
RESEARCH

"Shelter from the Storm": Military Service Member Spousal Caregiver Challenges and Barriers to Resources in the Midst of Enduring Conflicts

April Cobos

Christopher Newport University, US

april.cobos@cnu.edu

The enduring nature of the Global War on Terrorism has created a generation of active duty service members and recently retired veterans who spent the majority of their careers training and deploying to combat. Their long-term persistent service heightens the likelihood of symptoms of PTSD, moral distress, or moral injury (Frankfurt & Frazier, 2016) and the enduring nature of the conflicts means many remained undertreated or undiagnosed for extensive periods of time (Conard & Sauls, 2014). In the past decade, expansive research has begun to study the psychological implications of these extensive conflicts on service members and has begun to offer ways to mitigate and treat this generation. However, the research and institutional and financial support are often given to the active duty service member or veteran despite the knowledge that the active duty service member's combat service has extensive mental health impacts on the spouse caregiver and other family members. While research and resources for spousal caregivers and family members are becoming more frequent, this article argues the need for additional resources for spouse caregivers of active duty service members or recently retired service members who have served primarily in combat-related positions and who have cases of undiagnosed, underdiagnosed, or untreated cases of PTSD or moral distress or injury after several decades of conflicts. Implementing, and providing adequate awareness of, additional institutional and individual support services for the spousal caregiver can help to heal the family unit more effectively.

Keywords: PTSD; moral injury; spouse caregiver; Global War on Terrorism; military spouse resources

In the wake of the Global War on Terrorism, there is a generation of active duty service members and recently retired veterans who spent the better part of the last two decades consistently, persistently deployed and engaged in combat related labor or in training and preparing for deployments to combat zones (Turse, 2018). While only a small portion of service members in all branches of the U.S. Armed Forces would be defined by Department of Defense (DoD) policy as working in units exposed to direct combat missions, in reality, changes in methods of warfare and weaponry and the move towards more high-technological warfare has caused "the collapse of the front and rear," or the diminishing of a boundary between those on the front lines and those at a safe distance during wartime (Hables-Gray, 1993, p. 151). This collapse of the actual battlefield space makes it difficult to clearly determine who has been involved in combat related situations, specifically those units classified as combat support, performing work in and around the combat zone.

For example, Explosive Ordnance Disposal (EOD) technicians, whose job description defined them as combat support throughout the Global War on Terrorism, became an integral part of wartime operations in Iraq and Afghanistan because these conflicts relied heavily on the use of explosives like IEDs (United States Government Accountability Office, 2013). Their participation in the midst of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) significantly increased, most notably with the job of clearing a route of explosives before special forces teams ventured further. This particular military community had a disproportionate number of deaths and injuries between 2002–2016. Since 9/11, 135 EOD technicians have died between all four branches of the U.S. Armed Forces with a large majority dying from Improvised Explosive attacks (EOD Warrior Foundation). Hundreds more were critically injured from similar attacks, losing limbs, sustaining brain injuries, or other physical or psychological trauma. Others in combat support roles like this include combat medics, military

intelligence corps, translators and interpreters, cultural support specialists, dog handlers, and Marine and Army ground combat elements; all of which were significantly impacted by deaths and injuries during OIF and OEF (U.S. Army, 2018; Marines, 2020).

These deployments include encountering dangerous and life-threatening circumstances that induce psychological trauma in various forms, the most common of which are PTSD and moral distress and moral injury. The extent of such psychological trauma depends on the type of Military Occupational Specialty (MOS) and the length of time they remained in service, which heightens their chances of re-deploying and facing additional psychological trauma (Frankfurt & Frazier, 2016). Alongside the loss of life and injury, these units also faced long-term exposure to, and participation in, what Frankfurt & Frazier (2016) describe as transgressive acts or acts that can impair their moral beliefs and values. These service members also often faced substantial, persistent losses of comrades or saw their comrades severely injured. The associated trauma does not just end with the initial witnessing of injury or incident, but continues on into the follow-on funerals, memorial services, or hospital visits. The continual deployments also leave service members without the proper time to go through the stages of grief before they are required to return to training and conflict zones. All of these circumstances lead to lingering psychological injuries in varied forms that span a continuum of time and severity. Increased exposure to war, death, injury, and transgressive acts also increases the likelihood of PTSD or other related psychological injuries (Conard & Sauls, 2014).

The enduring nature of the OIF/OEF conflicts placed significant burden not only on these military service members, but also on their families, most especially their spouses. Due to the circumstances of American military life, even in peacetime, military spouses are already uniquely tasked with operating under conditions that civilian spouses do not always encounter, including being isolated from family and their hometown friends, who can serve as a support system in times of stress. Research also indicates the constant moves and uncertainty of deployments causes disruptions in the spouse's ability to attend and complete higher education or to consistently work in their career field (Ott, Morgan & Akroyd, 2018). These circumstances also classify them as geographically single parents, meaning the spouses find themselves alone and managing children and all of their emotional and physical needs, which can be significantly affected by the service member's absence from the home (Link & Palinkas, 2013; Everson, et al., 2014). Because the military service members so often come in and out of daily life routines, the burden of maintaining normal life schedules, everything from paying the bills to handling pet care falls on the military spouse for extended periods of time. These stressors are exacerbated by extensive deployments or lengthy deployments (Everson, et al., 2014), particularly

combat related deployments that cause extra anxiety and worry and can contribute to "long-term family dysfunction" (Link & Palinkas, 2013, p. 387).

In times of war, or when constant deployments are required in circumstances where service members are in more high risk situations, the burden on the military spouse means they do not have relief, and it often means managing a range of emotions that come from the deployment and reintegration of their spouse and the impacts it can have on the household and the family life. Spouses often become the sole emotional and psychological caregiver for their psychologically injured service member, in particular because many of these active duty service members and their family members have not had the time to be properly evaluated by a specialist to diagnose them with PTSD or moral injury (Sherman, Perlick, & Straits-Troster, 2012). This might be because the family does not recognize the signs of PTSD in the midst of an already disruptive, often chaotic life cycle of trainings, deployments, and military moves, or because the military service member fears that coming forward with their feelings or psychological trauma may mean they cannot return to active duty service (Sherman, Perlick, & Straits-Troster, 2012).

The reality is that the toll of these continuous combat deployments and related psychological trauma not only impact the service members or veterans, but also their families, often with the spouse serving as the caregiver of their mental and emotional needs, as well as trying to maintain a stable home life in the midst of the constant changes and life fluctuations (Sherman, Perlick, & Straits-Troster, 2012). Due to the combination of the continued presence in conflict, the potential for future conflict, and the under-treated, undiagnosed nature of their service member's PTSD or moral injury, spouse "partners might endure their own psychological duress" (Mansfield, Schaper, Yanagida & Rosen, 2014, p. 488). While there is extensive literature on how these conflicts impact active duty service members or veterans, particularly focusing on moral injury and PTSD treatments, there is little research on spousal caregiver challenges for those who are still in the midst of managing these variables. Some recent research has begun to address the impacts on the family for those active duty service members who remain deployable, although much of this research focuses on the children and managing parenting amidst the stress (Everson, et al., 2014; Gewirtz, et al., 2011; White, et al., 2011). However, Donoho, et al.'s (2018) study found that military spouses whose active duty service member was deployed had experienced combat-related events, was enlisted, and/or had a probable diagnosis of PTSD was more likely to screen positive for major depressive disorder (MDD). A concerning component of this study is that according to other research, even when active duty or veteran service members receive treatment, their spousal caregivers or other family members often do not, or do not have access to resources that can help ease their burden whether this

comes in the form of assistance with childcare, responsibilities at home, or with more institutionalized counseling or financial resources. According to Sherman, Perlick, & Straits-Troster (2012), while "partners and family members sometimes facilitate the veteran's accessing psychiatric treatment... they are not routinely included in treatment at most facilities at this time" (p. 350).

My initial interest in this topic stems from my own personal experience as a 17-year spouse of an active duty military service member who continues to work in a special forces military community that demanded rigorous, dangerous, consistent deployments between 2005–2017. From my own experiences and related academic research, I recognize there are a multitude of factors that challenge long-term caregiving with either a diagnosed physically or psychologically injured partner; however, there needs to be more attention given to the impacts and challenges on spousal caregivers with an active duty service member or recently retired service member who remains undiagnosed, underdiagnosed, or undertreated for a variety of reasons. As well, it is my belief that there are more cases of undiagnosed PTSD or related physiological injuries like moral injury in these communities during the career life period than have been documented, particularly in times of war. The lack of diagnosis places an even heavier burden on the spouse caregiver, who has to maintain the normalcy of the household while often finding oneself responsible for the mental health of the active duty service member since the service member has not sought out external help or completed a treatment plan.

As articulated above, my personal experience and related research indicates that active duty combat service members currently serving, or for those who serviced in a long-term capacity during OIF and OEF, are more likely to go without treating or diagnosing PTSD or moral injury, which causes substantial challenges to the spousal caregiver and related family members. I argue that while there are extensive studies on active duty and veteran service members who have been impacted by combat scenarios over the years and who have not received timely diagnoses and treatment, there is little research related to the impacts this has on the spousal caregiver. In regard to the research currently available, terms like secondary traumatization, caregiver burden, and compassion fatigue have been linked to the discussions, although there is some disagreement on the terms that should be used in studying this group of military spouse caregivers and their related symptoms. In the following section, these definitions will be discussed, as will terms like moral injury and PTSD, and how those active duty service or veterans who remain undiagnosed, underdiagnosed, and untreated or undertreated impact the entire family unit. From here, the possibilities and challenges of alleviating spousal caregiving burdens will be discussed, specifically the affordances and limitations of available institutional support programs. While some commands and units have options

in place to assist the families, not all commands, units, and branches have them consistently in place if those units have service members impacted by combat. Finances are a barrier to consistent assistance for the spousal caregiver and other related family members, as different military units are under certain budget constraints, meaning the majority of financial options for assisting spousal caregivers comes from non-profit organizations put in place over the past twenty years in an effort to alleviate some of these burdens and not all non-profit organizations service the branches and units equally. However, government mandates put in place in the past decade have helped with offering more alternatives for the spouse caregivers and the entire family unit in receiving mental health services and related resources.

Literature Review

A real issue of concern that still lacks research in academic and military communities is why so many active duty service members and recent retired service members avoid being diagnosed with mental health issues, and the follow-on impact this has on all of their dependents and caregivers. In my experience and in reviewing related research, it has been a combination of the following factors: 1) a gray space or lack of clear understanding of PTSD and related mental health concerns like moral distress and injury. This is compounded by the constant reintegration and movement back into combat spaces alongside the constant stress of duty station moves that make the service member and their family already in a state of upheaval, commonly understood amongst military families as just something to deal with. The range of emotions encountered during this time can be difficult to separate from PTSD or other psychological trauma, which might delay the diagnosis (Sherman, Perlick, and Straits-Troster, 2012). Aside from the service member and family not recognizing the need for treatment, the intense stigma associated with mental health issues should be considered a barrier to treatment. While this stigma can stem from mental health in society in general, within the military population, Hoge, et al.'s (2004) survey report indicates it is more directly connected with being perceived as weak, concerns of perception and lack of confidence by military leadership, concerns it could harm their career, and concerns they could not get time off of work for treatment. 2) A second complicating factor is the lack of understanding of the significant impact the active duty service member's psychological trauma has on the spouse caregiver, as there is currently very limited research (Mansfield, Schaper, Yanagida & Rosen, 2014; Sherman, Perlick, and Straits-Troster, 2012). There are also discrepancies in defining and diagnosing the symptoms with terms like secondary traumatization, caregiver burnout, and compassion fatigue all considered. Part of this problem has been the lack of relevant sources and education regarding what and how spouse caregivers should be treated or what kind of resources would be beneficial in helping them relieve the burden during or following times of high conflict.

PTSD and Moral Injury and Barriers to Diagnosis and Treatment

The lack of awareness and understanding from family and friends outside of the immediate family unit can be especially challenging to a spouse caregiver whose service member is showing signs of PTSD or moral injury. In my experience, it is challenging to maintain healthy family and friendship connections when the spouse caregiver is bogged down with the already daunting challenges of being a military spouse during conflict, plus the added stress of trying to support and sustain the mental health of the active duty service member. In terms of relationships with other family and civilian friends, or even military friends who do not work in combat, this often means defending the active duty service member or making excuses when their behavior is irrational or not perceived as normal in a social setting. This, in itself can be isolating, as other spouse caregivers I know whose active duty spouse have, or had, mental health concerns agree that eventually they stopped accepting social invitations because it became overwhelming to manage the circumstances, particularly if their service member was having a particularly daunting mental health day.

These circumstances are exacerbated by the lack of clarity in defining and diagnosing psychological trauma injuries, such as moral injury, PTSD, and even Traumatic Brain Injury (TBI). In textbook psychological terms, PTSD is defined as an "anxiety disorder that manifests after exposure to psychological trauma" (Lawford, et al., 2013, p. 87). Specifically, in relation to combat related service members, it is a common emotional disturbance with symptoms ranging from difficulties sleeping, concentrating and remembering, nightmares, nervousness or irritability, as well as anger and hostility, withdrawal, and emotional numbness (Arzi, Solomon, & Dekel, 2000; Lawford, et al., 2013). Part of the trouble with diagnosis is that the symptoms can range so widely and are dependent on many other factors including the past experiences, genetic predisposition, and mental health of the individual in question (Lawford, et al., 2013). Ghaffarzadegan, Ebrahimvandi, and Jalali's (2016) research places military service members with PTSD into three categories: healthy, ill-undiagnosed, and ill-diagnosed. While they acknowledge that some service members remain undiagnosed until they become veterans, what they do not acknowledge is the number of active duty and veterans who just never get diagnosed or never fully complete the process of diagnosis, even if they do receive some kind of psychological help along the way or finally get diagnosed after the time in conflict is over. This ill-undiagnosed space can have lasting impacts on the service member and his family caregivers and other dependents like their children. Ghaffarzadegan, Ebrahimvandi, and Jalali's (2016) research also concludes that it takes about 40 to 45 years for the veteran population to become PTSD-free after conflict, and that the peak for PTSD amongst veterans emerges six years after the war ends. This represents the long-lasting psychological effects of war. It also indicates that many active duty service members or

recently retired who served in the OIF and OEF conflicts might not yet have reached the height of their PTSD symptoms, and thus might not be seeking treatment. While the number of new diagnosed PTSD cases has declined since 2013 due to "decreasing number of troops in Iraq and Afghanistan in recent years" (Ghaffarzadegan, Ebrahimvandi, and Jalali's (2016), the current political trends suggest there is the possibility for US involvement in near future wars or conflicts, which could re-trigger symptoms and cause a major delay in this particular generation becoming PTSD symptom free. It also needs to be taken into consideration that many of these active duty combat service members have not stopped deploying, even if deployments have slowed down to some extent, as there have continued to be missions and conflicts in other areas of concern (Turse, 2018). All of this means that PTSD related injuries that remain undiagnosed or underdiagnosed and undertreated will continue to impact service members, veterans, and their families into the next several decades.

One of the biggest factors of concern with enduring conflict and continued service is whether or not active duty service members will have the time or the capability of being able to seek out diagnosis and treatment without it impacting their current service demands. Crawford, et al. (2015) found in a survey of active duty and veterans that the main barriers to diagnosis and treatment with probable PTSD were avoidance of psychiatric medications and the belief that treatment was unnecessary, while Hoge, et al. (2004) found service members had fears of impacts on their career or perceptions they would be considered weak. This partially extends from the stigmas associated with PTSD, but also that some are not experiencing PTSD, but instead moral injury or moral distress, and thus believe that since they are not experiencing PTSD symptoms, they do not need to seek treatment. Individuals who experience moral distress can exhibit symptoms such as guilt, frustration, shame, difficulty forgiving, and rejection. Papazoglou & Chopko (2017) distinguish between moral distress and moral injury with moral distress being related to "painful feelings and psychological disequilibrium" from not being able to make a morally proper decision, citing nurses who might be hindered from such a decision because of institutional or legal policy (p. 2). In comparison, they define moral injury as specifically related to "witnessing, failing to prevent, or participating in or perpetuating actions that deeply transgress moral beliefs and expectations" (Papazoglou and Chopko, 2017, p. 2). They provide examples such as death-related situations, killings, handling human remains, or being in direct contact with severely wounded victims they could not help. Given this distinction, it is possible that service members could become both morally distressed and morally injured, but moral injury seems to be a more likely diagnosis in a war related conflict. Some of these symptoms can also be clustered together with PTSD related symptoms, thus some service members might be experiencing both PTSD and moral distress or injury related symptoms to different degrees, which can add to the

difficulties in diagnosis of either or both (Papazoglou and Chopko, 2017; Nash & Litz, 2013).

Diagnosis for PTSD and moral injury are almost always done through self-reporting, which can result in errors of the rates of PTSD and moral injury, as it maybe underreported because of social stigma but can also be exaggerated with certain individuals motivated by disability compensation (Crawford, et al., 2015). While Crawford, et al.'s (2015) research did not find a direct link to concerns over career progression as a barrier in their survey responses, Ghaffarzadegan, Ebrahimvandi, and Jalali's (2016) research indicates that:

patients suffer a wide range of consequences of revealing their problems, such as a higher likelihood of losing jobs or being discriminated against in workplaces, lower income, difficulties in renting a residence and exclusion from social communities. Consequently, the perception of possible discrimination and other consequences of being labeled as mentally ill can affect the behavior of individuals going through the screening process. (n.p.)

In times of heightened military conflict, service members might not want to report their symptoms because of their desire to remain capable of deploying to conflict for a variety of reasons including feeling called to service and feeling like they want to continue working alongside their fellow service members and that seeking diagnosis and treatment could impact their ability to continue serving or would diminish leadership's confidence in their abilities (Hoge, et al., 2004).

Secondary Traumatization, Caregiver Burden, and Compassion Fatigue

In my own experiences, being married to a military service member who has been routinely deployed to conflict zones makes it hard to untangle what stems from normal long-term relationship cohabitation and what stems from long-term dysfunctions and disruptions to life that become issues of co-dependency or concerns of psychological trauma. This is especially true because the active duty service member and family have not had the ability to create a normal life pattern due to the constant interruptions with the training cycles and deployments. Also, due to the fact that the service members' jobs often require them to maintain a significant level of Operational Security (OPSEC), there is a natural sense of isolation already existing between the spouse caregiver and those family and friends in their lives, as well as physical separation due to movements to new duty stations every few years. Link & Palinkas' (2013) findings suggest that having experience with deployments does not mean spouse caregivers will have an easier time coping. In fact, their research notes that for the majority of spouses, deployments are always their greatest stressor, no matter how experienced they are with deployments, causing constant concern with over the safety of the service member, anxiety or depression, loneliness, and difficulty sleeping (Link & Palinkas, 2013).

These stresses are heightened when spouses are also concerned over the mental health of their active duty service member. As Arzi, Solomon, & Deke (2000) articulate, the spouses of both PTSD and TBI service members:

bear a heavy caregiver burden. Not only do they have to take care of their highly distressed and not fully functioning partners; but, in many cases, the entire responsibility for maintaining the family, including raising the children, doing the household chores and errands, and earning a living, falls on their shoulders. Previous studies indicated that spouses of PTSD casualties often tend to assume all or almost all the responsibilities for childcare, for maintaining the psychological well-being of all family members, and not infrequently for the families' finances. The spouses of PTSD veterans often become caught in a compassion trap, in which they sacrifice many of their own needs for the family. (p. 726)

Arzi, Solomon, & Dekel (2000) refer to this as conflictual independence, where the service member has heightened levels of emotional dependence on the spouse caregiver, which in turn heightens the spouse's sense of burden and distress. Their report indicates that the more emotional dependence and conflictual independence reported by the subjects, the higher the levels of burden and distress for the caregiver (Arzi, Solomon, & Dekel, 2000). They noted that spouses who indicated higher levels of separation-individuation were able to maneuver and manage their roles as caregivers and supportive partners more readily, which helped to maintain a healthy sense of well-being; however, many spouses noted difficulties in managing a healthy separation-individuation for the reasons indicated above.

To date, there has not been extensive research regarding either the challenges of spousal caregiving burden or compassion fatigue in relation to the spouses of active duty service members who have been in combat or are currently serving in enduring conflicts. The research that is available focuses on the impacts on spousal caregivers from post-Vietnam era or on the Gulf War era (Toomey, et al., 2019; Arzi, Solomon, & Dekel, 2000). The Vietnam era study reinforces that wives of Vietnam veterans with PTSD, as compared to veterans without, reported higher levels of anxiety and depressive symptoms, emotional exhaustion, headaches, sleep problems (Arzi, Solomon, & Dekel, 2000). Not to say this research is not valuable in assessing the current contexts, but there are some differences that need to be recognized, specifically the more enduring nature of the recent conflicts. Many OIF and OEF active duty service members have bridged several different periods of conflict sequentially without breaks in service or without retiring from service, which can cause differences in the way symptoms arise, how they are addressed or diagnosed, and how they are managed in the family unit. Some caregiver spouses are still dealing with the impacts of trainings, deployments, and Temporary Assigned Duty on

their daily life, while also simultaneously managing their active duty service member's emotional state. And while Sherman, Perlick, and Straits-Troster (2012) argue that "families exhibit remarkable strength and resilience in dealing with operational stress and combat-related issues," they also contend that significant untreated, undiagnosed, or under-treated PTSD or other moral injuries can seriously increase family stress and burden, can cause poor psychological adjustment in the spouse caregivers, and can cause intimate relationship problems (p. 350).

Some variations and disagreements exist in the related research about how to define the occurrences of spouse caregiver symptoms mentioned above. Some researchers reference this as secondary traumatization while other researchers have defined the symptoms as compassion fatigue or caregiver burden. Daniels (2009) argues there is little doubt that trauma-related distress in helpers exists, "but the controversy seems to be what this entails and what it should be called" (p. 154). The commonalities amongst them all is that spouses of service members experience a variety of negative psychological symptoms brought on by the long-term exposure to their active duty service member's contact with combat to include transgressive acts and death and injury, and that the longer the exposure the more likely it will cause long-term family dysfunction and problems within the relationship between the active duty service member and the spouse (Link & Palinkas, 2013). There is also agreement that while many families focus on getting treatment for the active duty service member or veteran, few caregiver spouses with symptoms seek diagnosis or treatment for themselves or have the resources available to do so. As well, there is the need for additional resources in order to heal the entire family unit impacted by wartime conflicts (Sherman, Perlick, & Straits-Troster, 2012; Link & Palinkas, 2013).

Discussion

In terms of understanding how PTSD and moral injury function to cause spousal caregiver burden, secondary traumatization, or compassion fatigue, the ultimate question is how to aid spouse caregivers now, and in times of future extended conflict, since family members of service members impacted by PTSD and moral injury, diagnosed or undiagnosed, treated or untreated, are not receiving sufficient assistance and aid (Sherman, Perlick, & Straits-Troster, 2012; Mansfield, Schaper, Yanagida & Rosen, 2014; Link & Palinkas, 2013). There are both institutional and individual support mechanisms in place that can be further adapted and adopted by additional organizations in order to benefit spousal caregivers to give them an overall better sense of mental health and well-being; however, all of these come with problems and limitations, which should be considered in future research focused on spouse caregiver resources.

Institutionalized Support

While some government wide initiatives have been established in the midst of the OIF and OEF conflicts, many of

them were reactionary, put into place with the realization that these conflicts were more enduring than initially anticipated with more severe impacts on both the individual combat veterans and their families. For example, in 2010, President Obama implemented the Caregivers and Veterans Omnibus Health Services Act with the intention to allow for financial or partial financial compensation of provisions of care for an injured veteran to include access to educational resources, support services, counseling, and respite care (Sherman, Perlick, & Straits-Troster, 2012). While this initiative was an important step towards ensuring spouse caregivers received adequate support, the concern to keep in mind is that service members who remained active duty could not receive Veterans Affairs (VA) benefits, which was a requirement of the 2010 Act (Link & Palinkas, 2013). Another limitation is the lack of knowledge regarding these programs that would keep families from seeking them out, as well as the lack of knowledge regarding PTSD and other related mental health injuries that would keep families from recognizing they can and should access these resources (Sherman, Perlick, & Straits-Troster, 2012). Sherman, Perlick, & Straits-Troster (2012) also note limitations, such as mental health staff that lack training in evidenced based family services, negative attitudes about the VA, veteran and family fears about participation, and the lack of understanding of eligibility for such programs. Creating more awareness in terms of the recognition of symptoms and the availability of programs and family member eligibility would be especially beneficial.

However, programs that have the potential for family involvement, in contrast to just focusing on the service member's mental health state "can help reduce PTSD symptoms, relationship distress, and caregiver burden" (Sherman, Perlick, & Straits-Troster, 2012, p. 350). The use of Cognitive Behavioral Conjoint Therapy (CBCT) has recently been piloted and adapted and used in REACH (Reaching out to Educate and Assist Caring, Healthy Families) programs. REACH programs are available in various formats throughout the continental United States partnering with other related organizations in order to provide counseling and related life adjustment resources to military service members and family. Link & Palinkas (2013) reinforce that with these kinds of group and family therapy sessions the focus should not remain solely on the veterans' needs but should "consider the spouses' health problems both service-connected and relevant to overall family health" (p. 388). FOCUS (Families Overcoming Under Stress) is another program that began in 2010 with a focus of family resilience by using "psychoeducation and skill building for emotional regulation, goal setting, problem solving, and family communication for active duty service members and their military families with particular emphasis on parenting issues" (n.p). While these programs were implemented during OIF and OEF, there still appears to be a lack of knowledge from active duty families about the program features and availability, which reinforces the need for the DOD and military communities to ensure family awareness and participation.

More recently, many U.S. Armed Forces military communities with service members impacted by conflict have begun to send their service members to The National Intrepid Center of Excellence (NICoE), a Department of Defense organization through the Walter Reed National Military Medical Center "working to advance the clinical care, diagnosis, research and education of military service members with traumatic brain injuries (TBI) and psychological health (PH) conditions" (Tricare, 2020, n.p.). They offer intensive inpatient and outpatient services, typically a four week program, where the first two weeks are clinical evaluations of the service member and the last two weeks are "treatment planning, family support, and beyond," which intends to provide caregiver and extended support for the future (Tricare, 2020, n.p.) Currently, there are ten centers called Intrepid Spirit Centers located at military bases throughout the country. However, the concern is long-term care. While it may allow for a few weeks or months of reprieve for the long-term spouse/caregiver, once the service member returns to their home and regular work routines of deployments and high stress work environment, many of those triggers can reoccur. The center was not opened until 2010, years after the conflicts were already in motion, and in the midst of many service members still serving, which severely limited their ability to access the resources. As OIF and OEF have come to a close, however, service members and their families are now beginning to understand the benefits of such an institutional program with 2,060 patients served in fiscal year 2019 as compared to 547 patients treated in fiscal year 2013 (NICoE Annual Report, 2019; NICoE Annual Report, 2013).

The heavy reliance on non-profit organizations focused on specific military communities marks another obstacle to institutional family support. While there are larger, broad reaching organizations like the Wounded Warrior Program or the Fallen Heroes Fund, which is a large financial sponsor of NICoE (Tricare, 2020), the majority of other non-profit programs are very specific in nature like the Lead the Way Foundation for Army Rangers, the EOD Warrior Foundation for Explosive Ordnance Disposal service members and family in all four branches, and the Navy Seal Foundation for Navy Seals and their families. The capability of these organizations to provide resources and financial support to military service members, veterans, and their families in need truly depends on donations that come in from corporations, businesses, and individuals. For instance, the 2018 Annual Report for the Navy Seal Foundation shows they were able to provide over \$20 million dollars in support through various programs including Warrior and Family Support, Educational Opportunities, Tragedy Assistance and Survivor Support, Warrior Transition, and Legacy Preservation (Navy Seal Foundation). In particular, in terms of offering support to the families, they note that they provided \$6.3 million dollars towards this portion of programming to include 35,000 hours of respite childcare in 2018 for deployed service member's children, which provides a respite to the

spouse who is at home, as well as offering remote location and homeschool grants. These resources provide assistance to a spouse caregiver who is managing the home and children alone. This also included pre, mid, and post deployment resilience events, fitness programs, family camp outs, and spouse resiliency retreats. Another \$6.8 million dollars was dedicated towards tragedy assistance and survivor support and an additional \$4.65 million towards warrior transition programs to aid in helping those who are transitioning out of the military, which includes both mental health and career counseling (Navy Seal Foundation).

In contrast, the EOD Warrior Foundation was only able to provide \$1.6 million dollars in support because of the limitations based on the amount of donations available. For reference, in 2011, it was reported that there were roughly 2,450 active duty SEALs with an additional 600 active duty SWCC (Special Warfare Combatant Craft Crewman), who are also considered part of the Seal commands (Navy Seals). In contrast, in 2012, it was reported there were roughly 7,000 EOD technicians across all four branches (EOD Warrior). Thus, despite the EOD community having more personnel and related family members to support, the Navy Seal Foundation has a substantially larger financial pool than does the EOD Warrior Foundation, which is likely impacted by many factors, but most certainly that Navy Seals are more well known in the general public as a special forces community that would be working in and impacted by conflicts like OIF and OEF. These inconsistencies in accessibility and dependence on the community's knowledge and awareness certainly impacts the non-profit organization's ability to provide extensive care to physically and psychologically injured service members and their families. It also means the organization has to choose who receives the funding based on need, which often goes towards cases of physical injury or those who are the most severely injured in PTSD cases with the funding focused on the service member rather than support and resources for the spouse caregiver (Sherman, Perlick, & Straits-Troster, 2012).

Conclusion

As the research indicates, the primary focus for resources in relation to PTSD and other psychological injuries has been on the active duty or veteran service members with minimal discussion on how the caregiver spouse and other intimate family members are impacted by the long-term family dysfunction and the overall negative impacts of the service member's enduring service in conflict zones. Even as the OIF and OEF conflicts have come to a conclusion, the reality is that many service members who were part of those conflicts are still negatively impacted, as Ghaffarzaghan, Ebrahimvandi, and Jalali (2016) research indicates in noting that it takes forty-five years post-conflict to have a healthy population of veterans. As well, many of the service members who participated in those conflicts are still working for the U.S. military in some form, continuing as active duty, reservists, or even as civilian contractors with

continued exposure and even the potential for reengagement and re-traumatization if other conflicts emerge in the near future (Turse, 2018).

Having both institutional and individual resources for the spouse caregiver to seek help is an important step in creating a healthier generation of service members and families; however, this involves ensuring spouse caregivers have access and even knowledge of the programs and resources available. While many of these resources have existed in the individual non-profit organizations related to each specific community, without spouses understanding that they can make use of these resources or how to gain access, they are not as effective. Of course, access to the more institutionalized programs does not eliminate the problem of limitations in individualized non-profit organizations who rely on fundraising and donations, which will continue to be a concern in terms of civilian knowledge and awareness of the non-profit organizations and the ways in which they support these military communities. As well, it might be a limiting factor that civilians and civilian organizations are less likely to donate to a military affiliated organization outside of times of conflict, and since OIF and OEF have ended, the belief that additional care or resources is no longer necessary could restrict someone's desire to donate or volunteer with such organizations.

Despite these limitations, the access to other institutional and programmatic resources are still available to include NiCoE, FOCUS on the family, and REACH. The current time period, in the wake of OIF and OEF, seems ripe for both service members and their spouse caregivers to take opportunities to seek out ways to gain and maintain tools for increased individual and family mental health. This can include participating in regular retreats available within the non-profit organizations, attending regular family, couples, group, or individual therapy sessions.

In closing, much of the literature and research available about the mental health impacts on both the service member and the spouse caregiver only began to appear after the OIF and OEF conflicts became long-term and enduring, in a very reactionary nature, leaving a generation of service members and their families struggling with this long-term dysfunction on their own or without having a full set of resources to aid them in recovering adequately. More research on this generation would be beneficial, particularly focused on the mental health impacts of spouse caregivers and can be used to benefit this particular generation of war veterans and their family caregivers, as well as future generations who might find themselves in similar contexts. As Link & Palinkas (2013) argue, "through prevention and early intervention, these activities may decrease the long-term impact of current and future conflicts" (p. 387). Having the research available can potentially change the way service members and their families are provided resources in the midst of future conflicts in contrast to waiting until the conflicts are in full motion, or nearing the end, to attempt to mitigate the mental health damages inflicted.

Competing Interests

The author has no competing interests to declare.

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How to cite this article: Cobos, A. (2020). "Shelter from the Storm": Military Service Member Spousal Caregiver Challenges and Barriers to Resources in the Midst of Enduring Conflicts. *Journal of Veterans Studies*, 6(1), pp. 250–258. DOI: <https://doi.org/10.21061/jvs.v6i1.171>

Submitted: 19 January 2020

Accepted: 02 May 2020

Published: 05 August 2020

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