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# Family Functioning and Secondary Traumatic Stress in Military Families: A Qualitative Study

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Family Functioning and Secondary Traumatic Stress in Military Families: A Qualitative Study

by  
Karlie Gams

MSW Clinical Research Paper

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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## Abstract

The purpose of this study was to explore secondary traumatic stress and family functioning in military families. Six licensed mental health professionals, including social workers and a marriage and family therapist with experience working directly with military families participated in this study. Using a qualitative design, participants were interviewed regarding their experience working with these families. Five themes emerged from the data including: (1) strength of communication within the family can impact functioning; (2) the non-veteran parent often takes on various aspect in the role of both parents; (3) children often present secondary traumatic stress symptoms outside of the home; (4) family functioning and responses to trauma are unique to each family; and, (5) family and couples counseling is an essential treatment tool for these families. Limitations were lack of discussion surrounding female veteran to male spouses, as well as same sex partnerships. This study presents information through the personal and professional lens of the participants and draws awareness to PTSD and secondary traumatic stress in military families.

## Acknowledgments

I would like to thank my husband, Seth, for supporting me throughout my education journey. Thank you for pushing me to keep going. Thank you for cleaning the house and making dinner when I had long days of school and internship. Most of all, thank you for loving me regardless of my crankiness and bad attitude late at night. Also, thank you to my parents for supporting me and my pursuit of my MSW. I could not have done it without you. I am so blessed to have such a great support system in my life. I love you all!

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## **Family Functioning and Secondary Traumatic Stress in Military Families: A Qualitative Study**

The demands of commitment to the United States military result in considerable strains on the military family. Military life can involve long periods of separation from family members for training and deployments, especially for active duty service members. Long periods of threat, such as exposure to combat during deployment, are contributing factors to mental health problems for service members and veterans during post-deployment, including posttraumatic stress disorder (PTSD) (Tuerk et al., 2010). It is estimated that posttraumatic stress disorder (PTSD) is two to three times more prevalent in service members and veterans than the civilian population; approximately 11 to 20% of all service members who served in Iraq and Afghanistan, 12% from the Gulf War, and 15% from the Vietnam War (Dohrenwend et al., 2006; Hoge et al., 2004; Kang et al., 2003; Ozer & Weiss, 2004).

While PTSD can have considerable impact on veterans and service members, there can also be significant impact on their families. Secondary traumatic stress and compassion fatigue can be found in caregivers and family members of veterans who have had traumatic experiences (Elwood, Mott, Lohr, & Galovski, 2011; Horrell, Holohan, Didion, & Vance, 2011). Figley (1995) defined secondary traumatic stress as “the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 10). Often used interchangeably, secondary traumatic stress is a term that can be applied to many populations such as close family and caregivers, while compassion fatigue refers to individuals in a helping profession including clinicians and social workers (Elwood et al., 2011). Individuals who have a

significant role in a trauma survivor's life may develop secondary traumatic stress symptoms, which may have a significant impact on family functioning (Elwood et al., 2011; Figley, 1995).

The negative symptoms of secondary traumatic stress mirror that of PTSD and can include avoidance of cues and reminders, hyperarousal, intrusive imagery, distressing emotions, and functional impairment (Bride & Figley, 2009). Additionally, Elwood and colleagues (2011) describe secondary traumatic stress as a natural consequence of caring for or living with individuals who have experienced trauma. Secondary traumatic stress is recognized in families of veterans with combat-related PTSD as well as other traumas and mental illnesses that can be attributed to military experience (Renshaw et al., 2011).

Families coping with a service member who is experiencing PTSD may be less supportive, adaptive, and cohesive than similar families where the service member does not experience PTSD (Davidson & Mellor, 2001). There are a number of reasons why an individual with PTSD experiences difficulties within familial relationships, notably with their significant other and their children. Symptoms associated with emotional numbing, including detachment from others, loss of interest in activities, and restricted affect can contribute to relationship distress (Meis, Erbes, Polusny, & Compton, 2010; Riggs, Byrne, Weathers, & Litz, 1998). Partners of service members with PTSD have reported lower relationship satisfaction, more caregiver and parental burdens, and poorer psychological adjustment than partners of service member who did not experience PTSD (Sherman, Zanotti, & Jones, 2005). The parent's trauma symptoms may also interfere with parenting capabilities. The emotions and reactivity of a service member with PTSD may have negative impacts on their ability to engage with their children (Paley, Lester, & Mogil, 2013). Additionally, emotional numbing as previously discussed can impact the parent-child relationship by interfering with the service member's

ability to have meaningful interactions with their children and decrease their capacity to be an external source of emotional regulation for their children (Paley et al., 2013; Ruscio, Weathers, King, & King, 2002).

While treatments to address PTSD have been evolved since the Vietnam War, it has been in the last 12 years in particular that treatments have become increasingly evidence based (Zeiss & Karlin, 2008). In an analysis of the effectiveness of Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE), participants had an average of 28% decrease in PTSD Checklist scores while PE had an average of 33% decrease (Karlin et al., 2010). While research indicates that Prolonged Exposure Therapy (PE) can have a considerable positive effect on veteran treatment outcomes, quality of life, as well as veteran views of treatment (Goodson et al., 2013; Kehle-Forbes, Polusny, Erbes, & Gerould, 2014; Wolf et al., 2015) there has been little research on evidence-based practices that are geared towards addressing secondary trauma and military family functioning. This gap may create disadvantages in providing effective support and treatment for the family.

Military families may face considerable barriers when it comes to accessing proper care. Some common barriers faced include payment for services, identification and connection to services for military-connected people or veterans who have separated from the military, and mental health stigma (Cogan, 2014). Military families facing difficulties due to secondary traumatic stress and impaired family functioning provide opportunities and challenges for social workers who support this population. The importance of trauma-informed practices and patient-centered care within this population also has implications as understanding the unique experiences and vulnerabilities of military connected families that are imperative in the provision of services (Weiss & Albright, 2014).

Based on research, it would be beneficial for clinical social workers and mental health professionals who provide services to veterans and their families to be familiar with their unique experiences that effect their family functioning. The purpose of this qualitative study is to explore the effects of secondary traumatic stress and family functioning in military families. A qualitative design was necessary for this study as it aimed to examine the experiences of these families from mental health professional's perspective. By identifying these unique challenges, clinicians may be better equipped to plan for and meet the long-term needs of these families.

## **Literature Review**

This literature review will examine definitions and previous research to help promote a better understanding how family functioning is impacted by the service member's experience of posttraumatic stress. Themes include the role of post-traumatic stress in military families, family functioning, and impacts of secondary traumatic stress. The purpose of this study is to examine how the experience of secondary traumatic stress impacts family functioning following the service member's experience of trauma. This section will conclude with an evaluation of current research.

### **Role of Post-Traumatic Stress**

The most recent version of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), classifies posttraumatic stress disorder (PTSD) as a trauma and stress-related disorder (American Psychiatric Association [APA], 2013). To meet diagnostic criteria for PTSD an individual must have personally experienced a traumatic event, observed a traumatic event, learned of a traumatic event that happened to a close friend or family member, or have first-hand intense or repetitious exposure to details of a traumatic event. Some instances that would constitute a traumatic event would be an incident that is life threatening, such as natural disasters, terroristic events, serious accidents, sexual or physical assault as a child or as an adult, or military combat (APA, 2013; Hamblen, 2009). In their study, Taft, Schumm, Panuzio, and Proctor (2008) found that Gulf War combat veterans that struggled with PTSD also had impacted family lives; withdrawal and arousal symptoms in particular were found to have a negative impact on family functioning. Symptoms of withdrawal and numbing may lead the service member to be sensitive to arousal and have decreased emotional control, which were significantly correlated with a negative impact on family functioning (Taft et al., 2008).

## **Military Families**

When considering secondary trauma experiences within a military family, it is important to understand the demographics of these families. In 2014 approximately 37.5% of all active duty members were married and had children, down from 42.5% in 1995 (U.S. Department of Defense [DoD], 2007; DoD, 2014). Just under 500,000 service members are married with children, comprising of approximately 1.2 million dependent children with at least one active-duty parent, 750,000 dependent children in Guard or Reserve families, and 665,619 spouses (Clever & Segal, 2013; DoD, 2014). Among the service members deployed in support of Operation Enduring Freedom (OEF) and Operations Iraqi Freedom (OIF), between 11-20% have PTSD; it has also been estimated that as high as 30% of Vietnam Veterans have had PTSD during their lifetime (U.S. Department of Veterans Affairs, 2015). A study by Dekel, Solomon, and Bleich (2005) showed that individuals that have close, long-term relationships with those who have significant psychiatric disorders often led to their own development of anxiety disorders, chronic stress, and depressive symptoms. Statistics regarding marital and parental status of service members raise concerns for intergenerational transmission of trauma, along with experiences of marital discord and emotional impairment of the children.

## **Impact on Significant Other and Relationship**

Exposure to the traumatic experiences of others can potentially be distressing for some individuals. Often this happens throughout the healing process where veterans with traumatic stress repeatedly, and vividly relive their experiences, secondarily exposing spouses and family to the trauma event (Briere & Figley, 2009). A spouse's commitment and involvement in a veteran's transition and healing may lead him or her to gradually experience similar symptoms as the veteran (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005). One study by Renshaw and

colleagues (2011) showed that a spouse was more likely to suffer from secondary traumatic stress when they attribute their symptoms to veteran's combat or trauma experience, rather than events in their own lives. Additionally, the spouses in this study who attributed their symptoms to their own lives were diagnosed with general psychological distress.

Deployments can take a toll on the relationship between a significant other and a service member, especially considering the possibility of the service member having a traumatic experience that may lead to the development of PTSD symptoms. In their research, Meis and colleagues (2010) explored the role of posttraumatic stress disorder and relationship quality among combat veterans. National Guard soldiers that recently returned from Iraq ( $n = 310$ ) participated in various surveys one month prior to deployment and again three months following deployment. The results from this study indicated that post-deployment PTSD symptoms in the service members were significantly associated with lower relationship quality with their spouse. In light of these findings, the results from Meis and colleague's (2010) study are relevant to the current study in that it shows a robust relationship between the spouse's emotionality, relationship satisfaction and the service member's posttraumatic stress symptoms.

In another study by Solomon and colleagues (1992), implications of combat stress reaction and PTSD in Israeli combat veterans were explored. Results from this study showed that when the wives ( $n = 120$ ) perceived their husbands to be suffering from PTSD they tended to display inner feelings of loneliness due to impaired family and marital relations, broad contexts of social dysfunction, and a decrease in social network satisfaction. These findings that include a broad range of social dysfunctions are relevant to the current study because experiences of secondary traumatic stress can include distressing emotions and functional impairment.

In their study, Allen and colleagues (2010) further investigated the link between combat-related PTSD in service members and elevated psychological distress in their spouses. In a sample of active duty couples ( $n = 434$ ), self-reports of relationship functioning from both the Army husband and the civilian wife. The results from this study indicated that levels of marital satisfaction, positive bonding, parenting alliance, and confidence in the relationship were less in couples who reported a combat-deployment within the last year than those who did not deploy. These results are relevant to the current study as it further supports the effects that combat-deployments can have on relationship and family functioning.

Researchers have also investigated protective and risk factors in spouses of veterans and services members who have experienced trauma. A study by Dekel and colleagues (2005) showed that relational ambiguity played major role in the mental health of the spouses. Spouses most likely to do well in caring for their veteran were ones who managed to preserve their own personal space. Additionally, there was less ambiguity in whether or not the veteran was a dependent person or an independent adult due to clear boundaries and relationship roles. Wives who reported that they felt as though their husband required constant care also reported high levels of ambiguity in their relationship roles, as well as loneliness and frustration. With ambiguity in relationship roles posing as a risk and protective factor, these wives experienced higher levels of distress than the wives who did not struggle with ambiguity (Dekel et al., 2005).

An additional risk factor for secondary traumatic stress in spouses can be explained by the correlation of experience and coping mechanisms. In their research, Bride and Figley (2009) found that spouses who had not been exposed to their partner's trauma in the past or had less experience with dealing with traumatic type stressors are more likely to develop secondary traumatic stress. Strong social supports along with active coping and support seeking were

correlated with lower levels of secondary traumatic stress, suggesting that these are protective factors for spouses.

### **Considerations for Children**

With upwards of two million children in active-duty, National Guard, and Reserve families it is important to consider child functioning, as well as parenting, when looking at family functioning as a whole (Clever & Segal, 2013; DoD, 2014). Herzog, Everson, and Whitworth (2011) explored correlations between the service member's traumatic stress symptoms and secondary stress experienced by their spouse and children. Soldiers and their spouses ( $n = 108$  couples) responded to a survey that included a variety of measures. Results from this study indicated that spouses of war soldiers are at an increased risk for secondary traumatic stress, including symptoms of avoidant thoughts, emotions, and behaviors as well as intrusion of unwanted cognitions and images of the spouses' experience. This can have a significant effect on parenting and relationships with their children. Additionally, internalized problems such as depression, anxiety, and somatization were found to be symptomatic of secondary trauma in the children of these veterans (Herzog, Everson, & Whitworth, 2011).

In their study, Chartrand and colleagues (2008) explored the effect of combat deployments on the behavior of young children in military families. Participants included children ages 1½ to 5 years old ( $n = 169$ ) in a child-care center on a Marine base. Results from this study showed that children of deployed parents exhibited increased behavioral issues compared to peers without a deployed parent. These results are relevant to the current study as it gives evidence for the effect of combat deployments on the emotional responses of very young children and give need for further investigation of the effects of deployment on military children.

One study by Chandra, Martin, Hawkins, and Richardson (2010) investigated the effect of parental deployment on the well-being of their children. Using focus groups and semi-structured interviews with school staff ( $n = 148$ ), emotional, behavioral, and academic issues of these children were enquired. Results from this study indicated multiple factors attributed to students' decreased ability to function well in school: poor mental health of the non-deployed parent, increased responsibilities at home, increased anxiety due to parental absence, and barriers to accessing mental health care. The results from Chandra and colleagues' study are relevant to the current study in that the initial psychological distress of a parent being deployed can lead to more serious emotional disturbance should proper care not be available and/or conditions continue once the parent returns from deployment.

In another study, Lester and colleagues (2010) looked further into the at-home life of children in military families and the impact of parental combat deployment. Using semi-structured interviews with at-home parents ( $n = 163$ ) and/or recently returned active duty parents ( $n = 65$ ) and their children ( $n = 272$ ), researchers measured the psychological distress of the child using a variety of measures. Results from this study indicated that parental distress along with the length of deployment predicted elevated anxiety and externalized symptoms in the children. Information from this study is relevant to the current study as it provided further evidence for psychological distress in the children of combat-deployed service members.

### **Adaptive Processes**

Adaptive processes of the couple, including positive connection (e.g. friendship, fun, intimacy) and communication, can be affected by deployments and PTSD symptoms in the service members (Allen et al., 2010). Sherman, Zanotti, and Jones (2005) described a number of ways that a service member's PTSD symptoms can contribute to adaptive processes within a

couple's relationship. For instance, the service member's avoidant symptoms can lead to rejection of activities with the spouse and isolation, escalation of conflicts can occur along with anger and tension due to arousal symptoms, and re-experiencing symptoms such as nightmares can interfere with intimacy by leading couples to sleep separately.

A study by Baptist and colleagues (2011) explored military marriages by conducting qualitative research to investigate the quality of the marriages following deployment. Interviews took place with service members ( $n = 12$ ) and spouses ( $n = 18$ ). Results from this study indicated that communication that is both frequent and open was an important adaptive process for the couples. Unshared stories or guarded experiences of trauma created barriers for couples to support and confide in each other. Additionally, wives that reported that they maintained their marriages by over-extending their responsibilities had negative effects on marital quality.

As a spouse over-extends responsibilities to compensate for a service member's behavior, they may inadvertently undermine the parenting alliance by mediating all interactions between the parent with PTSD symptoms and the children (Sherman, 2008). A study by Herzog, Everson, and Whitworth (2011) explored the spouse's emotional state and its contribution to the emotional distress in the children. In their study, Army National Guard families ( $n = 54$ ) were surveyed. Results from their study identified that the spouse's secondary traumatic stress symptoms served as a mediating variable between the service member's PTSD symptoms and their child's secondary traumatic stress symptoms. This aspect of familial functioning is important to the current research as it shows that the spouse plays a major role in the child's own emotional distress.

Wartime deployments can have considerable impact on reintegrating and adapting to family life post-deployment. In their study, Scott and colleagues (2014) investigated variables

that effect post-deployment adaptation in U.S. Navy families. Using qualitative and quantitative measures, a convenience sample of spouses of recently returned service members reported on many aspects of family functioning ( $n = 142$ ). Results from this study showed family adaptation was predicted by family interdependence and the number of previous deployments.

Additionally, responses from the spouses indicated that 90% of the families experienced positive adaptation responses to reintegration post-deployment. These results are important to the current study as it sheds light on the resilience of these families and how communication and interdependence plays a role in adaptive responses.

In another study, Dinshtein, Dekel, and Polliack (2011) conducted research that explored potential long-term consequences of living with a father with PTSD in adult children of Israeli war veterans. Adults whose fathers had chronic PTSD ( $n = 46$ ) participated in self-reported questionnaires, as did a group of adult children of war veterans who developed PTSD as a result of their service ( $n = 46$ ). Results from this study showed increased potential for secondary traumatization in children of PTSD war veterans, as the sample reported higher levels of distress across measures compared to the control group. Additionally, the results showed that the adult children of the PTSD war veterans experienced more difficulties with intimacy, possibly indicating a development of difficulties with social and intimate relationships during childhood. These results are relevant to the current study because it gives evidence to the long-term effects of the parent-child relationships when one parent has PTSD, as well as shows transmission of interpersonal relationship difficulties from one generation to the next.

## **Conclusion**

Empirical studies highlighted in this literature review have explored the effects that combat deployments and PTSD can have on family functioning. Overall, this research suggests

that the service member and veteran's experience of PTSD and combat deployments have considerable impact on the emotional function of both the spouse and the children. This literature shows that the situations of military families are unique to this population and show significant difference to their civilian counterparts. Given the nature and complexity of the emotional and functional issues that these families face, mental health professionals and social workers who support this population have many aspects of the family to consider.

## Conceptual Framework

### Theoretical Lens

The focus of this study is to explore the experience of secondary traumatic stress and family functioning in military families. Both Family Resilience Theory and the Family Adjustment and Adaptation Response Model (FAAR) provide a framework that facilitates a view of the military family as a whole.

**Family Resilience Theory.** The framework for this study is influenced by family resilience theory presented by Froma Walsh. The frame allows for the military family to be viewed in the context of resilience, or their ability to rebound and withstand crisis (Walsh, 1996). Resilience is a dynamic process encompassing positive adaptation within the context of significant adversity and challenges (Luthar, 2006).

Early views of resilience surrounded the explanation of how some children exposed to hardships were devastated by the trauma, while others exposed to similar situations emerged intact (Garmezy, 1974). Walsh (1996), built on the concept of resilience within an individual and broadened the scope of resilience processes to include relational resilience within a functional unit.

A basic premise in this systemic view is that serious crises and persistent adversity have an impact on the whole family. These stresses can derail the functioning of a family system, with ripple effects to all members and their relationships. In turn, key family processes mediate the recovery of all members and the family unit. These processes enable the family system to rally in times of crisis, to buffer stress, reduce the risk of dysfunction, and support optimal adaptation (Walsh, 2003).

Family resilience theory proposes that constructive communication, problem-solving processes,

shared beliefs, and healthy patterns of organization are crucial for the family's ability to respond to challenges and adversity (Walsh, 1996). With considerations from ecological and developmental perspectives, a family resilience framework views the broader sociocultural context of family functioning as it evolves over the multigenerational life-cycle. It seeks to understand crucial variables that contribute to family functioning and resilience to hardship (Walsh, 2003).

**Family Adjustment and Adaptation Response Model (FAAR).** This model pulls concepts from family stress as well as the family resilience theory. In the FAAR Model, families engage in processes that balance family capabilities and family demands. These demands and capabilities are unfolded by family meanings in the context of family adaptation or adjustment (Patterson, 2002). See *figure 1* (next page).

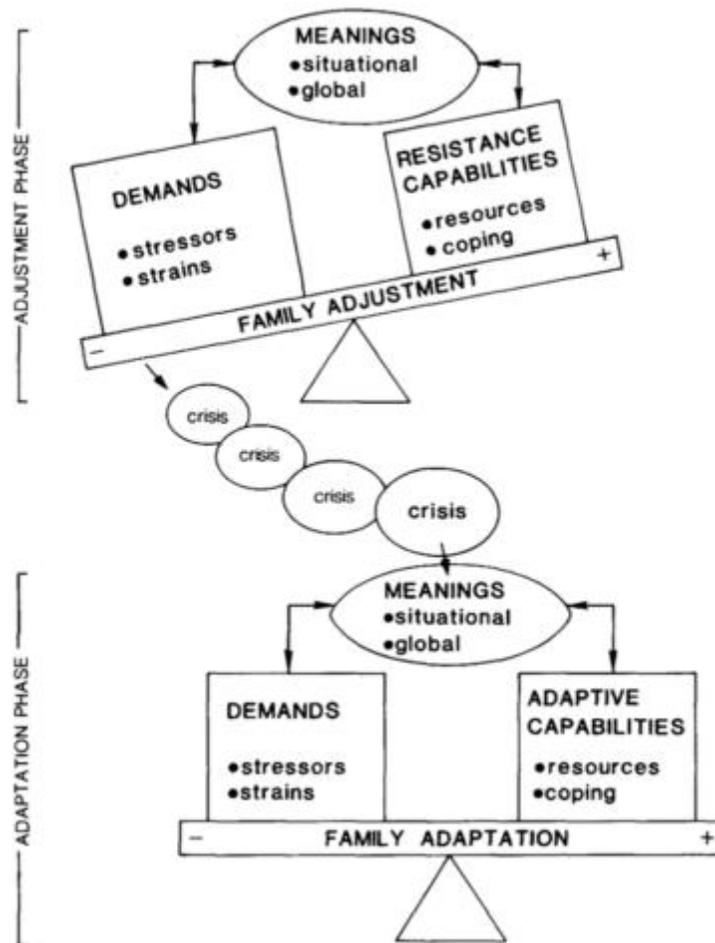


Figure 1. From “Families Experiencing Stress: I. The Family Adjustment and Adaptation Response Model: II. Applying The FAAR Model to Health-Related Issues for Intervention and Research.” By J. M. Patterson, 1988, *Family Systems Medicine*, 6, p. 209.

During the adjustment phase, family demands and capabilities are assessed. Family demands are comprised of ongoing family strains, stressors, and daily hassles. Normative stressors include expected events and transitions such as retirement, while non-normative stressors include untimely or unexpected events (e.g., death or severe injury) and transitional crises including family relocation and change in family roles due to injury or mental illness (McCubbin & Lavee, 1986; Patterson, 2002). Like all social systems, the family attempts to maintain balanced functioning, or homeostasis, using its capabilities (Patterson, 1988). Family capabilities include what the family has (resources) and what the family does (coping behaviors)

(Patterson, 2002).

Family meaning is an important construct in the FAAR Model, as they help shape the nature and extent of protective and risk factors for family functioning (Patterson, 2002). The model includes the family's world view and how they see their family in relationship to the community, how they see themselves as a unit or their identity as a family, and their definition of their demands and capabilities (Patterson, 1988). Understanding a family's beliefs and meanings can be important to understanding how a diagnosis of a chronic health condition or mental illness impacts family functioning in that it the family may have to change their prior beliefs or world view in order to adapt (Patterson, 2002).

When family demands outweigh the family's existing capabilities, this persisting imbalance can cause families to experience crisis (Patterson, 1988; Patterson, 2002). In military families, this crisis can lead to disorganization and discontinuity in family functioning, and poses a vulnerability for each member of the family unit to experience excessive stress (McCubbin & Lavee, 1986; Patterson, 2002). During the adaptation phase, the family attempts to restore homeostasis acquiring new resources or coping behaviors that are adaptive and help restore balance between demands and capabilities (Patterson, 2002).

### **Professional Lens**

My professional intentions for this study are to explore and deepen the understanding of military families and their experiences of trauma. I have had the opportunity to work indirectly with veterans and their families by assisting with research projects that took place at the Minneapolis VA Health Care Center. I hope to gain experience in direct practice clinical social work practice with this population in the future. By creating this new piece of literature, I hope

that other professionals as well as myself will hold a better understanding and be armed with targeted approaches for working with these families.

### **Personal Lens**

I am firm believer that a person is shaped by the community and family in which they are raised. I grew up in a military family. My father separated from the U.S. Army with an injury that made reintegrating difficult. Living in a rural community with few resources along with the emotional stress of his experience took its toll on the functioning of our family. While researching the subject, Family Resilience Theory resonated the most with me because even though we faced adversity and challenges, we worked together to become the stronger family unit we are today.

This project was written as a requirement of a Master of Social Work program. The importance of understanding the unique experiences of military families is imperative for providing short- and long-term services for these families.

## **Methods**

### **Research Design**

The purpose of this study was to explore the experiences of secondary trauma and family functioning within military families from a clinician's perspective. Since very little research has been directed towards this topic, this study was exploratory in nature. A qualitative type study was used in order to explore the unique experiences within military families. Methodology for this study addressed: sample, recruitment process, data collection, data analysis, and ethical considerations.

### **Sample**

The projected study size for this qualitative study was between 8 and 10 participants, as this is the suggested number of respondents for in-depth qualitative data collection (Padgett, 2008). The researcher located 6 participants ( $n = 6$ ) for this study. Convenience and snowball type sampling were utilized due to the relatively small number of professionals with specific professional backgrounds and characteristics needed to acquire rich qualitative data. These sampling types were used to locate respondents and used referrals and networking to locate additional respondents. All participants ( $n = 6$ ) met professional experience and licensure criteria in order to be eligible for this study. First, the participants had direct experience working with veterans and service members, as well as their families, amounting to at least one year. Second, they were a licensed mental health professional. Third, their scope of practice is within the state of Minnesota.

### **Demographic Information**

To respect anonymity of research participants for this qualitative study, demographic information was not collected. Four participants were male and two were female.

## **Work Experience**

Each of the six participants were licensed mental health professionals. Four participants were Licensed Independent Social Workers (LICSW), one was a Licensed Graduate Social Worker (LGSW), and one was a Licensed Marriage and Family Therapist (LMFT). Each of the participants worked with veterans and service members in counseling and therapy setting, and all had experience working with the veteran's spouse and/or children.

## **Recruitment**

The type of recruitment used for the study was convenience sampling. The researcher utilized social media to invite mental health professionals to participate, the posted invitation can be seen in Appendix C. The researcher then contacted professionals using an e-mail invitation. These professionals were also invited to forward the invitation to their colleagues and connections in the field, this can be seen in Appendix C. The clinicians who viewed the social media invitation were invited to refer other mental health professionals who may not be on social media for participation in the study (see Appendix C). The invitation for referral for additional participants elicited snowball typed sampling. Snowball sampling in conjunction with convenience sampling was necessary for this study in order to reach the appropriate number of interview participants suggested for in-depth interviewing (Padgett, 2008). After recruitment efforts, six participants took part in the interview process. The participants were compensated with a \$10 gift card for their participation.

Prior to collecting data, the researcher submitted an application to the University of St. Thomas Institutional Review Board (IRB) for approval to conduct the study. The level of review for this qualitative study was expedited.

## **Data Collection**

Data for this study was collected using semi-structured interviews. This process was chosen to allow for open-ended questions and for conversation to facilitate engaging interviews with participants. With consideration for confidentiality, the location of where interviews the interviews were to be conducted was taken into account. Interviews took place in a private location according to the participants' comfort and choosing, which was the participants' personal office for each interview. Each participant was presented with informed consent prior to the interview and time was allotted for questions and clarification. With consideration for potential emotional discomfort, each participant was provided with a professional resource sheet. With permission from each participant, the interview was audio-recorded.

The interview questions were influenced by the literature as related to experiences of secondary trauma and aspects of family functioning. The questions focused on issues such as common experiences of secondary traumatic stress in military families, family dynamics and functioning, possible risk and protective factors, and modalities of treatment for military families. The interview schedule can be viewed in Appendix B. Defining questions were included to allow the participants to define key concepts such as secondary traumatic stress, experiences based on parental or child status within the family, as well as functioning and adaptations.

## **Data Analysis**

The data collected as part of the study was analyzed using coding methods. Interviews were transcribed by the researcher. The researcher "coded" the transcripts and identified emerging concepts from the interviews. From emerging concepts, themes were identified. Padgett (2008) describes the coding process as, "close and repeated readings of the transcript (or

other text) in search of “meaning units” that are descriptively labeled so that they may serve as building blocks for broader conceptualization...usually after three or four transcripts – a start-list of codes is compiled and applied to additional transcripts” (Padgett, 2008 p. 152-153). Using a list of codes from each transcript, themes and sub-themes can be identified as a systematic way of recognizing differences and similarities between interviews.

### **Ethical and Confidentiality Considerations**

Due to the qualitative nature of the study, it was important to consider confidentiality with high importance. Each participant was given informed consent, seen in Appendix A, before beginning the interview. The informed consent included background information, procedures, risks and benefits of participating in the study, compensation, confidentiality, as well as explained voluntary participation in the study as well as obtained a signature of consent. This can be viewed in Appendix A. The researcher verbally discussed the voluntary nature of the study, the participant’s rights, issues concerning confidentiality, and asked open-ended questions to ensure that each participant understood the information that was provided.

Risk within this study was taken into consideration. As the semi-structured interview asked open-ended questions pertaining to experiences of secondary traumatic stress, the minimal risk of vicarious trauma was taken into account. Just as secondary traumatic stress can occur in close family and caregivers of individual who have PTSD, compassion fatigue or vicarious trauma refers to individuals in a helping profession including mental health professionals (Elwood et al., 2011). Mental health professionals who have worked with individuals who experienced symptoms related to trauma are more likely to be effected by vicarious trauma. The researcher took extra steps to ensure protection of the research participants. First, only licensed mental health professionals who met recruitment criteria were interviewed. Second, the

researcher stressed the voluntary nature of the study. Third, the participant's ability to withdraw from the study at any time was emphasized as well as the right to skip questions. In addition, the University of St. Thomas's Institutional Review Board as well as this researcher's clinical paper committee reviewed the content of the interview questions prior to the interviews.

Several precautions were taken to help ensure confidentiality of the participants. Participants were given and were explained verbally of an informed consent form. Participants were advised that they could skip any questions that they did not feel comfortable answering and that they could end the interview at any time. Additionally, the participants were informed of the voluntary nature of the study. All data that was collected was deidentified so that interviews could not be linked to respondents. All information from interviews was stored on a personal computer with password and firewall protection. Digital audio from the interviews, as well as transcripts, were stored on a password protected computer which remained stored in a secure and locked location. The audio and paper transcripts from the interviews will be destroyed by June 1<sup>st</sup>, 2020.

## **Findings**

This study explored the effects of secondary traumatic stress on family functioning in military families. Each of the six participants came from different professional backgrounds, but each had worked with veterans, service members, and their families in a counseling and therapy setting for at least one year. To protect the identity of the participants, no identifying information was collected. Any identifying information given by a participant during the interviews were redacted from transcription; this included personal information about the participant, the agency in which they work, and families that they drew examples from. All of the six participants were licensed mental health professionals and met the recruitment criteria for this study.

Five common themes emerged from the interviews: (1) strength of communication within the family can impact functioning; (2) the non-veteran parent often takes on various aspect in the role of both parents; (3) children often present secondary traumatic stress symptoms outside of the home; (4) family functioning and responses to trauma are unique to each family; and, (5) family and couples counseling are essential treatment tools for these families. Many of the quotes that are presented can be used in multiple themes, however they were included with the theme that was most applicable.

### **Communication**

The first of the themes involved communication amongst family members. While this theme mostly focuses on the impacts of the lack of communication, it includes overall perpetuation of familial issues when there's an absence or breakdown of communication. Five participants discussed communication as being a source of stress and anxiety. One participant

talked about breakdown in communication as a recurring theme in his work with military families:

*...something that I see reoccurring would be more breakdown in communication...that leads to a number of other issues with relationships, feeling supported, and all the things that would go into a loving, caring family or nuclear family kind of relationship.*

Another participant spoke about the spouse or partner's "silent role" in the relationship throughout the interview. They described the spouse's anxiety towards triggering the veteran's PTSD symptoms:

*One of the themes in the support group is [the spouse] always playing that silent part, or silent person. Not knowing what you can say, not sure what would make that veteran angry...these ladies have anxiety.*

A different participant added to this by stating the rules governing the family and communication impacts functioning within the family:

*...a lot of the couples I've met with where PTSD is involved, you see it mostly in their communication. And the rules governing the family...sometimes the veteran will subconsciously try to control the situation but not really thinking that, then the spouse feels like they don't have control and they're following the rules of that person... The spouse would be more of a protest, kind of like this will not stand, you're going to communicate with me, and I'm going to pursue you until you communicate with me.*

The spouse “pursing” the veteran was mentioned in three interviews. This is an additional quote that describes how the spouse may try to engage the veteran when there is a lack of communication:

*...the spouse is more likely to engage the veteran more. And then that will actually cause more issues because the veteran is not wanting to talk about it and the spouse is like “no we’re going to talk about this.” That’s never healthy either.*

### **Role of the Non-Veteran Parent**

The second theme involved the non-veteran parent and their role as “both parents” while the veteran is away. Each participant discussed the role of the non-veteran parent and how it impacts family functioning both when the veteran is away and when they come back. One participant’s response when asked about common scenarios that they see in their work highlights this theme:

*That veteran goes away and now that spouse is left behind in the role of veteran. You have one person playing both mom and dad. And then when they come back, when the veteran comes back, sometimes that spouse has a hard time letting go of that role right away because they’re set in this routine. They are so comfortable and the children are so comfortable at this point...*

An additional participant discussed how dynamics shift when the veteran returns home from a deployment:

*Mom stays home. She not only gets us ready for school and does all the meals, but also all the homework and goes to all the sporting events, and shuttles us here, here and here. Well the veteran’s coming in and trying to play catch-up*

*with all these things that he left for a year. There's a lot of shift there and kids feel that. They see other families where they are still whole and the dad hasn't left, and they have both parents. I think that's a huge dynamic shift there.*

Another element of this theme is the concept that that a veteran with PTSD may require a lot of assistance from the spouse to undertake everyday tasks. This was described as a “third child” or an additional child by three participants:

*The [spouse] has been both the mom and the dad to these kids, so at this point they get secondary traumatic stress and really burnt out...now they're dealing with possibly a third child when it comes to the symptoms that [the veteran] has...*

When asked to describe the impact that secondary traumatic stress has on a family, one participant stated:

*It's more of the depression symptoms that the spouse takes on...which they do mirror each other in a lot of ways. But it's a lot more sadness, or down and depressed, and just that burnt out feeling. Because now they're taking care of another person on top of kids and having to explain or make up excuses for their behavior to family members and friends and just the public in general.*

Another element within this theme is the spouses trying to protect the children, but alienating the veteran in the process. This happens when the spouse attempts to protect the children from the veteran's PTSD symptoms:

*What I've seen is that the spouse that's left behind when it comes to the children, they go into protection mode. I don't whether it's with he or she, but most of the veterans I work with are males. So she comes into protection mode for the children. So that's where the division come in with the children siding with the*

*parent that was there providing while the soldier was away. In cases I've seen before, it effects the children also and the spouse because the veteran feels like he's on an island by himself. He doesn't have the support because the children are sticking with mom and mom is in protection mode with her children. It effects the...children also want to protect mom also. They may side with her and that's where the veteran may feel alienated.*

### **Presentation of Symptoms in Children**

The third theme that occurred throughout all the interviews was that children tend to endorse behavioral issues outside of the home as a presentation of secondary traumatic stress. All six participants talked about how children display behavior type issues. This theme overlaps with the communication theme, as one participant's description of secondary traumatic stress in children involves communication skills:

*...adults have communication skills and they can verbalize what their feeling. They seek out therapy, they seek out friends, they seek out family members. But when you have a little kid or infant, they seem to have more disruptive behaviors. Whether it's towards mom, saying "no more," or throwing tantrums at school, being more aggressive to other kids. Those are the examples that I have seen. They just don't have the ability to communicate when they're frustrated. Especially when it comes to arguing and divorce, it just seems that the kids take that outside of the home and have more disruptive behaviors in other areas.*

Another participant added to this when asked about secondary traumatic stress in children:

*A lot of the time children are a little less involved with more complex conversations around it. So a lot of times what I see is kids are just like disengaging, feeling more distant, behavioral issues.*

Yet another participant described that children may start to have difficulties in school as behavioral issues tend to present in that setting:

*Children typically don't have as much of a voice, they can't demand that the veteran talk about what's going on and let them know those kinds of things. More typically they start to close off, shut down, start moving away, which will typically result in behavioral issues a lot of times. It's more noticeable in schoolwork, grades start dropping, maybe getting in altercations whether verbal or physical... their children start to take on a lot of the symptoms that the parents exhibit. Anger being a big one, they'll act out in school with peers.*

Another element within this theme involves how children react to PTSD symptoms exhibited by the veteran and how impactful their home environment is:

*...you see it more along the lines of behavior spikes. Which is probably due to the anxiety that they anticipate from the veteran, either not being present or being present and having re-experiencing symptoms. They become anxious anticipating that the veteran might lash out at them or the spouse. It creates a non-predictive environment which is essential for kids.*

A second participant described the impact of the home environment on the child's functioning as:

*A kid might go inwards, become quiet and not really knowing what happened, having behavior spikes at school. They're on pins and needles at home and go to*

*school where there's freedom, and they act however they want. And this won't be the same as it is at home, it'll be more acting out.*

### **Uniqueness of Each Family**

The fourth theme involved the uniqueness of all families and how each family will be impacted differently by stress. Five participants described situations in which families experienced traumatic stress and responded in ways that were unique to their circumstances: *It depends on what's going on...situation dictates.* These real life scenarios depict what it is like living with a veteran or service member who is experiencing PTSD. As one participant described, lack of communication surrounding the veteran's experience led this spouse to mirror his PTSD symptoms:

*Prior to service member coming home the spouse started experiencing nightmares, and the nightmare was actually a recurring nightmare so there was a theme to it. It was getting a phone call saying that their spouse had been gotten killed in action overseas. And then when the veteran came home, the veteran was starting to experience PTSD symptoms and was also having nightmares, and would talk in his sleep as the nightmare was going. As the nightmare was going on they would act some of it out and the spouse was taking notice...the veteran was very closed off when he was awake, so she would learn a lot about what happened or what went on...or themes of what went on while he was sleeping. She learned through that that there were two close calls with him...but she didn't know the details of what had happened. So that actually intensified her nightmares, and it also made her more hypervigilant.*

These scenarios also overlap with the Role of the Non-Veteran Parent theme. When asked to describe a family, another participant discussed a family where the veteran's PTSD symptoms were difficult for the family to deal with:

*When I started seeing him the child was maybe three months old. He's still having acts of rage in the household, never towards the partner. He would smash stuff, break stuff, smash the door or whatever off the hinges, broke the stove... Obviously with baby on board in the house, no longer is this tolerable. The tension between those two starts increasing. He keeps saying, "I'm never going to do anything or hurt anybody." Mom is saying, "you can't be throwing stuff around when there's an infant around!" ...And ultimately they ended up separating and getting a divorce. I think the catalyst for that was she was okay to handle that behavior, his anger and isolation, but there's a baby and she needed a second partner to help feed and bathe...*

Another element within this theme describes the toll that the veteran's health takes on the spouse. One participant described this scenario when asked to describe a family impacted by PTSD and secondary traumatic stress:

*...the veteran has PTSD and is also suffering from agent orange symptoms... So he's unable to walk, he's in a wheelchair, he also has a lot of anger issues as his health is declining. He's unable to use a lot of limbs. He can't sleep in the bed; he has to sleep in a chair upright. His spouse is his caregiver and she doesn't want to put him in like a hospice situation or anything like that. And in working with them, it's trying to help her realize that she can't do it all on her own. Help her work through her own anger at that, this is happening to her husband because*

*of his military service...She's got anger at the disease, the government, and then she's got the anger and frustration towards her husband because he can't help but to sometimes lash out at her because of what he's going through. And of lot of that, too, now is he wants to get a divorce because he doesn't want her to see him suffering like this. So it's a lot of processing this with them to help her understand not only the disease and PTSD, but also helping her to understand the trauma that it's causing her as well.*

### **Family and Couples Counseling**

The fifth theme that emerged from the interviews included what treatment method the participants believed to be the most beneficial for the families. Each of the six participants discussed aspects of family and couples counseling. This theme is centered around the importance of bringing the family together, and in many aspects overlaps with the Communication theme. A participant described the necessity of family and couples counseling when a veteran is experiencing PTSD:

*...giving them a sense of being a part of the process can really go a long way. A lot of times the veteran feel protective of their spouses and they don't want to tell them about the things that they've gone through...because they want to protect their spouse. When in reality the spouse doesn't want to know everything they went through, they want to know how to still feel a part of the process, a part of their lives, and a part of the recovery. You could do that without having to share the intimate details of everything the veteran has gone through. Rebuilding that connection that's been lost.*

Another participant further discussed family counseling when asked what treatment method they endorse for these families:

*Family counseling. Bring the family in. Veterans are notorious for wanting to do everything on their own, which includes counseling. They don't want to admit anything, they don't want to admit defeat, they don't want to admit there's something wrong. Being able to bring the family in is helpful to get the family's account of what's happening, but also to be able to see the strength that they have as a family or what could continue to be a strength. To know that the family is trying to help them and be there for them, sometimes they'll push that away without even knowing that.*

Another participant highlighted an additional element to this theme, that of helping the spouse feel like they are “on the same team” as the veteran:

*[The veterans] don't typically do a great job keeping the spouses involved in the treatment. A lot of times they keep them separate. I don't like that, I don't think it's helpful, I think it's hurting the relationship. I always like to have the spouse feel like they're involved and on the same team. And it doesn't mean that they have to know intimate details about the treatment itself, they just have to feel that sense of belonging.*

Yet another participant talked about the emotional information available to the spouses. They stated that couple's therapy is beneficial to exploring the both the veteran and the spouse's feelings towards their overall functioning:

*EFT, Emotionally Focused Couples Therapy. That allows them to get into the, the veteran specifically, primary emotion that they're experiencing. The spouse*

*probably doesn't have access to that information, typically. So getting that in treatment is enlighten for both partner and veteran.*

## **Discussion**

The purpose of this qualitative study was to explore secondary traumatic stress and family functioning in military families. The findings depicted the professional experiences of six mental health professionals who have worked with military families. Five themes resounded throughout the majority of interviews, including the importance of communication within the family, the role of the non-veteran parent, children, uniqueness of each family, and family and couples counseling being essential. These themes gave life to the clinical underpinnings from the literature and echoed findings from previous research studies.

### **Communication**

A major source of stress and anxiety for military families is the lack or breakdown of communication. It was stressed by five participants that communication affects multiple aspects of family relationships. The participants discussed how the lack of communication between spouses can lead to feeling less supported in the relationship and feelings of not having a voice. One participant stated that a frustrated spouse may be more likely to pursue or attempt to force the veteran to talk to them about their experiences and feelings. This can cause communication between partners to further breakdown as the veteran may feel attacked or forced relive traumatic experiences.

This theme was noteworthy as it echoed concepts presented in the literature review. Each participant's dialogue regarding communication was consistent with previous research by Baptist and colleagues (2011) that found that veterans who guard their trauma experience from their spouses create barriers for the couple to support and confide in each other. Additionally, research by Taft, Schumm, Panuzio, and Proctor (2008) found that symptoms of withdrawal and numbing were significantly correlated with a negative impacts on family functioning. This

supports the findings from the current study that the spouse often plays both a “silent role” in order to not trigger the veteran’s PTSD symptoms and a “pursuer” role in attempts to engage the veteran.

### **Role of the Non-Veteran Parent**

While the service member is deployed or away from home for extended periods of time, the spouse is often left behind to care for the children. In this theme, participants discussed the role of the non-veteran parent both when the veteran is away and when they are home. Each participant spoke to the impacts that the spouse’s role has on family functioning. One participant referred to the spouse being both mom and dad while the veteran is gone. Another spoke to how it can be difficult for the veteran to reintegrate back into their role in the family after being gone for a long period of time. Participants also spoke to the effect on parenting that this role-shift can have. A participant described this as the veteran being on an “island by himself,” or feeling alienated, when his opportunities to parent are nonexistent and his ability to parent are undermined upon return.

As mentioned in the literature review, a spouse over-extending their responsibilities in the household can lead to undermining the parenting alliance and alienate the veteran (Sherman, 2008). The findings nearly repeated the theme where participants discussed the role of the non-veteran parent in terms of taking on both parental roles while the veteran is away. Participants discussed how it can be difficult for the roles to shift once the family is set in this routine. As the spouse is trying to care for and protect the children, they may unintentionally push the veteran away and make them feel isolated. This theme also aligned with Allen and colleagues (2010), as their study found that combat-deployment was correlated with issues in marital satisfaction and parenting alliance, making this finding from the current qualitative study noteworthy.

## **Presentation of Symptoms in Children**

Throughout the interviews, the presentation of secondary traumatic stress in children was reflected on. All of the participants discussed how children tend to display behavior type symptoms outside of the home. One participant attributed these behavior issues in these children stemming from them not having the same level of communication skills as adults, as well as the amount of stress in the home environment. They may experience difficulties in school, evident by dropping grades and altercations with other students. Two participants regarded these behaviors spikes at school as being a release for the anxiety they feel in the unpredictable environment at home.

These findings are consistent with Chandra, Martin, Hawkins, and Richardson (2010) who found that the mental health of the non-veteran parent, responsibilities at home, and anxiety within the home can affect the emotional, behavioral, and academic issues for the children. Participants in the current study discussed the stress experienced by the spouse and how they tend to mediate interactions within the family, especially between the veteran and the children. This aligns with Lester and colleagues (2010) research on how stress in the non-veteran parent attributed to anxiety and externalized symptoms in the children. This finding is important because it shows that interactions and stress within the family effects each member of the that system.

## **Uniqueness of Each Family**

Participants in this study agreed that all families are unique and that everyone responds to trauma differently. Five participants gave examples of families who have experienced traumatic stress. One participant in particular stressed that circumstances and different situations dictate how each family experiences and responds these stressors. The stories told by the participants

gave life to other themes, including: a lack of communication leading to increased secondary traumatic stress symptoms in the spouse, the spouse being both parents to a child, and the overall toll that a veteran's PTSD can have on their spouse.

Bride and Figley (2009) described that levels of previous exposure to traumatic type stressors can predict increased secondary traumatic stress symptoms experienced by the spouse. This is consistent with the participants' discussion unique responses to stress for each family. This finding was further supported by research from Dekel, Solomon, and Bleich (2005) who found that individuals that have close, long-term relationships with those who have significant psychiatric disorders often led to their own development of anxiety disorders, chronic stress, and depressive symptoms.

### **Family and Couples Counseling**

When asked what they believed was the best course of treatment for families experiencing PTSD and secondary traumatic stress, a participants discussed that unshared stories and the veteran withholding information about their experiences effected multiple aspects of the relationship, including effective communication and feelings of support. All of the participants agreed that couples and family counseling is the most effective way to treat families where PTSD and secondary traumatic stress are present, as it provides a safe space for the veteran to communicate their experience with their spouse and family and builds a sense of being "on the same team."

This theme expanded on findings from Renshaw and colleagues' (2011) that found that when spouses that attribute their struggles to their husband's trauma experiences were more likely to experience secondary traumatic stress type symptoms rather than general psychological distress. Research by Meis and colleagues (2010) found that post-deployment PTSD symptoms

in the service members were significantly associated with lower relationship quality with their spouse. The current study responds to Meis and colleagues (2010) with the theme of couples counseling being necessary to help the spouse feel like they are “on the same team” as the veteran and assist in building more effective communication.

### **Strengths and Limitations**

**Strengths.** This qualitative study had two major strengths: the findings were displayed through the professional and personal lenses of the participants and it brings awareness to the military family’s experience of PTSD and secondary traumatic stress.

One major strength of this qualitative study was that the information collected was in the own words of the participants. Their work with military families has shaped their personal and professional lenses, and that provided valuable insight into what a families dealing with PTSD and secondary traumatic stress looks like. The examples that they provided gave life to concepts identified in the literature review.

Another strength of this study is that it draws awareness to PTSD, secondary traumatic stress, and family functioning within military families. As discussed in the findings, veterans tend to limit their emotions and hide their experiences from their families. Though some of the functioning behind this is to protect their family from their trauma experience, much of it is perpetuated by mental health stigma. While addressing stigma is a whole new topic, this qualitative study shows that all military families are unique in their experiences of trauma and stress and that there is hope beyond the PTSD. This qualitative study highlights the family’s experience of secondary traumatic stress and PTSD in hopes of increasing awareness for this unique population.

**Limitations.** The major limitations to this qualitative study were the lack of representation of female veteran to male spouse and same sex partnerships in both the literature and in the participant interviews, as well as limited sample size ( $n = 6$ ).

One limitation was that the majority of families discussed both in the literature review and findings consisted of male veterans and female spouses. The sample of professionals overrepresented this family type in the information they provided in their interviews. There was no mention of any other familial makeup. Additionally, very little information surrounding same sex partners was available.

An additional limitation is that the sample is not representative of all military families experiencing traumatic stressors. The sample in this qualitative study consisted of only six participants. Due to time constraints of the project, additional participants could not be located. Though the content of the interviews were rich in content, the findings could have been further supported had more participants been available.

### **Recommendations for Future Research**

A limitation to this qualitative study included the lack of representation of family types other than male veteran and female spouse. Female veterans and same sex couples were not discussed in this study due to lack of information in the literature and the extent of the participants' clinical experience. Due to this, one area in need of further exploration is that of different types of military families. A second area in need of attention are large scale exploratory, primary qualitative and quantitative research studies that relate to this topic. Research studies of a larger scope need to be executed in order to gain a richer understanding of this population. Future clinical social work practice would benefit from this additional research

to help inform practice and policy surrounding military families and help reduce barriers in the utilization of targeted mental health and community services.

### **Implications for Clinical Social Work Practice**

Findings from this study have implications for clinical social work practice. The first implication is that this qualitative study gives service providers an additional lens to inform their work with families. Each a mental health professional has the potential to provide services to a veteran and/or their family at some point in their career. For a clinician with limited experience working with this population, it may be difficult to draw connections surrounding the veteran's experience. The purpose of this study was to explore family functioning and secondary traumatic stress within military families in order to help inform practice. The second implication is that brings attention to the mental health of the often forgotten members of military families. The real life examples provided by the participants give life to the prescribed symptoms and clinical underpinnings of PTSD and secondary traumatic stress.

## **Conclusion**

This qualitative study has explored secondary traumatic stress and family functioning within military families. Six mental health professionals were identified and interviewed. The themes identified from these interviews included: strength of communication within the family can impact functioning, the non-veteran parent often takes on various aspect in the role of both parents, children often present secondary traumatic stress symptoms outside of the home, family functioning and responses to trauma are unique to each family, and family and couples counseling is an essential treatment tool for these families. Although the symptoms of PTSD and secondary traumatic stress are clinically prescribed, the experiences of traumatic stress are dependent upon the individual's perceptions and personal experiences. Each family experiences trauma differently and the modalities in which they address them can vary. Therefore, given the nature and complexity of the emotional and functional issues that these families face, it can be beneficial for clinical social workers and mental health professionals who provide services to veterans and their families be familiar with their unique experiences that effect their family functioning.

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## APPENDIX A



### Consent Form

#### [996281-1] Family Functioning and Secondary Traumatic Stress in Military Families: A Qualitative Study

You are invited to participate in a research study about family functioning and secondary traumatic stress in military families. I invite you to participate in this research. You were selected as a possible participant because you indicated interest by emailing the investigator. You are eligible to participate in this study because you are a licensed mental health professional and have current or past experience working with veterans, service members and their families. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Karlie Gams, with Kari Fletcher, MSW, Ph.D., LICSW as the research advisor, as a graduation requirement for MSW students at the University of St. Thomas and St. Catherine University. This study was approved by the Institutional Review Board at the University of St. Thomas.

#### **Background Information**

Based on research, it would be beneficial for clinical social workers and mental health clinicians who provide services to veterans and their families to be familiar with their unique experiences that effect their family functioning. The purpose of this qualitative study is to explore the effects of secondary traumatic stress and family functioning in military families. A qualitative design was necessary for this study as it aimed to examine the experiences of these families from mental health clinician's perspective. By identifying these unique challenges, clinicians may be better equipped to plan for and meet the long-term needs of these families.

#### **Procedures**

If you agree to participate in this study, I will ask you to do the following things: Participate in a semi-structured interview consisting of approximately 13 questions. The time commitment for this interview will be roughly 30-45 minutes and will take place in a private location of your choosing. The interview will be audio recorded. There will be no follow-up after the interview is completed.

#### **Risks and Benefits of Being in the Study**

The study has a risk of possible emotional distress. Though the likelihood is minimal, in order to help minimize risk the voluntary nature of this study is emphasized and eligibility requirements are enforced.

There are no direct benefits for participating in this study.

### **Compensation**

A \$10 gift card will be provided to each participant at the close of each interview regardless of participant withdrawal.

### **Privacy**

Your privacy will be protected while you participate in this study. Interviews may take place in a private location of your choosing.

### **Confidentiality**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include an audio recording of the interview and a transcript of the interview. Only myself and my research advisor, Kari Fletcher, MSW, Ph.D., LICSW, will have access to the transcripts. The audio and transcript files will be stored on my personal computer, which is password protected. All audio and transcript files will be destroyed no later than June 1<sup>st</sup>, 2020. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

### **Voluntary Nature of the Study**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with myself, Kari Fletcher, or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used. You can withdraw by stating that you no longer wish to participate. You are also free to skip any questions I may ask at any time.

### **Contacts and Questions**

My name is Karlie Gams. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me by email at [haeg3175@stthomas.edu](mailto:haeg3175@stthomas.edu). My research advisor, Kari Fletcher, MSW, Ph.D., LICSW, can be contacted at 651-962-5807 or by email at [kari.fletcher@stthomas.edu](mailto:kari.fletcher@stthomas.edu). You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or [muen0526@stthomas.edu](mailto:muen0526@stthomas.edu) with any questions or concerns.

### **Statement of Consent**

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

**You will be given a copy of this form to keep for your records.**

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**Signature of Study Participant**

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**Date**

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**Print Name of Study Participant**

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**Signature of Researcher**

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**Date**

## APPENDIX B

### Interview Questions

1. In your work, how have you engaged with service members and/or veterans who have experienced trauma and their families?
2. From your experience working with military families, how would you describe secondary traumatic stress or the impacts that military service has upon military families?
  - a) In spouses or partners?
  - b) In their children?
3. Are there "typical" or "common" scenarios you have observed where struggles experienced by service members/veterans impact the mental health of their close family members? If so, can you tell me about these?
4. Can you describe a family where you have seen secondary traumatic stress occur and how it impacted their everyday life?
5. When the impact of secondary traumatic stress is present in the family, do you see some differences you see between spouses and children in their responses to these stressors? If so, can you tell me a bit about these?
6. How do family dynamics differ in families that experience PTS than those who do not?
  - a) Could you give an example?
7. What would you describe as risk factors, such as behaviors, coping mechanisms for these families?
  - b) Skills, strengths, or protective factors?
8. What treatment methods have you seen be successful helping these military families?
9. What community resources have you seen be successful helping these military families?

10. Is there anything else that I did not ask that you think is relevant to add to our discussion?

11. Do you know any providers who have supported service members/veterans and their families experiencing PTS that would be willing to talk to me? If so, can you give me their contact info?

Thank you!

## APPENDIX C

Dear Potential Participant:

I am conducting a research study to explore secondary traumatic stress and family functioning in military families. Treatments to address PTSD have been evolved since the Vietnam War, and in recent years they have become increasingly evidenced-based. While research indicates that treatments such as Prolonged Exposure Therapy can have a considerable positive effect on veteran treatment outcomes, there has been little research on evidence-based practices that are geared towards addressing secondary trauma and military family functioning.

I am seeking volunteers to participate in a semi-structured interview to discuss military families from a mental health clinician's perspective. The results of this study will be used to identify unique experiences of these families in hopes that they may better equip clinicians to plan for and meet the long-term needs of these families. Interviews will take approximately 30-45 minutes. Participants will be compensated with a \$10 gift card.

### **Eligibility to Participate:**

Licensed Mental Health Professional

Have a current or past experience of direct practice with service members/veterans and their families

### **Ways to Participate:**

Email Karlie Gams at [haeg3175@stthomas.edu](mailto:haeg3175@stthomas.edu) with interest.

Thank you for your time and consideration. Please feel free to share this invitation with colleagues!

Principle Investigator: Karlie Gams

Research Advisor: Kari Fletcher, MSW, Ph.D., LICSW

This research is in no way affiliated with the Department of Veterans Affairs (VA).