82)</td>
<td>(-2.05, -0.88)</td>
<td>-5.36</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Ability to care for self</td>
<td>3.73 (1.03)</td>
<td>4.13 (0.64)</td>
<td>(-1.09, 0.29)</td>
<td>-1.25</td>
<td>.23</td>
</tr>
</tbody>
</table>

*Note.* CI = Confidence Interval; PTSD = Posttraumatic stress disorder; VA = Veterans Affairs
Appendix A. Relationship Closeness Inventory

RELATIONSHIP CLOSENESS INVENTORY (Snyder & Omoto, 1989)

As part of this study, we would like you to answer the following questions about your relationship with your significant other. Please keep him/her in mind and respond to the following questions:

1. Who is this person? (initial of first name only) _____________
   a. What is this person’s age? _______ What is your age? _______
   b. What is this person’s sex? _______ What is your sex? _______

2. Which one of the following best describes your relationship with this person (Check only ONE):
   _______ married _______ engaged _______ living together
   _______ dating

3. How long have you known this person? Please indicate the number of years and/or months (for example, 3 years, 8 months)
   _______ years _______ months

We would like you to estimate the amount of time you typically spend alone with this person (referred to below as “X”) during the day. We would like you to make these time estimates by breaking the day into morning, afternoon, and evening, although you should interpret each of these time periods in terms of your own typical daily schedule. (For example, if you work a night shift, “morning” may actually reflect time in the afternoon, but is nevertheless time immediately after waking.) **Think back over the past week and write in the average amount of time, per day, that you spent alone with X, with no one else around, during each time period.** If you did not spend any time with X in some time periods, write 0 hour(s), 0 minutes.

4. **DURING THE PAST WEEK, what is the average amount of time, per day, that you spent alone with X in the MORNING (e.g., between the time you wake and 12 noon)?**
   _______ hour(s) _______ minutes

5. **DURING THE PAST WEEK, what is the average amount of time, per day, that you spent alone with X in the AFTERNOON (e.g., between 12 noon and 6pm)?**
   _______ hour(s) _______ minutes

6. **DURING THE PAST WEEK, what is the average amount of time, per day, that you spent alone with X in the EVENING (e.g., between 6pm and bedtime)?**
   _______ hour(s) _______ minutes

Compared with the “normal” amount of time you usually spend alone with X, how typical was the past week? (Check one)
   _______ typical _______ not typical – if so, why? (please explain)
The following is a list of different activities that people may engage in over the course of one week. **For each of the activities listed, please check all of those that you have engaged in alone with X in the past week.** Check only those activities that were done alone with X and not done with X in the presence of others.

In the past week, I did the following activities alone with X: (Check all that apply)

- _____ did laundry
- _____ prepared a meal
- _____ watched TV
- _____ went to an auction/antique show
- _____ attended a non-class lecture or presentation
- _____ went to a restaurant
- _____ went to a grocery store
- _____ went for a walk/drive
- _____ discussed things of a personal nature
- _____ went to a museum/art show
- _____ planned a party/social event
- _____ attended a class
- _____ went on a trip (e.g., vacation or weekend)
- _____ cleaned house/apartment
- _____ went to church/religious function
- _____ worked on homework
- _____ engaged in sexual relations
- _____ discussed things of a non-personal nature
- _____ went to a clothing store
- _____ talked on the phone
- _____ went to a movie
- _____ ate a meal
- _____ participated in a sporting activity
- _____ outdoor recreation (e.g., sailing)
- _____ went to a play
- _____ went to a bar
- _____ visited family
- _____ visited friends
- _____ went to a department, book, hardware store, etc.
- _____ played cards/board game
- _____ attended a sporting event
- _____ exercised (e.g., jogging, aerobics)
- _____ went on an outing (e.g., picnic, beach, zoo, winter carnival)
- _____ wilderness activity (e.g., hunting, hiking, fishing)
- _____ went to a concert
- _____ went dancing
- _____ went to a party
- _____ played music/sang
The following questions concern the amount of influence X has on your thoughts, feelings, and behavior. Using the 7-point scale below, please indicate the extent to which you agree or disagree by writing the appropriate number in the space corresponding to each item.

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<tr>
<td>1</td>
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<td></td>
<td>Strongly agree</td>
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<td>2</td>
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<td></td>
<td>Strongly disagree</td>
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</table>

1. _____ X will influence my future financial security.
2. _____ X does not influence everyday things in my life.
3. _____ X influences important things in my life
4. _____ X influences which parties and other social events I attend.
5. _____ X influences the extent to which I accept responsibilities in our relationship.
6. _____ X does not influence how much time I spend doing household work.
7. _____ X does not influence how I choose to spend my money.
8. _____ X influences the way I feel about myself.
9. _____ X does not influence my moods.
10. _____ X influences the basic values I hold.
11. _____ X does not influence the opinions that I have of other important people in my life.
12. _____ X does not influence when I see, and the amount of time I spend with, my family.
13. _____ X influences when I see, and the amount of time I spend with, my friends.
14. _____ X does not influence which of my friends I see.
15. _____ X does not influence the type of career I have.
16. _____ X influences or will influence how much time I devote to my career.
17. _____ X does not influence my chances of getting a good job in the future.
18. _____ X influences the way I feel about the future.
19. _____ X does not have the capacity to influence how I act in various situations.
20. _____ X influences and contributes to my overall happiness.
21. _____ X does not influence my present financial security.
22. _____ X influences how I spend my free time.
23. _____ X influences when I see X and the amount of time the two of us spend together.
24. _____ X does not influence how I dress.
25. _____ X influences how I decorate my home (e.g., dorm room, apartment, house)
26. _____ X does not influence where I live.
27. _____ X influences what I watch on TV.
Now we would like you to tell us how much X affects your future plans and goals. Using the 7-point scale below, please indicate the degree to which your future plans and goals are affected by X by writing the appropriate number in the space corresponding to each item. If an area does not apply to you (e.g., you have no plans or goals in that area), write a 1.

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</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a great extent</td>
</tr>
</tbody>
</table>

1. ______ my vacation plans
2. ______ my marriage plans
3. ______ my plans to have children
4. ______ my plans to make *major* investments (house, car, etc.)
5. ______ my plans to join a club, social organization, church, etc.
6. ______ my school-related plans
7. ______ my plans for achieving a particular financial standard of living
Appendix B. Confidence Scale

CONFIDENCE SCALE (Stanley, Hoyer, & Trathen, 1994)

Please answer each question below by indicating how strongly you agree or disagree with the idea expressed related to your marriage. You can circle any number from 1 to 7 to indicate various levels of agreement or disagreement with the idea expressed. Please try to respond to each item.

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<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Neither agree or disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Strongly agree</td>
<td></td>
<td></td>
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</tbody>
</table>

1. I believe we can handle whatever conflicts will arise in the future. 1 2 3 4 5 6 7

2. I don't have much confidence in the future of my relationship. 1 2 3 4 5 6 7

3. I am not at all sure that we can make this relationship work for the long haul. 1 2 3 4 5 6 7

4. I feel good about our prospects to make this relationship work for a lifetime. 1 2 3 4 5 6 7

5. We may not have what it takes to keep this relationship going. 1 2 3 4 5 6 7

6. We can handle just about anything that comes our way. 1 2 3 4 5 6 7

7. I am not sure that we can avoid divorce or breaking up in the future. 1 2 3 4 5 6 7

8. I am very confident when I think of our future together. 1 2 3 4 5 6 7

9. We have the skills a couple needs to make a marriage last. 1 2 3 4 5 6 7

10. Our risk for divorce or breakup is probably greater than average. 1 2 3 4 5 6 7
Appendix C. Demographics Form

DEMOGRAPHICS FORM

Please complete the following information about yourself.

General Information

1. Age:_______

2. Race/Ethnicity:

   Select one:
   
   ☐ White/Caucasian
   ☐ Black/African American
   ☐ Hispanic/Latino
   ☐ Asian (Filipino, Japanese, Korean, Chinese, Vietnamese, etc.)
   ☐ American Indian or Alaskan Native
   ☐ Native Hawaiian or Pacific Islander
   ☐ Other, please specify: ________________________________

3. How many biological children do you have?

   ☐ 0   ☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7+

   Please list their gender and age:

   Boy or Girl (circle one): Age ________
   Boy or Girl (circle one): Age ________
   Boy or Girl (circle one): Age ________
   Boy or Girl (circle one): Age ________
   Boy or Girl (circle one): Age ________
   Boy or Girl (circle one): Age ________
4. How many stepchildren or adopted children do you have?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7+

Please list their gender and age:

- Boy or Girl (circle one): Age ______
- Boy or Girl (circle one): Age ______
- Boy or Girl (circle one): Age ______
- Boy or Girl (circle one): Age ______
- Boy or Girl (circle one): Age ______

**Education**

5. Years of education completed:

- < 12 years
- College graduate (B.S. or B.A. degree)
- GED
- Some graduate school
- High school diploma
- Completed post-graduate (M.S., M.A., M.D., Ph.D.)
- Some college

**Employment**

6. What is your current work status?

- steady full-time work
- steady part-time work
- intermittent or temporary work (full-time or part-time)
- unemployed or retired, but looked for work
- unemployed, and did not look for work
- Student, full-time       Current GPA: ______
☐ Student, part-time and working  Current GPA: ______
☐ Student, part-time and not working  Current GPA: ______

7. If you work full or part-time, what is your current job?
                                                                                   
How many hours do you work a week? __________________

**Residence**

8. Where do you live?

☐ Own home
☐ Rent apartment/home
☐ Rent room
☐ Staying with family
☐ Staying with friends
☐ Board and care/nursing home
☐ Other, *please specify:* __________________________

9. Who do you live with:
                                                                                   
10. TOTAL Household income:

☐ <$15,000 per year
☐ $15,001 to $30,000
☐ $30,001 to $45,000
☐ $45,001 to $60,000
☐ > $60,000
Appendix D: Background Information Form

PTSD Partner’s Group
Background Information Form

Name: __________________________________________

Veteran’s Name: ________________________________

Your age:_________________ Veteran’s age:______________

Relationship Status:

(1) Married
(2) Living together as if married
(3) In a committed relationship, but not living together

How many years have you and your significant other been together? ____________

How many years has your significant other been diagnosed with PTSD? ____________

Extent of your involvement or contact with significant other:

<table>
<thead>
<tr>
<th>Rare (once/week or less)</th>
<th>Minimal (once every few days)</th>
<th>Moderate (daily)</th>
<th>Extensive (24 hours/day)</th>
</tr>
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</table>

Please answer the following questions about your significant other’s behavior:

1. In the past 2 years, how many inpatient psychiatric hospitalizations has he/she had (at this VA or other hospitals)?

   0  1  2  3  4 or more

2. In the past 2 years, approximately what percentage of his appointments with the mental health providers (psychiatrists, psychologists, etc.) has he attended?

   0%  25%  50%  75%  100%

3. In the past 3 months, what percentage of days has your significant other taken their medications as prescribed?

   0%  25%  50%  75%  100%

   N/A

Please answer the following questions about your experiences and feelings over the past 30 days:

1. How confident do you feel in dealing with your significant other’s PTSD?
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<tbody>
<tr>
<td></td>
<td>Not at all confident</td>
<td>Somewhat confident</td>
<td>Very confident</td>
<td></td>
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</tbody>
</table>

2. How many days in the past month have you had difficulty managing your significant other’s behavior?

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<tr>
<td></td>
<td>0-5</td>
<td>6-10</td>
<td>11-20</td>
<td>21-27</td>
<td>28+</td>
</tr>
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</table>

3. How distressed or anxious are you about your significant other’s well being?

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<tbody>
<tr>
<td></td>
<td>Low level of distress</td>
<td>Moderate distress</td>
<td>Very high distress</td>
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</table>

4. How much do you understand about your significant other’s PTSD?

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<tr>
<td></td>
<td>Very little</td>
<td>Some</td>
<td>A great deal</td>
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</table>

5. How much do you know about what is available at this VA Medical Center to help your significant other cope with his PTSD?

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<tr>
<td></td>
<td>Very little</td>
<td>Some</td>
<td>A great deal</td>
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6. How well are you able to take care of yourself and meet your own personal needs?

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<tr>
<td></td>
<td>Very poorly</td>
<td>Somewhat</td>
<td>Very well</td>
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7. How much do you feel your significant other’s PTSD has impacted your relationship?

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<td></td>
<td>Very little</td>
<td>Some</td>
<td>A great deal</td>
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Thank you!
Appendix E. Participant Satisfaction and Feedback Form

PTSD Partner’s Group
Participant Satisfaction and Feedback Form

Please answer the following questions about your experiences and feelings over the past 30 days:

1. How confident do you feel in dealing with your significant other’s PTSD?

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<tr>
<td></td>
<td>Not at all confident</td>
<td>Somewhat confident</td>
<td>Very confident</td>
<td></td>
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</table>

2. How many days in the past month have you had difficulty managing your significant other’s behavior?

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<tr>
<th></th>
<th>0-5</th>
<th>6-10</th>
<th>11-20</th>
<th>21-27</th>
<th>28+</th>
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</table>

3. How distressed or anxious are you about your significant other’s wellbeing?

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<tbody>
<tr>
<td></td>
<td>Low level of distress</td>
<td>Moderate distress</td>
<td>Very high distress</td>
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</table>

4. How much do you understand about your significant other’s PTSD?

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<tr>
<td></td>
<td>Very little</td>
<td>Some</td>
<td>A great deal</td>
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</table>

5. How much do you know about what is available at this VA Medical Center to help your significant other cope with his PTSD?

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<tr>
<td></td>
<td>Very little</td>
<td>Some</td>
<td>A great deal</td>
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6. How well are you able to take care of yourself and meet your own personal needs?

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<tbody>
<tr>
<td></td>
<td>Very poorly</td>
<td>Somewhat</td>
<td>Very well</td>
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</table>

7. How much do you feel your significant other’s PTSD has impacted your relationship?

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<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td></td>
<td>Very little</td>
<td>Some</td>
<td>A great deal</td>
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</table>
Now that you have completed your participation in our group, we are hoping to get your feedback to help improve the group in the future. Please take your time answering the following questions, as we take your feedback seriously and value your input.

1. What did you like most about the group?

2. What did you like least about the group?

3. We are interested in knowing which sessions you found to be most helpful, and which sessions can be improved. On the line to the left of the session titles listed below, please rank the content sessions from 1-8 based on which sessions you found to be the most helpful (1) and least helpful (8).

   - Session 1: Introduction to the Group
   - Session 2: PTSD in Relationships
   - Session 3: Taking Care of YOURSELF
   - Session 4: Other Common Post-War Reactions
   - Session 5: Communication Skills
   - Session 6: PTSD Treatments
   - Session 7: CBT Basics – Challenging Negative Thoughts
   - Session 8: Relaxation Skills
   - Session 9: “We” versus “You” Approach to PTSD
   - Session 10: Review and Wrap-Up

4. For the session(s) you found to be least helpful, please tell us how we could improve this session to better meet your needs, or what additional information could be included in this session in the future:

5. Please look again at the sessions listed above. Would you change the order of the sessions in any way? For example, having a particular session earlier in the group, or reserving something for later? If so, please tell us which session(s) you would move, and to where you would move them.
6. What are the top three things you have gained from participating in our PTSD Partners Group?

1.

2.

3.

We would like to know the knowledge and/or skills you have gained as a result of participating in our group. Please read the following statements and rate the degree to which you agree or disagree with each.

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</thead>
<tbody>
<tr>
<td></td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neither Agree</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>Disagree</td>
<td>nor Disagree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

After participating in the PTSD Partner’s Group...

1. _____ I am more open to trying new approaches when coping with my partner and his PTSD.
2. _____ I am better able to cope with my partner’s PTSD.
3. _____ I am better able to cope with my own distress.
4. _____ I have a better understanding of my partner’s PTSD.
5. _____ I am more aware of the resources within the VA that are available for myself and/or my partner.
6. _____ I feel more comfortable talking to my partner about his PTSD.
7. _____ I feel less alone when it comes to coping with PTSD within my relationship.

Please use the space below to give us any additional comments or feedback you may have. Again, your feedback is highly valued, and we greatly appreciate you taking the time to provide it.

*Thank you again for your participation in our group!*
Appendix F: Weekly Satisfaction Measure

**WEEKLY SATISFACTION MEASURE**
(Whitton, Stanley, Markman, & Baucom, 2008)

These questions ask you to indicate your *current* level of satisfaction with various aspects of your relationship. Please answer each question using the response scale below.

<table>
<thead>
<tr>
<th>1. Not at all satisfied</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied are you with…</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. Your sex life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. Your partner’s physical appearance?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. Your partner’s social skills?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. The way your partner contributed to household chores?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. How your partner supported you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. Your partner’s intellect?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. Your interactions with your partner?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. The time you and your partner spent together?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. The way you and your partner resolved disagreements?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. How satisfied are you with your partner?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. How satisfied are you with your relationship with your partner?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. How satisfied are you with your relationship?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Appendix G.  Session Evaluation Form

PTSD Partner’s Group
Session Evaluation Form

Please indicate your rating on each of the following items by circling the appropriate number on the scale:

<table>
<thead>
<tr>
<th>TOPIC:</th>
<th>Poor</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall quality of the session:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Style of the group leader:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Relevance of this topic for you:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Usefulness of this information for you:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. How much new information did you gain from today’s session?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. How has today’s session helped you? (Check as many as apply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Learned more about the definition of PTSD/other post-war reactions.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>_____ Learned more about the causes of PTSD</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>_____ Learned more about the treatments for PTSD</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>_____ Had the opportunity to ask questions about mental illness</td>
<td></td>
<td></td>
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<tr>
<td>_____ Increased my awareness of various resources at the VA Medical Center</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>_____ Had the opportunity to talk to other partners who face similar issues</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>_____ Learned new ideas about how to help my significant other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Learned new ideas about how to better care for myself</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>_____ Felt that my role as a significant other of a Veteran is recognized and valued by the VA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Other: _______________________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. In your own words, what did you like about today’s session? How could this session be improved to better meet your needs?

8. Are there specific topics that you would like to see addressed in this group?
GROUP THERAPY MANUAL
FOR
PARTNERS OF COMBAT VETERANS WITH PTSD

VA SAN DIEGO HEALTHCARE SYSTEM

Manual developed by:
Heather Sones, M.S., Joshua Madsen, Ph.D., & Steven Thorp, Ph.D.
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Session 1: Introduction to the Group

The goal of this group is to provide education, skills, and resources to the significant others of Veterans who are diagnosed with PTSD.

PTSD oftentimes has a detrimental impact on the relationships in a Veteran’s life. Significant others often do not have a clear understanding of the disorder, and do not have many resources available to help them navigate the effects of this PTSD in the relationship. This, in turn, can have a serious impact on relationship health and functioning. Through education, skills, and support from women in similar situations, this group aims to provide the knowledge and tools that will allow you to better understand PTSD and its effects, promote self-care, and also help you to help your loved one cope with this disorder.

What will be covered in the group?
- Our group is scheduled to meet for 10 weeks and will include the following topics:
  - Defining PTSD and its impact in a relationship
  - The importance of self-care
  - Other common post-war reactions, and secondary traumatization
  - Effective communication with your significant other
  - The various treatment options (both therapy and medication) available
  - How to evaluate and change our negative thoughts
  - Relaxation skills to help during stressful times
  - Unitig with your partner in overcoming PTSD
  - Additional resources for coping with PTSD within a relationship

Again, this is your group. We assume that you are here because you want to be, so please be active and supportive in group, provide feedback, and ask any questions you may have along the way.

Your Group Leaders: ___________________________ Phone #: ___________________________
                                   ___________________________ Phone #: ___________________________

Day/Time/Location: ___________________________
Group Rules

1. PARTICIPATE
   - This is a group designed for you – please come on time and come to every session.
   - Call the clinic or a group leader in advance if you need to miss a group.
   - Because this is a group designed for you, you each are encouraged to share your experiences and participate in group discussions.

2. BE SUPPORTIVE AND RESPECTFUL OF OTHER GROUP MEMBERS
   - This group includes partners of Veterans from different war eras, so there will be generational differences. This is to be embraced and used as a learning experience. Any negativity resulting from group differences will not be tolerated.
   - Offer constructive feedback and support to other group members
   - This is not a venting forum – please stick to the session content. We understand that living with a Veteran with PTSD can be very difficult. Stories are encouraged, but only those relevant to the session material.

3. EQUAL TIME FOR ALL
   - Please give each person speaking the respect she deserves. Only one person speaking at a time - refrain from interrupting or having side conversations.
   - Turn off your cell phone.

4. DO THE ACTIVITIES and EXERCISES
   - There will often be homework assignments in the group. The material/skills you will learn can only benefit you. If you practice/review the material.
   - Bring this manual to every session.

5. CONFIDENTIALITY
   - Do not discuss personal things talked about in group with people outside of the group (no names or other identifying information)
   - You can discuss what you are learning in group with others
   - Group leaders will keep your information confidential within the VA system
   - Respect your partners' confidentiality as well
   - Limits to confidentiality
     - Immediate risk to yourself or others (thoughts of harming yourself, others, or another person's property)
     - Reason to believe that a child, elder, or dependent adult has been/is being abused
     - Threats to the building

6. FEEDBACK
   - This is a new group – the only way it will be improved is through your feedback! We will allow time for feedback at the end of every session.
   - Please be honest! Tell us what works and what doesn’t work.
   - If you are feeling like dropping out, PLEASE talk to us first – there is likely something we can do to address your concerns and make you feel more comfortable.
**Group Discussion**
What brings you into this group?
What are you hoping to learn and/or gain from being here?
What are YOUR needs you are looking to meet through this group?

**Homework:**
- Talk to your partner about this group, and you are encouraged to show them this manual. Although this is your group, it is important for him to feel like he can be involved with the skills and information you are learning.
Session 2: PTSD and Relationships

Homework Review:
- How did the discussion go? How did your Veteran respond? If you did not have the discussion, what got in the way?

**Group Question:** What do you know about PTSD? What questions do you have?

Definition of PTSD:
PTSD is a mental health disorder that results from experiencing a traumatic event. A “traumatic event” includes any event that is experienced personally, witnessed, or learned about that causes feelings of extreme fear, helplessness, or horror.

The symptoms of PTSD fall into three clusters:

1. **Re-experiencing symptoms:**
   - Distressing, unwanted memories of the event
   - Nightmares about the event
   - Flashbacks, or feeling as if the event were happening again
   - Becoming emotionally upset when things remind them of the trauma (“triggers”)
   - Having a physical reaction (heart racing, hands shaking, breathing heavier) to triggers.

2. **Avoidance and numbing symptoms:**
   - Avoiding thoughts or conversations about the event
   - Avoiding people, places, or activities that remind them of the event (e.g., avoiding triggers)
   - Feeling distant or cut off from other people
   - Losing interest in activities they used to enjoy
   - Feeling emotionally numb, or difficulty experiencing feelings like love and/or happiness
   - Difficulty remembering some important parts of the event
   - Feeling as if their future will be unexpectedly cut short, and not planning for the future

3. **Hyper-arousal symptoms:**
   - Hypervigilance – feeling constantly on guard and watchful of things going on around them. This can be both in public and at home.
   - Irritability and/or outbursts of anger
   - Difficulty sleeping
   - Difficulty concentrating on what they are doing or things going on around them
   - Exaggerated startle responses
PTSD within the Relationship:

What does PTSD look like within the relationship context? Some of the common PTSD symptoms from the perspective of the significant other include the following:

(Re-experiencing)
- Sudden shifts in behavior/mood when a memory enters their mind
- Disrupted sleep for both partners because of vivid nightmares. This could also include the Veteran acting out his dreams, which could be potentially dangerous for you if sharing a bed.
- Crying or becoming physically tense for no apparent reason.

(Avoidance/Numbing)
- Cutting themselves off from social activities, and potentially feeling more distant from you. This may lead to feelings of guilt, embarrassment, and/or anger.
- Unwillingness to discuss their combat experiences and/or traumatic events
- Isolating themselves from you, other people, and other activities they used to enjoy. This could lead to depression, and could also lead to you isolating yourself with them.
- Seeming aloof, or as if they do not care. It may be difficult for them to connect with you emotionally and express their love to you.
- No longer willing to plan future events with you or family due to feeling as if their future will be cut short.

(Hyperarousal)
- Unwillingness to go out to dinner or to other potentially crowded public places (e.g., grocery store, shopping mall)
- Becoming easily irritated, especially in public situations or when confronted with a trigger. The increased irritability often leads to more arguments within a relationship. This can lead to mutual avoidance and greater loneliness and distance.
- Difficulty focusing in conversations, and being easily distracted. This can also lead to an increase in arguments.

**Potentially Serious Issues**

Higher rates of divorce.
- Higher risk of partner and child abuse.
- Significant impacts on your own mental health.

(If any of these issues are of serious concern in your current relationship, please speak to a group leader immediately after group.)

Group Discussion

Do you recognize any of the PTSD symptoms in your loved one? What impact have they had on your relationship?
Important to Remember:
- Many of these symptoms are a set of "skills" your loved one learned in the military. Therefore, they may be more difficult to overcome.
  - Feeling detached or distant from people
  - Numbing their emotions in order to do their job
  - Hypervigilance/sleep problems
  - Quicker to get irritated or anger
  - Extreme startle reactions to loud noises
- Although these "skills" have likely caused distress in your relationship, they were also critical in keeping your loved one alive during combat.
- The *key* to overcoming many PTSD-related relationship issues is education. And that's why you are here.

Resources:
National Center for PTSD – www ptsd va gov

Homework:
- Please review the information covered today as well as the additional resources. We will answer any questions you have next week!
- Complete the "Impact of PTSD on Relationships" worksheet
Impact of PTSD on Relationships

In the space below, list the ways in which PTSD has impacted you as well as your relationship with your Veteran.

1. 

2. 

3. 

4. 

5. 

6. 

7. 

8. 

9. 

10. 

Session 3: Taking care of YOURSELF

Homework Review:
- Any questions about the material covered last week?
- Review "Impact of PTSD on Relationships" worksheet

Taking care of a loved one with PTSD can be exhausting, both physically and mentally. It is CRITICAL to be sure to take proper care of yourself at the same time. Ignoring your own needs can result in Secondary Traumatization.

Secondary Traumatization:
- Experiencing PTSD-like symptoms after learning about someone’s trauma or working with someone who has been traumatized
  - Intrusive images and/or thoughts
  - Anger and/or sadness
  - Feeling detached from others
  - Losing interest or pleasure in things you used to enjoy
  - Emotional exhaustion
  - Poor concentration
- These symptoms can happen in anyone caring for a person with PTSD – including family members and loved ones.
- Although our desire is to help our loved one, it’s critical to be in-tune with your own needs and well-being.
- What are some ways in which you can balance your life and care for both your loved one and yourself?

Group Discussion
Has anyone ever experienced secondary traumatization symptoms?
What are some ways you can better care for yourself?

Self-care Practices:
- Avoid isolation
  - Because individuals with PTSD may isolate from the outside world, it is common for their partners to do the same. This can lead to problems like depression and anxiety.
  - Remember to get out of your home and stay active, even if your partner cannot do some things with you. Not doing so can lead to resentment building within the relationship, which is detrimental to relationship functioning.
• Maintain your social life
  o Social support is a critical part of not only coping with PTSD, but also coping with caring for a loved one with PTSD. It also combats against the urge to isolate.
  o Reach out to friends and family for support. Look for local support groups.
  o Try to interact with at least one person from your social network each day.
• Sleep, diet, and exercise!
  o These three factors have a HUGE impact on your mood, physical health, and overall well-being.
  o Aim to get at least 6-8 hours of sleep every night.
    ▪ If your loved one has nightmares that frequently wake you, or potentially put you at risk (if he acts them out), discuss this with him. It may be best to discuss sleeping separately until his dreams are under control.
    ▪ If sleep is a significant issue for you, ask your group leader for additional information on practices to improve sleep.
  o Eat regular meals that include healthy, minimally processed foods.
    ▪ The fuel you put into your body can greatly influence both physical and mental health. Avoid frequently eating out or eating prepared, packaged meals.
  o Set a goal of exercising for at least 20 minutes 5 days a week. Exercise releases natural mood enhancers and often results in improved self-esteem.
    ▪ Exercise can also give you the opportunity to get out of your home and meet new people, therefore avoiding isolation and improving social support.

Resources:
• Family of a Vet Website:
  o http://www.familyofavet.com/spouses.html
• Secondary Traumatization:

Homework:
• Complete the “Taking Care of Yourself” Worksheet
Taking Care of Yourself

List below five activities you can do to better care for yourself:

1. __________________________________________________________

2. __________________________________________________________

3. __________________________________________________________

4. __________________________________________________________

5. __________________________________________________________

Now, choose one of the above activities and commit to doing it in the next week. After you complete the activity, write a couple sentences about what the experience was like for you, and how you felt afterwards. We will review these during the next session.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Session 4: Other Post-War Reactions

Homework Review:
- Review “Taking Care of Yourself” worksheet

Other Post-War Reactions:
- PTSD is not the only problem that can arise from experiencing combat. There are other potential difficulties that can arise, and can be more likely to occur in Veterans with PTSD.
  - Depression
    - Feeling sad or down for weeks at a time, to the point that it interferes with daily life.
    - PTSD and depression share many symptoms
  - Substance Use Disorders
    - Can vary in severity (abuse and dependence) – any difficulty with drugs/alcohol that is interfering with one’s occupation, relationships, and/or daily functioning.
    - Men and women who have experienced trauma and/or have PTSD are at higher risk of problems with drugs and alcohol.
  - Feelings of guilt/shame
    - Veterans who have survived traumatic events often suffer from feelings of guilt related to something they did or didn’t do, or guilt because they survived when others did not. Feelings of guilt can also stem from seeing the impact his service and/or PTSD has had on the family.
    - Guilt can be a risk factor for suicidality.
  - Aggressive behavior
    - Anger is a natural survival instinct that helped your loved one to cope and get through their deployment(s). Once home, it unfortunately can cause significant interpersonal problems (arguments, fights, abuse).
  - Suicidal thoughts
    - Rates of suicide have continued to increase in the Veteran population.
    - It’s important to know the general risk factors for suicide:
      - Previous attempts
      - Family history of suicide attempts
      - Recently diagnosed physical or mental health problem
      - Recent losses (occupational, family, relationship, financial)
      - Impulsivity or poor self-control
      - History of physical, sexual, or emotional abuse
      - Feelings of hopelessness
      - Alcohol or substance problems
      - Lack of social support
    - In addition, military populations have additional risk factors, including frequent deployments, longer duration of deployments, and deployment-related injuries
o It's ok to talk to your loved one about suicide. There are several warning signs to keep an eye out for:
  ▪ Expressing intent or plan for suicide
  ▪ Giving away possessions, saying goodbye
  ▪ Preoccupied with death or suicide (talking about it, thinking about it)
  ▪ Getting access to ways to commit suicide (buying a gun, etc.)
  ▪ Excessive guilt/shame about events during deployment
  ▪ Significant withdrawal from friends/family
  ▪ Lack of self care, slacking in personal hygiene

So, there are a lot of negative reactions that can happen after trauma. What's the good news??
The VA has various treatment opportunities that address ALL of the above problems! Being aware of the treatment opportunities available for your loved one is just one of the many ways you can help them to heal from their experiences.
(See Appendix for a list of these resources).

IMPORTANT: There are many negative reactions that can result from experiencing combat. It is important, however, to not blame everything that goes wrong on your partner's PTSD (or other condition).
  ▪ By blaming everything on PTSD, you and your partner are not allowing room for recovery and growth.
  ▪ It is important for you to understand what is and what is not PTSD.
  ▪ It is also important for your partner to communicate to you what is and what is not his PTSD.
    o This may not be easy for your partner to do in the moment. Allow them time to consider whether his actions are a result of PTSD or not.
    o Example – is your partner angry and on edge because of a recent trigger that brought up disturbing memories? Or is it because something upsetting happened at work?
  ▪ It is important to note whether you and/or your partner are overidentifying or underidentifying with the PTSD or other problems.
**Group Discussion:**
Using the graph below, identify some of the potential consequences of yourself or your Veteran *overidentifying* or *underidentifying* with the Veteran's PTSD

<table>
<thead>
<tr>
<th>Partner OVERIdentifying</th>
<th>Veteran OVERIdentifying</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Partner UNDERIdentifying</strong></td>
<td><strong>Veteran UNDERIdentifying</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Resources:**
Other Common Post-War Problems:
VA Mental Health Website:
http://www.mentalhealth.va.gov/
Suicide:
www.suicideoutreach.org

**Homework:**
- Practice "Catch and Tell" with your partner for the week.
“Catch and Tell”

Over the course of this group, we will be giving various assignments that are designed to help increase positive feelings and interactions within your relationship. Although the assignments can be effective if done on your own, you are encouraged to share them with your partner, and invite them to participate if they wish.

This week, notice at least one thing each day that your partner does and note it on the following chart. It is always possible to notice at least one caring behavior – even if you do not see your partner for an entire day.

Once you notice each caring behavior, acknowledge these behaviors by thanking your partner or letting them know you appreciate what they do for you.

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Caring Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>2/2/2012</td>
<td>He waited to have dinner with me because I had to stay at work late. Made me feel good.</td>
</tr>
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</tbody>
</table>
Session 5: Communication Skills

Homework Review:
- Review “Catch and Tell” worksheet

Group Discussion
What does effective communication include?
How do you know when you are communicating effectively with your partner?

Effective communication is key in any relationship. It is even more critical when there are added stressors, such as PTSD, impacting the relationship.

1. Assertiveness is a key component of communicating effectively.
   a. Passive VS Assertive VS Aggressive – what’s the difference?
   b. Assertiveness = Respecting yourself by communicating your needs while also respecting the rights and needs of the other person.

How do you respect the rights and needs of the other person?
- One way is through active listening
  - Verbal
    - Ask clarifying questions
    - Paraphrasing – telling the speaker what you heard
    - Tone of voice
    - “mm-hmm”s and “uh-huh”s
  - Non-verbal
    - Body language – leaning forward slightly, legs uncrossed
    - Attentiveness – not looking at the clock or fidgeting
    - Eye contact with the speaker
    - Facial expressions – smiling, looking interested, appropriate reactions to topics

How do you respect your own rights and needs?
- Communicate them via “I” statements
  - “I see…” – Label the specific situation you are discussing. Stick to the facts only!
  - “I feel…” – Label your emotions. This allows you to own them instead of placing the blame on the other person.
  - “I want/would like…” – Make a specific request of what you would like to see happen to improve the situation.
    - “I see… I feel… I want…”
Example: "I see the dishes are piling up in the sink again. I feel overwhelmed with the responsibilities around the house. I would like it if we could set a schedule for washing dishes so we can share this responsibility."

- Avoid the word "you" – it points a finger at the other person and increases the chances of them reacting defensively.

How do you respect both parties’ needs when the conversation is not going well?
- Take a time out! This allows both partners to calm down and collect their thoughts. But there are rules:
  - Have a code word or sign for taking a time out.
  - Set a specific time to reconnect and continue the discussion. This should be within 24 hours of initiating the time out.
  - Develop these guidelines for taking a time out with your partner before the first time you use it!

**Group Activity**

Pair up and practice using the above effective communication skills (active listening, I statements, time outs).
Give each other feedback!

**Homework:**
- Practice using your communication skills in interactions during the week. Track them on the following page.
# Effective Communication Practice Record

<table>
<thead>
<tr>
<th>Situation (who, what, when)</th>
<th>Active Listening Skills Used?</th>
<th>I Statements Used?</th>
<th>Take a Time-out?</th>
<th>Outcome?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband, discussing recent flashback, Tuesday night</td>
<td>Nodding, paraphrasing, leaning forward and making eye contact</td>
<td>I can tell (see) that these flashback are intense, I feel scared, I would like to make a plan for how we can handle them better as a team.</td>
<td>Yes (husband upset). Reunited in 1 hour.</td>
<td>Developed a plan for how I can help him during future flashbacks.</td>
</tr>
</tbody>
</table>
Session 6: PTSD Treatments

Homework Review:
- Review "Effective Communication Practice Record"

Group Question: What do you know about PTSD treatments? What are your questions?

There are many treatment options for PTSD available to your Veteran. Although they are the one getting treatment, it is just as important for YOU to know the treatments that are available.

**Studies have shown that treatments appear to be more successful in the context of a supportive family environment**

Therapy:
1) Prolonged Exposure Therapy (PE)
   - In this treatment, the Veteran revisits the memory of their trauma in session with their therapist. They will also be asked to confront situations outside of therapy that they have been avoiding.
   - What to expect:
     - Symptoms oftentimes get worse before they get better.
     - Veteran will be asked to listen to their therapy session recording each day. Please give them the space and time to do so alone.
     - Veteran will be confronting stressful avoided situations outside of therapy. This is often extremely challenging. They may or may not want you to come along. Be supportive regardless.

2) Cognitive Processing Therapy (CPT)
   - This therapy focuses on changing the way the Veteran thinks about themselves, the world, and others as a result of the trauma. Examples of these negative thoughts include, “The world is a dangerous place,” and “If I get close to someone, something bad will happen to them.”
   - They will learn how to challenge their negative thoughts and adopt a more adaptive way of thinking and behaving.
   - What to expect:
     - In the beginning, they will be asked to write a statement about how the trauma has impacted their life. Please give them the space and time they need to do so alone.
     - They will be asked to complete several worksheets between sessions. Encourage them to use their skills to challenge their thoughts.
3) **Cognitive Behavioral Therapy (CBT)**
   - Can include a combination of challenging and restructuring negative thoughts and exposure exercises.

4) **Eye Movement Desensitization and Reprocessing (EMDR)**
   - In this therapy, the Veteran will think about his trauma, as well as negative thoughts related to it, while engaging in another activity such as eye movements or finger tapping.

5) **Group Therapy**
   - This is the most readily available form of treatment for PTSD in the VA.
   - Groups include PTSD 101, PTSD Skills, CPT, CBT, Anger Management, Mantram Repetition, among others.
   - Some Veterans prefer this format because of the support they receive from their peers.

6) **Couples Therapy**
   - Couples therapy is available in the VA for partners experiencing relationship problems. This can include PTSD-related difficulties. There are even PTSD treatments available through couple's therapy.

**Common Medications:**
- Medications are often prescribed to help Veterans cope with their PTSD symptoms, especially those related to sleep, anxiety, mood, and irritability.
- Although medications have been shown to alleviate some PTSD symptoms, it is highly recommended that meds are used *in conjunction* with psychotherapy.

**Antidepressants**
- Examples:
  - Celexa (Citalopram)
  - Prozac (Fluoxetine)
  - Paxil (Paroxetine)
  - Zoloft (Sertraline)
  - Effexor (Venlafaxine)

Minipress (Prazosin) often used to help with nightmares.

**Resources:**
- National Center for PTSD – PTSD Treatments

**Homework:**
- Complete "Relationship Enhancing Thoughts" Worksheet
Relationship Enhancing Thoughts
Oftentimes thoughts about our relationship become weighed down by negative thoughts that maintain our current relationship distress. The best way to begin to create positivity in a relationship is by changing the way we think about our partner. Below is a list of questions to help you to begin to generate positive thoughts about your partner. Complete the following worksheet and review it each day.

What is a characteristic of you partners that you find endearing or lovable?
__________________________________________________________________________

What is a characteristic of you partners that makes you proud?
__________________________________________________________________________

List one of your partner’s physical attributes you like.
__________________________________________________________________________

What is one thing about your partner you would never want to change?
__________________________________________________________________________

Describe one good time from your relationship in a couple sentences.
__________________________________________________________________________
__________________________________________________________________________

Describe one romantic, special time in your relationship.
__________________________________________________________________________
__________________________________________________________________________

Describe the time you first met, and how you felt.
__________________________________________________________________________
__________________________________________________________________________

You are encouraged to share this with your partner and invite them to complete the worksheet, answering the questions about you. You can then share your responses with one another.
Session 7: CBT Basics – Challenging Negative Thoughts

Homework Review:
- Review “Relationship Enhancing Thoughts” worksheet

THOUGHTS
What we tell ourselves

ENVIRONMENT
Influences our thoughts, actions, and emotions

ACTIONS
What we do or don’t do

EMOTIONS
How we feel

The Cognitive Behavioral Therapy (CBT) Model

- How we think and act in any situation impacts our emotions. In turn, these emotions then influence our future thoughts and behaviors.
- Our environment (which includes our present surroundings, as well as our life experiences, values, etc.) also influences our thoughts, actions, and emotions. Therefore, two people may have different reactions to the same situation.

Group Discussion
Imagine you are walking down the street and you pass by someone you know. You attempt to make eye contact and say hello, but they do not acknowledge you.

What are some thoughts you would be having in this situation?
How would those thoughts make you feel?
How might those thoughts/feelings influence how you act towards this person the next time you see them?
Identifying and Challenging Negative Thoughts

- Virtually any negative emotion we feel is triggered by a negative thought. If we can work towards identifying and changing these thoughts, we can change our negative moods!

- Example:

  ![Flowchart Diagram]

  **EVENT:**
  You and your husband are in a store, and he suddenly becomes irritable and snaps back at you.

  **THOUGHT:**
  He never seems to be happy with me. I always make him so angry.

  **EMOTION:**

  **ACTION:**
  Stay quiet to avoid upsetting him more. Once home, you go into separate rooms and don’t speak for the rest of the evening.

- Negative thoughts tend to:
  - Use extreme language (e.g., always, never, must, should)
  - Discount important information or evidence against the thought.
  - Exaggerate negative events.
  - Catastrophize, or predict the worst possible outcome.
  - Be based on feelings rather than facts.

- Challenging Thoughts
  - Become a scientist and challenge the negative thoughts you have to see if they are realistic. If not, replace them with a more realistic thought.
  - Questions to use when challenging thoughts:
    - What is the evidence for AND against my thought?
    - Do I have any experiences that show this type of thought is not completely true all the time?
    - Is there anything that contradicts my thoughts that I might be discounting as not important?
- Is there any information about the current situation that I might be ignoring?
- Am I blaming myself for something over which I do not have complete control?
- What have I learned from previous experiences that could help now?
- Am I using words or phrases that are extreme or exaggerated?
- Am I confusing a low probability with a high probability?
- Are my judgments based on feelings rather than facts?

**Homework:**
- Practicing identifying and challenging your negative thoughts using the “Thought Challenging” worksheets.
## Thought Challenging Worksheet

<table>
<thead>
<tr>
<th>A. Situation</th>
<th>B. Thought</th>
<th>D. Challenge the Thought</th>
<th>E. Alternative Thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the event leading to the thought/emotion.</td>
<td>Write the thought related to the situation. How much do you believe this thought? (0-100%)</td>
<td>Use the questions listed above to challenge your thought written in Column B.</td>
<td>What is a new, more adaptive thought I could tell myself? Rate how much you believe this thought (0-100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Emotion</th>
<th>F. Re-rate Emotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify the emotion and how strongly you feel it (0-100%)</td>
<td>Now what do you feel? (0-100%)</td>
</tr>
</tbody>
</table>
Session 8: Relaxation Skills

Homework Review:
- Review "Thought Challenging" worksheets

Relaxation Techniques are important for both you and your partner. Why?
- Everyone oftentimes carries a lot of tension in their bodies and don’t realize it. These techniques help to relieve that stress.
- They can help you to relax during stressful times.
- The can help your partner to relax when PTSD symptoms get worse.
- You can help your partner to relax using these techniques when he is having re-experiencing symptoms (e.g., nightmares, flashbacks)

Breathing Retraining
- Oftentimes our breathing becomes more rapid and shallow when we are experiencing anxiety. This type of breathing can actually make anxiety worse.
- Retraining ourselves on how to breathe deeply and slowly is a very useful tool to help decrease anxiety in the moment.

Breathing Exercise
1. Choose a quiet, relaxing place and sit comfortably.
2. Focus on your breath. With each inhale, be sure to breathe from your belly and not from your chest.
3. Exhale slowly. Exhalation is the key to relaxing. While exhaling, it may be useful to say a word to yourself that has a calming or relaxing effect, such as "calm", or "relax".
4. After exhaling, pause for 3 to 4 seconds before inhaling again.
5. Slowly inhale, filling your entire lungs with air. Exhale as you say your calming word to yourself, then pause.

Inhale...exhale slowly...Caaaallll...hold 1...2...3...4...Repeat.

Grounding
- Grounding is a technique used to bring one’s attention to the present moment and the external world when anxiety, memories, or emotions become too overwhelming.
- These techniques are also effective for helping your loved one to come back to the present moment during a flashback or nightmare.
- Grounding is different than relaxation in that it is much more active. Your eyes stay open and scan the surrounding environment; the focus remains on the present – not the past or the future.
• **Mental Grounding** – focuses your mind on something else in order to stop you from thinking about your anxiety or other stressors.
  o Describe your environment in detail (sight, smell, touch, sound)
  o Play a categories game with yourself. Name as many TV shows, cars, songs, words that begin with “A”, as you can.
  o Describe an everyday activity, step by step, in great detail.

• **Physical Grounding** – focusing on your senses in the present moment
  o Run cool or warm water over your hands
  o Touch an object nearby and describe how it feels (a chair arm, pen, jacket, etc)
  o Do a body scan – starting at your toes and working your way up, pay attention to how each part of your body feels (your feet planted on the floor, the bend in your knees, your back pressed against the chair, etc.)
  o Clench and release your fists, noticing the different sensations.

• **Soothing Grounding** – ways of talking to yourself in a kind and gentle way.
  o Think of your favorites – what is your favorite color? Animal? Season?
  o Picture people you care about or admire.
  o Say a coping statement (“You can get through this”, “The negative feelings won’t last forever”, etc.)
  o Think of things you are looking forward to in the next week.

### Group Discussion

How/when might you use these techniques for yourself?
How/when might you use these techniques with your partner?

**NOTE:** Although these skills can be used with your partner, the primary reason for teaching them in this group is for your use. If you choose to use these with your partner, discuss the skills with him before a stressful situation arises in which they might be needed. It is critical to make sure your partner is open to you using these skills with him before attempting to do so.

**Homework:**

• Practice at least one relaxation skill (breathing, grounding) for at least 10 minutes a day. Track your mood and practices on the following page.
<table>
<thead>
<tr>
<th>Stress/Anxiety Level Before Relaxation (0-10)</th>
<th>Relaxation Skill Practiced (length in mins)</th>
<th>Stress/Anxiety Level After Relaxation (0-10)</th>
<th>Reactions to the Exercise?</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Grounding (describing my surroundings, playing categories; 15 mins)</td>
<td>4</td>
<td>Didn’t think it would work, but actually helped. Difficult to stay focused.</td>
</tr>
</tbody>
</table>

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Session 9: “We” versus “You” Approach to PTSD

Homework Review:
- Review “Relaxation Practice Tracking Record”

What is “we” versus “you”?
- Communal Coping – problems that arise in relationships are viewed as “our” problem versus “my” or “your” problem
- Studies have shown that couples (and individuals) are healthier if problems are confronted by both partners together rather than one partner being seen as the “victim”.

STRESS APPRAISAL:
Communal Approach
(our problem)

Individual Help/Support Giving
(our problem – my responsibility)

Communal Coping
(our problem – our responsibility)

ACTION:
My responsibility

Individualism
(my problem – my responsibility)

Help/support seeking
(my problem – our responsibility)

Our responsibility

Individual Approach
(our problem)
What are some examples of each type of coping? How can they impact individual and relationship functioning?

**Requirements for Communal Coping:**
1. **Communal View** - At least one partner believes in coping with problems as a “we”
2. **Communication** - Both partners communicate openly about the problem and are “on the same page”
3. **Communal Action** – Partners discuss and decide to both take action in addressing the problem

**Group Discussion**
How do you and your partner currently cope with PTSD? What are some ways you and your partner could take a communal approach to coping with PTSD?

**Resources:**

**Homework:**
- Complete “Coping Styles” worksheet
### Coping Styles

Over the next week, notice the ways in which you and your partner cope with problems in your relationship. What style of coping are you (and your partner) using? If not a communal approach, what could you do or say next time to increase the communal approach to problems in your relationship?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Style of Coping Used</th>
<th>Ways to Improve Communal Coping Next Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A loud noise at the store startles my husband and he runs outside to the car. I offer support, but he says he’s fine and can handle it on his own.</td>
<td>Individualism</td>
<td>Encourage him to talk with me about potential triggers, and how we can handle them best together. Ask what I can do to better support him the next time something unexpected happens.</td>
</tr>
</tbody>
</table>
Session 10: Review and Wrap-up!

Homework Review:
- Review “Coping Styles” Worksheet

What have we learned over the last ten weeks?
- What is PTSD?
- Other common post-war reactions and Secondary Traumatization
- Treatment of PTSD
- We versus You approach to PTSD
- Importance of Self-Care
- CBT Basics – Challenging Maladaptive Thoughts
- Grounding and Breathing
- Communication Skills

What have you found the most useful?

Have you learned anything else from this group that’s not listed above?

Are there any final thoughts you would like to share with the group?

Next Steps:
- Now that the group is completed, what will you (and your partner) do to continue to work on your relationship?