Combat veterans diagnosed with posttraumatic stress disorder: An argument for family-centered therapy

Cherie Bogel

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COMBAT VETERANS DIAGNOSED WITH POSTTRAUMATIC STRESS DISORDER: AN ARGUMENT FOR FAMILY-CENTERED THERAPY

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Cherie Bogel and Marion Wilson
June 2000
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ABSTRACT

Treatment for veterans who suffer from PTSD has focused upon only the veteran, through involvement in cognitive-behavioral approaches in individual and group therapeutic interventions. Family systems theory would indicate that inclusion of significant others in the treatment plan would contribute to the recovery of the veteran in treatment. This study tests three hypotheses concerning family relationships, family treatment-seeking, and efficacy of treatment for veterans with PTSD. The significance of family-centered therapy for PTSD sufferers is demonstrated, using bivariate analyses. This study employs survey research conducted over the Internet as part of its data collection methodology. Implications for social work practice include an increased emphasis on family-centered approaches for PTSD treatments.
ACKNOWLEDGMENTS

We dedicate this project to all those who contributed, both personally and professionally, to bring it to fruition. First and foremost, we wish to thank the military veterans who served our country, and who were willing to share their experiences with us. Our collective experience, while having the privilege to work with veterans during our internships with the Veterans Administration, provided the impetus for this study.

We are grateful to the Sociology Department of California State University, San Bernardino, for the excellent preparation and foundation they provided us, paving the way for our success as graduate students. We are particularly indebted to Dr. Patricia Little who mentored us as undergraduates in the Sociology Department, and was our constant guide, supporter and nurturer during our graduate experience.

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when we faltered, and for so generously sharing their expertise in the field of PTSD.

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To our families, we are deeply moved by your support and the sacrifices you made in order that we might pursue our dream. Our wish, particularly for our children, is that they find inspiration and gratification in their own endeavors - the possibilities are limitless!
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ASSIGNED RESPONSIBILITIES

This was a team effort in which both authors collaborated throughout the entire project. However, for each phase of the project, each author assumed separate responsibilities. These were assigned as follows:

1. Abstract...............................Marion Wilson
2. Acknowledgements......................Marion Wilson
3. Introduction............................Marion Wilson
4. Literature Review.......................Marion Wilson
5. Data Collection..........................Cherie Bogel
   Marion Wilson
6. Data Entry..............................Cherie Bogel
7. Data Analysis.........................Cherie Bogel
   Marion Wilson
8. Methods..........................Cherie Bogel
9. Results............................Cherie Bogel
10. Discussion........................Cherie Bogel
    Marion Wilson
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INTRODUCTION

Problem Statement

The psychological effects of combat experience on war veterans has been widely documented, ever since what is now called posttraumatic stress (PTSD) was discovered in soldiers and given names like shell shock, battle fatigue, and war neurosis (Boulanger, 1985). However, research on the impact of this disorder on significant others is limited. Figley (1985) describes the effects individuals can experience as “families of catastrophe.” The costs of providing social support can manifest as “vicarious effects,” or "infecting the family with trauma (pp. 409-411).” This emphasizes and supports the idea that the treatment of a veteran suffering from PTSD should include the victim’s significant others.

PTSD is a psychological reaction to the experience of overwhelming traumatic events such as combat, assault, sexual assault, natural disasters and accidents. PTSD affects people of any age, culture, or gender. According to the DSM IV, PTSD is defined in terms of three groups of symptoms: intrusive, avoidance and arousal (APA, 1994). These symptoms can affect individuals as well as their significant others.
Intrusive symptoms are characterized by vivid daytime memories or dreams of traumatic events, which may occur suddenly and without obvious cause, to the degree that individuals may believe the trauma is reoccurring. This is typically accompanied by intense emotions, such as grief, guilt, fear or anger (Bremner et al., 1992; Fairbank, Hansen, Bremner et al., 1991). These intrusive symptoms can be frightening not only for the individual experiencing them, but also for those who witness them. They may cause family members to worry about the PTSD sufferer, or be perplexed by their behavior.

Veterans may attempt to protect themselves from reliving traumatic events by withdrawing into themselves and avoiding situations, people or events that might evoke traumatic memories. In severe cases, PTSD sufferers may feel unable to feel emotions or respond appropriately to others and the challenges of everyday life (Figley, 1985). Avoidance and numbing demoralize them and isolate them emotionally and socially. Marital problems stemming from loss of emotion and intimacy, or physical aggression, have also been associated with PTSD (Carroll et al., 1985). Family members may feel rejected by the sufferer and
frustrated at having to assume responsibilities the traumatized person can no longer meet (Figley, 1985).

Severe trauma can cause individuals to feel vulnerable and frightened. They may be anxious and feel the need to be constantly on guard and watchful. Sleep is often disturbed and restless. They may feel irritable and angry with themselves and others. This may sometimes lead to aggressive and violent behavior. Memory, concentration, and decision-making are often affected. The effect of these symptoms on the family can be severe. Anger and irritability can be one of the most difficult symptoms of PTSD for families to endure. Anxiety can cause many difficulties, especially if the sufferer avoids going to public or crowded places.

According to the DSM IV, other problems associated with PTSD are feelings of panic, extreme fear, depression, loss of interest in normal activities, and reduced motivation. PTSD sufferers also often engage in potentially harmful habits and behaviors to cope with their symptoms. Thus, they may abuse alcohol or other drugs as a form of “self-medication” in an attempt to blunt memory. Again, this can be very difficult for families to cope with.
Living with the effects of PTSD, significant others can face isolation, feelings of helplessness, low self-esteem, lack of trust and anger. According to Figley (1985),

"The family is a critical support system to human beings before, during and after stressful times and that system and its members are also affected, sometimes even more than the victim (p. 75)."

These symptoms and the effects on the PTSD sufferer and significant others are the basis for the study. Another compelling reason to offer intervention for significant others of PTSD sufferers, is that there is also considerable evidence that PTSD symptoms in the family of origin increase the risk for PTSD in the individual (Watson et al, 1996). An effective intervention may improve the quality of life of those who are suffering, as well as provide a preventive measure for transmitting dysfunctional behaviors in future generations.

Problem Focus

In an effort to reach out to Vietnam veterans who needed help but were reluctant to seek it from more traditional sources, the Veteran Administration’s Vietnam Veteran Outreach Program was established in 1979, resulting
in a nationwide network of 209 storefront Readjustment Counseling Centers. In April 1991, in response to the Persian Gulf War, Congress extended the eligibility to veterans who served during other periods of armed conflict. These include World War II, Korea, Lebanon, Grenada, Panama, the Persian Gulf, Somalia, and, eventually Yugoslavia. The majority of veterans suffering from PTSD are Vietnam veterans, although there are increasing numbers of World War II and Korean War veterans who clinicians have come to recognize have been suffering with the affliction long before it became so widely recognized.

The goal of the Vet Center Program is to provide a broad range of counseling, outreach, and referral services to eligible veterans in order to help them make a satisfying post-war readjustment to civilian life. These services include individual, group, marital and family counseling, alcohol/drug assessments, sexual trauma counseling and referral services, and community education, among others.

The Veterans Administration Medical Centers (VAMC) also provides services to veterans suffering from PTSD, although they focus primarily on psychiatric treatment, such as psychopharmacology and crisis intervention,
associated with the disorder. Although the VAMCs offer
support groups to veterans, they do not routinely offer
counseling services to significant others, as an integral
part of the veteran's treatment plan. To acknowledge that
the entire family is profoundly affected when any family
member suffers from PTSD, requires that they all receive
some form of treatment. Education is the best line of
defense against being overwhelmed, for the veteran and
significant others. Caregivers can learn to care for
themselves and the survivor to minimize the effects of
"secondary" trauma reactions such as anxiety, fears, anger,
addiction, or problems in school, work or intimacy.

Family-centered treatment could achieve reductions in
the PTSD symptoms of veterans, as well as the "sympathetic"
PTSD symptoms of their significant others. It would
provide the benefits of increased hopefulness, self-esteem,
and interpersonal skills to all those involved. The
question this study seeks to answer is whether a family-
centered approach to psychotherapy can produce a more
positive outcome for the veteran and his significant
others. By comparing the outcomes of PTSD treatment for
veterans whose significant others also sought treatment
with those of veterans whose significant others have not
been involved in treatment, this study will endeavor to establish the efficacy of a treatment strategy for veterans that involves the treatment of their significant other as well.

Literature Review

Until recently, the study of traumatic stress has focused on PTSD that afflicts those people directly affected by a traumatic event. However, there is a growing awareness that it is not only the identified patient who suffers the repercussions of PTSD (Carroll et al, 1985; Figley, 1995); Kulka, 1990; McCann & Pearlman, 1990); Rosenheck & Pramila, 1985; Rosenheck, 1986).

The earliest literature that suggests indirect or secondary traumatization were studies of children and families of survivors of the Nazi Holocaust that concluded that the psychological reverberations of traumatic experiences may even persist into the next generation (Boulanger, 1985). Rosenheck and Nathan (1985) described the impact that a Vietnam veteran with severe PTSD had on his ten-year-old son. The term “secondary traumatization” was used to describe this impact, which is similar to the transgenerational effects observed in children of survivors of the Nazi concentration camps. Symptoms included intense
involvement in the emotional life of the father; deficient
development of ego boundaries; high levels of guilt,
anxiety, and aggression; and conscious and unconscious
preoccupation with specific events that were traumatic for
the father.

The National Vietnam Veterans Readjustment Survey
(NVVRS) conducted between November 1986 and February 1988,
provided statistics that help to illustrate the magnitude
of problems related to PTSD just among Vietnam vets and
their families: 1) More than 800,000 Vietnam vets suffer
from PTSD to some extent. 2) The suicide rate for Vietnam
veterans was 33% higher than that of the general
population. 3) 40% of Vietnam veterans had been divorced
at least once, 14.1% reported high levels of marital
problems, and 23% had high levels of parental problems.
4) Almost half of male Vietnam veterans had been arrested
or in jail at least once, and 11.5% had been convicted of a
felony. 5) Unemployment of veterans was twice the national
average (Kulka, 1990).

More recently, several studies confirm that
individuals who provide therapy to victims of PTSD often
are at risk for developing similar stress-related symptoms
(Stamm, G. Hudnall, 1995). "Vicarious traumatization"
(McCann and Pearlman, 1990) is defined as "a process of change resulting from empathic engagement with trauma survivors." According to Pearlman (1995), it can have an impact on the helper's sense of self, worldview, spirituality, affect tolerance, and interpersonal relationships.

Figley (1995), coined the term "compassion fatigue" to describe the effects on those individuals who provide therapy to victims of PTSD and who themselves often become victim to secondary traumatic stress disorder.

Further, descriptions of what constitutes a traumatic event in the DSM IV, clearly suggest that simply the knowledge that a loved one has been exposed to a traumatic event can be traumatizing (APA, 1994). Given that significant others are constantly exposed to the veteran's PTSD, the author argues that they are at particular risk for either vicarious traumatization or compassion fatigue, which may manifest as "sympathetic" PTSD symptoms.

Vicarious traumatization or "sympathetic" symptoms are more apt terms in the context of significant others than the compassion fatigue experienced by caregivers. Professional caregivers play different roles, form different relationships with the veteran, and have
different levels of training and expertise. Significant others, who lack the expertise, are more likely to experience sympathetic symptoms by virtue of the nature of their mutual relationship with the veteran. Significant others may react with compassion and understanding, but they are just as likely to experience blaming, anger or wishing the veteran would just get over his trauma, which are also sympathetic responses to a highly stressful situation.

There are numerous accounts by combat veterans about the personal aftermath of war, but there is scant literature on the perspectives of significant others who have endured years of living with someone suffering PTSD. Matsakis (1996) and Mason (1995) chronicle the experiences of Vietnam wives and give hope to those who may have lost belief in their sense of being competent, functional and effective support for their spouses and themselves. These authors provide anecdotal evidence in the form of personal accounts, but little formal research exists on systematic treatment interventions for both the veterans and veteran’s significant others.

Group therapy has been widely used in the treatment of veterans with PTSD. Group treatment has been proposed as
effective in enhancing self-esteem and hopefulness, reducing mistrust, improving interpersonal skills, and reducing social isolation (Herman, 1992; Solomon, 1992).

In an important study, Resick et al. (1989) found that group therapy using a cognitive processing model resulted in significant improvement in both PTSD and depressive symptoms as compared to wait-list control groups. Though the subjects of this study consisted of adult rape victims, their study demonstrated that group treatment may be effective in reducing core PTSD symptoms as well as problems with self-esteem and interpersonal relationships. Empirical inquiry into treatment outcome of group therapy with significant others of PTSD, and the potential benefits to veterans of such an intervention, is limited.

The cognitive behavioral approach, currently the most favored, involves learning skills for coping with negative thoughts through cognitive restructuring, managing anger, preparing for stress reactions, handling future trauma symptoms and urges to use alcohol or drugs, communicating and relating effectively with people (Resick et al., 1989; Wolf and Mosnaim, 1990). Assuming that PTSD affects the entire family system, the victim and significant others might benefit from receiving the same education and
intervention. Realizing that the PTSD sufferer is affected by the significant others in his/her family group, adds to the imperative of treating the significant others as part of the veteran's PTSD treatment.

Combat trauma can reverberate through family systems at any stage of the family life cycle (Scaturo and Hayman, 1992). As time passes, both the PTSD and the coping attempts often become entrenched in the family system (Figley & Sprenkle, 1978). Family consequences that arise from living with a veteran suffering from PTSD can include: emotional emptiness due to the veteran's learned numbing response to stress; loss of the parent or spouse from tasks and routines of family life, often due to the veteran's withdrawal or fear of getting close; and, the emergence of family patterns, such as distance or violence (which was necessary for survival), that increase distress and impede resolution (Rosenheck & Thompson, 1986). While emotional emptiness is typically considered an individual symptom, in the case of veterans' families, this individual symptom can be exhibited system wide (Figley & Sprenkle, 1978; Scaturo & Hayman, 1992; Rosenheck & Thompson, 1986).

Rosenheck and Thompson (1986) state that a veteran's preoccupations with combat experiences permeate and impair
family life, demonstrated by lower levels of cohesion, flexibility, and communication. The cumulative effect of this dysfunctional family environment would be to increase the veteran's isolation, decreasing both marital and parental satisfaction.

However, numerous studies have found that while the intensity of combat exposure has the greatest direct effect on the development of psychological pathology, perceived social support can mitigate some of its effects (Figley & Sprenkle, 1978; Shehan, 1987; Solomon, Waysman & Mikulincer, 1990).

The pervasiveness of hardships that are often experienced by all members of a family system, and the fact that social support appears to be key in reducing the veteran's PTSD symptoms, is the best argument for a family-centered approach. Wives/partners often bear primary responsibility for parenting and the emotional and financial support of the family (Figley, 1978). If the identified patient, the veteran with PTSD, is treated in isolation, he may never come to realize the extent to which his wife/partner has had to shoulder unaccustomed, different roles, and suffer his wrath, anger and frustrations. On the other hand, it can also provide an
opportunity for the veteran to express his appreciation for the support he received during the peripheral involvement in the family. A desirable outcome would be a rebalance of power and responsibilities between the partners. Work with the family involves addressing the needs of the spouse and children in addition to the veteran’s needs.

This research represents an attempt to study the relationship between PTSD, treatment sought by veterans and/or their spouses or partner, and self-reported satisfaction with relationship and treatment outcomes.

The authors formulated three hypotheses concerning the impact of PTSD on veterans and their spouse’s/partner’s treatment-seeking patterns and relationship satisfaction.

Hypothesis 1: Veterans whose family members seek treatment are more satisfied with their relationships.

Hypothesis 2: Veterans who are satisfied with their relationships, are more satisfied with their own treatment.

Hypothesis 3: Veterans whose family members also seek treatment are more satisfied with their own treatment.
RESEARCH DESIGN AND METHODS

Purpose of the Study

The purpose of the proposed study was to survey combat veteran's diagnosed with PTSD to discover: 1) psychological counseling services sought by veterans for the treatment of PTSD; 2) whether spouses/partners engaged in counseling; and, 3) self-reported satisfaction with marital or long-term relationship and treatment outcomes.

This project, though quantitative, used the post-positivist research paradigm, incorporating a comparison of two groups: military veterans who are clients of the Riverside Vet Center, and, combat veterans who responded to an Internet survey. This study points to trends and future research needs, and recognizes the influence of factors not measured in this study.

Sample

The sample was derived from two sources. The first was a survey distributed to combat veterans receiving treatment at the Riverside Vet Center, in Riverside, California; the second source was the same survey, posted on the Internet.

Requirements for participation included: 1) a minimum age of 18 years old; 2) respondent must be a combat veteran
diagnosed with PTSD; 3) respondent must be married or cohabiting; 4) willingness to participate in a study, disclosing sensitive information about PTSD diagnosis and treatment.

Instrumentation

A 37-item self-report questionnaire was utilized to obtain background characteristics of the participants (Appendix A). The questions focused on personal data, military service history, presence of PTSD specifically related to deployment and experience in combat, PTSD treatment history, partner/spouse’s psychological counseling history, and self-report relationship and treatment satisfaction. The instrument was created for this study based on concepts derived from the researchers’ collected professional and personal experiences, as well as existing literature.

The multiple-choice questions required a nominal or ordinal response for the independent variables. The self-report on the dependent variable of relationship and treatment satisfaction were indicated on a five-point Likert Scale format, asking participants to reflect on the degree of satisfaction in both of those areas.
Procedures

This study was conducted in two separate milieus, utilizing the 37-item questionnaire (Appendix A). Team Leader Thomas Hawkins of the Riverside Vet Center, distributed fifty questionnaires and observed the veterans completing the survey. Of the 50 surveys, 21 were returned to the researchers.

The second group was recruited via an email to various websites visited by veterans, requesting their participation in the survey (Appendix D). The websites targeted were those of veterans service organizations, and support groups (Appendix F) including: Disabled Veterans of America (DVA), Korean War Web Sites, Military Order of the Purple Heart, Military Woman, Persian Gulf Veterans' Foundation (PGF), Veterans of Foreign Wars (VFW), and Vietnam Veterans of America (VVA), among others.

A web page was constructed, in collaboration with a representative of the commercial programmer Worldsurvey, designed to implement the survey and for the purpose of gathering data gleaned from the survey questionnaire. The email to the veteran websites, directed them to access the questionnaire at the hosted home page.
The incoming responses were then automatically downloaded into a processed template for the creation of a data file. Specifically, survey responses were formulated into a set of string variables that Worldsurvey forwarded to the researchers, who in turn imported the data into Excel, a spreadsheet program with the capacity to do statistical analysis. Once the data file was created, and the variables defined, the calculations were done in the SPSS program for Windows, to be congruent with the Vet Center group, and in compliance with the research standards set forth for the project. The investigators did all of the data collection, coding, cleaning and construction of the data storage and retrieval system. The data gathering process lasted approximately one month; until such time that an adequate sample had been achieved.

Protection of Human Subjects

Subjects were advised that the study was conducted as a university research project, and they were informed of the purpose of the study. This included the identification of researchers and potential recipients of data.

Researchers provided a description of the study, including: procedures, approximate time to complete the survey, and statement of emotionally sensitive material
contained in survey (Appendix E). Participants' confidentiality was assured and protected in adherence to existing ethics and principles by obtaining informed consent (Appendix F). Numbers rather than names identified the respondents, and only the researchers had access to the responses. A debriefing statement cautioned the subject about the sensitivity of the information elicited and the right to discontinue the survey if it causes distress. Participants were provided with follow-up resources that are available, if required (Appendix G).
RESULTS

Description of Sample

Most of the 49 veterans who responded to the survey are males (87.5%) between the ages of 50 and 54 (61.2%) or 55-59 (20.4%). The majority of respondents (72.1%) are white, with 16.6% African American, 14.0% Latino, and 2.3% Asian American. Most of the respondents (66.7%) are married, while 14.6% are single, 16.7% are divorced and 2.1% are widowed.

Only 26.5% of the respondents have four-year college degrees or higher. Thirty-five percent of the sample is employed, while 7% are unemployed, 32.6% are on disability, and 20.9% are retired.

Nearly half (47.7%) of the respondents had served in the Marines, while 34.1% served in the Army, 9.1% in the Air Force, and 9.1% in the Navy. None of the veterans were currently on active duty, and all of them had received honorable discharges.

Fifty-one percent of respondents reported being wounded, while only 2 (4.1%) had been victims of sexual harassment or assault (both of them men). All of the respondents but one indicated that they were veterans of the Vietnam era, who had been in combat. Eighty-six
percent of respondents had received medals or commendations, and 75.6% had service-connected disability. While all of the veterans responding to the survey have been diagnosed with PTSD, only 47.7% are receiving disability for this condition. Most of the respondents (75%) had sought treatment at a Veterans Administration facility.

A univariate analysis, using frequency distributions, demonstrated how each independent variable contributes to treatment and marital/relationship satisfaction outcomes.

Comparison of Two Data Sets

Since veterans had access to the survey through two different sources, the Vet Center and the Internet, it was important to determine if there were significant differences between the two groups and what the nature of these differences might be. Independent samples T-Tests were run on all of the variables, with the groups divided into Vet Center veterans and Internet veterans. Significant differences were reported on the following variables: education (.000); marital status (.008); ethnicity (.041); branch of service (.000); wounded (.003); VA treatment (.000); and satisfaction with treatment (.024).
Crosstabulations were then run on each of these variables with the variable “Respondent from Vet Center?” as the other variable. In this way, the nature of the differences between the groups could be ascertained. The Chi-Squares and their levels of significance were also examined.

Veterans from the Internet group were more likely to have college degrees at the B.A. level and above. Forty-five and a half percent of the Internet respondents had four year degrees or higher, whereas only 14.3% of the Vet Center group had this level of education. The Chi-Square was significant at the .043 confidence level.

Respondents from the Internet sample were more likely to be single, but the Chi-square was not significant (.070). However, there were five respondents from this group whose survey responses were questionable; therefore we believe that the groups were actually comparable on this variable.

Internet survey respondents were more likely to be white (87%) compared to the veterans from the Vet Center, 55% of whom were white. The Chi-Square was significant (.048).
Marines were more represented among the Internet respondents than they were among those from the Vet Center (Chi-square significant at .002). In addition, respondents from the Internet group were more likely to have been wounded than were the Vet Center respondents (Chi-square significant at .004). We believe that this difference may be attributable to the number of veterans who responded to the invitation to participate in the study from the Khe Sanh Veteran's Association website (see Other Findings).

All of the veterans who responded from the Vet Center were currently in treatment at the VA facility, whereas only 52% of the Internet respondents had sought treatment at a VA facility (Chi-square significant at .000). Vet Center respondents were also more than twice as likely to be satisfied with their treatment than were Internet respondents (Chi-square significant at .002).

Relationship Satisfaction

Analyses of bivariate relationships were run, with "Satisfaction with Relationship After Treatment" as the variable. One interesting finding was that "Satisfaction with Relationship Before Treatment" was not significantly correlated with "Satisfaction with Relationship After Treatment." On the other hand, "Satisfaction with
Relationship After Treatment" is strongly correlated (.025 significance) with "Satisfaction with Joint Treatment."

One assumption about seeking joint treatment for relationship issues might be that people who are more highly educated are more likely to seek such treatment. This might be due to an increased awareness of the availability of such services, and perhaps a lower level of stigma associated with seeking such treatment. An independent samples T-Test was run on the three relationship variables, "Satisfaction with Relationship Before Treatment," "Satisfaction with Joint Treatment," and "Satisfaction with Relationship After Treatment." Their education levels, high school degree or less, and some college or more divided the two groups. The more educated group was more likely to respond to these questions, meaning that they were more likely to seek treatment.

Independent samples T-tests were also performed on the three relationship variables using employment status and PTSD disability as factors. We assumed that being employed, and therefore conforming to society's expectations for men to be providers, might enhance the psychological well-being of the employed veterans compared with those who were unemployed, on disability, or retired.
Increased psychological well-being might enhance relationship satisfactions; however, we found no significant differences between veterans who were employed and those who were not. In the same manner, we supposed that the increased economic stability receiving the higher levels of disability payments, associated with PTSD diagnosis, might result in enhanced relationship satisfaction; however, we found no significant differences between veterans who received disability payments for PTSD and those who do not, in their satisfaction with their relationships.

The most important correlations with "Satisfaction with Relationship After Treatment" were "Satisfaction with Joint Treatment." Therefore, we ran an analysis of variance (ANOVA) to test the strength of this relationship. The analysis of variance was significant at the .004 level, indicating that joint treatment is an important predictor of veterans' satisfaction with their relationships (Diagram 1).

Satisfaction with Treatment

Since "Satisfaction with Treatment" is an interval variable, we ran analysis of variances (ANOVAs) with the various nominal level independent variables that we felt
might be predictors. These included marital status, occupation, employment status, education, ethnicity, if the vet had sought treatment at a VA facility, if the vet had sought treatment at a private facility, and whether or not their partner had sought treatment. Of these analyses of variance, only two variables showed significance: occupation (0.016), and whether or not their partner had sought treatment (0.019). We then ran cross tabulations between "Has Partner Sought Treatment" and "Satisfaction with Treatment," and found that veterans whose partners had sought treatment were indeed more likely to be satisfied with their own treatment (58.3%) than those whose partners had not sought treatment (50%). The Chi-square for this cross tabulation was significant (0.024), but this small sample size would cause this to not be as conclusive as a larger sample would be. A correlation run between these two variables did not show significance, but the relationship between them runs in the direction that would support our hypothesis that a partner seeking treatment would have a positive effect upon the veteran's satisfaction with their own treatment. (See Diagram 3).
Other Findings

An unexpected result of posting the survey on the Internet was the number of veterans who sent email messages to the researchers. A common theme in these messages was pervasive mistrust amongst veterans of non-veterans and the government. Many voiced suspicion and a reluctance to answer the survey until they felt surer of the motives of the researchers. A total of ten veterans corresponded with the researchers by email.

Their comments were coded into two types: comments directed at the researchers and the immediate project, and comments regarding experiences with the Veterans Administration in general. All ten respondents directed comments toward the researchers. Of these, three were positive, five were neutral and/or suspicious, and two were negative. Three of these responses included remarks concerning the Veterans Administration; all of these were negative.

Portions of these email exchanges are recorded here to give the reader a more complete understanding of the context from which these veterans responded.

Positive to researchers / negative to the VA:
"Cherie and Marion: Please allow me to apologize if some of my brethren "dumped" on you. They've been lied to and abused so much they are an extremely bitter and disillusioned bunch. I don't blame them for being bitter and disillusioned, I do blame them for not focusing their anger.... My best to you and yours. Good luck in your endeavors. I for one know the value of your work, it has kept me sane and alive. God bless you and yours. (signed)"

Positive to researchers:

"Ladies: Well, I have not been diagnosed as or with PTSD. I stayed in the Military both as active and reserve. Retired in 1992 as a Major after 27 total years in the Marines and USAR...There are still certain sights, smells, sounds, and series of certain events that still cause me to “flashback” or that good old “fight flight” condition to arise. All in all I think I have done quite well... Raised a family and had a long carrer (sic) in law enforcement. However, there still (sic) many who for what ever the reason have never come home mentally from the conflicts” large or small. I hope and pray that your work can solve this riddle and bring even some little relief to these tortured souls. Semper Fi, (signed)"

Negative to the VA:

"My medical records were destroyed during the siege at Khe Sanh. I suffer (sic) chronic head pain for the last 20 years (sic) I am taking antidepressants and stress meds from a local doctor. The VA will not treat me for anything because there is nothing in my medical records about Vietnam. Catch-22 there is a 13-month gap. When I went to the VA 20 years ago about head pain I was told by a doctor that Vietnam, Vets crybaby’s. (sic). I refuse to go to a veterans facility after that."

At this point, the ethics of social work required that the researchers respond to this veteran as social workers,
not as researchers. In fact, each of the ten veterans who wrote to us received a personal reply from us. The reply to this veteran is recorded below:

"Hi Donald (pseudonym) - Thank you for taking the time to respond to our request to participate in the PTSD Research Study in such a personal way. I really didn't anticipate that people would take the time to respond in narrative form - it is much more interesting and satisfying, and gives a human voice to what must seem to some a cold, fact-finding mission. I was disturbed to hear of the bad treatment you received at the VA 20 year ago. I know that those of you who were at Khe Sanh had a particularly dramatic experience, which has dogged you in varying degrees. Although I understand your reluctance to venture into the VA again, a lot has changed in 20 years. For one thing, there have been extensive studies done on combat-related PTSD, particularly in Vietnam veterans, which have dispelled the notion that Vietnam vets are "crybabies." It is widely recognized that PTSD is a legitimate complaint, with many variations, and that Vietnam was in many respects a unique combat experience. I recently completed a one-year internship as a Readjustment Counselor at the Riverside Vet Center in Riverside, CA, where I had the privilege of working with veterans from all backgrounds and branches of service, struggling with the aftermath of combat. Some of these veterans also had difficulty in obtaining records because many were lost from the Personnel Records archives in a fire. In those cases, the burden of proof now lies with the government to prove that a veteran did not serve at the time and place they claim to have served. It sounds as though you have managed to get medical attention in the private sector. The advantage of seeking treatment in a VA facility is that you will encounter others with similar problems and concerns. I could not determine where you live, but I would urge you to call your local Vet Center to enquire about support groups and individual counseling if you feel you could benefit. They will also assist you in filling a claim for any disability you may be
experiencing. I hope that you won’t write the whole system off - there are those of us who genuinely care about veterans and their well-being. If you need assistance finding the Vet Center nearest you, please let me know. Thank you again for speaking up. All the best.
Marion Wilson"

Neutral/suspicious to researchers:

“Just how did you get my name and why did you connect me with PTSD?”

“...I’d like to know a little more about you and the study to safeguard myself etc., before I go spilling my guts out overt (sic) the Internet etc...If I agree to your study, I’d want a copy of it for my “doc”... If I (sic) convinced that you’re bona fide, then I have other names that might be of interest to you...Finally, how’d you get my e-mail address?”

Negative to researchers:

“I request that you immediately strike my e-mail name from your list. I do not like this request and question the motives of such a study.”

“This is the worst survey methodology I have encountered. You already know what answers you are seeking. You should be ashamed of this sloppy work. This is an insult to the veteran’s who served in combat.... The answers you get will be BS and you can use them as you want you (sic) are just another blood sucking leach (sic) who obtained the e-mail address (Khe Sanh Veteran’s Association) and are not entitled to the simplest courtesy.”

The context of suspicion and bitterness is relevant to an understanding of the energy it took for the veterans to respond to the survey. Not only were their responses a
gift to this study, it should be recognized that the respondents participated in the hope that their participation would help their fellow veterans.
DISCUSSION

Concepts / Constructs

Initially the researchers included all of the standard demographic measures such as age, gender, race, class and marital status, because we expected differences in the dependent variables attributable to these characteristics. However, we found that our sample was fairly homogeneous across the independent variables. Therefore, our analysis focuses upon only those characteristics that vary significantly in the sample.

The two concepts, or dependent variables, most important to this analysis, had to do with the veterans' marital satisfaction after receiving joint treatment, and their satisfaction with their own treatment. These were operationalized by two specific questions that asked respondents to rate their levels of satisfaction on each of these issues.

A veteran's satisfaction with his marital relationship is an important contributor to satisfaction with his own treatment, as reported in our results. This supports the literature on family-centered therapy that suggests that identified patients who seek treatment in isolation, do not fare as well as those whose families are involved in the
process. The rationale is that problems tend to permeate whole systems, and patients' distress is often a symptom of a dysfunctional system. Family-centered therapy can help family members understand their individual and collective contributions to the lack of homeostasis, and what they can do to restore it. While this study only addressed the effects of partners' treatment upon veterans' satisfaction with their own treatment, we can infer from our results that treating the whole family would be beneficial.

Satisfaction with treatment is the question we used to operationalize the concept of treatment efficacy. The limitation of this measure is that it is self-reported. However, we would argue that the veterans themselves are in the best position to evaluate whether or not the treatment was helpful. Our results, while not conclusive due to the small sample size, do indicate that there is a significant relationship between the partner receiving treatment, and the veterans' satisfaction with their own treatment.

In general, although our hypotheses were not always confirmed conclusively, much of the ambiguity can be attributed to our small sample size. The general trend in each of the relationships between variables pertinent to our hypotheses does support our predictions.
Our first hypothesis that veterans whose family members seek treatment are more satisfied with their relationships, was confirmed by running a correlation with the variables, “satisfaction with relationship after treatment” and “has partner sought treatment.” None of the respondents who answered “yes” to “has partner sought treatment,” indicated that they were dissatisfied with their relationships. The limitation to this confirmation is that none of the respondents who answered “no” to “has partner sought treatment,” responded to the question concerning their satisfaction with their relationship after treatment (Diagram 1).

Diagram 1
The second hypothesis, that veterans who are satisfied with their relationships, are more satisfied with their own treatment, was partially confirmed through a correlation between these two variables. While the significance of the correlation was .097, the direction of the relationship, illustrated by the scatter plot below (Diagram 2), indicates the tendency of a positive relationship to enhance treatment satisfaction.

![Diagram 2](image)

Finally, the third hypothesis, that veterans whose family members also seek treatment are more satisfied with their own treatment, provides the most robust evidence for the assertion that family-centered therapy is a viable, efficacious treatment strategy for veterans diagnosed with
PTSD. This relationship is demonstrated by a box-plot, which illustrates the correlation between these two variables (Diagram 3).

![Diagram 3]

Limitations of the Study

The limitations or inherent biases of this study include: 1) self-selection of subjects; 2) the ability to recruit a large enough sample in the time allotted; 3) reliance on data from self-report measure; 4) issue of class, namely exclusion of veterans without access to computers; 6) gender bias, because the majority of veterans are male; 7) race bias; 8) age bias due to less familiarity
with new technology by older veterans; 9) exclusion of veterans diagnosed with PTSD for any other than combat-related trauma; and, 10) reliance on cross-sectional data instead of longitudinal data. Because no control group is available, the results of this study can only be preliminary.

There were limitations relevant to the differences between the two types of data, Vet Center and Internet. The researchers found that the pen-and-paper format was more reliable, but there was an obvious bias inherent to this group, in that they were all in treatment at the Vet Center when they participated in the study.

The Internet group was a more heterogeneous population than the Vet Center, as evidenced on some variables. However, the Internet also had problems with bias, as well as accuracy problems. Internet respondents were more educated and predominantly white, reflecting a higher SES bias. Veterans in this higher category are more likely to have access to the Internet and computers. The accuracy problems were a result of responses to questions that had to be coded as "missing." The Vet Center surveys did not have this problem.
On the other hand, the combined sample overall is too homogeneous to evaluate the effectiveness of family-centered therapy on different groups in relation to age, race, gender and other cultural factors. Therefore, the results cannot be generalized. Another deterrent to generalization was the lack of respondents who are veterans of different eras. World War II, Korea, Vietnam and Desert Storm veterans had very different experiences and cohort effects (Rosenheck & Nathan, 1985; Rosenheck, 1986). There are also differential ethnic responses to war. Although white veterans have not suffered the effects of war any less, readjustment needs of the American minority veteran are compounded by the traditional ethnic minority problems of other stresses produced by prejudice in our society (Penk & Allen, 1991).

**Implications of Internet Survey Research**

There are inherent problems and pitfalls of conducting Internet surveys, primarily because it is a relatively new methodology. First, we must examine the universe they represent. It is estimated that 25 to 40 percent of U.S. homes use home computers. However, approximately only 5 to 6 percent of the population have a modem attached or have access to Internet service (McGuire and Ashford, 2000).
Therefore, the profile of a computer user is of someone who typically has a high income, is highly educated and technologically savvy. It is doubtful that this small group of Internet users represents the American population at large.

There were also technical challenges that the researchers encountered in their attempts to include veterans of all eras. Although we made a concerted effort to target groups representative of all the services and periods of combat (Appendix), there was no way to determine whether the webmasters of these sites had posted the request for participants in time for them to respond within the one month that the survey was posted on the home page. For example, in this study the majority of respondents were Vietnam veterans, which would suggest that only Vietnam veteran sites were accessed. On the other hand, this might also mean that Vietnam veterans are more proactive around these issues. We can only surmise, because there is no way to determine which website the respondents accessed and responded to.

Internet surveys also contain another fatal flaw. In most surveys of this type, there is no control over people answering more than once, or purposely-omitting data, to
skew the results of a survey they are interested in or opposed to. For example, there were five respondents who either did not understand the technology or chose not to answer the majority of questions, obfuscating the results.

**Implications for Future Study**

While this study has demonstrated that family-centered therapy may, in fact, have a positive effect on treatment outcomes for veterans diagnosed with PTSD, these results cannot be called "conclusive" due to the small number of respondents in the sample whose family members had sought treatment. A more powerful study could be constructed if a PTSD support and education group for family members were used as the basis of the sample.

Veterans whose family members were in treatment could be given pre- and post-tests that would measure their satisfaction with their relationships and with their own treatment. In addition, a control group of veterans whose family members were not in treatment could be given the same pre- and post-tests. In this way, a larger number of veterans whose family members had sought treatment could be compared to veterans who received only individual treatment, and more conclusive evidence supporting family-centered therapy could be obtained.
One of the obstacles to conducting a study, however, is the pervasive mistrust amongst veterans of non-veterans and the government. This might deter veterans from participating in a survey, which they may believe could be used for other purposes than those specified.
CONCLUSION

As researchers, we certainly experienced some of the problems and pitfalls on Internet survey methodologies. In spite of these shortcomings, we persevered in order to demystify the process, and to hopefully encourage others to venture out into this new vista. Today, as is often true with the introduction of new technologies, objections arise when a paradigm shift appears on the horizon. Researchers need to embrace the capabilities of the Internet rather than dismiss its significance. As the sheer number of users increase, the ability to conduct statistically accurate surveys becomes reality. As the outreach of the Internet expands, recruiting methods will become much easier and the profiles of respondents will more closely resemble all segments of the population (Maguire & Ashford, 2000).

An examination of the vast amounts of literature on the impact of PTSD attests to the growing concern for understanding in this area of human behavior and personality development. Although our awareness has increased in the past two decades, it also is apparent that we still have much work to do in the area of a family-centered approach to make our research, assessment and
treatment more comprehensive. Showing that having a significant other in treatment improves the condition of the veteran, may help the Veterans Administration to justify the treatment of significant others as a long-term treatment strategy for the veterans. As this occurs, we may move further toward a goal of early intervention and ultimately to one of minimizing the effects of PTSD on the veteran and his family.
APPENDIX A: Survey Questionnaire

PLEASE NOTE: IF YOU HAVE PREVIOUSLY COMPLETED THIS SURVEY, EVEN AT A DIFFERENT WEB SITE, PLEASE DO NOT RESPOND TO THIS ONE. THANK YOU FOR YOUR PREVIOUS SUPPORT.

Personal Data

1. Age:

2. Sex: Male Female

3. Years of Education:
   a) some high school
   b) high school graduate
   c) some college
   d) two year degree
   e) four year degree
   f) Post Graduate

4. Marital Status:
   a) single
   b) married
   c) living with partner
   d) divorced
   e) separated
   f) widowed
   g) never married

5. How many marriages?

6. Ethnicity:
   a) Asian American
   b) Black/African American
   c) Hispanic/Latino
   d) Native American/Alaskan American
   e) Pacific Islander
   f) White

7. Employment Status:
   a) employed
   b) unemployed
   c) disability
   d) retired

8. Occupation:
   a) professional, technical and managerial
   b) clerical/sales
   c) service
   d) agriculture, fishery, forestry, or related
   e) factory
   f) machine trades
   h) other

Military Information

9. Branch of Service:
   a) US Army
   b) US Air Force
   c) US Navy
   d) US Marine Corps
10. Currently on Active Duty?  

11. Periods of Service:
   a) Vietnam Theater
   b) Vietnam Era (non-theater)
   c) Persian Gulf
   d) Lebanon
   e) Granada
   f) Panama
   g) Korean War Zone
   h) World War II War Zone
   i) Somalia
   j) Other

12. Did you serve in a combat zone?  

13. If so, which of the following?
   a) Vietnam
   b) Lebanon
   c) Granada
   d) Panama
   e) Persian Gulf
   f) Korean War Zone
   g) World War II War Zone
   h) Somalia
   i) Other

14. Type of Military Discharge:
   a) Honorable (HD)
   b) General Discharge under Honorable Conditions (GD)
   c) Undesirable Discharge Under Other Than Honorable (UD)
   d) Bad Conduct (BD)
   e) Dishonorable Discharge (DD) or Dismissal (Officers)

15. Wounded?  

16. Prisoner of War?  

17. If yes,
   a) less than 30 days
   b) more than 30 days

18. Were you a victim of sexual harassment/assault while on combat duty?  

19. Medals and Commendations:  

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20. If yes,
   a) Purple Heart
   b) Purple Heart (more than one)
   c) Combat Action Ribbon
   d) Combat Infantry Badge
   e) Bronze Star
   f) Silver Star

21. Service-Connected Disability?  Yes  No

22. If yes, what percentage?  _____%

23. Do you receive disability compensation for service connected PTSD?  Yes  No

24. Have you sought treatment for PTSD at a VA facility?  Yes  No

25. If yes, where?
   a) Medical Center (VAMC)
   b) Outpatient Clinic (VA OPC)
   c) Vet Center

26. Have you sought treatment for PTSD in the private sector?  Yes  No

27. If yes, where?
   a) Psychiatrist
   b) Psychologist/Therapist or Counselor
   c) Family Doctor
   d) Pastoral Counseling

28. How would you rate your satisfaction of treatment?
   a) very satisfied
   b) satisfied
   c) neither satisfied nor dissatisfied
   d) dissatisfied
   e) very dissatisfied

29. Have you previously been in a long-term (one year duration or longer) relationship?  Yes  No

30. To your knowledge has your spouse or partner ever sought psychological treatment or counseling?  Yes  No

If no, you are finished. Thank you for your time.
If yes, please go on to next question.
31. If so, when did he/she seek treatment in relation to your combat experience?
   a) Before my combat experience
   b) After my combat experience
   c) Both before and after my combat experience

32. Type of treatment you spouse or partner received:
   a) Individual therapy
   b) Marital therapy
   c) Family therapy
   d) Group therapy

33. Did you and your spouse/partner seek treatment together in connection with your PTSD diagnosis?
   Yes
   No

34. If so, where was this treatment obtained?
   a) Medical Center (VAMC)
   b) Outpatient Clinic (VA OPC)
   c) Vet Center
   d) Private Sector

35. How would you rate your relationship satisfaction with your spouse/partner prior to treatment?
   a) very satisfied
   b) satisfied
   c) neither satisfied nor dissatisfied
   d) dissatisfied
   e) very dissatisfied

36. If you and your spouse/partner sought treatment together in connection with your PTSD, how would you rate the satisfaction of this treatment?
   a) very satisfied
   b) satisfied
   c) neither satisfied nor dissatisfied
   d) dissatisfied
   e) very dissatisfied

37. How would you rate your relationship satisfaction after treatment?
   a) very satisfied
   b) satisfied
   c) neither satisfied nor dissatisfied
   d) dissatisfied
   e) very dissatisfied
APPENDIX B: Request for Participation to Websites

A> To be posted on websites of Veterans Organizations and Support Groups

Dear Colleague:

We are conducting a study intended to suggest improved approaches to helping veterans combat Posttraumatic Stress Disorder, PTSD. And we are asking veteran related organizations like yours for help by obtaining respondents for our survey at:

http://www.worldsurvey.org/military_veterans_survey.htm

Please be good enough to inform qualified individuals whom you service or know, about the importance of this study and encourage them to respond. The note below explains the project.

If it be more convenient, you can print out the survey and mail completed hard copies to:

Marion Wilson, RRRRR, TTTTT, HHHHH Ca.

Thank you so much for your kind attention.

Cherie Bogel and Marion Wilson
APPENDIX C: List of Websites

Air Force Veterans - 13th AF of WWII
http://www.13afvets.org

California, Veterans of Foreign Wars
http://www.vfwca.org

Chinese American Veterans of WWII
http://www.weservedwithpride.com/dayofrec.htm

Desert Storm Vet Center
http://members.aol.com/dstormmom/vetcenter/index.htm

Disabled American Veterans
http://www.dav.org

HOT Links To Airborne Sites 201-300 (featuring the Dropzone Skyhook 5 parafoils)
http://www.dropsonepress.com/hoturl3.htm

Military Order of the Purple Heart Home Page
http://www.purpleheart.org

Military Woman
http://www.militarywoman.org/homepage.htm

Military Women Resource Guide
http://members.aol.com/veterans/warlib66.htm

Persian Gulf War Veteran’s Information & Referral Center
http://www.idir.net/~krogers

PTSD 101 (by Patience Mason)
http://espsun.space.swri.edu/patience/index.htm

Second Infantry Division in World War Two
http://home.worldnet.fr/~nguiffan

Veterans of Foreign Wars
http://www.vfw.org/home.shtml

Vietnam Veterans Home Page
http://vietvet.org

WWII and Aviation Links Page
http://www.geocities.com/CapeCanaveral/1393/ww2avi.html

World War II Veterans (1st Czechoslovakian Tank Brigade)
http://home.euneet.cz/kamm
APPENDIX D: Letter to Veterans

Dear Veteran,

You are kindly requested to participate in a study conducted for a Masters in Social Work thesis at the Department of Social Work at California State University, San Bernardino.

To participate, you must be at least 18 years old, and a combat veteran diagnosed with Posttraumatic Stress Disorder.

Our purpose is to assess effectiveness of treatment for veteran PTSD sufferers whose significant others have received psychological counseling, and those whose significant others have not sought psychological counseling. Our goal is to present our findings to the Veterans Administration, in the hopes of moving further toward the goal of early, comprehensive intervention to minimize the effects of PTSD on veterans and their families.

Information obtained is confidential, and you are requested to respond anonymously. Please do not include your name or any other identifier. Should you experience discomfort as a result of participating in the study, please contact the Veterans Administration or Readjustment
Counseling Service (Vet Center) in your area. Addresses and phone numbers are available online from http://www.ptsd.org or by calling 1(800) 827-1000.

If you are willing to participate, please access the survey at:


We are future social workers deeply committed to veterans and the recovery of those stricken by PTSD and to enhancing the quality of life for those who served their country and their loved ones. We appreciate your contribution in realizing our goals.

Sincerely,

Cherie Bogel and Marion Wilson

If you have any questions or concerns about the research, please feel free to contact Professor Rosemary McCaslin, Research Coordinator for the Department of Social Work (909/8800-5507, rmccaslin@csusb.edu).
APPENDIX E: Description of Study

You are requested to participate in a research study conducted by Cherie Bogel and Marion Wilson, Master of Social Work candidates, from the Department of Social Work at California State University, San Bernardino. The results of the study will contribute to their thesis. You are invited to be a participant in the study because you are at least 18 years old, and a combat veteran diagnosed with Posttraumatic Stress Disorder. Your participation in this study is voluntary and you may withdraw at any time. This study has been approved by the California State University San Bernardino, Institutional Review Board (CSUSB IRB).

Purpose of the Study

The purpose of this study is to measure the effectiveness of treatment for veteran PTSD sufferers whose significant others have received psychological counseling, and those whose significant others have not sought psychological counseling. It is our belief that family-centered approaches to therapy for PTSD play a very important role in recovery and quality of life of the veteran and his significant others. By expanding our
knowledge of PTSD, treatment and treatment outcomes, we may
move further toward a goal of early intervention,
ultimately, to one of minimizing the effects of PTSD on the
veteran and his/her family.

Procedures

If you agree to participate in this study, please
proceed to the questionnaire. The questionnaire should
take approximately 20-30 minutes to complete. The survey
will ask for personal data, including age, race and gender.
There will be a series of questions regarding your military
service history. Another group of questions will address
the presence of PTSD specifically related to deployment and
experience in combat, PTSD treatment history, significant
others' psychological counseling history, and, finally,
relationship and treatment satisfaction, if applicable.
Any questions or concerns about this study should be
addressed to Professor Rosemary McCaslin, Research
Coordinator for the Department of Social Work (909/8800-
5507, rmccasli@csusb.edu).
APPENDIX F: Informed Consent

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Please do not put your name, address, phone number, email address, or Web page URL anywhere on the questionnaire so that confidentiality can be maintained. Once the raw data has been entered into a computer, the questionnaires will be destroyed. Thereafter, raw data in the computer will be identifiable only by case identification numbers.
APPENDIX G: Debriefing Statement

Some questions may be uncomfortable to answer such as those regarding your PTSD diagnosis and treatment, education level, ethnicity and age. If you feel uncomfortable at any time, you may choose to stop filling out the questionnaire. If you continue to feel distressed or uncomfortable in any way, and feel as though you may be in need of assistance, please contact the Veterans Administrations or Readjustment Counseling Service (Vet Center) in your area. Addresses and phone numbers are available online from http://www.ptsd.org or by calling 1(800)827-1000.

Your participation is VOLUNTARY. If you decide to participate, you are free to discontinue participation at any time without penalty. Researchers do not have access to your questionnaire unless you transmit it to the website upon completion.

If you have any questions or concerns about the research, please feel free to contact Professor Rosemary McCaslin, Research Coordinator for the Department of Social Work (909/8800-5507, rmccasli@csusb.edu).
REFERENCES


