

Running Head: HIDDEN IN THE SHADOWS

Hidden in the Shadows: The Secondary Effects of PTSD

Jennifer C. Travis-Scott

University of Montevallo

Abstract

In light of the current wars, veterans are a rapidly growing vulnerable population. Although there are resources such as the VA for veterans, the people attached to them (e.g. their families and significant others) are not being treated or prepared for the aftermath of the often invisible battle scares or mental injuries that have been inflicted on their loved ones. These families often are unprepared and are unknowledgeable about the symptoms of PTSD, which may result in immense amounts of stress during the veteran's delicate readjustment to civilian life. In some cases, the stress of the PTSD has resulted in a breakdown of the family system. There is a substantial gap in the literature regarding the secondary effects of PTSD on families (e.g. spouses, children, etc.), this research will identify those gaps with special attention devoted to the specific needs of this population. This research, which is a comprehensive review of the literature, will first introduce post-traumatic stress disorder (PTSD) and the pathology of primary trauma, followed by a description of veterans with PTSD and the needs of them and their families. A family systems approach will be utilized to describe the effects of this condition on veterans and their families. In conclusion, after gaps in the literature have been identified, recommendations will be provided that may serve to address those gaps.

Introduction

In light of the current wars, veterans are a rapidly growing vulnerable population. Although there are resources such as the VA for veterans, the people attached to them (e.g. their families and significant others) are not being treated or prepared for the aftermath of the often invisible battle scares or mental injuries that have been inflicted on their loved ones (Figley, 1995). Many families are eager and prepared for the return of their loved ones, only to find that the veteran that left them is not the same person post-war. These families often are unprepared and are unknowledgeable about the symptoms of PTSD, which may result in immense amounts of stress during the veteran's delicate readjustment to civilian life. In some cases, the stress of the PTSD has resulted in a breakdown of the family system (Arzi, N.B., Solomon, Z. Dekel, R., 2000).

There is a substantial gap in the literature regarding the secondary effects of PTSD on families (e.g. spouses, children, etc.), this research will identify those gaps with special attention devoted to the specific needs of this population. This research, which is a comprehensive review of the literature, will first introduce post-traumatic stress disorder (PTSD) and the pathology of primary trauma, followed by a description of veterans with PTSD and the needs of them and their families. After the discussion of PTSD, a review of the secondary effects of this illness on family members and caregivers will be presented. A family systems approach will be utilized to describe the effects of this condition on veterans and their families. After the gaps in the literature have been identified, social service recommendations will be formulated to better aid this overlooked population of individuals. As the cornerstone of this research, Charles Figley's work on secondary traumatic stress has been used in order to act as a guide in understanding the secondary effects of trauma on the extended family system. In his book, *Compassion Fatigue*:

Coping with Secondary Traumatic Stress Disorder (1995), Figley defines secondary traumatic stress as the “natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995, p. 7).

PTSD

Post-traumatic stress disorder (PTSD), is a diagnosable mental illness that results from exposure to some form of primary trauma resulting in significant distress or impairment (Greenman, J., 2001; Harvey, M. R.H., 1996; Knox, J., 1999; Rothschild, B., 1997; Rubin, D.C., Boals, A., Berntsen, D., 2008). Traumatic events may include but are not limited to: primary and immediate threat to life or one’s body, witnessing threatening or deadly events, or hearing of violence to or the unexpected or violent death of another person (APA, 1994). Exposure to the traumatic event may cause a variety of symptoms that often appear within one to six months of the initial trauma. In the following months/years the individual may begin to suffer from a multitude of symptoms. These symptoms are categorized into three clusters: re-experiencing, avoidance and numbing, and hyper- arousal (APA, 1994; Rothschild, B., 1997; Rubin, D.C., Boals, A., Berntsen,D, 2008;). Symptoms that are associated with re-experiencing the trauma include intrusive thoughts and memories, flashbacks, nightmares, and/or psycho physiological reactions to stimuli associated with the trauma. The next cluster, avoidance and numbing, includes avoidance of particular places, people, thoughts, or conversation that may induce feelings or recollections of the traumatic event. Also included in this cluster is the individual’s inability to recall important aspects of the trauma, lowered interest in activities (personally and socially), detachment/estrangement, emotional numbing, and chronic isolation. The last cluster, hyper-arousal, consists of the insomnia, chronic irritability and agitation, difficulty

concentrating, hyper vigilance, and exaggerated startle response (APA, 1994; Greenman, J., 2001; Knox, J., 1999; Harvey, M., Birmes, P., Hatton, L., Brunet, A., Schmit, L., 2003; www.ncptsd.va.gov).

There are a variety of risk factors that may influence an individual's likelihood of developing PTSD. For example, age, development, initial distress level, intelligence, personality affects, thought processes, coping capabilities prior to trauma, and relationship between the victim and the offender (Harvey, M.; Greenman, J., www.medicinenet.com/posttraumatic_stress_disorder/). Although PTSD can develop at any age, the average age of onset is 23 (www.nimh.gov; www.emotionaltuning.com). The literature also identifies some co-morbidity between PTSD and other mental health conditions such as: major depression, general anxiety disorder, and substance abuse (Wilson, J., Keane, T.M., 2004).

Approximately 7%-8% of people in the United States will develop PTSD in their lifetime (www.ncptsd.va.gov). Somewhat higher rates of this disorder have been found to occur in African Americans, Hispanics, and Native Americans compared to Caucasians in the United States. The risk of developing PTSD is higher amongst groups exposed to traumatic events. For example, about 30% of veterans, 45% battered women, 50% of sexually abused children, and 35% of adult rape victims are more susceptible to developing symptoms of PTSD (www.nimh.gov; www.emotionaltuning.com).

PTSD in Veteran Populations

Estimates show that there are about 24-27 million veterans in the United States and Puerto Rico (www.census.gov, www.va.gov/vetdata). About six percent of the veteran population is female, 37% are age 65 and above, 2.6 million veterans are Black, 22.6 million are

White, about one million are Hispanic, and about 284, 000 are Asian American, Indian, or Alaska Native (www.census.gov/pres-release/www/2002/cbo2ff18.html). In light of the current wars and the ever-present potential for future wars, the implications for an increase in the veteran population is imminent; thus the number of veterans suffering from PTSD are also likely to increase.

Effects of Combat

In the book *Combat Stress Injury* (2007), Figley and Nash delve into the impact of combat on soldiers during wartime, postwar, secondary trauma of PTSD, and combat stress management programs. Aside from the physical injuries sustained that enhance fatigue and reduce stress tolerance during war, as time progresses, even minor illnesses affect many soldiers' feelings of wholeness, competence, and self-confidence (Figley & Nash, 2007). They identify five main stress areas or stressors that soldiers endure while in combat and after combat: physical stressors, cognitive stressors, emotional stressors, social stressors, and spiritual stressors.

Physical stressors are those environmental factors experienced by the veteran while in combat and postwar. Some examples of physical stressors include exposure to extreme weather conditions, such as extreme or prolonged exposure to heat and/or cold climates. They may also endure dehydration and wetness due to their surroundings. Soldiers also experience bouts of sleep deprivation, exposure to loud noises and blasts, illness or injury, and malnutrition while in combat. The stress experienced by the veteran may also include their time of deployment (average deployments are about seven to 14 months) (Figley & Nash, 2007).

Cognitive stressors refer to changes in the soldier's methods of thinking or thought processing abilities and are inflicted in a variety of ways. For example, if the soldier is provided

with too much information or is not provided with enough information about his/her duties and the tasks at hand, this results in disruption in cognitive abilities. Following that factor, any changes in the mission or their individual role, changes in rules of engagement, or conflicts with loyalty to themselves and their country plague them as well. Emotional stressors include the loss of friends to death or injury. As military peers typically have strong bonds of trust with fellow soldiers, the loss of a soldier may have a profound impact on emotional well-being. Feelings associated with emotional stressors include shock, disbelief, guilt, shame, and anger. While experiencing these emotions, the soldier is trained to remain partially numb to their losses. They must store up their grief in emotional “backpacks” that cannot be emptied or dealt with until the war is over and/or it is safe to attempt to work through the pain/losses (Figley & Nash, 2007). Another emotional stress factor is fear. Soldiers often experience the fear of death, being maimed, and fear of losing friends. They may also have feelings of shame and guilt as it relates to the individual’s perception of whether or not they have failed or succeeded in their mission, their comrades, and themselves. Many soldiers also experience survivor guilt after losing members of their troop and general loss of human life. Included is the difficulty of experiencing death around them, soldiers are also affected by the aftermath of war and carnage. Many soldiers, during and after war, often see others maimed and dismembered, which in its own way leaves deep emotional scars and imbedded visions that may never go away (Figley & Nash, 2007).

For many soldiers, isolation from social support, lack of privacy or personal space, and/or media and public opinion about the war they are in contribute to the social stressors they experience. Isolation from social support impacts all soldiers in different ways. Soldiers that have been deployed numerous times often develop ways to cope with being away from home and their families, but it can be particularly difficult for young and/or inexperienced soldiers that may

not have had the opportunity to get accustomed to military life or develop support systems within the military. While some soldiers experience social isolation and feelings of loneliness, they too seek privacy sometimes because they are always surrounded by their comrades, which is for their own safety, yet the soldier seeks to have his/her own space and time alone; in a sense everything during deployment is communal (Figley & Nash, 2007). Media and public opinion also are social stressors for soldiers in that they may feel that their effort or labor is in vain and/or unappreciated by their country. Many times, even while fighting to protect their country, there may be numerous objections to the war in which they are fighting and to their actions as a whole, or as an individual. Spiritual stressors include the soldier losing faith in God and/or be unable to forgive others or themselves for things that were done while in combat (Figley & Nash, 2007). Soldiers' belief systems can be challenged in that they may question the omnipotence and benevolence of an almighty God that would allow such human cruelty and carnage of war to exist in the world. Some soldiers leave combat feeling disappointed and let down by those their comrades and in themselves. They often find it hard to forgive or forget the horrors of war and the actions taken by them and/or their peers (Figley & Nash, 2007).

Understanding PTSD from a Systems Theory

In the field of Social Work, systems theory is utilized to illustrate and understand the relationship between an individual and his/her environment, and how they affect each other. One's environment consists not only of material possessions such as their home, car, etc; but also of family members (e.g. spouses, children, and extended family members), neighbors, co-workers, the community, and friends. One of the core principles of systems theory states that "All systems seek goal attainment and a state of homeostasis" (Hoffman & Sallee, 1994). Veterans suffering from trauma have experienced a disruption in their state of homeostasis,

which in turn affects all other components of that veteran's system (i.e. family, etc). It is important to use this principle as it pertains to the veteran and his/her systems, which includes the family because of the global impact of PTSD. Systems theory is also valuable when attempting to understand the bio-psycho-social effects of PTSD on Veterans and their families. For example, the experience of trauma by the veteran indirectly influences their family, social, occupational, and spiritual systems. The individuals that are indirectly affected by the veteran's trauma may suffer from PTSD-like symptoms from being in chronic contact with the veteran. In a sense, the emotions can be contagious (Newell, 2007). Many veterans suffering from PTSD are not able to function at an optimal level to work, especially with others, thus their occupational and social systems are negatively affected due to their PTSD symptoms. Also, veteran's spirituality is also questioned and/or modified because of their trauma and their search to find meaning and solace in the aftermath of their traumatic experience(s).

Compassion Fatigue, Vicarious Traumatization, and Secondary Traumatic Stress

Systems theory is applicable when exploring the realms of PTSD and its global impact via compassion fatigue, vicarious traumatization, or secondary traumatic stress (STS) on Veterans' families. Although all three terms are similar and in some ways interrelated, they also have different symptoms that make them unique. Compassion fatigue can be distinguished from vicarious traumatization and STS in that compassion fatigue affects the caregiver's emotional capacity to continue to provide healthy and positive support while maintaining their own emotional wellbeing (Figley, 1995). In his book *Compassion Fatigue* (1995), Charles Figley states that individuals suffering from compassion fatigue have been "traumatized by concern", and that caregivers have the potential to experience compassion fatigue from chronic contact with an individual with PTSD (Corney, M.S., 1995; Figley, 1995). People suffering from

compassion fatigue often have episodes of deep sadness and depression, sleeplessness, and general anxiety (Corney, 1995). Caregivers may also be plagued by dreams, nightmares, and intrusive thoughts similar to what the person with PTSD experiences (Corney, 1995).

The second approach that describes the secondary effects of PTSD is vicarious traumatization. Vicarious traumatization (VT) causes a shift in an individual's cognitive schemas and belief systems resulting from empathetic engagement with trauma survivors (Pearlman, L.A., 1999; Pearlman & Saakvitne, 1995; Stamm, 1990). Symptoms associated with vicarious trauma may manifest via intrusive imagery and painful affect (Pearlman & MacIain, 1995). Some contributing variables to VT include the traumatic situations and individual's identification with the victim and his/her trauma. Some situational variables include exposure to graphic details of abuse and human cruelty and suffering and one's personal history of traumatization may also be a factor in the development of VT. The relationship between the caregiver and the victim may affect the likelihood of the caregiver developing symptoms of VT because the caregiver may over identify with their loved one's trauma.

Secondary traumatic stress (STS) is the third approach that describes the secondary effects of PTSD. According to Figley (1995), secondary traumatic stress occurs when caregivers such as family, friends, or others, come into continued constant contact with trauma survivors. Through their chronic contact with the individual with PTSD, they (caregivers) become indirect victims of the trauma; thus STS "infects" the entire system after first appearing in only one member (Figley, 1995). Symptoms of STS are parallel to those found in people that have been directly exposed to trauma such as intrusive imagery, thoughts, and dreams related to the victim's traumatic experience; avoidant responses, and physiological arousal (Crestman, 1999; Figley, 1995; McCann & Pearlman, 1990). Other symptoms of STS include difficulty

concentrating, avoidance of the individual with PTSD and their situations, and hypervigilance to stimuli of their loved one's trauma (Figley, 1995).

Trauma Reactions & the Family

The review of the literature revealed a number of studies investigating the effects of STS. Several studies have been conducted on the secondary effects of PTSD on veteran's family, especially their wives and children. In a study conducted by Solomon and colleagues (1992), the team focused on the effects of combat and PTSD in veteran husbands in relation to psychiatric symptoms in wives. Their findings revealed increased levels of somatization, depression, anxiety, loneliness, hostility, and impaired marital, family, and social relations in wives of veterans diagnosed with combat stress reaction (CSR) and PTSD (Arzi, et. al). They also found greater conflict and reduced marital satisfaction and cohesion in couples with a spouse suffering from CSR or PTSD (Solomon, et. al, 1992). Another study found that wives of combat veterans with CSR had more psychiatric problems than wives whose husbands were in combat but did not have CSR or PTSD (Nelson & Smith, 2005). Riggs, Byre, Weathers, and Lily (1998) work with PTSD couples found increased relationship distress, difficulties with intimacy, and relationship problems. Lev-Wiesel and Amir (2001) conducted a nonclinical study on Holocaust survivors and their wives and found that anger, hostility, paranoia, and interpersonal sensitivity levels related to increased levels of STS symptoms in spouses. Another study by Nelson (1999) consisted of three groups: veterans, childhood sexual abuse victims, and a control group. Nelson concluded that veterans experienced higher levels of individual stress symptoms and trauma symptoms than other groups, and veteran partners reported higher levels of stress and STS symptoms. A study on single and dual trauma couples found that couples classified as 'single and/or dual trauma couples' reported having communication problems, difficulty with intimacy,

and interpersonal aggression (Nelson, B.S., Wangsaard, S., Yorgason, J., Kessler, M.H., Carter-Vasol, E., 2002). Also, many issues that were reported by trauma survivors included individual stress symptoms, anxiety, depression, isolation, poor relationship quality, and reduced intimacy. Some issues that affected the couple's relationship quality primarily included isolation, reduced intimacy, and the trauma survivor's reluctance to discuss details of their trauma. In a study of STS in Dutch couples, the participants reported the veteran's difficulty with reintegrating themselves back into their pre-war state, as well as problems allowing their loved ones to retake their places in the veteran's life (Bransen, I., van der Ploeg, H.M., Turisk, J.W.R., 2002). Higher levels of aggression in families with PTSD were also reported in this study. One study researched the psychological effects of combat related violence in veterans and their families. This study found that the veteran's anger was associated with troubled family relationships and contributed to secondary trauma in family members (Galovski, T., Lyons, J.A., 2003). It was also reported that the veteran's PTSD severely impacted functioning in many areas including causing increased marital instability, possibly due to their difficulty reintegrating. Some factors that contributed to post-war combat violence and reintegration included the veteran's spouse's familial resources during their partner's deployment and pre-deployment condition of their marriage. A large number of couples reported relationship distress, and wives of combat veterans with CSR reported feelings of anxiety, loneliness, hostility, severe psychopathology, and less optimism. Wives of combat veterans with CSR and PTSD not only reported higher levels of the above emotions, many of them also reported having been diagnosed with obsessive-compulsive disorder (OCD). This study also found more levels of violence on part of the veteran, lower levels of happiness and life satisfaction, and higher levels of depression. Wife battering was also reported, and the reports ranged from the wives experiencing sporadic bouts of abuse to some

wives reporting chronic abuse with the veteran. The abuse was followed by rejection and lack of communication that eventually led to more violence. In many cases, the abuse cycle eventually led to crisis such as a suicide attempt or marital separation. The veteran often has difficulty discarding aggression that was appropriate during wartime, trouble controlling violent impulses, and difficulty resuming trust in others, including spouses and children.

The relationship between the veteran with PTSD and his or her children are also negatively affected in a variety of ways, which often result in behavioral and emotional problems in the children. One study reported, veterans also tended to be controlling, overprotective, and demanding with their children (Harkness, 1993). The veteran's PTSD symptoms have been found to negatively impact the development of positive child-parent relationships, which are mostly caused by the veteran's numbing and avoidance symptoms (Galovski, T., Lyons, J.A., 2003). Children of PTSD parents were found to have more behavioral problems and experienced nightmares, severe academic difficulties, depression, distress, feelings of self-doubt, aggressive behaviors, and social issues regarding their ability to relate to their peers. It was also found that children might be more influenced by seeing violence in their home more so than the actual PTSD symptoms. It was also found that STS can be transmitted in one of three ways: the child can be directly traumatized by parent's behaviors (ex: through violence); the child may over identify with the parent with PTSD; or the child may be indirectly affected by nonspecific family dysfunction (Galvoski & Lyons, 2004). Another study found that STS can be transmitted to children in four ways: silence, overdisclosure, identification, and re-enactment. Silence affects the child in that the child senses fragility when the parent keeps silent in efforts to not upset the parent with PTSD. Overdisclosure occurs when the parent attempts to make the child understand, but instead of gaining understanding, the child is often frightened by the information.

Identification happens by the child being constantly exposed to the parent's PTSD symptoms. Re-enactment takes place between the veteran and the child when the veteran invites the child to re-enact traumatic events from the veterans past, which may then leave the child believing he or she is to blame for the veteran's trauma.

Conclusion

In conclusion, the literature revealed a wealth of information on PTSD; it's symptoms, potential contributing factors, statistics, the veteran population and some of their experiences pre and post war. The literature also identified the secondary effects of PTSD on caregivers and family members who are in constant contact with the veteran with PTSD, as well as identified research that has been done to bring more awareness to the issues affecting those experiencing STS. Throughout this comprehensive review, numerous gaps have been identified and recommendations will be made regarding those gaps. The first major gap in research literature is that there is no definite way to describe secondary traumatic stress symptoms such as compassion fatigue, vicarious traumatization, and STS. Since there is no absolute distinction between these three terms, it is difficult to accurately measure the constructs. The next gap found in this literature pertains to the spouses and children of veterans with PTSD. Although some research has been done on spouses and children of veterans with PTSD, more current research needs to be done to better address the symptoms experienced by spouses and children. Another gap in the literature is that the majority of the research done on the secondary effects of PTSD on spouses has been on the wives of veterans, and little has been done on husbands of female veterans suffering from PTSD. The next gap is regarding the effects of vicarious traumatization on individual's spirituality, and if spirituality can or does serve as a buffer to the effects of STS. Since there are wars currently going on, current information is needed on the effects of combat

on the new veterans, their families, and their overall systems. The last gap identified regards gay and lesbian couples, and how one partner's PTSD affects their relationship and systems as a whole. In order to better serve these populations and address these gaps, more research is needed so that in the future more programs can be created to better aid the veteran's loved ones. Awareness and educating the veteran and their families may also serve to better equip and assist the family with aiding the veteran, tending to the veteran's and their personal needs as well.

References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, D.C.: American Psychiatric Association.
- Arzi, N.B., Solomon, R., & Denkel, R. (2000). Secondary traumatization among wives of PTSD and post-concussion casualties: Distress, caregiver burden and psychological separation. *Brain Injury*, 14(8), 725-736.
- Birmes, P., Hatton, L., Brunet, A., & Schmitt, L. (2003). Early historical literature for post-traumatic symptomatology. *Stress and Health*, 19, 17-26.
- Brady, J. L., Guy, J.D., Poelstra, P.L., & Brokaw, B.F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, 30 (4), 386-393.
- Bramsen, I., Van Der Ploeg, H.M., & Twisk, J.W.R. (2002). Secondary traumatization in Dutch couples of World War II survivors. *Journal of Consulting and Clinical Psychology*, 70(1), 241-245
- Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, 52 (1), 63-70.
- Bride, B.E., Radney, M. & Figley, C.R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155-163.
- Carlson, E.B., Ruzek, J. PTSD and the Family. Retrieved June 9, 2009, from http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_family.html

- Conrad, D., & Keller-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect*, 30, 1071- 1080.
- Creamer, T. L., & Liddle, B.J. (2005). Secondary traumatic stress among disaster mental health workers responding to September 11 attacks. *Journal of Traumatic Stress*, 18 (1), 89-96.
- Figley, C .R. (2002). The history of trauma practice: Origins of traumatology and prospects for the future, part 1. *Journal of Trauma Practice*, 1 (1), 17-32.
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel: Levittown, PA.
- Figley, C. R., & Nash, W. P. (2007). *Combat stress injury: Theory, research, and management*. New York: Taylor and Francis.
- Galovski, T., Lyons, J.A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on veteran's family and possible interventions. *Aggression and Violent Behavior*, 9, 477-501.
- Goff, B.S.N., & Smith, D.B. (2005). Systematic traumatic stress: The couple adaptation to traumatic stress model. *Journal of Marital and Family Therapy*, 31 (2), 145-156.
- Howe, P. H., & McDonald C. *Traumatic stress, turnover, and peer support in child welfare*. Conference Presentation at Child Welfare League of America Finding Better Ways Conference: Washington D.C. (2001)
- Lerias, D., & Byre, M. K. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health*, 19, 129-138.
- Maltas, C., & Shay, J (1995). Trauma contagion in partners of survivors of childhood sexual abuse. *American Journal of Orthopsychiatry*, 64(4), 529-539.
- Nelson, B.S., Wangsgaard, S., Yorgason, J., & Kessler, M.H. (2002). Single and dual trauma couples: Clinical observations of relational characteristics and dynamics. *American Journal of Orthopsychiatry*, 72(1), 58-69.
- Nelson, B.S., & Wright, D.W. (1996). Understanding and treating post-traumatic stress disorder symptoms in female partners of veterans with PTSD. *Journal of Marriage and Family Therapy*, 22(4), 455-467.
- Pearlman & McCann (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Journal of Psychology: Research and Practice* 26 (6), 558-565.
- Rothschild, B. (2000). *The Body remembers: The psychophysiology of trauma and trauma treatment*. New York/London: W.W. Norton & Company.

Solomon, A, Waysman, M, Belkin, R, Levy, G., Mikulincer, M., & Enoch, D. (1992). Marital relations and combat stress reaction: The wife's perspective. *Journal of Marriage and Family Therapy*, 54(2), 316-326

Van der Kolk, B.A., McFarlane, A.C., Weisaeth, L. (2007) Traumatic Stress. The Guilford Press: New York, NY

Wiesel, R.L. & Amir, M. (2001). Secondary traumatic stress, psychological distress, sharing of traumatic reminiscences, and marital quality among spouses of holocaust child survivors. *Journal of Marital and Family Therapy*, 27(4), 433-444.

Wilson, J.P., Keane, T.M., (2004) Assessing Psychological Trauma & PTSD. The Guilford Press: New York, NY.

PTSD Statistics. Retrieved June 16, 2009 from www.emotionaltuning.com/gpage.html

NIMH Post-Traumatic Stress Disorder. Retrieved June 16, 2009 from <http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-easy-to-read/index.sht>.