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Relationship satisfaction, the influence of trauma, and needs analysis of military couples

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Relationship satisfaction, the influence of trauma, and needs analysis of military couples

Abstract
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RELATIONSHIP SATISFACTION, THE INFLUENCE OF TRAUMA, AND NEEDS

ANALYSIS OF MILITARY COUPLES

A THESIS

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Abstract

Previous research has found that the stresses of a military lifestyle, including military trauma, may be detrimental to intimate relationships. This study explored the relationships between PTSD symptoms, relationship satisfaction, and perceived barriers to accessing couples counseling resources in a sample of military service members or veterans and their partners (N=29). In addition, a needs analysis was performed to determine couples’ mental health service utilization and the most common barriers to utilizing couples counseling. Results revealed no significant relationship between PTSD symptom severity and relationship satisfaction. Relationship satisfaction was significantly negatively correlated to number of perceived barriers to accessing couples counseling resources ($r = -.50, p = .003$). The majority of participants had never used couples counseling resources (65.5%). The most commonly reported barriers to treatment were stigma (44.8%), lack of awareness of resources (20.7%), and unwillingness of one partner to participate in treatment (20.7%). Results suggest measures need to be taken to reduce stigma and increase awareness of couples’ mental health resources in the military in order to improve quality of relationships, increase resilience, and improve personnel retention rates.

Keywords: relationship, military, PTSD, barriers, needs analysis
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Introduction

Like many couples, soldiers and their partners face challenges in maintaining healthy and satisfying relationships. However, unlike other couples, stressors such as long and frequent deployments, exposure to combat, and anxiety regarding high casualty rates, place even more strain on military couples (Karney & Crown, 2007). Concordant with these additional stressors, percentage of marriages that end in a given year in the military have consistently increased since 2000 (Karney & Crown, 2007) and approximately 75% of soldiers referred for behavioral health evaluations post-deployment report problems in their romantic relationships or with their children (Meis, Barry, Kehle, Erbes, & Polusny, 2010a).

One contributing factor to these relationship problems may be the presence of trauma symptoms. Approximately 10-18% of combat troops serving in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have been identified as having probable Posttraumatic Stress Disorder (PTSD) following deployment, and many more troops experience subclinical trauma symptoms (Litz & Schlenger, 2009). PTSD is a disorder characterized by re-experiencing of a traumatic event accompanied by symptoms of increased arousal, avoidance of stimuli associated with the trauma, and general avoidance or emotional numbing (Diagnostic and Statistical Manual, 4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). Not only do these symptoms impair functioning in the soldiers themselves, research has also shown that a spouse’s perceptions of their combat veteran partner’s symptoms may function as a mechanism of transmission of mental health symptoms to the spouse (Renshaw, Rodrigues, & Jones, 2008), such that PTSD may result in mental health difficulties in both partners within the relationship.
In addition to affecting both partners individually, trauma symptoms in the military population can lead to less communication, validation, and intimacy between partners (Erbes, Meis, Polusny, & Compton, 2011), yet treatment for PTSD often focuses on intrapersonal problems, ignoring interpersonal problems that can result from symptoms of trauma. In this paper, the author examined the implications of trauma symptoms for military couples’ relationship satisfaction. Understanding how trauma symptoms affect romantic relationships can lead to more effective treatment for couples and to a more integrative treatment for individuals with PTSD. The author also conducted a needs analysis of military couples to examine the extent to which couples know about available counseling services, if these services address interpersonal symptoms of PTSD, barriers to utilizing counseling services, perceived service needs, and specific relationship skills they would like help with. This information can lead to more targeted and effective interventions as well as the development of efforts to increase mental health service utilization.

**Impact of Military Service on Relationship Functioning**

Karney and Crown (2007) noted several aspects of military service that have a significant impact on couple and family functioning. They pointed out that the majority of military service members are in the lowest pay grades, and many indicate that it is difficult to meet financial obligations. Also, due to frequent moves, it is difficult for partners of military service members to sustain steady employment. Possibly due to the negative effects financial stress has on communication, financial strain is a reliable predictor of marital dissolution for military couples (Karney & Crown, 2007). Another factor that may contribute to conflict is the frequent inadequacy of housing allowances. Karney and Crown (2007) found that couples often cannot afford to live in the neighborhoods near the base and, as a result, live a significant distance from
the base, often in neighborhoods they are not satisfied with. The authors note that couple’s satisfaction with housing has been associated with quality of communication and marital satisfaction.

In addition to these general stressors associated with military life, deployment related stressors also strain couple and family functioning. Deployments during operations in Afghanistan and Iraq have been longer and more frequent, a higher proportion of deployed service members have been exposed to combat, and casualty rates are higher than they have been since Vietnam (Karney & Crown, 2007). Inherent demands of working in the military such as combat deployment, separations from family members, and a highly stressful work environment that involves physical and mental danger can all lead to problems in family and couple functioning (Adler-Baedar, Pittman, & Taylor, 2005). For example, research from several time periods shows that combat exposure leads to increased marital difficulties for veterans (Gimbel & Booth, 1994). Couples who spend time apart due to deployment have decreased opportunities for communication, problem-solving, and spending time together in ways that make them closer as a couple (Karney & Crown, 2007). Military service members may return home changed by the experience of war and partners and children who remained home may have adapted to more independent roles within the family. This makes readjustment after deployment an especially difficult challenge for military families (Karney & Crown, 2007). Military members returning from deployments with symptoms of trauma face even more difficulties with reintegration. The remainder of this literature review will examine the relationship between military trauma and relationship satisfaction.

**Relationship Between Military Trauma and Relationship Satisfaction**
Previous research has demonstrated that combat and military-related trauma may be detrimental to intimate relationships. Gewirtz, Polusny, DeGarmo, Khaylis, and Erbes (2010) found that an increase in PTSD symptoms on the PTSD Checklist – Military Version (PCL-M) between 1 month prior to returning home from OIF and 1 year post-deployment was associated with poorer couple adjustment as measured by the Dyadic Adjustment Scale – 7. In a similar study, Erbes et al. (2011) examined predictors of relationship adjustment among National Guard soldiers with Posttraumatic Stress Disorder (PTSD). Male and female soldiers completed measures of relationship adjustment and a PTSD checklist within 2-3 months of their return from combat duty (Time 1) and 1 year later (Time 2). They found that soldiers who screened positive for PTSD showed significantly poorer relationship adjustment at both time points. At Time 1, dysphoria and reexperiencing were the PTSD factors most strongly correlated with poor relationship adjustment. At Time 2, dysphoria and avoidance most strongly predicted poor relationship adjustment. Erbes et al. (2011) concluded that dysphoria symptoms increased emotional withdrawal from partners and reduced opportunities for communication, validation, and intimacy, leading to lower rates of couple adjustment in soldiers with PTSD than in soldiers without PTSD.

Utilizing the same sample, Meis et al. (2010a) found a significant interaction: as relationship adjustment increased, the correlation between PTSD symptom severity and likelihood of using individual mental health services increased. The authors concluded that more supportive romantic relationships encouraged soldiers with the greatest need for treatment to use available mental health services. These results indicate that improving couples’ functioning may be an important target for increasing service utilization in the military.
Allen, Rhoades, Stanley, and Markman (2010) also examined the relationships between PTSD, recent deployment, and various marital outcomes; however, these researchers looked at a wider variety of marital satisfaction indicators. Married couples comprised of an active duty U.S. Army husband and a civilian wife completed self-report questionnaires separately and privately. The questionnaires included items about time of deployment; marital satisfaction; confidence in marital strength; positive bonding, which included questions about friendship, intimacy, fun, and felt support; parenting alliance; dedication; satisfaction with sacrificing for spouse; and negative communication. The researchers found that PTSD symptoms were significantly positively correlated with negative relationship patterns in all marital functioning areas examined. Allen et al. also found that adaptive processes accounted for some of the relationship between PTSD and marital satisfaction. Because of this, the authors concluded that teaching communication skills and positive bonding might be particularly helpful for this population.

In order to determine which cluster of PTSD symptoms was most associated with decreased relationship satisfaction, Nelson Goff, Crow, Reisbig, and Hamilton (2007) studied the relationship between specific trauma symptoms and marital or relationship satisfaction. Couples consisting of male soldiers and female partners volunteered to participate. Male participants who had been recently deployed to Iraq or Afghanistan and their civilian female partners completed a questionnaire about traumatic events, a PTSD scale, and an assessment of relationship functioning. The researchers found that the trauma symptom clusters of avoidance/numbing and dissociation predicted the majority of the variance in relationship dissatisfaction scores for soldiers and their wives. Soldiers’ decreased ability to experience and express a wide range of emotions and to socially engage with other people may lead to some of the negative consequences of PTSD seen in relationships. In addition, the PTSD hyperarousal symptom
cluster has been shown to be significantly associated with intimate partner aggression; angry outbursts or physical aggression can reduce opportunities for effective communication needed for problem solving and expressing support, lending even more stress to military couples’ relationships (Monson, Taft, & Fredman, 2009).

Noting that the majority of existing studies on PTSD and relationship satisfaction only include PTSD symptoms and relationship satisfaction as variables, Meis, Erbes, Polusny, and Compton (2010b) looked at known correlates of PTSD or relationship satisfaction to better understand the mechanisms by which trauma symptoms and decreased relationship satisfaction co-occur. Specifically, they were interested in the possible mediating or moderating roles of preexisting negative emotionality and comorbid problem drinking. In a sample of Army National Guard soldiers, negative emotionality was significantly correlated with post-deployment PTSD symptoms but not with relationship quality. Problem drinking did not strengthen the association between PTSD and relationship problems. Considering both indirect and direct effects, the authors concluded that negative emotionality predisposed soldiers to PTSD, which contributes to decreased relationship quality. The effects of PTSD symptoms on relationship functioning noted earlier such as increased anger, difficulty expressing feelings, and avoidance, may explain why PTSD remained strongly associated with relationship satisfaction above and beyond other correlates included in the study.

The studies just reviewed consistently indicated a pattern of relationship dissatisfaction as a result of military trauma symptoms. However, only one study identified specific skills that could be taught to military couples to prevent relationship deterioration as a result of trauma (Allen et al., 2010), and none of the researchers specifically asked the couples what they thought would be useful to learn about or discuss in a therapeutic setting. This is a large gap in the
literature that needs to be filled in order to develop targeted interventions for improving relationship satisfaction for military couples.

**Impact of Relationship Functioning on PTSD Treatment**

As mentioned previously, several studies have found significant associations between PTSD and relationship satisfaction. Because of this association, it is possible that including partners in PTSD treatment may simultaneously lead to a decrease in trauma symptoms as well as improved relationship satisfaction. To study this hypothesis and to add support to previous smaller studies finding success with couple treatment for PTSD (Sautter, Glynn, Thompson, Franklin, & Han, 2009), Monson et al. (2012) recruited a sample of veterans and conducted a randomized controlled trial of Cognitive Behavioral Couple Therapy (CBCT) for PTSD with 40 couples in which one partner met criteria for PTSD; the couples varied in sex, type of trauma, and sexual orientation. Half of the couples were assigned to a wait-list control group while the other half attended 15 sessions of CBCT for PTSD. CBCT for PTSD is a manualized treatment divided into three phases. The first phase includes psychoeducation about the interrelatedness of PTSD and relationship functioning and the rationale behind this mode of treatment. The second phase includes treatment similar to graduated exposure therapy as well as communication, problem-solving, and decision-making skills. Couples develop a list of situations, people, or feelings they have been avoiding as a couple due to PTSD; next, they generate a list of activities to counteract this avoidance and gradually complete activities from that list between therapy sessions. In the third phase of treatment, dysfunctional core beliefs and maintenance factors of PTSD and relationship problems are addressed.

The authors found that the effect sizes for treatment with CBCT for PTSD and comorbid symptoms were equal to or larger than effect sizes found previously with individual treatments.
for PTSD. In addition, improvement in relationship satisfaction was significant and effect sizes for this outcome were also equal to or larger than those for other couples interventions. These improvements were maintained at a 3-month follow up assessment. These findings have important implications; previous studies show that although individual treatment for PTSD improves the patient’s psychosocial functioning, improvements are not necessarily found in intimate relationship functioning (Schnurr, Hayes, Lunney, McFall, & Uddo, 2006). A treatment that simultaneously improves PTSD symptoms and relationship functioning, such as the treatment outlined above, is clearly preferable. More research is needed to replicate the results of this study with larger military samples and to directly compare the efficacy of CBCT with other individual and couple treatments for PTSD.

Increased social support, including emotional support provided by intimate partners, has been associated with less severe PTSD symptoms in general and improved treatment response in exposure therapy with OIF and OEF veterans (Price, Gros, Strachan, Ruggerio, & Acierno, 2011). Ignoring relationship problems while attempting to treat PTSD symptoms may restrict treatment gains and waste limited mental health resources within the military. These results further support the use of couple treatment for PTSD.

Mental Health Service Utilization

If couples therapy may be more effective than individual treatment at simultaneously addressing military trauma and relationship satisfaction, how likely are military couples to seek such services? What barriers might military couples encounter if they wish to seek treatment to address trauma or relationship problems? Several studies have examined mental health service utilization and barriers to mental health treatment for the military population in general, but few have examined barriers for utilization of couple’s therapy specifically. The Mental Health
Advisory Team (MHAT) assesses OIF related mental health issues; the first report created by MHAT (MHAT-I) was the product of survey responses of 756 active duty Soldiers. The MHAT-II surveyed 2,064 Soldiers. The MHAT-I (U.S. Army, 2003) revealed that only 27% of military service members with a mental health disorder received treatment at any time during their deployment. The MHAT-II (U.S. Army, 2005), found that this had increased to 41%; nevertheless, a large proportion of service members with mental health problems go untreated. In addition, these numbers do not include service members who may develop symptoms after their deployment and service members who underreport symptoms (American Psychological Association [APA], 2007). Although this report did not assess couple’s mental health service utilization, these findings may indicate that many couples in need of treatment do not make use of available services.

Interestingly, findings from MHAT-I (U.S. Army, 2003) revealed that only 32% of military service members who were interested in mental health treatment actually received help from a chaplain, physician, or mental health professional. This suggests the presence of significant barriers to care. A study by Hoge, Auchterlonie, and Milliken (2006) found a higher rate of utilization of mental health services (31%) among Army and Marine service members returning from Iraq compared with service members returning from other locations. The authors deduced that a higher rate of mental health service utilization was associated with higher combat exposure. In support of this conclusion, Meis et al. (2010a) found that individual mental health service utilization increased with greater PTSD symptom severity. In Hoge et al.’s (2006) study, approximately half of service members referred for mental health treatment post-deployment actually received mental health care within the next year. The results of this study also indicated that veterans who screened positive for any mental health disorder were significantly more likely
to leave military service within one year after deployment. Understanding and addressing barriers to mental health treatment may lend insight into strategies to increase service utilization for individuals and couples experiencing problems and lead to increased military retention rates.

**Barriers to Military Mental Health Treatment**

Researchers who study barriers to military mental health treatment typically find that potential barriers fall within the categories of acceptability, accessibility, and availability (APA, 2007; Huebner, Alidoosti, Brickel, & Wade, 2010). A study by Hoge et al. (2004) was one of the first to empirically examine barriers for military mental health treatment. They administered surveys to four combat infantry units – one Marine Corps unit and three Army units. They found that, of participants who screened positive for a mental health disorder, only 38 to 45 percent indicated interest in receiving help and only 23 to 40 percent actually sought mental health care.

**Availability.** Nearly a quarter of deployed service members indicated that they did not know where to go for help or believed that behavioral health services were not available (U.S. Army, 2003). There may be a number of reasons for this lack of availability. One significant problem is that there is a shortage of uniformed behavioral health professionals (APA, 2007). The significant number of psychologists who are deployed in order to directly provide mental health services to military personnel makes this shortage even more severe for military members and their families within the United States.

Beyond this shortage, military psychologists that are available suffer from burn out, high attrition rates, and the difficulties of balancing competing demands as a psychologist and as an officer (APA, 2007). Military psychologists face increased workloads with the deployment of their fellow psychologists as well as the stress that results from their own deployments and separations from friends and family (APA, 2007). The MHAT-II found that 33% of Army
behavioral health personnel surveyed indicated that they had experienced burn out and 27% endorsed low motivation for their work (U.S. Army, 2005). Even more importantly, 15% of respondents noted that these problems were interfering with their ability to provide care to their clients. In addition, many military psychologists lack necessary training for addressing deployment related needs of service members. Attempting to assuage these difficulties via referrals to civilian mental health professionals also comes with problems such as civilian unfamiliarity with military culture and delays in treatment due to a lengthy referral process (APA, 2007).

Awareness of available services, or lack thereof, can also serve as a barrier to treatment. Huebner et al. (2010) surveyed 578 participants online and 108 participants in focus groups, representing every branch of the military and including both service members and spouses of service members. Respondents varied significantly in awareness of available services. Frequently, respondents indicated that they were overloaded with information and information was given at the wrong times. They were given information about multiple resources but if they were not in need of those services at the time they heard about them, they would forget the information. Respondents also indicated that there was a lack of a consolidated list of resources. Military members noted that when dealing with other stressors pre- or post-deployment, they did not want to add the stress of locating phone numbers and information for resources. Contrary to these findings, spouses of service members often indicated that they were unaware of available resources. This may have been because military members are too busy with their work to remember to relay information to their partners. This can be a significant barrier to mental health service utilization for family members of service members.
Huebner et al.’s (2010) study also revealed a significant limitation to surveys screening for mental health symptoms routinely administered immediately post-deployment. The Post-Deployment Health Assessment (PDHA) is a survey used by the Department of Defense to assess physical and mental health and is required to be completed by service members before they are reunited with their families (APA, 2007). This is the information source for many estimates of prevalence of mental health symptoms post-deployment, such as those used by the MHAT reports. Participants in Huebner et al.’s (2010) survey stated that they were often not honest when completing the PDHA so that they could avoid being marked as having any problem that might delay the reunion with their families, a limitation that had been previously speculated (Hoge et al., 2006). For this reason, the prevalence of mental health disorders after deployment may be greatly underestimated and, as a result, estimates of how many service members receive mental health treatment when it is needed are likely lower than reported.

Partially due to these concerns, the Department of Defense initiated a second screening 3 to 6 months post-deployment called the Post-Deployment Health Re-Assessment (PDHRA). Milliken, Auchterlonie, and Hoge (2007) found that soldiers endorsed significantly more mental health concerns, including PTSD symptoms, on the PDHRA than the PDHA and were consequently referred at significantly higher rates for mental health treatment. The researchers found that concerns about interpersonal functioning quadrupled between the time of the PDHA and the time of the PDHRA. Because the PDHA is administered immediately after deployment, soldiers might not have been aware of interpersonal difficulties until returning home and interacting with family members.

**Accessibility.** Availability barriers often interact with accessibility barriers. For example, long wait-lists for behavioral health appointments and limited access to mental health care for
family members are largely a result of the shortage of mental health care professionals in the
military (APA, 2007). Common concerns that researchers found among service members
pertaining to accessibility to services were difficulty scheduling an appointment and difficulty
getting time off work (Hoge et al., 2004; U.S. Army, 2003; U.S. Army, 2005). Clinic hours on
base often overlap with regular work hours, meaning military personnel or their family members
must take time out of their work schedules to attend an appointment. This is complicated by the
fear of stigma associated with receiving mental health treatment in military settings – military
service members may be reluctant to ask for time off for a mental health appointment (APA,
2007; Huebner et al., 2010).

Another example of the interaction between availability and accessibility barriers is that
long wait-lists for mental health appointments which decrease service accessibility are created by
the shortage of mental health professionals mentioned earlier and the often complicated referral
process. Treatment delays can last for weeks or months. As a result, service members may quit
seeking services for mental health problems altogether or lose motivation for treatment (APA,
2007).

Feeling uncomfortable at resource centers on base due to poor customer service,
difficulty finding childcare during times programs were offered, and the remote location of
support services on military bases have also been indicated as accessibility barriers (Huebner et
al., 2010).

**Acceptability.** Across studies, stigma is the most commonly reported barrier to care,
regardless of rank (Hoge et al., 2004; U.S. Army, 2003; U.S. Army, 2005). Respondents to
Huebner et al.’s (2010) survey frequently described the military culture as promoting strength
and hiding weakness. This culture often conflicts with encouragement to access support services
as needed (Huebner et al., 2010). Real or perceived stigma can either be related to receiving a mental health diagnosis or the perception that behavioral health care available through the military is low quality (APA, 2007). Hoge et al. (2004) found that military personnel who met criteria for a mental health disorder were approximately two times more likely than those without a mental disorder to express concern about stigmatization as a barrier to receiving mental health services, agreeing with statements such as “Members of my unit might have less confidence in me,” “My unit leaderships might treat me differently,” and “I would be seen as weak.” Another common concern was fear of unit leadership blaming them for their problems. Other studies have found similar frequently endorsed barriers (U.S. Army, 2003; U.S. Army, 2005).

As mentioned earlier, there was an increase in mental health service utilization among military members with mental health problems from the time MHAT-I was conducted and the time MHAT-II was conducted; however, perceptions of stigma remained the same (U.S. Army, 2005). This implies that increased service utilization was the result of some other factor besides decreased stigma. There are several reasons for this enduring perception of stigma. Many military personnel believe that their medical records are readily accessible and that seeking mental health care will damage their career in the military (APA, 2007). However, no empirical research has been conducted to examine the accuracy of these beliefs. In reality, a mental health diagnosis can indeed disqualify members of the military from certain positions, meaning confidentiality within military mental health settings is limited. This is often enough of a reason for military members to downplay mental health symptoms and forgo seeking services (APA, 2007; Huebner et al., 2010). This relaxed definition of confidentiality also has implications for the family members of military personnel. Service members may be concerned that mental health
problems in their family may damage their careers and therefore discourage them from utilizing the military mental health system (APA, 2007).

In summary, accessibility, availability, and acceptability barriers of mental health treatment interact to inhibit service utilization by many service members in need of treatment. Because of the interaction between these barriers, service utilization will likely not improve if only one type of barrier is addressed while ignoring the consequences of the others. For example, addressing the commonly cited concern of a shortage of mental health professionals in the military may not significantly increase service utilization if a high perception of stigma remains (Tanielian & Jaycox, 2008). Of the categories of barriers, perceived or real lack of acceptability, or stigma, appears to be the most widespread and enduring deterrent to treatment. Research into whether or not this stigma is real in the military community could serve as a starting point for breaking down this barrier. If the stigma is real, changes in military policy pertaining to confidentiality in mental health treatment and the effect a mental health diagnosis has on career prospects would be needed. If this stigma is mostly imagined or assumed, military personnel could be made aware of these findings thereby reducing the effects of this barrier.

Addressing Gaps in the Literature: The Present Study

The link between trauma symptoms and decreased relationship satisfaction in the military has been well documented. Despite the awareness of this problem, the literature currently lacks information pertaining specifically to service utilization or barriers to service for couples in the military. It is possible that many of the same barriers that prevent individuals and family members separately from seeking treatment may have a similar impact on couples. This study sought to examine how service utilization and barriers to treatment for couples are similar to and different from those found for individuals in the military. The needs analysis portion of the
survey used in this study gathered information about how many military couples are using couples therapy resources, which ones they are using or would like to use, and perceived barriers to receiving treatment for relationship problems. These are all questions that have been asked of service members pertaining to their own mental health treatment, but the issue of couples’ mental health treatment has been largely ignored in previous surveys. With research indicating that the success of individual mental health treatment for disorders such as PTSD is partially dependent on the strength and support service members receive from intimate relationships, it is important to understand barriers that may block military couples from strengthening their relationship via the use of mental health resources.

Another goal of this study was to understand the extent to which interpersonal symptoms of trauma are addressed in treatment for PTSD either by including an intimate partner in treatment or by discussing how to cope with interpersonal symptoms within individual treatment for PTSD, such as irritability, avoidance, or feelings of detachment in the context of a romantic relationship. Research has shown that individual treatment outcomes for PTSD are weakened when military service members do not feel supported in their social relationships. Correspondingly, initial research on the effectiveness of a couples therapy format for treating PTSD has indicated that couples treatment is just as effective, if not more so, as individual interventions for treating PTSD symptoms with the added benefit of simultaneously improving relationship satisfaction. To date, no research has been conducted to understand the extent to which these research findings have been applied to practice. To fill this gap, the present study included survey questions about PTSD treatment modality and content.
The aim of the present study was to gather preliminary information missing from the current literature in order to direct future research and practice. Specifically, this study explored the following hypotheses:

1. Increased severity of PTSD symptoms will be associated with decreased relationship satisfaction.

2. Lower levels of relationship satisfaction will be associated with a higher number of perceived barriers to accessing counseling resources.

3. Military service members with PTSD who address interpersonal symptoms of trauma in either individual or couples counseling will have higher relationship satisfaction than military members with PTSD that do not address interpersonal symptoms during counseling.

Given the positive influences that a highly functional and supportive relationship has on treatment outcomes of military service members and the higher service utilization by individuals with PTSD in supportive relationships, understanding how couples treatment can be delivered most effectively is of high importance for the mental health of military personnel. It is also important to understand the most effective modality of treatment so that limited military mental health resources are used efficiently.

Method

Participants

Participants included military service members or veterans who were in a committed relationship at the time of the study and had been on active duty anytime between 2001 and the current date, and spouses or partners of a military member who met the above criteria (N=29). Each participant completed all applicable sections of the survey; therefore, all responses were used in analyses. The study was designed for people who are literate in English at the 8th grade
level. Military members who were deployed at the time of the study were excluded due to the potential effects that combat stressors may have had on the results. Participants were recruited through snowball sampling methods. The researcher emailed military service members and their spouses or partners known to her asking them to forward the recruitment email to other potential participants they knew.

Individuals self-identified as White or of European origin (82.8%), Latino or Hispanic (13.8%), and Multi-racial (6.9%). The mean age was 29.10 (SD=5.01). Sixty nine percent of the participants were female. All participants self-identified as heterosexual.

Participants self-identified as a partner of a military service member or veteran (58.6%), a military service member or veteran (34.5%), or both (6.9%). Respondents who were military service members or veterans were members of the Marine Corps (41.7%), Army (33.3%), Air Force (16.7%), Navy (8.3%), and National Guard (8.3%). These military members identified their status as veteran (50.0%), active duty (41.7%), or active reserve (8.3%). Twenty five percent of military member respondents had never been deployed, 58.3% responded to the survey post-deployment, and 16.7% took the survey pre-deployment. Of participants who identified themselves as military members or veterans, mean number of deployments was 1.50 (SD = 1.09). Of those who had been deployed since 2001, mean length of time since most recent deployment was 2.37 years (SD = 2.15). Respondents were either in a committed relationship or marriage and living together (86.2%) or not living together (13.8%). Participants had been in their current relationship for an average of 5.43 years (SD = 3.04).

Measures

Demographic questionnaire. The demographic questionnaire (Appendix A) gathered descriptive information including: age, gender, ethnicity, relationship status, length of
relationship, military service branch, number of deployments, time since most recent
deployment, military status (i.e., veteran, active duty, etc.), deployment status, and sexual
orientation.

**PTSD Checklist – Military Version (PCL-M)** (Weathers, Litz, Huska, & Keane, 1994). The severity of military trauma symptoms was assessed using the PCL-M (Appendix B). The PCL-M asks about symptoms in response to "stressful military experiences." It is often used with active service members and veterans. This self-report measure assesses reexperiencing, avoidance, and hyperarousal symptoms of PTSD. Participants are asked to rate the frequency of each symptom on the 17 item self-report checklist with answers given on a five-point Likert-type scale; 1 indicating “not at all” and five indicating “extremely,” with higher total scores indicating greater severity of trauma symptoms. The PCL-M has been found to have an internal consistency reliability of .96 and a discriminant validity of .64. Internal consistency reliability in the current sample was .77.

**Relationship Assessment Scale (RAS)** (Hendrick, Dicke, & Hendrick, 1988). The RAS (Appendix C) is a 7-item scale designed to measure general relationship satisfaction. This scale was chosen because it was designed to assess global relationship satisfaction for any individual in an intimate relationship, not a marital relationship exclusively. Respondents answer each item using a 5-point scale ranging from 1 (low satisfaction) to 5 (high satisfaction) The RAS has been found to have an internal consistency reliability of .86. Internal consistency reliability in the current sample was .90.

**Needs analysis.** A needs analysis (Appendix D) was created to assess: the extent to which couples know about available counseling services, which services they have used and why, if these services address interpersonal symptoms of PTSD, how helpful the couples
counseling services were, barriers to utilizing counseling services, perceived service needs, types of couples counseling modalities respondents would utilize, main stressors encountered during their relationships, and specific relationship skills respondents would like help with. Responses were in the form of checklists and free responses.

**Procedure**

In this study, participants were presented with and asked to read the document of informed consent. They were reminded that they were free to not answer any question they did not feel comfortable with and that their responses were anonymous. After indicating consent to the online survey, they were presented with the demographic questionnaire. Military members and veterans were presented with additional questions about military branch and deployment status that were not visible to partners of military service members. Respondents with military experience then completed the 17-item PCL-M to assess the severity of PTSD symptoms; this measure was not visible to partners of military service members. All participants then completed the 7-item RAS to measure general relationship satisfaction. For the needs analysis, participants were asked to “check all that apply” in response to questions about perceived needs and barriers to accessing couples counseling resources. Participants were also encouraged to offer additional detail about responses in free text boxes. Military members and veterans were asked additional questions about whether they had received mental health treatment for PTSD, whether this treatment was in an individual or couples format, and if this treatment addressed interpersonal symptoms of PTSD. These military-specific questions were not visible to non-military-affiliated participants. Pacific University’s Institutional Review Board approved this study.

**Results**
Descriptive data for the PCL-M and RAS are provided in Table 1. The suggested cut-point for the PCL-M in general population samples is 30-35 (U.S. Department of Veterans Affairs, 2012).

Table 1

**Means, Ranges, and Standard Deviations for PCL-M and RAS Total Scores**

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>M</th>
<th>Minimum</th>
<th>Maximum</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCL-M</td>
<td>12</td>
<td>24.5</td>
<td>17</td>
<td>33</td>
<td>6.29</td>
</tr>
<tr>
<td>RAS</td>
<td>29</td>
<td>28.79</td>
<td>17</td>
<td>35</td>
<td>5.43</td>
</tr>
</tbody>
</table>

**Hypothesis 1: Increased severity of PTSD symptoms will be associated with decreased relationship satisfaction**

A Pearson product-moment correlation was calculated between PCL-M total score and RAS total score (RAS scores were converted to z-scores) to determine if a significant relationship existed between the two variables in a sample of military service members and veterans. A one-tailed test p value of less than .05 was required for significance. The results of the correlational analysis indicated that the correlation between PCL-M total score and RAS total score was negative but small and not significant (\( r = -.03, p = .47 \)).

**Hypothesis 2: Lower levels of relationship satisfaction will be associated with a higher number of perceived barriers to accessing counseling resources**

A Pearson product-moment correlation was calculated between RAS total score (RAS scores were converted to z-scores) and total number of perceived barriers to accessing counseling resources to determine if a significant relationship existed between the two variables in a sample of military service members and veterans and their partners. A one-tailed test p value of less than .05 was required for significance. There was a significant negative relationship.
between RAS total score and total number of perceived barriers \( r (29) = -.50, p = .003 \) (see Figure 1). The 95% confidence interval for the population correlation coefficient would be between a value of -.84 and -.16.

![Scatterplot depicting the correlation between participants’ RAS total score and total number of perceived barriers to mental health treatment.](image)

**Figure 1.** Scatterplot depicting the correlation between participants’ RAS total score and total number of perceived barriers to mental health treatment.

**Note.** RAS total scores were converted to z-scores before calculating the correlation coefficient.

**Hypothesis 3:** Military service members with PTSD who address interpersonal symptoms of trauma in either individual or couples counseling will have higher relationship satisfaction than military members with PTSD that do not address interpersonal symptoms during counseling.
This hypothesis was not tested because only one participant indicated that he addressed interpersonal symptoms of trauma in individual or couples counseling.

**Analyses of Group Differences**

Data was further analyzed, using one-way analysis of variance (ANOVA), for differences between the group of military members or veterans and the group of partners of military members or veterans. A one-way ANOVA was conducted to evaluate the difference between military members and their partners pertaining to: number of perceived barriers to treatment, number of couples counseling resources participants were aware of, total number of relationship stressors endorsed, and total number of relationship areas participants indicated they wanted help with. The independent variable included two conditions: current military members or veterans and partners of military members or veterans. The dependent variables were: number of perceived barriers to treatment, number of couples counseling resources participants were aware of, total number of relationship stressors endorsed, and total number of relationship areas participants indicated they wanted help with. Prior to interpreting the ANOVAs, the data were tested to determine if the homogeneity of variance assumption was violated. The Levene’s test for the equality of variance was not significant for number of perceived barriers to treatment ($F = .02, p = .90$), number of couples counseling resources participants were aware of ($F = .99, p = .33$), and total number of relationship areas participants indicated they wanted help with ($F = .16, p = .69$), so equal variances were assumed. The one-way ANOVAs were not significant for any of the outcome variables, indicating that there were not significant differences in number of perceived barriers to treatment, number of couples counseling resources participants were aware of, or total number of relationship areas participants indicated they wanted help with among the two groups. Levene’s test was significant for total number of relationship stressors endorsed ($F = .
6.01, \( p = .02 \), so equal variances were not assumed. The Welch test indicated that there was not a significant difference between groups on number of relationship stressors endorsed \( (F = 2.66, p = .12) \).

**Needs Analysis**

Results of several questions from the needs analysis are depicted below (see Table 2 and Table 3).

Table 2

<table>
<thead>
<tr>
<th>Counseling Format</th>
<th>Participants Aware of Resource (%)</th>
<th>Participants Who Have Used Resource (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaplain</td>
<td>72.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Face-to-face counseling</td>
<td>69.0</td>
<td>20.7</td>
</tr>
<tr>
<td>Marriage retreats</td>
<td>62.1</td>
<td>13.8</td>
</tr>
<tr>
<td>MFLAC</td>
<td>58.6</td>
<td>10.3</td>
</tr>
<tr>
<td>Online behavioral health resource center</td>
<td>44.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Relationship enhancement classes</td>
<td>44.8</td>
<td>3.5</td>
</tr>
<tr>
<td>None</td>
<td>10.3</td>
<td>65.5</td>
</tr>
<tr>
<td>Other(^a)</td>
<td>3.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

*Note. MFLAC = Military Family Life Consultant.*

\(^a\)One participant indicated awareness of "VA-counseling."

Of 10 participants who had used relationship counseling, just one indicated that the relationship counseling addressed trauma symptoms. On a scale from 0 “not at all helpful” to 10 “completely resolved/learned to handle our issues,” respondents who had attended relationship counseling rated the helpfulness of this counseling as 5.8 on average \( (SD=2.4, \text{mode}=8) \).
Table 3

<table>
<thead>
<tr>
<th>Barriers to Accessing Counseling Resources</th>
<th>Participants Endorsing Barrier (%)</th>
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</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>44.8</td>
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<tr>
<td>Not aware of available resources</td>
<td>20.7</td>
</tr>
<tr>
<td>Unwillingness of one partner</td>
<td>20.7</td>
</tr>
<tr>
<td>Location</td>
<td>13.8</td>
</tr>
<tr>
<td>Cost</td>
<td>6.9</td>
</tr>
<tr>
<td>Lack of available services</td>
<td>6.9</td>
</tr>
<tr>
<td>None</td>
<td>31.0</td>
</tr>
<tr>
<td>Other a</td>
<td>6.9</td>
</tr>
</tbody>
</table>

aTwo participants indicated difficulty finding time for an appointment as a barrier to treatment.

Respondents indicated that they would most likely use relationship counseling resources in the form of couples counseling (74.1%), online education (44.4%), or preventative measures (44.4%). The main challenges respondents reported they faced in their relationships were frequent separations (51.7%), difficulty communicating (41.4%), limited family time (41.4%), financial stress (34.5%), lack of physical intimacy (27.6%), and frequent moves (27.6%). Relationship areas that participants frequently wanted help with were communicating (27.6%), physical intimacy (27.6%), dealing with time apart (24.1%), and spending time together (24.1%). Several participants (27.6%) reported that there were no relationship skills or areas they would like help with.

Participant responses to the question “What do you feel is missing from available services or could be improved to help with your relationship?” fell into four main themes: stigma, awareness, accessibility, and familiarity with a counselor. Several respondents noted that reducing “stigma of counseling and mental health problems,” and keeping counseling off of a military member’s records would increase participation in counseling. Participants also mentioned that progress in treatment is stunted when they cannot see the same therapist consistently. There were mixed views on the effectiveness of relationship counseling advertising
– some respondents felt services were sufficiently advertised while others, partners of service members in particular, were not aware of services and felt that more advertisement was needed. Making time for therapy sessions on a busy military schedule was also reported as a challenge. Other suggestions included a support group for partners of military service members, “sexual counseling,” and greater focus on relationships in which both partners are members of the military.

**Discussion**

The purpose of this study was to explore the relationships between relationship satisfaction, trauma symptoms, and perceived barriers to treatment among military service members or veterans and their partners. A needs analysis was included to further understand the extent to which couples mental health resources are used and which resources military couples are interested in.

**Hypothesis 1: Increased severity of PTSD symptoms will be associated with decreased relationship satisfaction**

The hypothesis that increased severity of PTSD symptoms would be associated with decreased relationship satisfaction was unsupported. Unlike previous findings, relationship satisfaction as measured by the RAS did not decrease significantly with increased total scores on the PCL-M, although the relationship was in the predicted direction. Among the sub-sample of participants who completed the PCL-M (n=12), the average score was 24.5, indicating that the sample as a whole did not exhibit a clinically significant level of PTSD symptoms. It is possible that a limited sample size and a limited range of scores on the PCL-M led to findings that conflict with other research. Gewirtz et al. (2010) found that an increase in PTSD symptoms on the PCL-M was associated with poorer couple adjustment. Similarly, Allen et al. (2010) found
that PTSD symptoms were significantly positively correlated with negative relationship patterns in all marital functioning areas examined. Further supporting this pattern of findings, Erbes et al. (2011) found that soldiers who screened positive for PTSD showed significantly poorer relationship adjustment both 2-3 months after their return from combat duty and 1 year later. Based on the findings of the current study, it may be hypothesized that trauma symptoms at subclinical levels do not have a significant negative effect on relationship satisfaction.

**Hypothesis 2: Lower levels of relationship satisfaction will be associated with a higher number of perceived barriers to accessing counseling resources**

The hypothesis that lower levels of relationship satisfaction would be associated with a higher number of perceived barriers to accessing counseling resources was supported. Total scores on the RAS and total number of perceived barriers to treatment were significantly negatively correlated, $r (29) = -.50, p = .003$, meaning that participants who perceived more obstacles to obtaining couples mental health treatment were less satisfied with their relationships on average. To the researcher’s knowledge, this relationship has not been studied previously. Based on previous surveys of barriers to mental health treatment in the military population, it is understandable that people in need of relationship support who perceive help as hard to obtain may feel an increased sense of hopelessness, lowering their relationship satisfaction. While previous surveys have found that military members acknowledge several barriers to treatment, this finding highlights why it is important to address those barriers. Price et al. (2011) found that increased social support, including emotional support provided by intimate partners, was associated with less severe PTSD symptoms and improved treatment response in OIF/OEF veterans. It is important to address barriers to couples mental health treatment in order to
improve relationship satisfaction and, in turn, increase resilience of military service members during and after traumatic experiences.

**Hypothesis 3:** Military service members with PTSD who address interpersonal symptoms of trauma in either individual or couples counseling will have higher relationship satisfaction than military members with PTSD that do not address interpersonal symptoms during counseling

Due to only one participant receiving treatment for PTSD, this hypothesis was not tested. Future studies could target a population of military service members who have received treatment for PTSD and examine the differences in relationship satisfaction pre- and post-treatment among those who address interpersonal symptoms during treatment and those who do not. It would be useful to replicate findings of Monson et al. (2012) that indicated that including partners in PTSD treatment yielded treatment effect sizes equal to or larger than effect sizes found with individual treatments for PTSD. It is important to continue to examine which modality of PTSD treatment leads to the most comprehensive improvement in military members’ life functioning.

**Needs Analysis**

Based on this study, it seems that barriers to care and rates of service utilization of individuals in the military can be generalized to military couples. Previous research has found that 23 to 40 percent of military service members have sought mental health care (Hoge et al., 2004). The results of this study indicated that a similar percentage (34.50%) of respondents have used couples mental health services. Previous research has also found that nearly a quarter of deployed service members indicated that they did not know where to go for behavioral health services (U.S. Army, 2003); similarly, 20.7% of participants in this study indicated that they
were not aware of available couples counseling resources. Barriers to receiving couples mental health care appear to be similar to barriers to individual mental health care in the military. For example, stigma was the most commonly endorsed barrier to couples mental health care in this survey, as it was in surveys assessing barriers to individual treatment (Hoge et al., 2004; U.S. Army, 2003; U.S. Army, 2005). This study also provides more specific preliminary information about military couples that has not been gathered previously. For instance, respondents indicated that they would most likely use relationship counseling resources in the form of couples counseling, online education, or preventative measures. The main challenges respondents reported they faced in their relationships were frequent separations, difficulty communicating, limited family time, financial stress, lack of physical intimacy, and frequent moves. Relationship areas that participants frequently wanted help with were communicating, physical intimacy, dealing with time apart, and spending time together. This information can be used in designing interventions for military couples.

**Limitations and Strengths**

Small sample size was a major limitation to this study, resulting in less statistical power, increased Type II error, and decreased ability to generalize findings. In addition, only 12 respondents were members of the military or veterans and only one of these participants had received treatment for PTSD. This prevented some goals of this study from being met: it was not possible to evaluate relationship satisfaction differences in service members addressing interpersonal symptoms of PTSD compared to those that did not and it could not be determined whether a couples therapy modality or an individual treatment format for PTSD was more effective at improving relationship satisfaction. The majority of military service members or veterans did not exhibit clinically significant PTSD symptoms. This restricted range of PTSD
symptoms reduced the ability to observe differences in relationship satisfaction across the full range of symptom severity. Replication with a larger, more diversely symptomatic sample may yield different results.

This study was also limited by the recruitment method. The use of snowball sampling, rather than random sampling, may have induced self-selection bias into the results. It is possible that military service members or veterans who experience significant symptoms of PTSD would be less likely to voluntarily respond to a survey that asks them to think of ways in which the traumatic experience has affected their lives. Therefore, the results of this study may only be applicable to military populations with low levels of trauma symptoms. In addition, there was an underrepresentation of non-Caucasian, non-heterosexual relationships and the average length of participants’ current relationships was relatively short (5.43 years). Military couples with different characteristics may have responded to questions about relationship satisfaction, service utilization, and barriers to care differently.

Because of the cross-sectional and exploratory nature of this study, there was no pretest to evaluate relationship satisfaction before military involvement. It cannot be assumed that variations in relationship satisfaction are only due to military involvement or trauma symptoms. In relation to this, no causality can be determined based on this study - only relationships between variables were evaluated.

Despite these limitations, this study is a valuable first step in understanding service utilization and barriers among military couples and how they relate to PTSD symptoms and relationship satisfaction. Previous surveys have focused only on individual mental health; however, with the knowledge that increased social support via intimate partners is associated with less severe PTSD symptoms and improved treatment response (Price et al., 2011), it is
appropriate that the topic of military couples’ relationship satisfaction receive more research attention.

**Suggestions for Further Research**

Replication of existing studies is always beneficial to increase generalizability and accuracy of findings. This study could benefit from replication with a larger, more ethnically diverse sample. Recruiting participants with different sexual orientations, a wider range of PTSD symptoms, and lengthier relationships would also be useful in understanding how relationship satisfaction and barriers to care vary in relationship to those characteristics.

In order to ensure that the most effective treatment modality is being used to treat PTSD, future research could examine the efficacy of individual treatment for PTSD and couples treatment for PTSD both in reducing symptoms of trauma and increasing relationship satisfaction. Additionally, it would be useful to compare the efficacy of PTSD treatment that does not address interpersonal symptoms of trauma, such as difficulties in communication, validation, and intimacy, and PTSD treatment that does focus on those areas. A longitudinal study examining relationship functioning throughout the course of a military career would be useful in locating when and in what circumstances the most difficulties arise in order to target those areas in couples mental health treatment.

Another important area for further research is the stigmatization of mental health care in the military. It is the most common barrier to utilization of individual mental health care in the military and, as found by this study, utilization of couples mental health resources. Researchers could first evaluate military service members’ perceptions of colleagues who use mental health care resources and their assumptions of how they would be perceived if others found out they used mental health resources. This information could be used to inform military policy on the
confidentiality of mental health services and diagnoses and in developing campaigns to reduce stigma of mental health care in the military. Changing military policy to keep mental health care usage and diagnoses confidential, except for predetermined diagnoses that would directly affect job performance, may reduce fear of stigmatization and increase mental health service usage in the military population.

**Conclusion**

Previous research has documented the many challenges military couples face in creating and maintaining satisfying and supportive relationships, including the challenges posed by PTSD symptoms. This study examined the relationships between PTSD symptoms, relationship satisfaction, and perceived barriers to utilization of couples’ mental health resources. No relationship was found between PTSD symptoms and relationship satisfaction. Levels of relationship satisfaction were negatively correlated with number of perceived barriers to accessing counseling resources. Other goals of this study were to assess the extent to which interpersonal symptoms of trauma are addressed in treatment for PTSD and to determine the current utilization of couples’ mental health resources and the preferred format of couples’ services. Whether PTSD treatment that addresses interpersonal symptoms of trauma is associated with increased relationship satisfaction remains to be determined, as the makeup of respondents to this survey did not allow for testing of that hypothesis. The majority (65.5%) of participants had not used any form of relationship counseling. The most commonly cited barriers to care were stigma, unwillingness of one partner, and lack of awareness of available services. The most commonly used relationship resources were face-to-face counseling, marriage retreats, and Military Family Life Consultants. Participants indicated that they would be most likely to use relationship counseling in the form of traditional couples counseling, online education, or
preventative measures (i.e., relationship counseling prior to deployment). These findings are important in informing military policy related to decreasing stigma and increasing awareness of couples mental health resources. Improving the quality of military couples’ relationships could possibly decrease severity of mental health symptoms and increase resilience of military personnel, thereby improving retention rates in the military.
References


approach to the reduction of PTSD avoidance symptoms: Preliminary findings. *Journal of Marital and Family Therapy*, 35, 343-349. doi: 10.1111/j.1752-0606.2009.00125.x


Appendix A

Demographic Questionnaire

Are you ______?:
__A Service Member or Veteran
__The partner of a Service Member or Veteran
__Both

Age:_____________

Gender:
__Male
__Female
__Other:_____________

Sexual Orientation:
__Heterosexual
__Gay or Lesbian
__Bisexual
__Other:_____________

Which group best describes your ethnicity (check all that apply)?:
__African American or Black
__Asian or Pacific Islander
__Latino or Hispanic
__American Indian or Alaskan Native
__White or of European Origin
__Other:________________

Marital or relationship status:
__In a committed relationship/marriage and living together
__In a committed relationship/marriage and not living together
__Not in a committed relationship/marriage

How long have you been with your spouse/partner?: _________________

Military service members only:

Military service branch (if applicable):
__Air Force
__Army
__Coast Guard
__Marine Corps
__National Guard
__Navy
Number of deployments since 2001 (if applicable): __________

Length of time since most recent deployment: __________

Which option best describes your current status?:
  __Active duty
  __Combat duty
  __Active Reserve
  __Inactive Reserve
  __Veteran
  __Retiree

Which option best describes your deployment Status:
  __Pre-deployment
  __Currently deployed
  __Post-deployment
  __Never been deployed

Have you ever been formally diagnosed with PTSD?:
  __Yes
  __No
  __Unsure
Appendix B

PTSD Checklist – Military Version (PCL-M)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
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<tbody>
<tr>
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<td>16.</td>
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<td>17.</td>
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</table>

Has anyone indicated that you've changed since the stressful military experience? Yes ___ No ___
Appendix C

RELATIONSHIP ASSESSMENT II SCALE:

Please mark on the answer sheet the letter for each item which best answers that item for you.

How well does your partner meet your needs?

A B C D E
Poorly Average Extremely well

In general, how satisfied are you with your relationship?

A B C D E
Unsatisfied Average Extremely satisfied

How good is your relationship compared to most?

A B C D E
Poor Average Excellent

How often do you wish you hadn’t gotten in this relationship?

A B C D E
Never Average Very often

In what extent has your relationship met your original expectations:

A B C D E
Hardly at all Average Completely

How much do you love your partner?

A B C D E
Not much Average Very much

How many problems are there in your relationship?

A B C D E
Very few Average Very many

NOTE: Items 4 and 7 are reverse scored. A=1, B=2, C=3, D=4, E=5. You add up the items and divide by 7 to get a mean score.
Appendix D

Needs Analysis

What relationship counseling resources are you aware of, if any (check all that apply)?
__Chaplain
__Military Family Life Consultant (MFLAC)
__Face-to-face counseling
  Please indicate which organization this service is provided through (e.g., Military OneSource, military treatment facility, etc.): ___________________________
__Online behavioral health resource center
  Please indicate name of resource center, if known: ___________________________
__Relationship enhancement classes
  Please indicate name of program, if known: ___________________________
__Marriage Retreats
  Please indicate name of program, if known: ___________________________
__Other: ________________________________________________________________
__None

Which relationship counseling resources have you used, if any (check all that apply)?
__Chaplain
__Military Family Life Consultant (MFLAC)
__Face-to-face counseling
  Please indicate which organization this service is provided through (e.g., Military OneSource, military treatment facility, etc.): ___________________________
__Online behavioral health resource center
  Please indicate name of resource center, if known: ___________________________
__Relationship enhancement classes
  Please indicate name of program, if known: ___________________________
__Marriage Retreats
  Please indicate name of program, if known: ___________________________
__Other: ________________________________________________________________
__None

Have you ever received counseling services for relationship issues with your current partner?
__No
__Yes
  Please describe service utilized: ____________________________________________
  Reason for seeking counseling: ____________________________________________

How helpful has relationship counseling been for your relationship on a scale from 0 to 10 (with 0 being “not at all helpful” and 10 being “completely resolved/learned to handle our issues”)? ________

Has this relationship counseling addressed trauma symptoms?
What, if any, barriers exist to accessing counseling resources (check all that apply)?

- Stigma (e.g., “reaching out for counseling is a sign of weakness”)
- Location
- Cost
- Unwillingness of one partner
- Lack of available services
- Not aware of available resources
- Other: ____________________________
- None

What do you feel is missing from available services or could be improved to help with your relationship? __________________________________________________________

What type of service modality would you most likely utilize (check all that apply)?

- Online education
- Preventative measures
- Lecture style presentation
- Support group
- Skills group
- Couples counseling
- Telephone or Skype counseling
- Other: ______________________________________________________________

What are the main challenges or stressors you encounter in your relationship (check all that apply)?

- Frequent separation
- Difficulty communicating
- Frequent moves
- Limited family time
- Dishonesty
- Infidelity
- Financial stress
- Domestic violence
- Substance abuse
- Lack of physical intimacy
- Coping with mental health difficulties (e.g., depression, grief, PTSD, etc.)
- Coping with physical injury
- Changes in marital roles and expectations
- Problems with children
- Deployment related stressors
- Reunion related stressors
- Other: ______________________________________________________________
What, if any, are some relationship skills/areas you would like help with (check all that apply)?

- Preparing for deployment
- Dealing with time apart
- Adjusting to different roles
- Managing reintegration after deployment and reconnecting
- Managing relocations
- Conflict resolution
- Communicating
- Physical intimacy
- Spending time together
- Collaborative problem-solving and decision making (e.g., related to finances, children, etc.)
- None
- Other: ____________________________________________________________

Military service members only:

Are you currently receiving mental health treatment for Posttraumatic Stress Disorder (PTSD)?

- No
- Yes

  Which modality was/is used for treatment?
  - Individual counseling
  - Couples’ counseling
  - Both
  - Other: ________________

Has this treatment addressed the interpersonal difficulties associated with PTSD?

- No
- Yes

  What are/were the interpersonal difficulties that are addressed during treatment (check all that apply)?
  - Avoidance
  - Feelings of detachment
  - Irritability/outbursts of anger
  - Restricted range of feelings
  - Other: ______________________________