

# One Day at a Time: The Experiences of Partners of Veterans With Posttraumatic Stress Disorder

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The intimate partners of veterans living with posttraumatic stress disorder (PTSD) often have few opportunities to articulate in their own words how the disorder affects them and their families. Besides relationship challenges and stress associated with assuming a caregiver role, partners may endure their own psychological distress. These occurrences may be overlooked when treating PTSD, as the focus is usually on the veteran and from the veteran's perspective. Engaging significant others and understanding their perspective is paramount to both the veteran's recovery and the well-being of the couple. We mailed surveys to partners of veterans with PTSD as part of a larger study that assessed PTSD-related knowledge, beliefs, treatment involvement, and quality of life. At the end of the survey was an optional free-text section inviting partners to share any other information related to their circumstances. Of all survey respondents, over half ( $n = 252$ ) provided comments. We used this opportunity to explore these partners' experiences of living with a veteran diagnosed with PTSD. Using a thematic analysis framework, independent raters coded comments relating to relationships, partner/family reactions, protective factors, mental health services, reactions to study participation, and general remarks. Findings highlighted the myriad ways in which PTSD impacts both partners and families, strategies partners use to cope, and specific mental health services they believe would be most beneficial. Responses suggested a continued need to include partner perspectives in future work, and to provide mental health services targeted to partners of veterans with PTSD.

*Keywords:* posttraumatic stress disorder, veterans, intimate partners, quality of life, marital relationship

Posttraumatic stress disorder (PTSD) among veterans remains a chronic, often difficult struggle with lasting effects on personal relationships. Yet, how the disorder affects those closest to them is often not captured through traditional treatment or research. Between fiscal years (FY) 2005 and 2010, PTSD diagnoses within the

U.S. Department of Veterans Affairs, Veterans Health Administration (VHA) grew at an annualized rate of roughly 12%, and nearly 500,000 veterans had at least one outpatient visit for PTSD in FY 2010 (Hermes, Rosenheck, Desai, & Fontana, 2012). PTSD affects many veterans' lives; however, given that approximately

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70% of veterans are married (Department of Veterans Affairs, 2010), the number of affected individuals is considerably larger, and is even higher when those in unmarried, committed partnerships are included.

The influence of PTSD on intimate relationships and partner psychological well-being can be substantial (Lambert, Engh, Hasbun, & Holzer, 2012). Data from previous studies identified associations between more severe symptoms of PTSD and poorer relationship quality (Meis, Barry, Kehle, Erbes, & Polusny, 2010), lack of intimacy (Riggs, Byrne, Weathers, & Litz, 1998), and physical aggression (Taft, Watkins, Stafford, Street, & Monson, 2011). Partners may experience sleep difficulties (Outram, Hansen, Macdonell, Cockburn, & Adams, 2009), anxiety, depression (O'Toole, Outram, Catts, & Pierse, 2010), and caregiver burden (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005). Moreover, these problems appear to have a larger impact among military and veteran partner samples compared with civilian groups (Lambert et al., 2012).

Although this research has provided compelling evidence that veterans' PTSD deeply affects those around them, these studies have tended to use quantitative methods with small, clinic-based, and convenience samples (Renshaw & Caska, 2012; Sautter et al., 2006; Sherman et al., 2005), or only sampled veterans (Meis et al., 2010). Qualitative work in this area often relies on semistructured interviews (Dekel et al., 2005; Lyons, 2001; Outram et al., 2009), which focus participant conversations, but may limit responses to researchers' predefined constructs rather than allow respondents to address their most salient concerns. Empowering individuals to self-identify prominent issues in their relationships is vital for clinicians and others to be able to support partners living with a veteran diagnosed with PTSD.

We present qualitative data obtained from the optional, free-text section in a survey of partners of veterans with PTSD. Our survey aimed to identify opportunities for developing and augmenting partner education and involvement in veterans' care, and improving quality of life for veterans and their partners. We received a large, unexpected number of comments. The strength of the emotional narratives shared and their explicit calls for additional services were so compelling that we wanted to examine the comments using a thematic approach to help us categorize and better understand the issues facing partners of veterans with PTSD. Given the data-collection method, we emphasize the exploratory nature of this effort. Rather than testing specific hypotheses, we aim to synthesize and describe the information offered by intimate partners. To our knowledge, this is the first study to provide a description of the "lived experience" of partners of veterans diagnosed with PTSD by examining the written words of their significant others.

## Method

### Participants

As part of a larger survey study examining PTSD-related knowledge, attitudes, beliefs, care involvement, and quality of life, partners of veterans diagnosed with and seeking treatment for PTSD in the Veterans Affairs Pacific Islands Health Care System (VAPIHCS) provided written commentary about their experiences.

For the parent study, we mailed eligible veterans study information and asked them to pass the information along to their spouses or intimate partners. Of the 1,911 veterans presumed contacted, 573 intimate partners (hereafter *partners*) opted into the study and 455 partners returned completed surveys. Of the completed surveys, 252 partners included written comments, which we examined and have presented here. Complete details describing study eligibility criteria and recruitment are described elsewhere (Mansfield, Schaper, & Rosen, 2014). The VAIPHCS Institutional Review Board approved all study procedures and waived the requirement for documentation of informed consent.

Table 1 displays the demographic profile of qualitative respondents (hereafter *respondents*). Nearly all respondents were female ( $n = 243$ , 96.4%) with a mean age of 57.6 years ( $SD = 10.4$ ). The average duration of the intimate partnership with the veteran was 26.7 years ( $SD = 14.3$ ), and almost half of the respondents (46.4%) reported children—including adult children and grandchildren—living in the home. Most respondents lived within the Hawaiian Islands (83.0%) and self-identified as White (32.5%), Native Hawaiian or Pacific Islander (30.6%), Asian (17.5%), or of multiracial/multiethnic heritage (15.5%). The majority were partnered with veterans from the Vietnam War (71.8%) and Persian Gulf War (18.3%) eras.

### Survey

The survey comprised 82 items asking partners to endorse their knowledge of PTSD symptoms and treatments; beliefs about PTSD etiology, treatment, and prognosis; the couple's communication and level of the partner's participation in the veteran's treatment; and changes (positive, negative, no change) in the partner's quality of life (e.g., physical, emotional, social domains) attributable to their partners' PTSD. At the end of the survey, we included a prompt for an optional, free-text section stating, "If there is anything else that you would like to share relating to PTSD in veterans and your own experiences, please do so below."

### Data Analysis

We based our exploration on the thematic analysis (TA) approach, which aims to identify important themes (i.e., patterns of meaning) from the data (Joffe, 2012). An advantage of TA is that it provides a flexible approach to analyzing qualitative data without losing the depth of the data content (Braun & Clarke, 2006). Thus, our intent was to identify broad themes among the comments that participants wrote.

Comments ranged in length from one sentence to several typed pages and were transcribed verbatim. To determine themes, two research assistants (2nd and 3rd authors) independently reviewed all comments, identified provisional themes encompassing the majority of data, and sought approval from the first author. Six themes were identified: (a) mental health service encounters and requests for help, (b) relationships, (c) partner or family reactions to living with someone with PTSD, (d) protective factors, (e) responses to the study, and (f) miscellaneous comments. We developed a codebook of operational definitions, key words, and examples, and clarified codes as needed throughout the process. Coders independently parsed text segments from respondent data

Table 1  
*Characteristics of Commenters, Noncommenters, and Respondent-Matched Veterans*

Demographic	Commenters ( <i>n</i> = 252)		Noncommenters ( <i>n</i> = 203)	
	<i>n</i>	%	<i>n</i>	%
Age (years), <i>M</i> ( <i>SD</i> )	57.6	(10.4)	56.3	(12.3)
Time in relationship (years), <i>M</i> ( <i>SD</i> )	26.6	(14.3)	27.9	(14.9)
Gender <sup>a</sup>				
Women	243	96.4	196	96.6
Men	8	3.2	7	3.4
Race/Ethnicity <sup>b</sup>				
White	82	32.5	63	31.0
Hawaiian/Pacific Islander	77	30.6	57	28.1
Asian	44	17.5	41	20.2
Multiple races/ethnicities	39	15.5	26	12.8
Hispanic	4	1.6	5	2.5
Black	4	1.6	3	1.5
American Indian/Alaskan Native	1	0.4	0	0
Missing data	1	0.4	8	4.0
Location <sup>c</sup>				
Hawaii	209	83.0	166	81.8
Guam, American Samoa, CNMI	43	17.0	37	18.2
Veteran service period				
World War II	4	1.6	4	2.0
Pre-Korean	0	0	1	0.5
Korean	8	3.2	7	3.5
Post-Korean	1	0.4	1	0.5
Vietnam Era	181	71.8	132	65.0
Post-Vietnam	12	4.8	13	6.4
Persian Gulf/OEF/OIF	46	18.3	45	22.2

*Note.* *T*-test and chi-square analyses did not indicate any statistically significant differences between groups ( $\alpha = .05$ ) for the variables presented; percentages may not add to 100 due to rounding; CNMI = Commonwealth of the Northern Mariana Islands; OEF/OIF = Operation Enduring Freedom/Operation Iraqi Freedom.

<sup>a</sup> One respondent was missing data for gender. <sup>b</sup> One respondent was missing data for race/ethnicity. <sup>c</sup> Although the home address was known for all respondents, individuals living in Guam, American Samoa, or CNMI were grouped together to avoid potential identification of veterans or their partners due to fewer participants from these locations.

into themes, with the first author reviewing any discrepancies. Comments could fall into more than one theme to capture all relevant content. Overall interrater agreement was 92.3%.

## Results

Comments most frequently addressed mental health services (59.5%), relationships (49.2%), and partner or family-member reactions (40.9%; see Table 2). Independent-samples *t* tests

indicated that comments by category did not vary appreciably with the partner's age or length of time in the intimate partnership (all *ps* > .05). However, chi-square analyses indicated that, when compared with respondents without children living at home, partners with children in the home were more likely to describe troubled relationships,  $\chi^2(1) = 5.11, p = .02$ ; adverse reactions to the veteran's PTSD,  $\chi^2(1) = 6.44, p = .01$ ; and making behavioral changes as a result of the veteran's PTSD,

Table 2  
*Presence, Rater Agreement, and Descriptive Data of Respondents, by Theme*

Theme	Presence of category <i>n</i> (%) <sup>a,b</sup>	Rater agreement (%)	Age in years <i>M</i> ( <i>SD</i> )	Relationship length in years <i>M</i> ( <i>SD</i> )	Children living in home <i>n</i> (%) <sup>c</sup>
Mental health services	150 (59.5)	90.9	56.9 (10.4)	26.4 (14.2)	74 (63.3)
Relationship	124 (49.2)	100.0	56.7 (10.3)	26.8 (13.6)	65 (55.6)
Partner/family reaction	103 (40.9)	89.3	57.8 (8.8)	27.6 (12.9)	60 (51.3)
Protective factors	44 (17.5)	94.8	57.7 (11.5)	30.1 (14.0)	24 (20.5)
Response to Study	44 (17.5)	93.3	58.5 (9.1)	26.8 (13.4)	23 (19.7)
Miscellaneous	67 (26.6)	85.3	59.2 (9.4)	27.9 (14.8)	30 (25.6)

*Note.* Categories are not mutually exclusive.

<sup>a</sup> Percent of all responses. <sup>b</sup> Percentages do not add to 100 because comments may have been coded in multiple categories. <sup>c</sup> Percentage of individuals with children living in home (*n* = 117).

$\chi^2(1) = 5.30, p = .02$ . All quotes were edited for grammar and ease of reading, with removal of identifying information. Additional quotes are available upon request.

### Mental Health Services

Most comments (59.5%) mentioned mental health services, namely, experiences getting care, or requests for help. Some were critical of the veteran's treatment and services; others praised the process, citing positive changes in their own and the veterans' lives. Several respondents detailed what they believe has helped (e.g., getting involved with other veterans) and hindered (e.g., taking too many different prescribed medications) the treatment process. Many partners expressed wanting greater involvement in the veteran's treatment. Reasons included gaining a better understanding of PTSD, wanting to talk with a professional, offering providers information they would not otherwise have due to the veteran's dishonesty or lack of disclosure, or to simply share the perspective of someone experiencing daily life with the veteran.

#### Partner A.

In general family members seem to be left out. The VA doesn't realize that the issues that have caused the veteran to have PTSD can also result in the family having PTSD, but there is no help for the family. The veteran cannot get better if the family, especially the spouse, still struggles with PTSD.

Respondents also described positive and negative experiences with couples' therapy, individual treatment, and PTSD psychoeducation groups. Comments conveyed disappointment with mental health service cuts, touting the value of these programs and need for support.

#### Partner B.

We used to have a women's group meet at the VA center in [city] that was disbanded due to staffing cuts and reorganization. I really miss this, it helped TREMENDOUSLY with learning about PTSD, recognizing triggers in order to prevent, prepare for, or avoid rages, and reducing enabling. Please help us and bring this back. Other wives I have bumped into agree that we can't do this ourselves—we need guidance.

Some respondents criticized local facilities for low staffing levels or appointment wait times. Others felt the VA health care system was difficult to navigate with few resources for assistance.

#### Partner C.

When scheduling appointments it is difficult because the wait time is usually 30 days . . . Also, there does not seem to be a structure to the VA system, for example, who you see first or who you see next . . . This system makes it very challenging for a veteran with PTSD to have faith in a system that fights you every step of the way instead of being a solid support system for our soldiers.

Many respondents requested help for veterans and themselves. Partners who requested help for their veterans were often very direct (e.g., Partner D simply wrote, "Please, please, help him more!"). Partners who requested individual treatment for themselves often described chronic distress, feeling alone in their situation and needing assistance, but not knowing where to start.

### Relationships

Half (49.2%) of the respondents reflected on their intimate partnerships and provided observations of veterans' interactions with family and friends, both positive and negative. Among those who mentioned marital relationships, most described long-term emotional withdrawal and communication difficulties—common problems among veterans diagnosed with PTSD. Respondents often expressed either frustration with or sadness about the relationship changes. Outside the home, they described a pattern of not developing close relationships with others or of relationship disintegration. In general, respondents shared vivid descriptions of the "rollercoaster" of PTSD and how it has affected their lives, often for decades.

#### Partner E.

As a spouse of 40 years it has finally got a name—PTSD. This condition or disorder was not great to live through and live with. Heaven knows how many times I wanted to walk out on this man. Living in fear of what any outcome might have been and protecting the children was always constant . . . It has affected the lives of our children and I'm sure they have issues that they keep to themselves as adults today . . . It still affects them today, and I know they have been stressed and are still stressed by his actions today.

Besides recounting relationship difficulties, some respondents (10.6%) included accounts of verbal, emotional, and physical abuse—typically of a chronic and unpredictable nature and occurring during an angry outburst. Most expressed an inability to identify triggers that elicited the veteran's quick temper, and as the frequent target, learned to brace themselves for the consequences. Many also described abusive behavior directed toward their children, which complicated veterans' current parent-child relationships. Nevertheless, respondents shared that they often chose to stay to keep the family together because of continued love for the veteran. Others stated that they would like to leave, but felt a sense of obligation and envisioned the veteran getting worse if they did. Still, several respondents attributed the abuse to PTSD and appeared to be more forgiving—reflecting that leaving the marriage was not an option.

#### Partner F.

Every day I ask myself why am I here, why do I keep myself in this marriage. Why do I let myself get beat down with verbal abuse. My life would be so much easier being single. "But" I do it because I didn't meet him this way, He's ill and I can't leave him this way. I see him getting worse if I leave.

In contrast, some respondents described their commitment to their marriages and each other, which helped them to persevere. They did not describe a perfect or easy life, but rather an acceptance that challenges will occur, with a willingness to tackle them together.

#### Partner G.

My husband has a sincere desire to prevent PTSD from impacting our lives negatively. He talks to me about it and attends sessions and group meetings at the VA to help him with anger and irritability, which flares up occasionally. He tries very hard to control it and I try to be patient and understanding.

## Partner/Family Reactions

Partners referenced their own or other family members' responses to veterans' PTSD (40.9%), including positive and negative adaptations and altered behaviors (e.g., reallocation of household and daily responsibilities). Despite the challenges described by many, several partners appeared to endure by cultivating more positive thinking.

### Partner H.

Take it a day at a time. Always have a positive attitude. Always embrace your significant other with love, understanding and support! It helps in your relationship.

Most partners who had negative reactions to their veterans PTSD wrote about years of living with stress, frustration, and fatigue. They observed maladaptation in their children, and expressed how the veteran's symptoms and behaviors had taken a toll on their own well-being.

### Partner I.

The amount of stress on a spouse impacts all aspects of life, causing illness, financial hardship when they cannot work due to PTSD, and the overall quality of life. Some days I could not tell you what happiness is. We merely exist and continue to make sacrifices to keep a peaceful environment and a nonconfrontational mood. And I feel guilty writing this? Like I am sharing a deep secret. Many of our friends and family would be shocked to learn how deep the impact has been. I live with a chameleon, who puts on a different face for others. They don't see the everyday emotional roller coaster we ride to protect him and me from anything that could be emotionally destructive.

Respondents also described adjustments that they and other family members had made to cope with the veteran's PTSD symptoms, even at their own expense. Some changes included avoidance of war-related movies or family functions, taking over household responsibilities to avoid placing stress on the veteran, and becoming the primary breadwinner. Several individuals remarked that they constantly "walked on eggshells" to keep the peace in the household. Some indicated their frustration at the changes; others appeared to accept them as a part of their lives.

### Partner J.

We no longer have company because my friends do not want to spend time with him. My children (from a previous marriage) feel uncomfortable around him and choose not to visit unless necessary. I constantly feel like I have to be accommodating, being careful what I say so I do not anger him. When I say something that bothers him, he snaps and raises his voice and I feel like glass is shattering inside me. I can only imagine what other spouses/partners go through and sympathize with them.

## Protective Factors

Respondents cited various resources and skills for coping with stress (17.5%), including social support, faith, or education about PTSD. They reported using prayer and reflection to find daily strength to cope with their difficulties, and how their faith had kept them in the relationship when they may have otherwise left. Several stated that knowledge of PTSD and its symptoms helped

them to reframe the problems previously attributed to the person and not the illness.

### Partner K.

I only met with my husband's PTSD counselor once. It was very eye-opening. More spouses should meet with the counselor. She explained to me why my husband does things in a certain way. I had a better understanding of why he does things the way he does.

## Responses to Study

Some respondents (17.5%) offered reflections on the process of participating in the study. Many expressed gratitude for "thinking of the spouses" and asking about their experiences and opinions. These reflections were noteworthy, particularly because many respondents remarked that they had never, even after years of VA services, been asked about their thoughts or opinions.

### Partner L.

"Thank you for someone in the VA finally recognizing that there needs to be services available for spouses and partners of veterans."

## Miscellaneous

We also coded miscellaneous comments that did not fit into any other theme (27%). Given our focus on the veteran's significant other, we did not apply a theme to text that was unrelated to the partner. Comments ranged from the veteran's medical conditions (e.g., diabetes) to the VA compensation and pension process, and comments that did not provide enough contextual information to code them within one of our themes (e.g., listing PTSD symptoms).

## Discussion

To our knowledge, our study is the first to examine the written remarks of partners of veterans with PTSD. We aimed to characterize their experiences with PTSD using their own words. Our hope was that, in doing so, we might provide clinicians and researchers a glimpse into their lives that might not be readily apparent. Our invitation to leave comments was open-ended and unrestricted, completed at the partner's leisure, and provided a level of anonymity not afforded through in-person data collection. The relatively high, unexpected response to this invitation suggests our methods induced many respondents to share information most salient to them. In addition, our sample was more ethnically diverse and comparatively larger than previous studies sampling veterans' partners (Dekel et al., 2005; Lyons, 2001). Through partners' own voices, we identified desired services and areas for continuing research and therapeutic enhancement.

Generally, partners described living with someone who communicates poorly, is emotionally distant and easy to anger, which in turn, affects partners' well-being. Many wrote about their deteriorating relationships and resulting feelings of sadness, isolation, anger, and stress. Our findings corroborate previous accounts of PTSD's detrimental effects on relationship quality (Meis et al., 2010), partner distress (Lambert et al., 2012), and behavioral adaptation among caregivers and families (Outram et al., 2009).

Consistent with others' descriptions (Lyons, 2001; Outram et al., 2009), partners frequently discussed mental health services. Many wanted greater involvement in the veteran's treatment to

offer providers insight they might not otherwise receive. Despite several respondents having attended veterans' appointments and participating in couples' therapy, few were currently involved in PTSD treatment. It is unclear if the discrepancy between the desire for greater involvement and partner participation in treatment was due to individual barriers—including veterans restricting participation—or system barriers, such as availability of couples' and family programs. Besides continued research examining factors related to care involvement (Sautter et al., 2006; Sherman, Blevins, Kirchner, Ridener, & Jackson, 2008), clinicians treating PTSD should explore potential challenges and treatment gains of including the intimate partner.

Aside from directly participating in PTSD treatment, many partners expressed a need for spouse or family support groups, individual therapy, or both, to address their own distress. Several had sought individual treatment, yet this appeared to be the exception. This disparity between partners wanting and receiving treatment has been reported elsewhere (Sherman et al., 2005), and represents a gap for the VA and others treating veterans with PTSD to address. The need for intimate partner services is underscored by accounts of abuse among some respondents who often described feeling helpless—not knowing what to do or where to access help. Such reports highlight the familial impact of PTSD and the importance of considering the safety of intimate partners and children. Although clinicians cannot always gain access to family members, we stress the importance of providing family services and support where possible.

Our themes reflect the far-reaching effects of PTSD, with content yielding several recommendations for practice. First, clinicians should keep in mind that partners might have been living with the effects of PTSD for years, possibly decades. Like others (Dekel et al., 2005; Lyons, 2001), our findings suggest that this chronicity may enmesh the identity of the partner with the veteran's PTSD. The illness often dictated partners' behavior; to keep peace in the household and mitigate negative effects on children, partners likely found it easier to change their own thinking and behavior than expect change in the veteran. Second, clinicians should include children of all ages in family work. Many respondents expressed deep concern about how growing up with a parent with PTSD had affected their children, and may be influencing their adult children's current lives and relationships. Third, we stress the importance of providing psychoeducation, recognizing that extra effort may be needed to engage some individuals. Partners who mentioned that they had acquired knowledge about PTSD cited its helpfulness in better understanding the veteran and coping with difficult situations. Last, we urge providers to remain up to date on available resources for partners. Clinicians often have limited interaction with families; thus, providing them with resources whenever possible is invaluable. A variety of media should be used, including in-person groups, Internet resources, and telephone help lines, with special attention to the availability of support in less urban areas.

This exploratory effort has several limitations. The larger survey study was not conceptualized with a qualitative analysis in mind. Qualitative research inherently includes a degree of interpretation, and TA has been criticized for being too flexible and lacking focus (Braun & Clarke, 2006). Relying on written comments included with participants' returned surveys precluded asking follow-up questions, clarifying remarks, and offering support. In addition, a

self-selection bias exists in our sample, both in terms of survey participation and providing commentary. Not all families chose to participate in the original survey (Mansfield et al., 2014) and roughly half (55%) of respondents from the original study provided qualitative remarks. We cannot know why some participants chose to leave comments and others did not. Finally, the majority of respondents were female, which limits the generalizability of our findings. Although partners did not identify issues that were necessarily gender-specific, the experiences, needs and wishes of male partners should also be fully explored.

The utility of free-text, "anything else" data has been questioned (Garcia, Evans, & Reshaw, 2004). Still, analyzing these data may capture important aspects missing from previous research and inform future studies (O'Cathain & Thomas, 2004). Despite not knowing exactly how participants interpreted our invitation to "include anything else," or what motivated specific responses (e.g., to include only topics not on the survey, to expand on survey items), the themes we identified through our analysis were not assessed in the survey. The survey—essentially a checklist—did not include items pertaining to abuse, mental health services for partners or children, protective or coping factors, the veterans' relationships with others (e.g., children, friends), or the research process. Our findings strengthen the existing literature in this field and do so using partners' words—a method that questionnaires alone cannot generally capture.

Ours was mostly a sample of Vietnam veterans' partners whose experiences and needs may differ from partners of more recent veterans. A recent report by the RAND Corporation summarized the differences between pre-9/11 and post-9/11 military caregivers and the needs of each group (Ramchand et al., 2014). Findings highlight that post-9/11 caregivers are typically younger, employed, and more likely to miss work without resources to offset the lost income than their pre-9/11 or civilian caregiver counterparts. They are often caring for younger veterans with mental health or substance-use issues, more likely to utilize mental health services themselves, and to use such resources more often. Yet despite the reported differences between these groups and their veteran partners, they remained similar in their need for support services.

Several efforts are underway to support partners who want to help their loved ones' recovery. If the veteran is reluctant to seek treatment, education and family-facilitated engagement approaches can help the family understand the condition and teach them ways to encourage their loved ones to get care (Monson, Macdonald, & Brown-Bowers, 2012). One example designed for various psychological conditions, including PTSD, is the Support and Family Education Program (Sherman, 2003). Al-Anon (Timko et al., 2014) and Community Reinforcement and Family Training (Meyers, Miller, Hill, & Tonigan, 1998) are other examples of education programs designed to support families of substance users, and could potentially be tailored to families coping with PTSD. Another partner-focused approach aims to help caregivers of people with chronic illnesses reduce their own stress (Griffin et al., 2014). For example, Building Better Caregivers, a web-based education and peer-support program shown to be helpful to caregivers of people with Alzheimer's disease, (Lorig et al., 2012), is now being used in the VA Caregiver Support Program for caregivers of veterans with a variety of disorders, including PTSD. Another method involves engaging the partner as a coach who

supports the veteran's PTSD treatment. The Lifestyle Management Course (Devilley, 2002) is one partner-supported approach and focuses on aiding the veteran rather than improving the functioning of the couple. If the couple wants to alleviate both PTSD symptoms and improve relationship functioning, PTSD-specific family therapies such as cognitive-behavioral couple's treatment for PTSD (Monson, Schnurr, Stevens, & Guthrie, 2004) can be used to treat PTSD within a relationship context. Finally, generic family therapy may be appropriate for couples who want to work on improving their relationships but do not want to address PTSD specifically.

Perspectives from adult children who grew up in households in which a parent had PTSD can provide valuable insight about growing up in such an environment and represent one of several areas for further exploration. As a new generation of veterans is raising their children, better information about how to treat and support these families is critical. Continued effort should also be directed toward client, partner, environmental and other factors that tend to encourage or dissuade partner participation in veteran treatment. Testing of various participation-promotion techniques could be especially useful. The context of culture—both the military culture and veteran and partner ethnographic influences—must also be evaluated. Although only two respondents wrote about culture, cultural beliefs likely influence the level of comfort and openness in discussing PTSD, and family involvement in mental health treatment, if treatment is sought at all. Lastly, research on the effectiveness of various coping resources and strategies for intimate partners would only enhance current knowledge and practice.

By sharing their lives with veterans, partners observe the ups and downs associated with PTSD and are often on the receiving end of its impact. When involved in care, they can provide clinicians with a different perspective, and given the right tools, may be able to help alleviate PTSD symptoms, improve marital and family relationships, and enhance veterans' quality of life. As Partner A stated, "The Vet can't get better if the family, especially spouse, still struggles with PTSD." Indeed, if social support begets symptom reduction (Ozer, Best, Lipsey, & Weiss, 2003), a psychologically healthy partner and family may provide the most effective relief (Campbell & Renshaw, 2012).

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### Correction to Mansfield et al. (2014)

In the article “One Day at a Time: The Experiences of Partners of Veterans With Posttraumatic Stress Disorder,” by Alyssa J. Mansfield, Kim M. Schaper, Alana M. Yanagida, and Craig S. Rosen (*Professional Psychology: Research and Practice*, 2014, Vol. 45, No. 6, pp. 488–495. <http://dx.doi.org/10.1037/a0038422>), the institutional affiliation of Alyssa J. Mansfield, Kim Schaper, and Alana M. Yanagida was incorrectly set as “Veterans Affairs Pacific Islands Health Care System, Honolulu, Hawaii”. It should have been “National Center for PTSD Pacific Islands Division, Veterans Affairs Pacific Islands Health Care System, Honolulu, Hawaii”. The institutional affiliation of Craig S. Rosen was incorrectly set as “Veterans Affairs Palo Alto Health Care System, Menlo Park, California and Stanford University School of Medicine”. It should have been “National Center for PTSD Dissemination and Training Division, Veterans Affairs Palo Alto Health Care System, Menlo Park, California and Stanford University School of Medicine”. The online version of this article has been corrected.

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