RELATIONSHIP OF CENTRALITY OF TRAUMATIC EVENTS TO
PSYCHOSOCIAL EXPERIENCES IN MILITARY VETERANS

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Katherine N. Sperry
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DEDICATION

This thesis is dedicated to my father

G. Brooks Sperry,

my grandfathers, Willard S. Sperry and John F. McMahon,

and to all other women and men who have served

in the United States Military.
ACKNOWLEDGMENTS

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This study examined levels of guilt toward a traumatic military-related event, the centrality of that event to one’s identity, and individuals’ satisfaction with social relationships related to the severity of posttraumatic stress symptomology in a U.S. military population. Participants (N = 88) were recruited through veteran and military facilities, campus resources, and online networks. Participants were asked to complete a twenty-minute online questionnaire, which included a background information form, a military-related traumatic event recall, questions regarding social relationships, and three questionnaire measures on the centrality of traumatic events to autobiographical narratives, PTSD symptomology, and trauma-related guilt. The primary focus of this study was to evaluate trauma-related guilt cognitions, the centrality of the specified traumatic event to participants’ autobiographical narratives, and relationship satisfaction.
in relation to posttraumatic stress symptomology. All three proposed hypotheses were partially supported. Results indicated that guilt cognitions, the centrality of the traumatic military-related event to personal identity, and relationship quality all impacted posttraumatic stress symptomology. Further detail is provided in the study.
CHAPTER I

INTRODUCTION

This study explored the relationships between guilt, the centrality of a military-related traumatic event, and the impact of military experiences on social relationships to posttraumatic stress symptoms in United States military veterans. These four concepts were explored from a schema-based theoretical framework. This study aimed to find relationships between the four concepts in order to shed light on how these concepts might impact the treatment of posttraumatic stress disorder. While there is much research on posttraumatic stress disorder and military personnel, there is little research exploring the interactions between the four concepts. This research will add to the literature on posttraumatic stress disorder (PTSD) by exploring how it is influenced by feelings of guilt, the centrality of a military-related traumatic event to one’s life narrative, and the stability and quality of social relationships in a military population.

Background

Individuals process traumatic events differently and deal with such events in various ways. One possible outcome of traumatic processing is the symptoms, and possible development, of PTSD. Posttraumatic stress disorder is a fairly recent anxiety disorder categorized by the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 (DSM-IV-TR; American Psychiatric Association, 2000).
Posttraumatic stress disorder can result from a multitude of events, but is primarily triggered by a traumatic event that serves as a threat to one’s life. Traumatic events that provoke PTSD symptoms may include rape, physical or sexual abuse, natural or human disaster, and military combat. This paper will primarily discuss the impacts of military trauma on the development of PTSD.

Posttraumatic stress disorder can be an extremely debilitating anxiety disorder that affects many people who have suffered from trauma. According to the National Center for PTSD (U.S. Department of Veterans Affairs, 2007) 7-8% of individuals in the United States will experience PTSD in their lifetime. The Military population is one group that is greatly affected by trauma and PTSD. In 2000, the United States Census Bureau estimated that the veteran population makes up about 12.7% (p. 198) of the United States population. It is estimated that between 11-30% of veterans and active duty personnel suffer from PTSD depending on the war era (U.S. Department of Veterans Affairs, 2007). With the high percentages of veterans and military personnel in the U.S. population suffering from PTSD, it is important to gain more understanding of their combat-related experiences.

Posttraumatic stress disorder has commonly been associated with combat-related trauma and can be recorded back to the United States Civil War. “War Neuroses” and “General Nervous Shock” were coined and entered the medical vernacular in the 1860s. During the U.S. Civil War, posttraumatic stress disorder was referred to as “Da Costa Syndrome,” or “Soldier’s Heart” (Shorter, 2005, p. 225). Individuals with Soldier’s Heart exhibited cardiac symptoms, irritability, and increased arousal. In 1877, Jean-Martin Charcot devised the term “Traumatic Hysteria” (as cited in Shorter, 2005, p. 224).
In 1888, Hermann Oppenheim coined the term “Traumatic Neurosis” from observing individuals who were involved in railway accidents and related traumas. WWI introduced the world to modern warfare practices such as the use of explosives, chemical weapons, and trench warfare. This introduction of modern warfare brought about new meaning to combat-related trauma. In WWI “Shell Shock” was used to refer to brain trauma caused by exploding shells (Shorter, 2005, p. 225). In WWII the terms for combat-related trauma were “Combat Neurosis” and “Operational Fatigue,” or “Battle Fatigue.” In 1944, the term for combat trauma became “Acute Grief” (Shorter, 2005, p. 225). After the Vietnam War these symptoms became known as Post-Vietnam Syndrome. Posttraumatic stress disorder was eventually coined in the mid 1970’s through the efforts of anti-war and anti-Vietnam groups. The Diagnostic and Statistical Manual for Mental Disorders formally recognized posttraumatic stress as an anxiety disorder in 1980 (Shorter, 2005, p. 225).

PTSD has been widely recognized as a prominent diagnosis within the VA healthcare system. The Veterans Administration found that approximately 30% of Vietnam Veterans and 10% of Gulf War Veterans were diagnosed with PTSD (U.S. Department of Veterans Affairs, 2007). The three most recent U.S. military campaigns have taken place in Afghanistan and Iraq. The first military campaign is known as Operation Enduring Freedom (OEF), which began on October 7, 2001, in Afghanistan. The second military campaign, Operation Iraqi Freedom (OIF), ran from 2003 to 2010 and took place in Iraq. The third military campaign is known as Operation New Dawn (OND), taking place in Iraq, which picked up after OIF was ended in 2010 (Torreon, 2012). Generally, studies among OEF/OIF VA users consistently show a rise in prevalence of PTSD over time. Veterans of the Iraq and Afghanistan wars (OIF, OEF)
show a lifetime prevalence rate of 11-20% for PTSD (U.S. Department of Veterans Affairs, 2007). Seal et al. (2009) examined data from 2002 through 2008 and found the rate of new PTSD diagnoses in 289,328 OEF/OIF VA users increased from 0.2% (1 of 439 veterans) to 21.8% (62,929 of 289,328 veterans) over the six-year span. Frayne et al. (2011) found that veterans with a diagnosis of PTSD had more medical diagnoses and utilized primary care services more frequently than veterans without PTSD.

Evidenced by the sheer numbers of veterans seeking treatment, and the prevalence rates, it is evident that PTSD is having an alarming impact on our veterans returning from combat. Dr. Terence Keane, of the VA Boston Healthcare System, believes PTSD in veterans demands more attention: “Few national health crises are more deserving of the greatest efforts of the world’s top scientists” (University of Texas Health Science Center at San Antonio, 2013). This is a national health crisis that demands further research and options in approaching PTSD treatment.

The current research explored the relationship of posttraumatic stress symptoms in U.S. Veterans and active/non-active duty personnel, and how guilt, the centrality of a certain military-related traumatic event to one’s life narrative, and the quality of participants’ relationships related to PTSD symptoms.

Statement of the Problem

I have proposed three hypotheses: (1) Greater perceived connection and social support from relationships will relate to a decreased prevalence of PTSD symptoms, (2) The more central the participant’s traumatic event to their own identity, the higher
indication of guilt and PTSD symptoms, (3) The higher participants’ experiences of trauma-related guilt, the higher the indication of PTSD symptoms.

The problem this study aims to explore is that increasing numbers of U.S. Veterans are being diagnosed and seeking treatment with PTSD. The ways in which Veterans view traumatic events may hold a key to possible clinical treatment approaches as well as more information on how the concepts of PTSD, trauma-related guilt, centrality of events, and relationship quality interrelate.

Purpose of the Study

The purpose of this study was to evaluate the relationships between PTSD, guilt, the centrality of the stated traumatic event to one’s life narrative, and the quality of one’s relationships among a U.S. Military population. This study was partly modeled after Robinaugh and McNally’s study (2010), “Autobiographical memory for shame or guilt provoking events: Association with psychological symptoms.” Robinaugh and McNally (2010) conducted a survey of 179 individuals (119 students) in the Boston area. Participants recalled an event associated with guilt or shame, and answered questionnaire measures of PTSD, shame, guilt, and depression. Additionally, the researchers evaluated features of the recalled memory including the visual perspective and the centrality of the event to the participant’s life narrative (p. 648). Robinaugh and McNally found that shame and the centrality of events predicted depression and PTSD symptoms. The researchers found that guilt was not a significant predictor. Some of the procedures found in Robinaugh and McNally’s study (2010) were chosen for this study to test in a U.S. military population.
Theoretical Framework

Schema theory is a well-suited framework for studying the development, maintenance, and treatment of PTSD symptoms. Schema theory is a way of mentally representing and organizing personal knowledge at different levels of abstraction (Dalgleish, 2004, p. 232). “Schemas are parsimonious mental representations that serve as models of aspects of the world, the self and other people” (Dalgleish, 2004, p. 232). Schemas, or preexisting representational structures, are filters that new experiences sift through in order to make sense and organize new information. Fiske and Taylor (1991) acknowledged that schemas are resistant to change, and that change happens slowly over time. With time, individuals are able to integrate conflicting schemas into preexisting schemas, such as experiences of trauma: “PTSD seems to be critically about fitting the experience of the traumatic event into one’s prior understanding of things” (Dalgleish, 2004, p. 233). Schema theory is the theoretical framework in this study used to interpret PTSD symptomology, trauma-related guilt, the centrality of a traumatic military-related event to autobiographical narrative, and quality of relationships.

Definition of Terms

*Posttraumatic stress disorder* will be abbreviated throughout this manuscript as PTSD, referring to the clinical diagnosis as well as self-reported prevalence rates and symptomology. The *Centrality of Events Scale* will be abbreviated as CES, and this term refers to the instrument used to measure how central a traumatic event is to one’s life narrative (Berntsen & Rubin, 2006). The PTSD Checklist – Stressor Specific Version will be abbreviated as PCL-S and measures DSM-IV PTSD symptom criteria based on a
specific stressful experience (Weathers, Litz, Herman, Huska, & Keane, 1994). The Trauma-Related Guilt Inventory will be abbreviated as TRGI and measures trauma-related guilt (Kubany, 2004). A few current war-era terms: (1) *Operation Iraqi Freedom*, (2) *Operation Enduring Freedom*, and (3) *Operation New Dawn* will be abbreviated as follows: OIF, OEF, and OND. These three war-eras refer to veterans who served in Iraq and surrounding areas from 2003 - 2010 (OIF), veterans who served in Afghanistan and surrounding areas from 2001 to present (OEF), and veterans involved in the Iraq war after August 2010 (OND) (U.S. Department of Veterans Affairs, 2011).
CHAPTER II

LITERATURE REVIEW

Posttraumatic Stress Disorder

**PTSD and Military Veterans**

Posttraumatic Stress Disorder can be a challenging and debilitating mental health disorder that continues to impact numerous military service members. Diagnoses of PTSD have been rising dramatically among United States’ military service women and men and further research is needed to help and understand what these individuals experience. The concepts of how central these experiences are to individuals’ autobiographical narratives, how trauma-related guilt influences PTSD symptomology, and the impact of relationships on PTSD symptomology and overall wellbeing will be examined.

Breslau et al. (1998) conducted a study with a sample size of 2,181 in the Detroit metropolitan area on trauma and PTSD prevalence in the community. Breslau et al. found that the highest risk (20.9%) for developing PTSD was related to experiencing violence and assault. For this reason it is imperative to continue working with combat military veterans in a mental health capacity, who face violence and assault on a daily basis.

Rosenheck and Fontana (2007) conducted a study on trends in the VA treatment of PTSD and other mental disorders, with a sample of all veterans who
received any type of mental disorder treatment from the U.S. VA from fiscal years 1997 ($n = 530,267$), 1999 ($n = 582,300$), 2001 ($n = 640,462$), 2003 ($n = 717,400$), and 2005 ($n = 826,253$) (p. 1722). The researchers found that VA specialty mental health program enrollment increased by 56 percent from the fiscal year 1997 to fiscal year 2005 with an annual growth rate of seven percent per year (p. 1722). Researchers also found that PTSD diagnoses doubled from 1997 to 2005 (p. 1722-723). It is unknown whether there are truly more instances of PTSD, or if the diagnosis is becoming more recognized, and less stigmatized in today’s modern society. Rosenheck and Fontana (2007) believe the increase in PTSD diagnoses may be attributed to the comprehensive Department of Defense and VA active screening of soldiers returning from overseas (p. 1726). Whereas PTSD diagnoses may be rising for a number of different reasons, the fact remains that PTSD diagnoses are rising amongst our military service members and continued research and treatment are needed for this population.

Although combat-related trauma has always played a role in the evaluation and treatment of military service members throughout history, manifesting in different ways during different war eras, military combat today has changed; therefore the nature of the trauma experience has also changed. Today there are a wide variety of combat environments (e.g., urban, maritime, jungle, desert) and enemies may be known or ambiguous. The Iraq War has exposed service members to unique and challenging contexts such as gorilla warfare and terrorist actions:

In this context, there is no safe place and no safe role, although some roles are particularly high risk, such as patrolling dangerous areas and driving trucks. Service members in Iraq need to maintain a high degree of vigilance, which can cause chronic anxiety and strain. They constantly need to moderate their responses to possible threats in order to avoid mistaking civilians for potentially lethal
combatants or causing collateral damage to civilians in urban environments. (Litz, 2007, p. 219)

Litz describes the high-stress environment military service members are facing today. Part of this high-stress environment includes a constant state of hyper arousal, fear, anxiety, and an attempt to regulate these emotions for self-preservation. This combat context provides a clear illustration of why some service members develop combat-related trauma or PTSD (Litz, 2007).

Hoge et al. (2004) conducted a survey on OEF/OIF service members some of which were pre and/or post deployment. Researchers examined mental health problems among Army veterans who served in Afghanistan (N = 1962), Iraq (N = 894), and US Marines who served in Iraq (N = 815). The veterans in this study reported their combat experiences illustrated much of what Litz (2007) describes. Some reported experiences such as: receiving incoming artillery, rocket, or mortar fire, being attacked or ambushed, being shot at or receiving small-arms fire, seeing dead bodies or human remains, shooting or directing fire at the enemy, and knowing someone who was seriously injured or killed (Hoge et al., 2004, p. 18). Reporting and witnessing these types of traumas exemplifies the unique and challenging contexts service members experience during combat.

Not only do service women and men experience combat trauma, they may also encounter military sexual trauma (MST). A survey by Lipari and Lancaster (2003) asked 60,415 active-duty service members of the Army, Navy, Marine Corps, Air Force, and Coast Guard to answer 19 behaviorally based survey items for the Workplace and Gender Relations Survey in 2002 (p. 5). Questions were asked regarding: crude or offensive behavior, unwanted sexual attention, sexual coercion, sexist behavior, and
sexual assault (pp. 11-12). Participants reported experiencing sexual harassment as follows: crude or offensive behavior (Females = 45%, Males = 23%); unwanted sexual attention (Females = 27%, Males = 5%); sexual coercion (Females = 8%, Males = 1%); sexist behavior (Females = 50%, Males = 17%); and sexual assault (Females = 3%, Males = 1%) (p. 12). While most military-related trauma is from active duty combat, some service members may face an additional terror of military sexual trauma.

There are many variables that should be considered when diagnosing a mental disorder, particularly PTSD. Diagnosing PTSD includes examining pre-trauma factors, trauma factors, and post-trauma factors (Foa & Meadows, 1998). All three factors include taking into account, “individual characteristics, environmental aspects, objective components, and subjective interpretations” (p. 179). The present study was primarily focused on trauma factors and post-trauma factors, such as violence encountered in combat and the challenges faced when returning to civilian life, as subjective participant interpretations.

**DSM-IV-TR Criteria**

The most widely accepted diagnostic criteria for PTSD comes from the *Diagnostic and Statistical Manual of Mental Disorders*. Although there is an updated version (DSM-V), the DSM-IV-TR will be utilized because the questionnaires used in this study reference this version. According to the DSM-IV-TR an adult individual must experience six criteria to meet the diagnosis for posttraumatic stress disorder. Criterion (A) regards the exposure to a traumatic event. The individual must witness or experience an event that involved threat of death or serious injury to self or others. The individual must also respond to the event with intense fear, helplessness, or horror. Criterion (B)
regards persistent re-experiencing of the traumatic event. The individual must exhibit at
least one of the following in regards to re-experiencing the event: (1) intrusive thoughts
or perceptions, (2) distressing dreams, (3) acting or feeling as if the event were recurring,
(4) intense distress at exposure of an internal or external cue that symbolizes the event, or
(5) physiological reactivity.

Criterion (C) regards the persistent avoidance of associated stimuli and a
numbing of general responsiveness that was not present before the trauma. This
avoidance and numbing may be exhibited by three or more of the following: (1) an
avoidance of thoughts, feelings, or conversations associated with the trauma, (2) an
avoidance of activities, places, or people associated with the trauma, (3) the inability to
recall important aspects of the event, (4) a diminished interest or participation in
significant activities, (5) feeling detached from others, (6) a restricted range of affect,
and/or (7) a sense of a foreshortened future. Criterion (D) regards persistent increased
arousal. Increased arousal may be indicated by two or more of the following: (1) the
difficulty falling or staying asleep, (2) irritability or outbursts of anger, (3) difficulty
concentrating, (4) hypervigilance, or (5) an exaggerated startle response. Criterion (E)
states that the duration of symptoms in Criteria B, C, and D is more than one month.
Criterion (F) states that the disturbance causes clinically significant distress or
impairment in social, occupational, or other important areas of functioning.

There are three specific types of PTSD that are recognized after the six criteria
are met: (1) Acute PTSD if the symptoms are less than three months, (2) Chronic PTSD
if the symptoms have continued three months or more, and (3) Delayed Onset PTSD if
the onset of symptoms is at least six months after the stressor (American Psychiatric Association, 2000).

**PTSD and Suicide**

Not only does PTSD have a large impact on our military veterans, so does suicide. Combining PTSD with suicidal ideology can create a lethal combination. Suicide rates are extremely high among Veterans, “There is no dispute on one issue: the military rate has been climbing faster than the civilian rate. According to the Pentagon, the military rate of 18.5 suicides per 100,000 service members in 2009 was up from 10.3 suicides per 100,000 in 2002 — an 80 percent increase. A comparable civilian suicide rate rose by about 15 percent in the same period” (Dao & Lehren, 2013).

In one study by Davidson, Hughes, Blazer, and George (1991) researchers examined PTSD in the Piedmont region of North Carolina with a civilian population of 2,985. Researchers found 39 (1.3%) participants had PTSD while 2,946 (98.7%) participants did not have PTSD (p. 717). Of the participants who had PTSD, 19.8% reported a suicide attempt compared to the non-PTSD group who reported 0.8% suicide attempts. Researchers found that the participants with PTSD were 14.9 times more likely to attempt suicide than participants without PTSD. After adjusting for co-morbid depression, individuals with PTSD were 8.2 times more likely to attempt suicide than those without PTSD (p. 718).

If a civilian population has such a high correlation of PTSD and suicide (Davidson et al., 1991), what does that mean for the military population? Brenner et al. (2011) conducted a study using 79 control patients, and 81 clinical patients with a history of suicide attempts in a two-year timespan. The 81 clinical patients were chosen on the
basis of having an electronic medical record documenting a suicide attempt and receiving VA health care. Researchers found that the probability of a suicide attempt for those diagnosed with PTSD were 2.8 times more likely than for those without PTSD (Brenner et al., 2011, p. 420). Although Davidson et al. (1991) found a higher likelihood of suicide with those diagnosed with PTSD than Brenner et al. (2011), the numbers are still elevated. The sample size (Brenner et al., 2011) was not as vast as Davidson et al.’s (1991), but a veteran population is already prone to increases in trauma due to combat. That is particularly true if assault and violence have the highest predictive factor (20.9%) for PTSD (Breslau et al., 1998).

Researching the experiences of Vietnam era veterans, Bullman and Kang (1994) found that veterans diagnosed with PTSD were more likely to attempt suicide than those without PTSD sampled from the Agent Orange Registry (AOR). Agent Orange, or dioxin, is an herbicide that was used during the Vietnam War to clear lush areas of vegetation, also known as herbicidal warfare, that has been linked to health problems some veterans still deal with today. From a sample of 16,257 Vietnam veterans from the AOR, those with a diagnosis of PTSD \( (n = 4,247) \) were at an increased risk of death by suicide when compared to those without PTSD \( (n = 12,010) \). Twenty-six percent is a staggering number of service members diagnosed with PTSD in this study. The results of this study indicate a probability of one in four Vietnam era veterans are at an increased risk of death by suicide.

Moving forward to the most recent military era vets, in a sample of 407 Iraq and Afghanistan War veterans referred to VA mental health care, Jakupcak et al. (2009) found that OEF and OIF veterans who screened positive for PTSD were over four times
more likely to endorse suicidal ideation than those without PTSD symptoms (p. 303). It is important to note that about half (49.6%) of the OEF/OIF veterans in this study screened positive for PTSD (Jakupcak et al., 2009, p. 304). Again, as with Bullman and Kang’s research (1994), PTSD cases are extremely elevated in military veterans.

Hendin and Haas (1991) examined risk factors for suicide in 100 Vietnam era veterans. The study included questionnaires and five semi-structured interviews. High risk factors for attempting suicide included persistent guilt related to wartime experiences (both combat action and survivors guilt), depression, and severe cases of PTSD (p. 588). A more detailed look at the relationship between PTSD and guilt will be discussed further in this review of literature.

**PTSD and VA Healthcare Utilization**

Veterans have special mental and physical needs when it comes to healthcare. Historically, there has been much resistance from veterans in obtaining VA healthcare. Such resistance includes stigmas and barriers to healthcare that continue to influence the amount of care veterans receive today.

Historically, the women and men of the United States military have underutilized the Veterans Affairs Healthcare system. In 1990, it was estimated that only 10% of Vietnam veterans enrolled in the VA, while only 7.5% reported ever having used VA mental health services (Kulka et al., 1990).

When acknowledging combat trauma, there has been a long history of stigma around obtaining mental health services. Hoge et al. (2004) found that significant barriers veterans reported to obtaining mental healthcare included the fear of judgment. Participants reported they did not want to be judged by leadership and peers for seeking
mental healthcare. Researchers also found, “Concern about stigma was disproportionately greatest among those most in need of help from mental health services” (p. 20). Litz (2007) found that other concerns for receiving mental health care included: distrust of mental health professionals, concern about privacy, logistical barriers (e.g., availability, time, money, transportation), concerns of unit leaders and peers regarding them negatively, and concerns about negative career impact (p. 222).

Recently, enrollment in VA healthcare has increased dramatically for U.S. service men and women. In 2008 it was estimated that 41% of all 837,458 separated (i.e., no longer active duty) OIF and OEF veterans eligible for VA health care enrolled in the VA since 2002 (Kang, 2008). With an estimated 153 VA medical centers and 900 VA outpatient clinics nationwide (Seal et al., 2009, p. 1652) it is encouraging to see service men and women utilize the specialized services available.

However, with the persistent stigma veterans experience for receiving mental health care, de-stigmatizing mental health care needs to be a priority in both the mental health profession as well as in the military community.

**PTSD and Types of Treatment**

Treating military-related PTSD can be complicated due to its many facets. Treatment for PTSD has changed over time. Today there are current standards and methods for helping veterans cope with military-related PTSD. Two popular modes of treatment include psychological first aid and cognitive-behavioral therapy (CBT).

Psychological first aid focuses more on immediate needs, and less on therapy or treatment (Litz & Gray, 2004). Psychological first aid entails providing social support, the option to share, information on what service members may expect in the weeks
following the trauma, as well as referrals for counseling in the future (Litz, 2007, p. 225).

The purpose of psychological first aid is, “To improve social support, greater help-seeking, increased understanding and acceptance of the experience, and reduced sense of stigma among those who need care” (Litz, 2007, p. 226). Litz notes that more research is needed to demonstrate the effectiveness of psychological first aid.

Cognitive-behavioral therapy is a widely accepted treatment method for trauma survivors. Benight and Bandura (2004) state that CBT for trauma is focused on beliefs and behaviors: “The event must be confronted in a way that restores a sense of control through reconstrual or improved coping that alleviates stress reactions and behavioral impairments” (p. 1135). Foa and Jaycox (1999) propose Cognitive Behavioral therapy can be divided into three categories: (1) exposure procedures, (2) anxiety management procedures, and (3) cognitive therapy. Foa and Jaycox described exposure therapy as: “a set of techniques designed to help patients confront their feared objects, situations, memories, and images (e.g., systematic desensitization, flooding).” According to Foa and Jaycox, anxiety management treatment may include controlled breathing, relaxation training, social skills training, positive self-talk and imagery, and distraction techniques (e.g., thought stopping). Additionally, cognitive therapy focuses on the process of identifying dysfunctional or untrue thoughts and beliefs (cognitions) while challenging these cognitions and replacing them with functional, realistic cognitions (Foa & Jaycox, 1999).

Foa and Jaycox (1999) suggest one treatment model for treating PTSD within CBT is Prolonged Exposure Therapy (PE): breathing retraining (10 minutes in one session), education about common reactions to trauma (25 minutes in session 2), imaginal
exposure (reliving) to the trauma memory (30-45 minutes during sessions 3-12), in vivo exposure to trauma reminders in life between sessions, and 9 to 12 weekly or twice-weekly 90-minute sessions of imaginal exposure and prolonged exposure therapy (Foa & Jaycox, 1999).

There are a variety of ways professionals in today’s society approach the treatment of veterans with military-related trauma. For immediate care of trauma, debriefing and psychological first aid are most widely supported. For prolonged and sustained care of trauma, cognitive behavioral therapy is the most widely supported model of treatment to help heal veterans and reacclimatize them to the civilian world.

Centrality of Events

Individuals experience personal events everyday and throughout the lifespan. Some events may be perceived as positive, neutral, negative, or somewhere on the spectrum. However, when negative events become central to one’s identity they pose a potential psychological difficulty. Integrating negative memories into one’s main life narrative and making them a central component to one’s meaning making, particularly if the event is traumatic in nature, can be maladaptive and cause continued distress.

Accessible and vivid memories help to anchor individuals to their life story’s narrative and timeline as well as provide reference points for meaning and decision-making: “A life is not ‘how it was’ but how it is interpreted and reinterpreted, told and retold” (Bruner, 1987, p. 31). Generally, positive events are remembered most and integrated into an individual’s narrative. Pillemer (2001) proposes four general categories
of experience when examining the centrality of life events: (1) Originating Events, (2) Turning Points, (3) Anchoring Events, and (4) Analogous Events.

First, Originating Events are memories that tend to be detailed, vivid, and specific and are tied to long-term goals as well as a conscious or unconscious life plan of action. Additionally, Originating Events command attention, and induce strong feelings, while also conveying a durable sense of causality for why things are the way they are (Pillemer, 2001, p. 127). Originating Events are primarily fueled by memories of the event rather than the event itself (Pillemer, 1998, pp. 83-87). An example of an Originating Event would be witnessing the events on September 11, 2001. Depending on the individual, this event might elicit the desire to enlist in the military, or to help in some way, while also instilling a durable sense of why personal and public security in America has changed forever.

The second category of experience Pillemer (2001) described is that of Turning Points in one’s life story. Bernsten and Rubin (2006) suggest that Turning Points in the life story are causal agents. Turning Points are concrete episodes that tend to alter one’s life plan. Recurring memories of Turning Point events continue to motivate the pursuit of new goals. As with Originating Events, Turning Points also convey a strong sense of causality (Pillemer, 2001, p. 127). An example of a Turning Point would be witnessing the death of a friend or service member during combat. This event might cause the individual to feel the need to continue their military service/become a career officer, or it might elicit strong feelings to leave the Armed Forces.

The third category of experience by Pillemer (2001) is Anchoring Events. Anchoring Events fasten us to prominent events in our life story that provide the
foundation for belief systems. An Anchoring Event is an enduring memory that guides individual beliefs of how the world works. Anchoring Events are valuable in that they guide individuals to pursue continued positive stimuli and avoid stimuli that may have been aversive in the past (p. 128). An example of an Anchoring Event would be witnessing the serious injury of a fellow service member due to shrapnel from an IED going through a nearby window. This event might elicit the individual to be cautious and to avoid windows during combat in the future, while also warranting a prolonged belief that windows equal harm and danger.

The final category of experience Pillemer (2001) proposes is Analogous Events. Analogous Events offer models of how individuals should properly behave. Present situations trigger memories of similar past events, which then help individuals to make decisions appropriately (p. 128). An example of an Analogous Event would be the experience of going through Basic Training. The individual would learn the rules of being a military service member (e.g., proper stance, rank, handling of weaponry, proper etiquette and attire, how to address a higher-ranking official, and protocols during combat). While reviewing the centrality of life events further, the above categories of experience of Originating Events, Turning Points, Anchoring Events, and Analogous Events will be referenced.

While positive events tend to be most remembered, negative or traumatic events that become central to one’s identity can be damaging and destructive. Traumatic events can be interpreted as Turning points as well as Anchoring events and can validate or invalidate current schemas and guide behavior. The availability heuristic described by Tversky and Kahneman (1973) is related to centrality of events in that the more available
certain memorable events, the more likely individuals believe these events more likely to recur. “We judge the frequency and probability of specific classes of events by the ease with which we are able to retrieve them” (Berntsen & Rubin, 2006, p. 221). If a traumatic event becomes so available and readily retrievable, it can instill barriers to growth, guide behavior, and perpetuate maladaptive beliefs of trauma reoccurrence.

Although the centrality of a traumatic event can become unconstructive and harmful, these events can also lead to posttraumatic growth (PTG) when examining the event with purpose and self-worth. Posttraumatic growth is positive life change as a result of struggling with a traumatic event (Groleau, Calhoun, Cann, & Tedeschi, 2013).

In a study by Groleau et al. (2013) researchers examined centrality of events to the development of both posttraumatic distress and posttraumatic growth in an undergraduate population of 187 students (p. 478). Variables examined included: core beliefs challenge, deliberate rumination, intrusive rumination, found meaning, search for meaning, centrality of event, PTSD symptoms, and PTG (p. 480). They found that the centrality of events was moderately to strongly positively related to both posttraumatic distress and posttraumatic growth. For posttraumatic distress, researchers found the centrality of an event to be a, “small but significant unique predictor of posttraumatic distress” (p. 481). Researchers found the variables disruption of core beliefs, intrusive rumination, and the search for meaning of the event to be significant indicators of posttraumatic distress (p. 481). Researchers suggest that, “Clinicians need to be alert to the degree to which traumatic events are becoming either positive and adaptive components of the individual’s identity and life narrative, or negative and maladaptive components” (p. 482). While most previous research indicates the centrality of a
traumatic event to be damaging; there is hope that the Anchoring event or Turning point can lead to healing when examined in the appropriate light.

For the purpose of this study, the centrality of a military-related traumatic event is hypothesized to begin as maladaptive. This maladaptation is due to the event being central to one’s autobiographical narrative as well as the lack of schema integration. Clinicians need to be aware of schema congruence and to help guide patients towards a positive and adaptive outlook on the trauma they experienced. “Opportunities for positive life change may exist whenever memories of momentous events are open to reconsideration and reinterpretation” (Pillemer, 2001, p. 131).

Guilt

Trauma-related guilt can impede daily functioning, influence PTSD symptom severity, PTSD treatment, and recovery for military veterans. Trauma-related guilt has been shown to affect recovery and treatment (Kubany & Manke, 1995). Kubany defines guilt, “as an unpleasant feeling accompanied by a belief that one should have thought, felt, and/or acted differently” (Kubany, 1994, p. 5). Feelings of trauma-related guilt can also be interpreted as the inability to effectively integrate the trauma with an individual’s beliefs that existed prior to the traumatic exposure (Held, Owens, Schumm, Chard, & Hansel, 2011, p. 709). The reasoning for studying trauma-related guilt, the difference between shame and guilt, and the impact of trauma-related guilt on PTSD symptomology will be explored through empirical studies and the Trauma-Related Guilt Inventory Scales (Kubany, 2004) in the current study.
The reasoning for studying trauma-related guilt within the context of PTSD symptomology, relationships, and the centrality of a specified traumatic event to autobiographical narrative comes from Robinaugh and McNally’s study (2010). Robinaugh and McNally examined shame and guilt as they related to PTSD symptomology and the centrality of a traumatic event to one’s identity in a mostly student population from the greater Boston area. The researchers found shame predicted both depression and PTSD symptom severity, but found guilt did not (p. 650). One of the aims for the current study is to examine guilt, in addition to the other variables, in order to see if guilt is a significant predictor of PTSD symptomology within a U.S. military population.

The terms guilt and shame tend to be used interchangeably, but there is a clear difference between these terms when examining their relationship to trauma. Lewis (1971) defined the difference between shame and guilt as shame encompassing the negative evaluation of the entire self while guilt concerns the self’s negative evaluation of specific behaviors. So, while shame tends to involve the negative perception of oneself, guilt is related to actions taken or not taken. Guilt and shame can affect everyday life in a myriad of ways including the negative experience of the self and one’s social behavior, and diminish or eliminate help seeking behavior. Guilt and shame can also impede emotional processing of a traumatic event, and may seriously disrupt the effectiveness of therapy (Lee, Scrugg, & Turner, 2001, pp. 451-2).

In a study by Leskela, Dieperink, and Thuras (2002) researchers examined shame-proneness and guilt-proneness in 107 former prisoners of war (the same sample of surviving POWs previously studied by Engdahl, Dikel, Eberly, & Blank, 1997). All
participants were male and resided in North Dakota, Minnesota, or Wisconsin. The mean age of participants was 75.4 years (SD = 3.5). Participants took a survey based on three questionnaires: Test for Self-Conscious Affect (TOSCA; Tangney, Wagner, & Gramzow, 1989), PTSD Checklist – Military for DSM-IV (PCL; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), and the Combat Exposure Scale (CES; Keane et al., 1989). Leskela et al. (2002) found that 28% of participants met the criteria for PTSD and that only shame-proneness was positively correlated with the severity of PTSD symptoms. (p. 225). This is an interesting finding in that researchers did not find guilt-proneness statistically significant. It should be noted that participants’ traumas occurred an average of more than 50 years prior to the study (Leskela et al., 2002, p. 226). So, shame may have been present before the trauma, any guilt cognitions may have been resolved since the occurrence of combat, or the trauma may have been integrated into a congruent schema, leaving shame, an overall assessment of the self, as pervasive (Leskela et al., 2002, pp. 225-226). Lee et al. (2001) describes the experience of guilt versus the experience of shame: “The individual may feel guilty about the specific event, but this does not alter his beliefs about himself: his sense of self remains intact, and his feelings of guilt remain circumscribed to the event” (p. 462). While shame has a more global range, guilt concerns specific behaviors related to the traumatic event and thus will be the focus of the current study.

Schema Theory is the theoretical framework used to interpret findings in the current study. The idea of schema congruence and incongruence is well illustrated within the concept of guilt. Lee et al. (2001) proposed the notion that the development of trauma-related guilt involves schema incongruence. Researchers suggest that guilt
cognitions do not “match” individuals’ current schemas regarding the event and thus impede negatively on the traumatized person. One further explanation by Lee et al., “In the context of PTSD, pervasive feelings of guilt can arise when the meaning of the traumatic event conveys a violation or departure from standards of behaviour and/or a feeling of responsibility for causing harm to others” (p. 461). It is proposed that a traumatized individual needs to integrate or “match” schematic representations of the world as well as meaning of the self to the schema incongruence of the trauma in order to recover (p. 456).

While Schema Theory is able to provide an explanation of why guilt may manifest, Henning and Frueh (1997), examined combat guilt and its relationship to PTSD symptoms. Henning and Frueh note that guilt is not one-sided but multi-faceted. “Guilt includes behavioral, emotional, and cognitive components” (p. 802). Forty U.S. military veterans diagnosed with combat-related PTSD participated in their study and were given the Clinician Administered PTSD Scale (CAPS; Blake et al., 1990; Weathers & Litz, 1994) as well as four self-report measures: Revised Combat Scale (RCS; Gallups, Laufer, & Yager, 1981), Mississippi Scale for Combat-Related PTSD (M-PTSD; Keane, Caddell, & Taylor, 1988), The Guilt Inventory: Trait Guilt (TGI-TG; Kugler & Jones, 1992), and Combat Guilt Scale (CGS) developed by the researchers for their study (1997). Researchers found that most military veterans experienced some level of guilt related to combat. Types of reported guilt included: acts of commission (i.e., something a veteran did during combat), acts of omission/error (i.e., something a veteran did not do, or did by accident or error), shame-guilt, survival guilt, and guilt regarding one’s thoughts/feelings. The two most prevalent reported types of guilt were acts of omission/error and
commission (Henning & Frueh, 1997, p. 806). These results indicate the highest levels of guilt tended to be from actions taken or not taken, while in combat.

In a study by Owens, Steger, Whitesell, and Herrera (2009) researchers examined meaning in life in relation to PTSD symptomology. Researchers hypothesized meaning in life would moderate PTSD symptoms, guilt, and depression. In this context, meaning in life is referred to as one’s perceptions that one’s personal life is meaningful (p. 655). A total of 174 military veterans participated in this study and answered five self-report questionnaires including The Combat Exposure Scale (Keane et al., 1989), the PTSD Checklist – Military version (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993), the Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995), the Guilt Inventory-Trait Scale (Kugler & Jones, 1992), and the Meaning in Life Questionnaire (Steger, Frazier, Oishi, & Kaler, 2006). Researchers found that severe PTSD was reported by participants who also reported more combat exposure, depression, guilt, and less meaning in life (Owens, et al., 2009, p. 655). Henning and Frueh (1997) as well as Owens et al. (2009), illustrate the types of guilt experienced by combat veterans as well as significant predictors of PTSD severity. While these two studies demonstrate the negative impact of feelings of guilt on U.S. military veterans, Edward S. Kubany, a dominant figure on trauma-related guilt, helped to develop the Trauma-Related Guilt Inventory (TRGI).

Kubany, a prominent authority on guilt and trauma research, developed the Trauma-Related Guilt Inventory over a series of explorative studies and literature reviews (Kubany, 1994; Kubany et al., 1996; Kubany, Abueg, Kilauano, Manke, & Kaplan, 1997). While examining guilt in military veterans, Kubany (1994) found that contrary to
popular belief, “survival guilt” could not account for all reports of trauma-related guilt. Kubany predicted that guilt was much more complexly related to trauma than military veterans only experiencing “survival guilt.” In a survey study by Kubany et al. (1997) researchers found the most reported trauma-related guilt sources in 107 Vietnam veterans were: (1) “Not being able to do more for those who were wounded or suffering” (70%) (p. 245); (2) “Surviving an incident, battle, or the war when others did not” (65%) (p. 246); (3) “Not having a proper way of saying goodbye for someone who died” (65%) (p. 246); (4) “Your inability to save lives of or prevent harm to buddies, other Americans, or our allies” (64%) (p. 246); (5) “Seeing or hearing about Americans who had been killed by the enemy” (61%) (p. 246); and (6) “Seeing or hearing about children who had been killed, wounded, or crippled by military actions” (61%) (p. 246). From these trauma-related guilt report outcomes, Kubany and Manke (1995) defined guilt cognitions into four categories.

Kubany and Manke (1995) identified four cognitive components of guilt frequently identified in traumatized populations: (1) the violation of personal standards of right and wrong, (2) the perceived responsibility for causing the traumatic event, (3) the perceived lack of justification for actions taken, and (4) false beliefs about pre-outcome knowledge/hindsight-bias (Lee et al., 2001, p. 456). From these general components, Kubany and Manke (1995) developed the Trauma-Related Guilt Inventory (TRGI) for use in cognitive therapy. Kubany (2004) later refined the inventory and the subsequent scales and subscales that are used today. The TRGI consists of three scales: Global Guilt, Distress, Guilt Cognitions, and three subscales: Hindsight-Bias/Responsibility,
Insufficient Justification, and Wrongdoing (Kubany, 2004). The TRGI scales will be discussed in further detail in this study.

Holding trauma-related guilt beliefs can be a large impediment to recovery, particularly for U.S. military combat veterans. The studies discussed above illustrate the negative impact trauma-related guilt can have on an individual (Henning & Frueh, 1997; Kubany et al., 1997; Owens et al., 2009). Lee et al. (2001) suggest therapy that does not account for guilt may worsen post-trauma reactions (p. 452). Additionally, individuals with trauma-related guilt need to “match” their negative incongruent schemas to a more positive schema in order to eliminate guilt cognitions (p. 456). PTSD and/or trauma-related guilt sufferers must integrate their traumatic experience into a more positive and congruent representation of the world, self and others in order to live free from trauma-related guilt. Unlike the findings in Robinaugh and McNally’s (2010) study on guilt and shame provoking events, the impact of trauma-related guilt is predicted to significantly impact PTSD symptom severity in the current study of U.S. military veterans.

Relationships

Research has shown that social relationships are extremely important to human overall wellbeing. Given that humans are social creatures, relationship formation, relationship quality, and relationship maintenance all impact an individual’s overall wellbeing. Individuals’ trauma experiences, particularly military-related trauma and PTSD, can have a huge impact on service members’ social relationships. “A trauma is not an isolated transient event,” (Benight & Bandura, 2004, p. 1134) traumas encroach upon every aspect of an individual’s being and that includes relationships with others. The
implications of how military-related trauma and PTSD can influence social relationships, how PTSD influences self-disclosing trauma to others, types of social support sought, and intimate relationships will be discussed.

PTSD has the serious potential to negatively impact veterans’ cognitive beliefs and social functioning. In a study by Tsai, Harpaz-Rotem, Pietrzak, and Southwick (2012) researchers recruited 164 OEF/OIF veterans from primary care or mental health clinics at the VA Connecticut Healthcare System. Researchers sought to examine the role of coping, resilience, and social support in regards to PTSD in veterans returning one year or less from Iraq and Afghanistan. Participants were given a packet of self-report measures that included questions regarding sociodemographics, service duty, PTSD symptoms, partner and family relationships, life satisfaction, coping, and social support. Researchers found that veterans who screened positive for PTSD reported more cognitive-behavioral avoidance, a greater fear of losing vigilance, and poorer social functioning and lower life satisfaction (p. 143). Additionally, those who screened positive for PTSD reported greater difficulties in their relationships with romantic partners, a less cohesive family, less social support, more dysfunctional thought control, and less resilience than other treatment-seeking veterans without a PTSD diagnosis (p. 143). Tsai et al. (2012) found numerous social detriments for the veterans with a PTSD diagnosis and illustrated how important social relationships are to every individual. Social networks have been shown to play an influential role in mediating PTSD symptomology.

Relationships are made up of various social networks that tend to meet individual needs differently. Wilcox (2010) studied social relationships and PTSD symptomology in 83 male married combat veterans who exhibited some degree of PTSD
symptoms. Participants were given the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) and the PTSD Checklist, Military Version (PCL-M; Weathers & Ford, 1996). Wilcox found that combat veterans differentiate between sources of social support including family, friends, military peers, and significant others separately, as opposed to one overall construct of social support (Wilcox, 2010, p. 179). This finding is interesting in that each category of social support may be considered a separate network (i.e., family network, friend network, military peer network, and significant others network). Social support is a complex construct and each form of social support may impact and be impacted differently by the veteran’s traumatic experience. Results also indicated that higher perceived social support from family, significant others, and military peers was significantly related to lower symptoms of PTSD. Friends, on the other hand, were not significantly related to PTSD symptomology positively or negatively. Wilcox found that higher perceived social support of family, significant others, and military peers most influenced lower levels of PTSD symptomology. It is interesting to note that the friend network was not significantly related to PTSD symptomology. One rationale given by Wilcox (2010) is that friends may have less of a buffering effect than family, military peers, and significant others (p. 179). Also, participants’ friend networks, post-deployment, may transform into a military peer network. While Tsai et al. (2012) illustrated how PTSD symptoms may impact veterans’ social relationships, Wilcox (2010) introduced the idea of separate social networks. The idea of separate social networks holds meaning in that specific social networks may be more buffering of PTSD symptomology than others (e.g., military peers) in the context of a U.S. military population. So, how do these social networks
actually play a role in reducing PTSD symptomology and severity? Self-disclosure, and
talking about the traumatic event to trusted support networks might be the key to
reducing PTSD symptomology.

A study by Bolton, Glenn, Orsillo, Roemer, and Litz (2003) explored the
long-term impacts of self-disclosure on mental health. Bolton et al. (2003) examined self-
disclosure practices in 426 military personnel deployed to peacekeeping operations in
Somalia. Participants were asked a series of questionnaires based on self-disclosure,
perception of the reaction to disclosure, combat exposure, other stressors associated with
peacekeeping, and posttraumatic stress (pp. 205-206). Participants reported disclosing
their peacekeeping experiences in Somalia primarily to other military personnel (78%),
followed by a partner/spouse (69%), family (69%), friends (62%), or a professional
counselor or clergy person (16%). The pattern of self-disclosure in this study appears to
be those closest to the veterans and their experiences (e.g., military personnel). Bolton et
al. found that self-disclosure was negatively associated with PTSD symptom severity.
Bolton et al. also found that participants’ reactions to self-disclosure were significantly
related to PTSD symptom severity (p. 208). In this study, U.S. military personnel who
talked about their combat-related trauma felt comfortable with the idea of talking to
others, and were comfortable with the networks they chose to disclose to, all showed a
decrease in PTSD symptom severity. This study by Bolton et al. (2003) illustrates that
self-disclosing to social support networks helped to reduce veterans’ PTSD symptom
severity. Next, perceived social support and attitudes will be discussed.

Laffaye, Cavella, Drescher, and Rosen (2008) conducted a survey study with
128 male veterans who completed a residential treatment program for PTSD. Participants
were evaluated at two time points, six months apart. Researchers aimed to evaluate participants’ perceived interpersonal support and stressors for veteran peers, spouses, nonveteran friends, and relatives. Participants were mailed a questionnaire that included the PTSD Checklist Military Version (PCL-M; Weathers & Ford, 1996) as well as interpersonal resources and interpersonal stressors subscales of the Life Stressors and Social Resources Inventory (LISRES; Moos, Fenn, & Billings, 1988). Laffaye et al. (2008) found that veteran peers made up participants’ largest social network and were the most common source of emotional support. Additionally, veteran peer relationships were rated as being supportive and relatively stress-free, as opposed to marital relationships that had equal levels of support and stress (Laffaye et al., 2008, p. 399). Once again, this study by Laffaye et al. (2008), in addition to Wilcox (2010) and Bolton et al. (2003), exemplifies the strong need for veterans to reach out to military peers. Self-disclosing to other veterans who may understand shared experiences at the greatest level (in terms of social networks) is an important factor to consider when assessing individual trauma therapy and recovery.

In addition to other social networks, intimate couple relationships can be greatly affected when military-related trauma is introduced into a couple’s relationship. In a 2008 survey of over 49,000 military spouses, 6% reported problems prior to deployment, while 23% reported marital problems post-deployment (Department of Defense, 2009). Increasing from 6% to 23% post deployment is a vast difference and may account for service members who return to civilian life with military-related trauma. This statistic may also be influenced by the nature of long-distance relationships, as well as other intimate relationship factors.
In a study by Melvin, Gross, Hayat, Jennings, and Campbell (2012) intimate couple functioning and posttraumatic stress symptoms were examined in the context of resilience. A total of 66 couples (132 respondents) were included in this study where the male was the service member \( n = 39 \), or both members of the couple were service members \( n = 27 \). Participants were sent mailed surveys, which included demographic information as well as five measures: the PTSD Checklist (PCL; Weathers et al., 1993), the Revised Connor-Davidson Resilience Scale (R-CD-RISC; Campbell-Sills, Forde, & Stein, 2009; Connor & Davidson, 2003), the Revised Dyadic Adjustment Scale (RDAS; Heyman, Sayers, & Bellack, 1994) regarding couple functioning, the Women’s Experience of Battery (WEB; Smith, Earp, & DeVellis, 1995), and the Traumatic Experience Questionnaire (TEQ; Vrana & Lauterbach, 1994). Researchers found that 23% of couples \( n = 15 \) had posttraumatic stress symptoms (PTSS) that indicated a possible clinical diagnosis for PTSD and that higher levels of PTSS were associated with lower couple functioning and resilience (p. 164). Interestingly, Melvin et al. also found that individuals with a high resilience score reported higher couple functioning regardless of PTSS (Melvin et al., 2012, p. 164). While couple functioning can be greatly reduced with the introduction of posttraumatic stress symptoms or PTSD into an intimate relationship, Melvin et al. illustrates that resiliency can mediate couple’s functioning positively, regardless of posttraumatic stress symptoms.

In a longitudinal study by Koenen, Stellman, Stellman, and Sommer (2003) researchers examined risk factors of PTSD among 1,377 veterans who served in the Vietnam War. Participants were chosen based on having served in the Republic of Vietnam (or surrounding areas) between 1961 and 1975 and who participated in two
mailed questionnaires in 1984 and 1998 (almost identical) regarding health and well-being. Researchers focused on the changes that occurred over time from the questionnaire given in 1984 to the second mailed questionnaire given in 1998. The mailed questionnaire posed questions regarding demographic information, a detailed military service history, perceived social support, emotional distress, and PTSD symptoms. Researchers found that participants who had PTSD at any time since their service reported less perceived social support at homecoming (p. 982). Participants who had diagnosed PTSD in both 1984 and 1998 reported more perceived negative community attitudes at homecoming as well as less help from family after returning from combat than those without PTSD. Koenen et al. (2003) concluded their results indicated recovery from PTSD might be significantly related to perceived community attitudes and involvement, as well as perceived level of community support (p. 985). This study by Koenen et al. (2003) suggests that having a diagnosis of PTSD or PTSD symptoms may influence perception of others. Their study also illustrates how community support and attitudes are important factors that influence military veterans’ experiences upon their return to civilian life.

Human social relationships are extremely important for development, cohesion, and overall wellbeing. When an individual experiences a trauma, social relationships are even more crucial for support and treatment: “At the intraindividual level, people are enabled rather than merely buffered by social supports” (Benight & Bandura, 2004, p. 1134). Social support is crucial and has been shown to be a protective factor:
Social support is considered to be an especially important protective factor. It has been shown to reduce stress, depression, and enhance health. Supporters model coping attitudes and skills, provide incentives for engagement in beneficial activities, and motivate others by showing that difficulties are surmountable by perseverant effort. The enabling function of social support can enhance self-efficacy. (Benight & Bandura, 2004, p. 1134)

When considering treatment and recovery for military-related traumas and PTSD, social relationships are one of the most important factors. The influences of military peer support, social network support, self-disclosure, community attitudes, and resiliency should all be examined in the context of treatment and recovery from military-related trauma.

Limitations

Studying the three concepts of trauma-related guilt, the centrality of a traumatic-related event to autobiographical narrative, and relationship quality relating to PTSD symptomology in a U.S. military population may hold some limitations. Examples of limitations include the population under study. The U.S. military population is a very specific group with particular needs and is very different from studying a civilian population experiencing PTSD symptomology. Changes in the military have occurred throughout its history. Veterans from different War Eras can be very different in many respects. This means that studying concepts in one generation of veterans may not be relevant to another generation of veterans.

Additionally, Schema theory may not be the best-suited theoretical framework for this study. The sample size for this study was small. Finally, this study is not experimental and thus inferences and conclusions cannot be made.
Research Hypotheses

This study examined three hypotheses: (1) Greater perceived connection and social support from relationships will relate to a decreased prevalence of PTSD symptoms, (2) The more central the participant’s traumatic event to their own identity, the higher indication of guilt and PTSD symptoms, (3) The higher participants’ experiences of trauma-related guilt, the higher the indication of PTSD symptoms.
CHAPTER III

METHODOLOGY

Participants

The participants in this study included 88 United States military veterans and/or active duty personnel (21 female, 65 male). The average age range of participants was between 26-30, with an overall age range of 22 to 61 or older. Participants were able to take the survey for course extra credit as well as a chance to win a gift card.

When participants were asked what branch of the military they served in 12 (13.6%) participants identified as having served in the United States Air Force, 44 (50%) served in the United States Army, 19 (21.6%) served in the United States Marine Corps, 16 (18.2%) served in the United States Navy, and one (1.1%) served in the National Guard (see Table 1). Of the participants, two additionally identified as having served in both the United States Army and Navy, and one participant additionally identified as having served in both the United States Army and Marine Corps. See Table 1.

Most participants identified as having served in the War on Terror (57, 66.3%), one served during WWII (1.2%), one served in the Korean conflict (1.2%), 16 served in Vietnam (18.6%), five served in Lebanon/Grenada (5.8%), ten served in the Persian Gulf War (11.6%) and 14 (16.3%) identified as having served in a war/location other than what was listed (see Table 2). Of the participants, seven individuals additionally identified as having served in both the Persian Gulf War and the War on
Table 1

Military Branch

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</tbody>
</table>

Note: This table illustrates which branches of the United States Military the participants in this study identified serving under. It should be noted two participants identified serving in both the Army & Navy and one participant identified serving in both the Army & Marine Corps.

Table 2

Conflict Era

<table>
<thead>
<tr>
<th>Conflict Era</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>WWII (1941-1946)</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Korean Conflict (1950-1955)</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Vietnam Era (1961-1975)</td>
<td>16</td>
<td>18.6</td>
</tr>
<tr>
<td>Lebanon/Grenada (1982-1984)</td>
<td>5</td>
<td>5.8</td>
</tr>
<tr>
<td>Persian Gulf War (1990-1991)</td>
<td>10</td>
<td>11.6</td>
</tr>
<tr>
<td>War on Terror, OEF, OIF, OND (2001-present)</td>
<td>57</td>
<td>66.3</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>16.3</td>
</tr>
</tbody>
</table>

Note: (7 Persian Gulf & WOT)(2 Vietnam & Lebanon/Grenada)(1 Korean & WOT)
(1 Lebanon/Grenada & Persian Gulf)(1 Vietnam & WOT)

Terror. Two participants additionally identified as having served in both Vietnam and Lebanon/Grenada. One participant additionally identified as having served in both the Korean Conflict and the War on Terror. One participant additionally identified as having served in both Lebanon/Grenada and the Persian Gulf War. Lastly, one participant
additionally identified as having served in both Vietnam and the War on Terror. See Table 2.

Participants’ military service ranged from 0-1 year (4.5%) to 10+ years (20.5%). Most participants identified as having served in the United States military for 10+ years (20.5%).

Materials

Participants were asked to complete several surveys as part of this research study. The first form participants completed indicated participant background information (see Appendix A) including one’s: gender, age, religious affiliation, ethnicity, household annual income, relationship status, number of children, and level of education. Participants were then asked to recall and report a traumatic military-related event. This concept of asking participants to recall a traumatic event is informed by Robinaugh and McNally’s 2010 study, “Autobiographical Memory of Shame or Guilt Provoking Events: Association with Psychological Symptoms.” The objective is to obtain a first-hand account of the traumatic military-related event direct from the participant. Although trauma is subjective, the purpose of describing the traumatic event was first to see if participants had experienced military-related trauma and that they met criteria to complete the study. Additionally, the traumatic military-related event was referenced throughout the entire study.

After reporting a traumatic military-related event, participants were asked three open-ended questions developed by the researcher regarding their personal relationships: (1) In general, how do you feel your military experiences have impacted
your relationships with others? (2) Do you believe the traumatic event you recounted has changed or impacted your close relationships? (3) How has serving in the United States military impacted the way you relate to others and develop relationships?

Following the information background form, this study was conducted using three structured questionnaires: The Centrality of Events Scale (Berntsen & Rubin, 2006), the PTSD Checklist - Stressor Specific Version (Weathers et al., 1994), and the Trauma-Related Guilt Inventory (Kubany, 2004).

The Centrality of Events Scale (Berntsen & Rubin, 2006) was used to measure “the extent to which a memory for a stressful event forms a reference point for personal identity and for the attribution of meaning to other experiences in a person’s life” (p. 220). This scale is comprised of 20-items on a 5-point Likert scale ranging from Totally Disagree (1) to Totally Agree (5). The CES was designed to answer three components: (1) The degree to which the “Event became a reference point for the generation of expectations and attribution of meaning to other events in the person’s life”, (2) How central the event became a component of personal identity, and (3) How much of a turning point the event is in the life history. Three example questions, in respective order are: “This event has become a reference point for the way I understand new experiences,” “I feel that this event has become part of my identity,” and “I feel that this event has become a central part of my life story.” The full 20-item CES showed high reliability (α of .94) and researchers found the scale correlated weakly .38 with PTSD symptom severity (Berntsen & Rubin, 2006). The researchers’ participant sample consisted of 707 undergraduate students. An undergraduate population is an entirely different type of population than that of U.S. military veterans. Thus, Berntsen and Rubin’s study
measured different populations, which supports the use of both the CES and PCL-S in the current study under investigation.

Post-traumatic stress disorder symptoms were measured using the PTSD Checklist - Stressor Specific Version (PCL-S) that asks about symptoms in relation to an identified “stressful experience” (Weathers et al., 1994). This scale included 17-items. Participants were asked to indicate how much they had been bothered by each problem within the last month on a 5-point Likert scale ranging from Not at All (1) to Extremely (5). All questions lead with the prompt: “How much have you been bothered by _______ within the last month.” Example questions from the PCL-S included: (1) “Repeated, disturbing memories, thoughts, or images of the stressful experience?” (2) “Repeated, disturbing dreams of the stressful experience? And (3) “Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?” Internal consistency for the PCL-S is high with a range between .94 (Blanchard et al., 1996) to .97 (Weathers et al., 1994). Test-retest reliability was reported as .96 at 2-3 days and .88 at one week (Blanchard et al., 1996; Ruggiero, Del Ben, Scotti, & Rabalais, 2003). The PCL-S was found to highly correlate with the Mississippi PTSD Scale (.82), Impact of Event Scale (.77) and Keane PTSD scale (.77) (Ruggiero et al., 2003).

Feelings of guilt related to trauma were measured using the Trauma-Related Guilt Inventory (TRGI) (Kubany, 2004). The TRGI included 32-items on a 5-point Likert scale. This inventory included five sets of 5-point Likert scales: 23-items ranged from Extremely True (4) to Not at all True (0), 6-items ranged from Always True (4) to Never True (0), 1-item ranged from Not Guilty at All (0) to Extremely Guilty (4), 1-item ranged from Never (0) to Always (4), and 1-item ranged from None (0) to Extreme (4). Seven
items were reverse scored. The TRGI was designed to measure three components of trauma-related guilt: (1) Global Guilt, “I experience intense guilt that relates to what happened,” (2) Distress, “I am still distressed about what happened,” and (3) Guilt Cognitions. The Guilt Cognitions component was made up of three subscales: (1) Hindsight-Bias/Responsibility, “I could have prevented what happened,” (2) Wrongdoing, “I had some feelings that I should not have had,” and (3) Insufficient Justification, “What I did was completely justified.” The internal consistency estimates for a group of Vietnam Combat Veterans (N=120) were .92 for Global Guilt, .90 for Distress, .94 for Guilt Cognitions, .89 for Hindsight Bias/Responsibility, .80 for Insufficient Justification, and .84 for Wrongdoing (Kubany, 2004).

**Procedures**

Participants were recruited through a multitude of methods including flyers and announcements posted on college campuses, flyers given to various Veterans Administration buildings, Craigslist postings, an information Facebook page, as well as through e-mail correspondence to various VA PTSD program supervisors in California, and veteran organizations throughout the country. This study was conducted online through SurveyMonkey. Participants’ confidentiality was maintained and participants could only be identified by their computer’s IP address. Each participant was given as much time as desired to complete the survey at a location of their choice. First participants read and agreed to the Informed Consent (see Appendix A), giving permission to take part in this study. Next, participants were asked to answer 20 questions regarding demographic information including questions on gender, age, religious
affiliation, race and ethnicity, household annual income, relationship status, number of children, and level of education. Then, participants were asked to describe a military-related traumatic event that they had experienced during their service. Participants could list as much or as little detail as they felt comfortable. Following these steps, participants answered three questionnaires referring back to the impact of the traumatic event they described (see Appendix B). Participants were asked to complete the Centrality of Events Scale (Berntsen & Rubin, 2006), the PTSD Checklist - Stressor Specific Version (PCL-S) (Weathers et al., 1994), followed by the Trauma-Related Guilt Inventory (TRGI) (Kubany, 2004).

The survey took most participants approximately 15 to 20 minutes to complete. At the end of the survey participants were provided with a debrief describing the aims of the study as well as national veteran resources (see Appendix C) in case the survey triggered any distressing thoughts or feelings. Participants were then able to contact the primary researcher to be entered for a chance to win a gift card, or request extra credit participation for a college course. Participants were thanked for their time and thoughtfulness in completing the survey.
CHAPTER IV

RESULTS

Qualitative data were analyzed from the participant background form including open-ended as well as Likert-scale questions. In addition, results from the Centrality of Events Scale (Bernsten & Rubin, 2006), the PTSD Checklist – Stressor Specific Version (Weathers et al., 1994), and the Trauma-Related Guild Inventory (Kubany, 2004) were analyzed using quantitative methods.

Qualitative Data

Several descriptive statistics were analyzed from the participant background form participants completed at the beginning of the survey. The primary researcher imported the survey data from SurveyMonkey to Excel and then to SPSS for analyses. The open-ended questions were analyzed one at a time, question by question across participants. Next, participant responses were analyzed for each question to identify themes as they emerged. First broad general categories were developed, and secondarily an additional column was made to narrow down the categories to specific themes. Then, the emerging themes were defined, and all supporting quotes were compiled for each theme. Next, themes were formatted and the presentation of data was presented in tables.

Participant Background Form

The participant background form included several questions regarding demographic information as well as questions on military work satisfaction, mental
health information, mental health counseling, mental health counseling satisfaction, relationships, and a military-related traumatic event. A few of the questions on the participant background form assessed military work satisfaction and whether the military had ever provided participants with mental health information. When participants were asked “What has been your satisfaction of working in the United States military?,” most participants (38.6%) identified being “satisfied.” Other participants identified being “dissatisfied” (4.5%), “somewhat dissatisfied” (8%), “neutral” (19.3%), and “somewhat satisfied” (29.5%) on a 5-point Likert scale. See Table 3.

Table 3

Working for the United States Military

<table>
<thead>
<tr>
<th>1. What has been your level of satisfaction with working in the United States military?</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>34</td>
<td>38.6</td>
</tr>
<tr>
<td>Somewhat Satisfied</td>
<td>26</td>
<td>29.5</td>
</tr>
<tr>
<td>Neutral</td>
<td>17</td>
<td>19.3</td>
</tr>
<tr>
<td>Somewhat Dissatisfied</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>4</td>
<td>4.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Has the United States military (or any of its constituents) provided you with mental health information or resources?</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>71</td>
<td>81.6</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>18.4</td>
</tr>
</tbody>
</table>

Note. This table depicts participants’ levels of satisfaction working in the United States military and whether the United States military provided participants with mental health information.

When asked “Has the United States military (or any of its constituents) provided you with mental health information or resources?” 71 participants (81.6%) answered that the United States military had provided them with mental health
information or resources, while 18.4% ($n = 16$) of participants reported the United States military did not provide them with mental health information or resources. See Table 3.

Next, participants were asked if they had ever received mental health counseling, what kind of mental health counseling they received, and the type of mental health counseling they attended. Over half of the participants (60.2%, $n = 53$) reported that they had attended some form of mental health counseling, while 30.7% ($n = 27$) reported that they had not attended mental health counseling. Four (4.5%) reported that they had not attended mental health counseling but that they plan to, and 4.5% ($n = 4$) reported they would consider attending mental health counseling. See Table 4.

Of the participants who attended mental health counseling, most participants identified as receiving counseling for depression/anxiety (63.5%, $n = 40$), followed by PTSD (57.1%, $n = 36$), relationship concerns (34.9%, $n = 22$), drugs or alcohol (20.6%, $n = 13$), other reasons (19%, $n = 12$), self-improvement (19%, $n = 12$), and domestic violence (6.3%, $n = 4$). See Table 4. Of the participants who attended mental health counseling, the average number of sessions reported was 17.57. Participants reported they attended anywhere from one to 100 counseling sessions.

Participants reported having attended various types of counseling including: individual counseling (92.2%, $n = 59$), group counseling (32.8%, $n = 21$), family counseling (15.6%, $n = 10$), and other (3.1%, $n = 2$). See Table 4. The majority of participants who attended counseling reported receiving their mental health counseling through the military (55.7%, $n = 34$), followed by private counseling (31.1%, $n = 19$). Additionally, participants (26.2%, $n = 16$) received counseling through other services, participants (13.1%, $n = 8$) received counseling through in-patient or hospital treatment,
and participants (6.6%, \( n = 4 \)) received counseling through their primary care physician or through county mental health services (6.6%, \( n = 4 \)). See Table 4.

Table 4

*Mental Health Counseling*

<table>
<thead>
<tr>
<th>1. Have you ever attended mental health counseling?</th>
<th>( n )</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>53</td>
<td>60.2</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>30.7</td>
</tr>
<tr>
<td>No, but I plan to</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>No, but I’d consider it</td>
<td>4</td>
<td>4.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. What did you receive counseling for?</th>
<th>( n )</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs/alcohol</td>
<td>13</td>
<td>20.6</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>4</td>
<td>6.3</td>
</tr>
<tr>
<td>PTSD</td>
<td>36</td>
<td>57.1</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>40</td>
<td>63.5</td>
</tr>
<tr>
<td>Relationship concerns</td>
<td>22</td>
<td>34.9</td>
</tr>
<tr>
<td>Self-improvement</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. What kind of counseling did you attend?</th>
<th>( n )</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>59</td>
<td>92.2</td>
</tr>
<tr>
<td>Group</td>
<td>21</td>
<td>32.8</td>
</tr>
<tr>
<td>Family</td>
<td>10</td>
<td>15.6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Where was this counseling received?</th>
<th>( n )</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through the military</td>
<td>34</td>
<td>55.7</td>
</tr>
<tr>
<td>Primary care physician</td>
<td>4</td>
<td>6.6</td>
</tr>
<tr>
<td>County mental health services</td>
<td>4</td>
<td>6.6</td>
</tr>
<tr>
<td>Private counselor</td>
<td>19</td>
<td>31.1</td>
</tr>
<tr>
<td>In-patient/hospital treatment</td>
<td>8</td>
<td>13.1</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>26.2</td>
</tr>
</tbody>
</table>

*Note.* This table depicts the attendance of counseling, what participants received counseling for, the kind of counseling, and where the counseling was received.

Following the above participant background form questions, participants were asked about their overall satisfaction or dissatisfaction with the mental health counseling they received.
When participants were asked “What is your overall satisfaction with the counseling you have received?” 27.7% identified their satisfaction with counseling as “neutral,” 26.2% of participants were “satisfied,” 20% of participants identified as “somewhat satisfied,” 13.8% were “dissatisfied” and 12.3% were “somewhat dissatisfied” on a 5-point Likert scale with an average rating of 3.32. See Table 5.

Table 5

<table>
<thead>
<tr>
<th>Overall Satisfaction with Mental Health Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your overall satisfaction with the counseling you received?</td>
</tr>
<tr>
<td>Satisfied</td>
</tr>
<tr>
<td>Somewhat Satisfied</td>
</tr>
<tr>
<td>Neutral</td>
</tr>
<tr>
<td>Somewhat Dissatisfied</td>
</tr>
<tr>
<td>Dissatisfied</td>
</tr>
</tbody>
</table>

Note. This table illustrates participants’ overall satisfaction with the mental health counseling they received.

Those participants who reported being satisfied with their counseling services attributed satisfaction to a number of reasons. Factors that contributed to satisfaction with mental health counseling included: caring staff and counselors (n = 8), great listeners (n = 4), strong leadership (n = 1), feeling treated like a priority and satisfied with the resources available at the VA (n = 4), learning helpful tips and skills training (n = 5), free counseling from the VA (n = 1), finding counseling helpful (n = 10), and being with others who understood what the individual was going through (n = 2), with a total N of 35 (see Appendix D).

Participants who were dissatisfied with the mental health counseling they received indicated various reasons. Factors that contributed to dissatisfaction with mental health counseling included: inexperienced or incompetent counselors or staff (n = 11),
lack of tools and coping skills provided \((n = 3)\), limited time, limited availability of counselors, and not enough counseling sessions \((n = 4)\), gender of therapist (female would have preferred a female counselor) \((n = 1)\), unorganized VA health care system \((n = 3)\), rotating counselors in the VA system \((n = 2)\), story telling rather than working on issues \((n = 2)\), the counselor was not a veteran or could not relate to patient \((n = 5)\), disagreement with counselors’ methods \((n = 2)\), and impersonal counseling \((n = 3)\), with a total \(N\) of 36 (see Appendix D).

**Relationship Questions**

At the end of the participant background form, participants were asked three open-ended questions developed by the researcher regarding their personal relationships. The three open-ended relationship questions were examined for patterns, evaluated, and coded. The primary researcher identified six main themes across the three open-ended relationship questions: (1) increased confidence, (2) difficulty with emotions, (3) difficulty trusting, (4) negative connection with others, (5) meaning making, and (6) positive connection with others.

In the first open-ended relationship question, [(1) In general, how do you feel your military experiences have impacted your relationships with others?] participants’ responses were coded into the categories of increased confidence \((n = 5)\), difficulty with emotions \((n = 3)\), difficulty trusting \((n = 7)\), negative connection with others \((n = 29)\), meaning making \((n = 10)\), and positive connection with others \((n = 6)\) with a total \(N\) of 60. This means a total \(N\) of 21 participants had some sort of experience in the military that impacted their relationships positively with others and a total \(N\) of 39 participants
had some sort of experience in the military that impacted their relationships negatively with others.

In the second open-ended relationship question, [(2) Do you believe the traumatic event you recounted has changed or impacted your close relationships?] participants’ responses were coded into the categories of difficulty with emotions (\(n = 7\)), difficulty trusting (\(n = 8\)), negative connection with others (\(n = 27\)), meaning making (\(n = 4\)), and positive connection with others (\(n = 6\)) with a total \(N\) of 52. A total \(N\) of 10 participants reported the traumatic event changed or impacted their close relationships positively, and a total \(N\) of 42 reported the traumatic event changed or impacted their close relationships negatively.

The third relationship question [(3) How has serving in the United States military impacted the way you relate to others and develop relationships?] participants’ responses were coded into the categories of increased confidence (\(n = 8\)), difficulty with emotions (\(n = 1\)), difficulty trusting (\(n = 10\)), negative connection with others (\(n = 36\)), meaning making (\(n = 1\)), and positive connection with others (\(n = 9\)) with a total \(N\) of 65. A total \(N\) of 18 participants reported their military experiences impacted the way they relate and develop relationships with others positively (increased confidence, \(n = 8\); meaning making, \(n = 1\); positive connection with others, \(n = 9\)), and a total \(N\) of 47 participants reported their military experiences impacted the way they relate and develop relationships with others negatively (difficulty with emotions, \(n = 1\); difficulty trusting, \(n = 10\); negative connection with others, \(n = 36\)). (See Appendix E).
Traumatic Event Recall

Participants were also asked to recall and report a traumatic military-related event prior to completing survey questions on relationships. The purpose of recalling a traumatic military-related event was first to see if participants met the criteria to take the survey, and secondly, to make the traumatic event fresh in the memory prior to answering the survey questions associated with the traumatic event. The responses to the open-ended question on a traumatic experience were examined, evaluated, and coded. The primary researcher identified multiple themes in participants’ responses. Participants’ memories of a traumatic event responses were coded into six main themes: personal loss \((n = 32)\), removed loss \((n = 20)\), prolonged exposure \((n = 3)\), threat to self \((n = 56)\), threat to others \((n = 30)\), and adjustment \((n = 13)\) with a total \(N\) of 154. Results indicated a total \(N\) of 138 instances of experiencing a traumatic event related to location, while a total \(N\) of 16 instances of experiencing a traumatic event related to duration. (See Appendix F).

Quantitative Data

Following the participant background form, participants were asked to complete three questionnaires. The three questionnaires included The Centrality of Events Scale (Berntsen & Rubin, 2006), the PTSD Checklist – Stressor Specific Version (Weathers et al., 1994), and the Trauma-Related Guild Inventory (Kubany, 2004) in order to evaluate the relationship between participants’ traumatic event and the centrality of the event to the life story, the level of PTSD symptom criteria, and the level of trauma-related guilt.
Centrality of Events Scale

The primary researcher developed an artificial scoring scale in order to make better sense of participant scores by dividing scores into five categories ranging from “Very Low” (score = 20-36) to “Very High” (score = 85-100). See Table 6. Participant scores ranged from 26 to 100 (Very Low, n = 5; Low, n = 6; Average, n = 20; High, n = 31; and Very High, n = 20). The “High” interpretation was the most frequently indicated by participants. A “High” score indicates that the military-related traumatic event was highly central to the participant’s life story. In this study participants rated the CES with an overall average score of 72.9 (M = 3.60, SD = 1.27). This indicates that the traumatic event recalled was a central part of most participants’ lives.

The CES breaks down the questionnaire with three primary categories. Category one included questions regarding the degree to which the traumatic event was a reference point that generates meaning to other life events. Category two included questions regarding the degree to which the event was a central component of personal identity, and the third category regarded the event as a turning point in the life story. See Table 7 for a breakdown of each category. Participants had an average score of 27.73

Table 6

<table>
<thead>
<tr>
<th>Score Ranges</th>
<th>Interpretation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-36</td>
<td>Very Low</td>
<td>5</td>
<td>6.1</td>
</tr>
<tr>
<td>37-52</td>
<td>Low</td>
<td>6</td>
<td>7.4</td>
</tr>
<tr>
<td>53-68</td>
<td>Average</td>
<td>20</td>
<td>24.7</td>
</tr>
<tr>
<td>69-84</td>
<td>High</td>
<td>31</td>
<td>37</td>
</tr>
<tr>
<td>85-100</td>
<td>Very High</td>
<td>20</td>
<td>24.7</td>
</tr>
</tbody>
</table>

Note. This table depicts participant score ranges from “Very Low” to “Very High.” It should be noted this score interpretation table is artificial and was developed by the primary researcher.
Table 7

*CES Question Breakdown by Category*

<table>
<thead>
<tr>
<th>Category Number</th>
<th>Category Description</th>
<th>Items</th>
<th>Score Range</th>
<th>Avg. Score</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the event a reference point (or anchor point) for generating expectations and attribution of meaning to other events?</td>
<td>1, 2, 4, 9, 12, 13, 17, 20</td>
<td>8-40</td>
<td>27.73</td>
<td>24</td>
<td>3.42</td>
<td>1.28</td>
</tr>
<tr>
<td>2</td>
<td>Is the event a central component of personal identity?</td>
<td>3, 5, 6, 7, 8, 19</td>
<td>6-30</td>
<td>23.41</td>
<td>18</td>
<td>3.86</td>
<td>1.19</td>
</tr>
<tr>
<td>3</td>
<td>Was the event a turning point in the life story?</td>
<td>10, 14, 15, 16, 18</td>
<td>5-25</td>
<td>17.68</td>
<td>15</td>
<td>3.5</td>
<td>1.38</td>
</tr>
</tbody>
</table>

Note. This table depicts the three-category breakdown of questions asked in the CES.

\(M = 3.42, SD = 1.28\) for category one, an average score of 23.41 \((M = 3.86, SD = 1.19)\) for category two, and an average score of 17.68 \((M = 3.5, SD = 1.38)\) for category three.

While scores in all three categories lay above the median (see Table 7), average scores in categories one and three were mid-range, and the average score for category two was elevated. Results on the CES indicated that most participants reported their military-related traumatic event as a central component to their personal identity.

In addition to the average scores and three categories, Table 8 depicts particular questions of interest in the CES. All six questions were answered with a score of five “totally agree” and were the greatest frequency answer on those items. Four out of six questions of interest resided under the second elevated category regarding personal
### Table 8

**CES Questions of Interest**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Category</th>
<th>Score</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>I feel that this event has become part of my identity.</td>
<td>2</td>
<td>5</td>
<td>32</td>
<td>39</td>
</tr>
<tr>
<td>5</td>
<td>This event is making my life different from the life of most other people.</td>
<td>2</td>
<td>5</td>
<td>35</td>
<td>43.2</td>
</tr>
<tr>
<td>7</td>
<td>I believe that people who haven’t experienced this type of event think differently than I do.</td>
<td>2</td>
<td>5</td>
<td>47</td>
<td>57.3</td>
</tr>
<tr>
<td>16</td>
<td>This event permanently changed my life.</td>
<td>3</td>
<td>5</td>
<td>46</td>
<td>56.1</td>
</tr>
<tr>
<td>18</td>
<td>This event was a turning point in my life.</td>
<td>3</td>
<td>5</td>
<td>35</td>
<td>42.7</td>
</tr>
<tr>
<td>19</td>
<td>If this event had not happened to me, I would be a different person today.</td>
<td>2</td>
<td>5</td>
<td>36</td>
<td>43.9</td>
</tr>
</tbody>
</table>

*Note.* This table depicts particular questions of interest with the highest frequency, all rated with the highest score of five “totally agree.”

identity. These questions of interest illustrate that participants most frequently reported the belief that others who had not experienced a similar traumatic event think differently. Second, participants reported the event changed their lives permanently. Third, participants reported they would be a different person if the event had not happened. Additionally, participants reported the belief that their lives differed from the lives of others, that the event was a turning point in their lives, and the traumatic military-related event became part of their identity.

**PTSD Checklist – Stressor Specific Version**

The PCL has a total symptom severity score range from 17-85. The PCL has three suggested cut-point scores based on participant characteristics developed by the
authors (Weathers et al., 1994). Participants in this study fell under the second and third cut-point scores. Cut-point scores are average score ranges for each population when screening positively for PTSD. The typical population for the second cut-point score includes specialized medical clinics (e.g., Traumatic Brain Injury or pain) or VA primary care. This cut-point score has an estimated 16-39% prevalence of PTSD, resulting in a total score of 36-44. The typical population for the third cut-point score includes the VA or civilian specialty mental health clinics. This cut-point score has an estimated 40% or above prevalence of PTSD, resulting in a final score of 45-50.

In the current study, participants most frequently scored in the 40% or above cut-point score range \( (n = 48) \). Participants had an overall average score of 47.44 \( (M = 2.76, SD = 1.44) \). This score of 47.44 lies in the third highest cut-point range \( (45-50) \) with an estimated prevalence of 40% or above for PTSD. See Table 9 for a breakdown of the cut-point scores.

Table 9

<table>
<thead>
<tr>
<th>Estimated Prevalence of PTSD</th>
<th>Suggested PCL Cut-Point Scores</th>
<th>( N )</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-29</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>30-35</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>36-44</td>
<td>45-50</td>
<td>48</td>
</tr>
<tr>
<td>TOTAL</td>
<td>79</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* This table illustrates where participant scores fell on the suggested PCL cut-point scores.

Meeting the DSM-IV PTSD symptom criteria on the PCL requires at least one B item (questions 1-5), three C items (questions 6-12), and at least two D items
Symptoms rated as “Moderately” or above (responses 3 through 5 on individual items) are counted as present. There were a total of 41 participants (51.9%) who met the DSM-IV PTSD symptom criteria on the PCL-S in this study.

In addition to considering the cut-point scores and the DSM-IV PTSD symptom criteria, there were three questions of particular interest on the PCL-S due to participant high score frequency reporting. See Table 10. Participants most frequently indicated a score of four “quite a bit,” for question one, and five “extremely,” for questions 13 and 16. This indicates that most participants reported elevated disturbing memories of the stressful event, trouble falling or staying asleep, and being “super alert” or on guard.

Table 10

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Score</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Repeated, disturbing memories, thoughts, or images of the stressful experience?</td>
<td>4</td>
<td>22</td>
<td>27.5</td>
</tr>
<tr>
<td>13</td>
<td>Trouble falling asleep or staying asleep?</td>
<td>5</td>
<td>23</td>
<td>28.8</td>
</tr>
<tr>
<td>16</td>
<td>Being “superalert” or watchful or on guard?</td>
<td>5</td>
<td>26</td>
<td>32.5</td>
</tr>
</tbody>
</table>

Note: This table illustrates three PCL-S questions that were elevated and most frequently scored.

Trauma-Related Guilt Inventory

In this study participants’ measures on the TRGI indicated an overall Guilt Cognitions Scale T-score of 57.35 ($M = 50$, $SD = 10$); a Global Guilt score of 52.74; a Distress Scale score of 52.58; a Hindsight Bias/Responsibility Subscale score of 48.96;
an Insufficient Justification Subscale score of 47.94; and a Wrongdoing Subscale score of 50.64. See Table 11. The main overall Guilt Cognitions Scale score lied in the “High Average” interpretation of experiencing trauma-related guilt illustrating that most participants had an elevated connection of guilt cognitions related to trauma. The breakdown of frequency scores in each interpretation can be found in Table 12.

Table 11

_Average TRGI T-Scores_

<table>
<thead>
<tr>
<th>Scale</th>
<th>T-Scores</th>
<th>Interpretation</th>
<th>Average TRGI T-Scores</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Guilt (4-items)</td>
<td>≤29T</td>
<td>Very Low</td>
<td>52.74</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Distress (6-items)</td>
<td>30T-39T</td>
<td>Low</td>
<td>52.58</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Guilt Cognitions (21-items)</td>
<td>40T-44T</td>
<td>Low Average</td>
<td>57.35</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Hightsight Bias/Responsibility (7-items)</td>
<td>45T-55T</td>
<td>Average</td>
<td>48.96</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Insufficient Justification (4-items)</td>
<td>56T-59T</td>
<td>High Average</td>
<td>47.94</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Wrongdoing (5-items)</td>
<td>60T-69T</td>
<td>High</td>
<td>50.64</td>
<td>50</td>
<td>10</td>
</tr>
</tbody>
</table>

*Note. This table depicts the average TRGI T-Scores for each scale as well as the Interpretation T-Scores.*

_Statistical Analyses_

Three hypotheses were tested in this study and are described below.

**Hypothesis One**

The first hypothesis proposed that greater perceived connection and social support from relationships would relate to a decreased prevalence of PTSD symptoms. This hypothesis was conducted using three One-Way ANOVAS at the .05 alpha level. This hypothesis was partly supported.
Table 12

TRGI T-Score Ranges

<table>
<thead>
<tr>
<th>T-Scores</th>
<th>Interpretation</th>
<th>Global Guilt</th>
<th>Distress</th>
<th>Hindsight-Bias/Responsibility</th>
<th>Insufficient Justification</th>
<th>Wrongdoing</th>
<th>Guilt Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤29T</td>
<td>Very Low</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30T-39T</td>
<td>Low</td>
<td>18</td>
<td>16</td>
<td>25</td>
<td>15</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>40T-44T</td>
<td>Low Average</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>12</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>45T-55T</td>
<td>Average</td>
<td>24</td>
<td>23</td>
<td>27</td>
<td>32</td>
<td>41</td>
<td>27</td>
</tr>
<tr>
<td>56T-59T</td>
<td>High Average</td>
<td>16</td>
<td>14</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>60T-69T</td>
<td>High</td>
<td>15</td>
<td>12</td>
<td>7</td>
<td>12</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>≥70T</td>
<td>Very High</td>
<td>4</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Total N</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>77</td>
</tr>
</tbody>
</table>

*Note.* This table displays the T-Score ranges for each Scale by frequency of participants.
Regarding hypothesis one, only relationship question three [How has serving in the United States military impacted the way you relate to others and develop relationships?] was found to be significant, $F(6, 73) = 3.72, p = .003$. Relationship questions one and two did not support the hypothesis. On question three results indicated that participants with a lower PCL-S score reported their military experiences impacted the way they relate and develop relationships with others positively, specifically: increased confidence ($M = 38.13, SD = 20.84$) and positive connection with others ($M = 25.25, SD = 8.17$). As expected, participants with a higher PCL-S score reported their military experiences impacted the way they relate and develop relationships with others negatively, specifically through: difficulty trusting ($M = 41.11, SD = 15.79$), and negative connection with others ($M = 51.32, SD = 17.23$). It should be noted that difficulty with emotions and meaning making were omitted from this analysis because they each only had an $N$ of one. The results from question three can be found in Table 13.

Table 13

**Hypothesis One: One-Way ANOVA**

<table>
<thead>
<tr>
<th>Relationship Theme</th>
<th>$N$</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative connection with others</td>
<td>34</td>
<td>51.32</td>
<td>17.23</td>
</tr>
<tr>
<td>Difficulty Trusting</td>
<td>9</td>
<td>41.11</td>
<td>15.79</td>
</tr>
<tr>
<td>Increased Confidence</td>
<td>8</td>
<td>38.13</td>
<td>20.84</td>
</tr>
<tr>
<td>Positive connection with others</td>
<td>8</td>
<td>25.25</td>
<td>8.17</td>
</tr>
</tbody>
</table>

*Note.* This table depicts the number of participants for each theme as well as the means and standard deviations obtained from a One-Way ANOVA.

**Hypothesis Two**

Hypothesis two proposed the more central the participant’s traumatic event to their own identity, the higher indication of guilt and PTSD symptoms. A series of
vivariate correlations and multiple regression analyses were conducted. Correlation analyses at the .05 alpha level were used for all correlations. This hypothesis was partially supported. Six significant Pearson correlations were found. Total CES scores were positively correlated with total PCL scores, $r(78) = .542, p < .001$, Guilt Cognition Scores, $r(75) = .584, p < .001$, TRGI Global Guilt Scores, $r(75) = .460, p < .001$, TRGI Distress Scores, $r(75) = .592, p < .001$, TRGI Hindsight Bias/Responsibility Scores, $r(75) = .351, p = .002$, and TRGI Wrongdoing Scores, $r(75) = .402, p < .001$. Total CES scores and TRGI Insufficient Justification Scores were not significantly related. Results indicated that participants’ experiences of distress were most significantly related to CES, followed by guilt cognitions, PCL total score, global guilt, wrongdoing, and hindsight bias/responsibility. Pearson correlations are shown in Table 14. Additionally, a multiple regression analysis was conducted to examine the relationships between Total CES score and predictor variables PCL-S Total score and TRGI Guilt Cognitions Scale Score. The Guilt Cognitions Scale Score was chosen to represent overall trauma-related guilt because it is the highest indicator for trauma-related guilt (21-items) amongst the three scales and three subscales of the TRGI. The multiple regression model with two predictors produced $R^2 = .429, F(2, 74) = 27.8, p < .001$. Results indicated that higher scores on the PCL-S and the TRGI Guilt Cognitions Scale predicted higher scores on the CES.

Hypothesis Three

The third hypothesis proposed that the higher participants’ experiences of trauma-related guilt, the higher the indication of PTSD symptoms. This hypothesis was supported. Five significant Pearson correlations were found. Total PCL scores were
Table 14

Hypothesis Two: Pearson Correlations

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pearson Correlation</th>
<th>CES Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCL Total Score</td>
<td>Pearson Correlation</td>
<td>.542***</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>80</td>
</tr>
<tr>
<td>TRGI Guilt Cognitions Score</td>
<td>Pearson Correlation</td>
<td>.584***</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>80</td>
</tr>
<tr>
<td>TRGI Global Guilt Score</td>
<td>Pearson Correlation</td>
<td>.460***</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>77</td>
</tr>
<tr>
<td>TRGI Distress Score</td>
<td>Pearson Correlation</td>
<td>.592***</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>77</td>
</tr>
<tr>
<td>TRGI Hindsight Bias/Responsibility Score</td>
<td>Pearson Correlation</td>
<td>.351**</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>77</td>
</tr>
<tr>
<td>TRGI Insufficient Justification Score</td>
<td>Pearson Correlation</td>
<td>.162</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.160</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>77</td>
</tr>
<tr>
<td>TRGI Wrongdoing Score</td>
<td>Pearson Correlation</td>
<td>.402***</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>77</td>
</tr>
</tbody>
</table>

Significant correlations: * p < .05. ** p < .01. *** p < .001.

positively correlated with TRGI Guilt Cognition Scores, \( r(75) = .550, p < .001 \), TRGI Global Guilt Scores, \( r(75) = .520, p < .001 \), TRGI Distress Scores, \( r(75) = .731, p < .001 \), TRGI Hindsight Bias/Responsibility Scores, \( r(75) = .261, p = .05 \), and TRGI Wrongdoing Scores, \( r(75) = .545, p < .001 \). Results indicated that participants’ experiences of distress were most significantly related to PCL scores, followed by guilt cognitions, the feeling of wrongdoing, global guilt, and hindsight-bias/responsibility. Total PCL scores and TRGI Insufficient Justification Scores were not significantly related. These Pearson correlations are shown in Table 15.
### Table 15

**Hypothesis Three: Pearson Correlations**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pearson Correlation</th>
<th>Sig.</th>
<th>N</th>
<th>PCL Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRGI Guilt Cognitions Score</td>
<td>Pearson Correlation</td>
<td>.550***</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>TRGI Global Guilt Score</td>
<td>Pearson Correlation</td>
<td>.520***</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>TRGI Distress Score</td>
<td>Pearson Correlation</td>
<td>.731***</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>TRGI Hindsight Bias/Responsibility Score</td>
<td>Pearson Correlation</td>
<td>.261*</td>
<td>.022</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.022</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>TRGI Insufficient Justification Score</td>
<td>Pearson Correlation</td>
<td>-.090</td>
<td>.434</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.434</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>TRGI Wrongdoing Score</td>
<td>Pearson Correlation</td>
<td>.545***</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>.000</td>
<td>77</td>
<td></td>
</tr>
</tbody>
</table>

Significant correlations: * $p < .05$, ** $p < .01$, *** $p < .001$. 
CHAPTER V

DISCUSSION

All three hypotheses examined in this study were partially supported.

Hypothesis One

Hypothesis one proposed that greater perceived connection and social support from relationships would relate to a decreased prevalence of PTSD symptoms. This hypothesis was partially supported.

Three relationship questions were asked to investigate this hypothesis, yet only relationship question three [How has serving in the United States military impacted the way you relate to others and develop relationships?] was found to be statistically significant. On question three, results indicated that participants with a lower PTSD symptomology score on the PCL-S reported their military experiences positively impacted the way they relate to and develop relationships with others, specifically through increased confidence and positive connection with others. As expected, participants with a higher PCL-S score reported their military experiences negatively impacted the way they relate and develop relationships with others, specifically through difficulty trusting, and negative connection with others.

Results indicated that increased confidence and positive perceived connection with others correlated with lower PTSD symptomology. Results also indicated that
difficulty trusting and negative perceived connection with others correlated with higher PTSD symptomology. These results support findings that individuals’ social networks tend to be extremely important and may act as a buffer for PTSD symptomology if the social networks are supportive and perceived positively. An alternative explanation is that decreased PTSD symptomology may enable better social interaction. It also supports the findings that for individuals who do not have supportive social networks, or if social networks are perceived negatively, PTSD symptomology can increase (Koenen et al., 2003; Tsai et al., 2012; Wilcox, 2010).

Hypothesis Two

Hypothesis two proposed the more central the participant’s traumatic event to their own identity, the higher indication of guilt, as well as PTSD symptoms, as indicated by the Centrality of Events Scale (Berntsen & Rubin, 2006), the Trauma-Realted Guilt Inventory (Kubany, 2004), and the PTSD Checklist – Stressor Specific Version (Weathers et al., 1994). This hypothesis was partially supported. A multiple regression analysis was conducted to examine the relationships between Total CES score and predictor variables PCL-S Total score and TRGI Guilt Cognitions Scale Score. Results indicated that higher scores on the PCL-S and the TRGI Guilt Cognitions Scale predicted higher scores on the CES.

Six significant Pearson correlations were used to analyze the relationships between the centrality of a traumatic military-related event to PTSD symptomology, as well as the centrality of a military-related traumatic event to trauma-related guilt. Results indicated that participants’ experiences of distress (TRGI Distress Scale) were most
strongly positively correlated to CES, followed by the TRGI Guilt Cognitions Scale, PCL-S total score, TRGI Global Guilt Scale, TRGI Wrongdoing Subscale, and TRGI Hindsight Bias/Responsibility Subscale. Total CES scores and TRGI Insufficient Justification Subscale Scores were not significantly related. Results indicated that the more central the military-related traumatic event was to participants’ autobiographical narratives, the higher indication of trauma-related guilt. For example, Lee et al. (2001) proposed that pervasive feelings of guilt could arise if the traumatic event holds deep meaning to the individual and are a departure from the individual’s ethical and moral standards (p. 461).

It is interesting to note which guilt scales and sub-scales most positively related to total CES scores. The TRGI Distress Scale had the strongest correlation with total CES scores. Kubany (2004) described the Distress Scale as measuring the general severity of PTSD and depression related to the specified traumatic event (p. 10). It is suggested that a Distress Scale score of 60T or higher is a strong indicator that the individual may be suffering from PTSD and/or would benefit from trauma therapy (p. 10). There were 21 participants in this study (27%) who reported a Distress Scale score of 60T or higher. These results indicate the greater the centrality of the traumatic event to one’s identity, the tendency for higher guilt-related distress. These results also support Robinaugh and McNally’s (2010) findings that “aversive emotional events are associated with psychological distress when memory for those events is central to one’s identity and autobiographical memory” (p. 651).

The second strongest correlation between the CES scores variable was the Guilt Cognitions Scale variable. The Guilt Cognitions Scale indicated the irrational guilt
cognitions individuals believed about a specified traumatic event (Kubany, 2004, p. 10, 12). These guilt-related beliefs reflect distortions in reality and exaggerate the degree to which the individual contributed to the traumatic event (pp. 10, 12). There were 30 participants in this study (39%) who reported a Guilt Cognitions score of 60T or higher. These results indicated that guilt cognitions were very prevalent in the sample of participants in this study. Lee et al. (2001) proposed the development of guilt cognitions could be attributed to schema incongruence. Guilt cognitions in traumatized individuals do not “match” current schemas and thus impact the individual’s cognitions negatively.

The third strongest correlation to total CES scores, interestingly, was total PCL-S scores. Berntsen and Rubin (2006) found a weak correlation (.38) between PTSD symptomology and the centrality of traumatic events. Groleau et al. (2013) on the other hand, found a moderate to strong relationship between the two concepts. Results in the current study indicated the more central the traumatic event to personal identity the higher indication of PTSD symptomology in a U.S. military population.

The fourth strongest correlation to total CES scores was the Global Guilt Scale. Of the TRGI, the Global Guilt Scale is probably the most important index of problem severity (Kubany, 2004, p. 10). The Global Guilt Scale measures overall guilt. It is suggested that a Global Guilt score of 60T or higher suggests guilt is a significant problem that needs to be attended to in order to recover fully (p. 10). There were 19 participants in this study (25%) who reported a Global Guilt score of 60T or higher. Results indicated overall guilt was positively correlated with the centrality of the traumatic event to personal identity. Whereas shame tends to hold a more global evaluation of the self, and guilt tends to be more event-specific, Lewis (1971) identified
that guilt may cause an individual to hold negative evaluations of the self and one’s social behavior.

The fifth strongest correlation to total CES scores was the Wrongdoing Subscale from the TRGI (Kubany, 2004). The Wrongdoing subscale measures the degree to which respondents believe they have violated personal morals and standards of right and wrong. This subscale is most closely related to religious guilt and sinfulness (Kubany, 2004, p. 12). There were 13 participants in this study (17%) who reported a Wrongdoing Subscale score of 60T or higher. These results indicated the more central the specified traumatic event to personal identity, the greater the beliefs of wrongdoing. In Henning and Freuh’s (1997) study, the researchers found combat veteran participants most frequently identified feelings of guilt involving acts of omission/error and acts of commission (p. 806). This is directly related to Wrongdoing in that veterans’ highest reports of guilt involved acting, not acting, or making a mistake (i.e. wrongdoing).

The last significant correlation to total CES scores was the Hindsight Bias/Responsibility Subscale. This subscale measures the degree to which respondents feel personally responsible for what happened during the traumatic event (Kubany, 2004, p. 12). This subscale is based on individuals’ beliefs about the traumatic event after it occurred. Individuals hold a belief that they could have prevented what happened, based on knowledge after-the-fact, and thus assume personal responsibility for the traumatic event. There were 13 participants in this study (17%) who reported a Hindsight Bias/Responsibility score of 60T or higher. Results indicated the more central the traumatic event to autobiographical narrative, the greater sense of responsibility and belief that the trauma could have been prevented. Bertsen and Rubin (2006) propose
traumatic events that become central to identity can instill barriers to growth, guide behavior, and perpetuate maladaptive beliefs of trauma reoccurrence. Groleau et al. (2013) found the disruption of core beliefs, intrusive rumination, and the search for meaning of the traumatic event were the most significant indicators of PTSD (p. 482). These results support the findings in this study that centrality of a traumatic event can lead to a greater sense of responsibility or beliefs that the event could have been different.

The Insufficient Justification Subscale from the Trauma-Related Guilt Inventory (Kubany, 2004) was not significantly correlated with total CES scores. This outcome was not expected. The Insufficient Justification Subscale measures the belief that actions taken during the traumatic event were not justified (p. 12). There were 12 participants in this study (16%) who scored 60T or higher on the Insufficient Justification Subscale. This Subscale was the lowest reported 60T or higher scale out of the six measures in the TRGI. The lower scores participants reported on the Insufficient Justification Subscale may be interpreted in a few different ways. First, that Insufficient Justification is not significantly related to the centrality of the traumatic related event. A second explanation might be that the majority of participants in this study did not experience or report beliefs of insufficient justification for actions taken during the traumatic event. Additionally, participants may not have understood the question prompts under the Insufficient Justification subscale.

Hypothesis Three

Hypothesis three proposed that the higher participants’ experiences of trauma-related guilt, the higher the indication of PTSD symptoms. This hypothesis was partially
supported. Results indicated that participants’ experiences of distress as measured by the Trauma-Related Guilt Inventory (Kubany, 2004) were most strongly correlated to PCL-S scores, followed by the TRGI Guilt Cognitions Scale, TRGI Wrongdoing Subscale, TRGI Global Guilt Scale, and TRGI Hindsight Bias/Responsibility Subscale. Total PCL-S scores and TRGI Insufficient Justification Subscale scores were not significantly related. This outcome was not expected. The Distress Scale of the Trauma-Related Guilt Inventory (Kubany, 2004) had the strongest correlation to PCL-S scores. Again, the Distress Scale provides a general measure of PTSD and depression severity, and 21 participants in this study (27%) reported a Distress score of 60T or higher.

Results for hypothesis three indicated greater beliefs of trauma-related guilt tended to relate to higher PTSD symptomology. Owens et al. (2009) found that participants who reported severe PTSD also experienced guilt (p. 655).

Conclusions

The findings in this study support previous research in that relationship quality (Benight & Bandura; Laffaye et al., 2008; Wilcox, 2010), the centrality of a traumatic event to autobiographical narratives (Bermtsen & Rubin, 2006; Groleau et al., 2013; Lee et al., 2001), and trauma-related guilt beliefs (Henning & Freuh, 1997; Kubany, 1994; Kubany et al., 1996; Kubany et al., 1997; Kubany, 2004; Kubany & Manke, 1995; Lee et al., 2001; Owens et al., 2009) are associated with higher levels of PTSD symptomology in a U.S. military population.

The current study under investigation was unique and added to the literature in a variety of ways. Participants were asked questions regarding mental health counseling
in a number of ways and results indicated that changes need to be made to the way veterans receive mental health counseling in order to better accommodate U.S. military service members. Participants were also asked to recall a military-related traumatic event. Results indicated traumatic events were most strongly related to location and duration.

Participants answered three questions regarding relationships and participants indicated they most frequently had negative relationship experiences related to the military-related trauma they experienced. Additionally, participants had elevated scores on all three questionnaires (CES, PCL-S, TRGI). After statistical analyses were run, results indicated that PTSD symptomology, trauma-related guilt, and high centrality of the specified traumatic event to autobiographical narratives were present in the sample of participants in this study.

This information is important for treatment implications and future research on the treatment of PTSD in military veterans. Clinicians and healthcare providers need to be aware of the three concepts examined in this study in relation to PTSD severity and symptomology in order to better serve the military population. Overall results indicated guilt cognitions, the centrality of the traumatic military-related event to each client’s autobiographical narrative, and the importance of relationship networks in a U.S. military population suffering from trauma, all need to be addressed in therapy and during recovery.

Limitations

There were several limitations to this study. Firstly, this study was not experimental, and therefore conclusions cannot be made from the findings. Another
limitation includes the number of participants. There were only 88 individuals who participated in this study and not all 88 participants answered all questions asked in the online survey. Another limitation includes the amount of accuracy, carefulness, and time participants took in answering the online survey. Additionally, there were 93 survey questions asked, such that participants might have experienced survey burnout. Another limitation to this study is generalizing to the wider military population. The participants who participated in this study may not be a representative sample of the wider U.S. military population. For instance, most participants in this study reported fighting in Iraq or Afghanistan. OIF/OEF veterans only make up a portion of all U.S. military veterans. Approximately 25% of participants in this study were women. This percentage is not an accurate representation of women in the military, and women are more likely to take surveys than men. Lastly, self-selection bias, those who chose to participate in the survey versus those who did not participate, limits the implications of the findings in this study.

In addition to overall limitations, there were some limitations specific to Hypothesis One. There are inherent limitations in molding qualitative results into categorical variables for the purpose of quantitative analysis. Although there were three relationship questions only question three was found to be significant. It may be that the third relationship question may have been the most straightforward, or that the third relationship question directly asked how serving in the military impacted relating to others and developing relationships. Additionally, the relationship questions were fairly similar. Participants might have felt the relationship questions asked were too alike and thus gave similar responses or omitted responses to certain questions. Coding was
conducted by the primary researcher and was not conducted using inter-rater reliability. Coding themes might not have been an accurate representation of participants’ responses.

Implications for Future Research

This study provides many implications for future research. Participants in this study most frequently reported they received counseling for depression/anxiety (63.5%), followed by PTSD (57.1%). Therefore, an implication for future research is to examine the role depression plays in terms of centrality of events to autobiographical narrative and trauma-related guilt. A second implication for future research would be to examine mental health counseling. There were a number of participants in this study who reported being dissatisfied with the mental health counseling they received. A future implication for research could address how mental health services may be adapted to better meet the needs of U.S. military service members. Additionally, there was a limited response to the relationship questions. Were the questions too intrusive, and if so, why? Is there a different approach or method that needs to be examined when formulating questions regarding personal relationships? Another implication for future research is to examine the Insufficient Justification Subscale of the Trauma-Related Guilt Inventory (Kubany, 2004). The Insufficient Justification Subscale was the only scale on the TRGI in both hypotheses two and three that was not statistically significant. Was the Insufficient Justification Subscale not relevant for the participants in this study? What about the Insufficient Justification Subscale resulted in a non-significant correlation? A final implication for future research should be to examine ideal methods or approaches to use in therapy to specifically address trauma, guilt, and the centrality of a military-related
event to autobiographical narratives. One specific example might be to examine cognitive behavioral approaches against critical incident stress management (CISM).
REFERENCES
REFERENCES


Frayne, S. M., Chiu, V. Y., Iqbal, S., Berg, E. A., Laungani, K. J., Cronkite, R. C., . . .


APPENDIX A
Title of Research: Relationship of centrality of traumatic events to psychosocial experiences, IRB# 212-08

You are invited to take part in this research study. Before agreeing to participate in this research study, it is important that you read the following explanations of this study.

**What will be done during this research study?**
Participation in this study involves completing an online information form as well as an online survey about your experiences of traumatic events related to your military service. It should take you 45 to 60 minutes total to complete the survey questions. After you have completed the survey, you have completed the study.

**What are the possible risks of being in this research study?**
You might have some uncomfortable feelings such as sadness or anger when you reflect on your experiences. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time without penalty.

**What are the possible benefits to you?**
You will be given a chance to reflect on some personal information about your past. You might feel a sense of personal satisfaction from knowing that you are helping others by sharing your information. However, you may not get any benefit from being in this research study.

**Incentives**
After completing the study, you may enter to win 1 of 5 $25 VISA gift cards! If you are taking a course at Chico State or another institution that accepts extra credit for research participation, you may earn extra credit points for participating in this research.

**What are the possible benefits to other people?**
The information you share may be used to help shed light on how individuals adjust to civilian life after serving in the United States Armed Forces.

**What are the alternatives to being in this research study?**
Instead of being in this research study, you can choose not to participate. There is no penalty for non-participation.
How will information about you be protected?
Reasonable steps will be taken to protect your privacy and the confidentiality of your study data.

Confidentiality will be maintained to the degree permitted by the technology used. Your participation in this online survey involves risks similar to a person’s everyday use of the Internet.

The information from this study may be published in scientific journals or presented at scientific meetings, but your identity will be kept strictly confidential.

For further information about the nature of this research or about your rights as a research participant please contact

Katherine Sperry, M.A. candidate
knsperry@gmail.com

Dr. Elise Cole
California State University, Chico
400 West First Street
MODC 206
Chico, CA, 95929
emcole@csuchico.edu

By completing the online survey you are agreeing to participate in this research.
APPENDIX B
Relationship of Centrality of Traumatic Events to Psychosocial Experiences, IRB#212-08

Participant Background Form Questions

What is your gender?

Male
Female

What is your age?

18-21
22-25
26-30
31-40
41-50
51-60
61 or over

Do you have a religious affiliation?

Buddhist
Christian
Hindu
Jewish
Muslim
Not religious
Spiritual, not religious
None
Other

Which race or ethnicity do you most identify with?

American Indian/Native American
Asian
Black/African American
Hispanic/Latino
Pacific Islander
White/Caucasian
Other
What is your household annual income?

- Less than $10,000
- $10,000 - $19,999
- $20,000 - $29,999
- $30,000 - $39,999
- $40,000 - $49,999
- $50,000 - $59,999
- $60,000 - $69,999
- $70,000 - $79,999
- $80,000 - $89,999
- $90,000 - $99,999
- $100,000 - $149,999
- More than $150,000

What is your current relationship status?

- Single, Never Married
- Married
- Separated
- Divorced
- Widowed
- Other

How many children do you have?

What is the highest level of education you have completed?

- Less than High School
- High School/GED
- Some College, No Degree
- 2-Year College Degree (Associate’s)
- 4-Year College Degree (BA, BS)
- Master’s Degree
- Doctoral Degree
- Professional Degree (MD, JD)

In which branch (or branches) of the United States military have you served?

- Air Force
- Army
- Coast Guard
- Marine Corps
- Navy
- Other
In which conflicts have you served for the United States military?

- WWII (1941-1946)
- Korean Conflict (1950-1955)
- Vietnam Era (1961-1975)
- Persian Gulf War (1990-1991)
- War on Terror, OEF, OIF, OND (2001-present)
- Other

How many years (to date) have you served in the United States military?

- 0-1
- 1-2
- 2-3
- 3-4
- 4-5
- 5-6
- 6-7
- 7-8
- 8-9
- 9-10
- 10+

What has been your satisfaction of working in the United States military?

- Dissatisfied
- Somewhat Dissatisfied
- Neutral
- Somewhat Satisfied
- Satisfied

Has the United States military (or any of its constituents) provided you with mental health information or resources?

- Yes
- No

Have you ever attended mental health counseling?

- Yes
- No
- No, but I plan to
- No, but I’d consider it
What did you receive counseling for?

- Drugs/alcohol
- Domestic violence
- Post-traumatic Stress Disorder (PTSD)
- Depression/anxiety
- Relationship concerns
- Self-Improvement
- Other

If you have attended mental health counseling how many sessions did you attend?

What kind of counseling did you attend?

- Individual
- Group
- Family
- Other

Where was this counseling received?

- Through the military
- Primary care physician
- County mental health services
- Private counselor
- In-patient/hospital treatment
- Other

What is your overall satisfaction with the counseling you have received?

- Dissatisfied
- Somewhat Dissatisfied
- Neutral
- Somewhat Satisfied
- Satisfied

What contributed to your satisfaction or dissatisfaction with the counseling you received?

Open Ended Questions
Traumatic Event

Please describe a traumatic or distressing event you have experienced related to your military service. Please provide as much detail as you feel comfortable; this event will be referenced throughout the study.

Relationships

In general, how do you feel your military experiences have impacted your relationships with others?

Do you believe the traumatic event you recounted has changed or impacted your close relationships? Please explain.

How has serving in the United States military impacted the way you related to others and develop relationships?
APPENDIX C
Veteran Resources

Speak Out and Advocate for Yourself and Fellow Service Members

Veterans Crisis Line
1-800-273-8255 or Text to 838255

Vet Center Combat Call Center, United States Department of Veterans Affairs
1-877-WAR-VETS
1-877-(927-8387)

Find a Vet Center Near You
http://www2.va.gov/directory/guide/vetcenter_fsh.asp

Vet Center, United States Department of Veterans Affairs
http://www.vetcenter.va.gov/

United States Department of Veterans Affairs
www.va.gov
APPENDIX D
<table>
<thead>
<tr>
<th>Satisfaction with Counseling</th>
<th>n</th>
<th>Examples</th>
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</thead>
</table>
| Caring staff and counselors  | 8 | 1. “Through military one source I received some free counseling sessions to help cope with the return of my Afghanistan deployment. The psychologist listened and gave me helpful tips on how to adjust to living back in States given what I had experienced in the Middle East. I attended the sessions once a week for 8 weeks. At the completion of the sessions I felt like I was able to better understand why I was feeling the way and was and the proper ways to filter the emotions and confusion.”  
2. “I currently have a great counselor at the VA”  
3. “caring staff”  
4. “the care and compassion from the Doctor”  
5. “They really care to hear my worries and concerns that i have experience in the past.” |
| Great listeners              | 4 | 1. “they listen to you and they care about your feelings and thoughts”  
2. “The counselor's ability to listen and let myself work out my problems.” |
| Strong leadership            | 1 | 1. “Strong leadership” |
| Treated like a priority/satisfied with resources available | 4 | 1. “Anytime I require anything I can call”  
2. “I'm satisfied with the resources that are available, but I've never had a need to receive any counseling.”  
3. “This counseling was provided to all returning troops to determine if further counseling was needed. I was satisfied with this service because it takes a big effort for the armed forces to provide this service to everyone in that served in a combat zone.” |
| Learned helpful tips/skills training | 5 | 1. “The alcohol treatment helped me realized there was more to life than just drinking, and relationship concerns helped me that there was more to live for.”  
2. “I received good advice”  
3. “Care has included training in many skills to help cope with problems associated with PTSD.”  
4. “The lady gave me lots of good information and suggestions on how to think about things. Also, I was able to get in contact with her unlike most VA doctors.”  
5. “Healthier relationship with my fiance and father, being able to open up to someone about my experiences” |
<table>
<thead>
<tr>
<th>Satisfaction with Counseling</th>
<th>n</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free counseling</td>
<td>1</td>
<td>“The service was free and I was treated like a priority. The VA employs highly qualified medical personnel.”</td>
</tr>
</tbody>
</table>
| Found counseling helpful     | 10| 1. “My counselor helped me see the world in a different way and overcome behaviors and misconceptions that were destructive.”  
2. “Helpful”  
3. “I have recently switched to a new doctor and seem to be responding to counseling positively. My previous counselor caused me to trigger and end up in the hospital. I believe that my case was above her talents.” |
| Being with others and/or a counselor that understood what he/she was going through | 2 | 1. “The ability to air out issues with other brothers in arms, knowing I was not alone in what I was feeling.”  
2. “The level of understanding the therapist had in understanding military life and the difficulties that enlisted people face. Also understanding some of the military culture.” |
| Total                        | 35|          |

<table>
<thead>
<tr>
<th>Dissatisfaction with Counseling</th>
<th>n</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Inexperienced or incompetent counselors/staff | 11| 1. “Most VA counselors really pissed me off.”  
2. “I thought the Counselor had more issues than I did.”  
3. “I was dissatisfied with the counseling due to the lack of understanding from the counselors. They failed to understand what I was talking about concerning the military and the struggles I faced outside of the military.”  
4. “Counselor inexperienced. Partner unwilling to participate”  
5. “My therapist fell asleep while we met.”  
6. “Incompetent” |
| Tools and coping skills were not provided | 3 | 1. “She listened well, but didn't really have any tools that helped me.”  
2. “Nothing that I didn't already know, going through the motions, etc.”  
3. “It helped with alot but not everything. no coping skills in place.” |
| Limited time/not enough counselors/not enough sessions | 4 | 1. “Right now, I am going to the VA and it seems as though there are not many counselors. I have to wait weeks to be seen.”  
2. “I don’t get seen as much as I need to be and all they do is pump me full of pills, both of which lead to my most recent suicide attempt”  
3. “VA has so many patients their time is limited. Private doctor was over a ten year period but had little experience with PTSD.” |
<table>
<thead>
<tr>
<th>Dissatisfaction with Counseling</th>
<th>$n$</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender of therapist (Female would have preferred a female)</td>
<td>1</td>
<td>1. “would have preferred to see a female therapist”</td>
</tr>
</tbody>
</table>
| Unorganized VA healthcare system | 3 | 1. “The counselor did not like that I continued to report that I had sustained serious medical malpractice incident and was in need of medical treatment as a result. The VA refused to acknowledge the incident and refused to provide any medical treatment despite my continued complaints of serious medical problems to my doctors, the patient advocate, the chief of medicine, and the director both in person and in writing. Seeing the counselor (a VA staff member) on time a week was my only way to try to obtain much needed medical treatment for my broken hip (a result of s-ray), dislocated shoulder (diagnosed by private physician and MRI) and other serious medical issues resulting from the malpractice. As the VA chose to falsify the medical records, this counselor became more aware of the seriousness of the issue and made several efforts to help me, however the counselor stated that fear for their job precluded them from following VA policy to properly report my complaint. We spent NO time discussing PTSD related to my initial service connected issue.”  
2. “One session. Never put in records. Never followed up like they should.”  
3. “Unorganized health system. Technician was diagnosing instead of doctor.” |
| Rotating counselors at the VA | 2 | 1. “Some counselors are great and others are horrible. Counselors are always rotating, so you can't keep your favorite. It makes it hard to relate to a new person each time.” |
| Story telling rather than working on issues | 2 | 1. “Some times the counseling turned into telling war stories versus working on issues”  
2. “The treatment I received while on active duty was great. However, the day after retiring I was no longer eligible to see that counselor. Instead I had to rely on the VA, which is difficult, at best, to schedule. I attended some group sessions with the VA, but found the whining and false bravado to be equally intolerable.” |
| Counselor was not a veteran or could not relate to patient | 5 | 1. “The individual counselor had no real point of reference to make her advice and empathy credible, nor did she ever seem to offer any exercises or advice as to how to make things better. The group therapy sessions were more of a complaint session, and other than helping individuals realize that they were not alone, the atmosphere was not one of positive energy and really just seemed to rile up negative emotions in all involved without a form of diffusion.”  
2. “Therapist was not a veteran.”  
3. “the counselors could not relate to what I was going through and the things that I have done. Then kept feeding me book answers and no true empathy.”  
4. “The therapist had no idea of what he was talking about. Totally out of touch with the reality of being a combat vet.” |
<table>
<thead>
<tr>
<th>Dissatisfaction with Counseling</th>
<th>n</th>
<th>Examples</th>
</tr>
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</table>
| Disagreed with counselors’ methods | 2  | 1. “Was not happy with the counselors methods”  
2. “I have seen many "therapists" all with many different approaches, none of which helped me.” |
| Impersonal counseling | 3  | 1. “Counseling through the military was non personal”  
2. “The degree of care was minimal. It felt more like a check in the box than therapy” |
| Total | 36 |          |
## Relationships

<table>
<thead>
<tr>
<th>Code: Relationships Q1: In general, how do you feel your military experiences have impacted your relationships with others?</th>
<th>Definition</th>
<th>n</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Increased Confidence** | An increase in self-efficacy or self-worth resulting from experiences in the military | 5 | 1. “It helped me to not be shy”  
2. “I’m more confident than I once was. My experience as a manager and team leader help me to recognize my strengths”  
3. “My experience has really helped me to be able to be more confident in dealing with others as a leader that is” |
| **Difficulty with Emotions** | Difficulty processing, expressing, relating, or regulating emotions | 3 | 1. “I can't identify my own emotions sometimes so it’s hard to know what I’m feeling”  
2. “In general, it is difficult for me to express emotion and the effect is life altering”  
3. “Misunderstood, lose temper easily” |
| **Difficulty Trusting** | Difficulties believing others have your best interest at heart. | 7 | 1. “I'm slow to connect with people and I keep them at a distance”  
2. “I am super over vigilant”  
3. “I feel that I am more suspicious of others and their interactions with me” |
| **Negative Connection with Others** | Experiencing a negative relationship or connection with others. | 29 | 1. “I avoid people, only interacting with others when I have to”  
2. “I feel a lot more distant from the general civilian population”  
3. “Terrorized my family for 39 years” |
<table>
<thead>
<tr>
<th>Code: Relationships</th>
<th>Definition</th>
<th>$n$</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Q1: In general, how do you feel your military experiences have impacted your relationships with others? | Finding purpose and value out of experiences taken away from serving in the military | 10 | 1. “I feel it has impacted my relationships positively in a good way”  
2. “They have made me much more honest. I rarely hold anything back when talking to people. They have also made me appreciate my relationships more. Now, I cherish the times that I have with people I love”  
3. “I have been humbled and appreciate all that I have in my life” |
| Meaning Making | Experiencing a positive relationship or connection with others. | 6 | 1. “Learned to deal with fear and handle it. Learned to relate to others unlike me”  
2. “In some ways it brought me closer to others”  
3. “Now, three years after retiring, I’ve become a softy. I quit talking to my family back home for seven years because they couldn’t understand me. I’ve worked hard to rebuild those connections” |
<p>| TOTAL | | 60 | |</p>
<table>
<thead>
<tr>
<th>Code: Relationships Q2: Do you believe the traumatic event you recounted has changed or impacted your close relationships?</th>
<th>Definition</th>
<th>( n )</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Confidence</td>
<td>An increase in self-efficacy or self-worth resulting from experiences in the military</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
| Difficulty with Emotions | Difficulty processing, expressing, relating, or regulating emotions | 7 | 1. “Yes, the events have made me angry inside and prone to violence. When someone is aggressive, I react with greater aggression and everyone it makes a relationship tough”  
2. “Yes, I became very paranoid and agitated. I disliked crowds and was startled easily”  
3. “My anger and depression issues don’t allow me to be as close as I could be” |
| Difficulty Trusting | Difficulties believing others have your best interest at heart. | 8 | 1. “Yes, it is difficult to trust anyone”  
2. “Absolutely! It takes a while before I trust people. It is hard to date because I have to date other military. They are the only ones who ‘get me’”  
3. “Yes, I feel that I am less trusting of others and that I want to be more clear of boundaries” |
| Negative Connection with Others | Experiencing a negative relationship or connection with others. | 27 | 1. “Normal life has seemed very unimportant/dull and caused great emotional stress in my close personal relationships”  
2. “I've had two divorces. Detached and removed from family and friends”  
3. “I believe that the traumatic event in my life has pushed people, especially loved ones away from me. I take responsibility only for that which I could control not the ambiguity of life and situations that we encounter” |
<table>
<thead>
<tr>
<th>Code:</th>
<th>Definition</th>
<th>$n$</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td><strong>Relationships Q2:</strong></td>
<td>Do you believe the traumatic event you recounted has changed or impacted your close relationships?</td>
<td></td>
<td></td>
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</tbody>
</table>
| **Meaning Making**           | Finding purpose and value out of experiences taken away from serving in the military | 4   | 1. “I understand that the nature of life is entropy and death. Everyone I love is going to die and there is nothing that I can do about it”  
|                              |                                                                          |     | 2. “It allows me to understand the evil in this world and protect those I love and care about from it”                                 |
| **Positive Connection with Others** | Experiencing a positive relationship or connection with others. | 6   | 1. “I am more protective of the people I have close relationships with. I feel like I need to watch over and keep them safe”   
|                              |                                                                          |     | 2. “Yes, I value my relationships more”                                                                                               
|                              |                                                                          |     | 3. “It makes me treasure those closest to me more. I know you can lose someone in the blink of an eye, so I am more prone to tell people how I feel about them”  |

**TOTAL**                                                                 | 52   |                                                                                                                                  |
<table>
<thead>
<tr>
<th>Code: Relationships Q3: How has serving in the United States military impacted the way you relate to others and develop relationships?</th>
<th>Definition</th>
<th>n</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Increased Confidence** | An increase in self-efficacy or self-worth resulting from experiences in the military | 8 | 1. “In the military, you work with so many different people from different ethnic backgrounds that I feel it is easy for me to make friends”  
2. “The military taught me a lot about proper behavior in a professional setting. It forced me to be more proactive about telling people what I was and wasn't ok with in my workspace. It helped me to realize what kind of worker I am and how I am motivated. In general it helped me become a more outspoken and stubborn person”  
3. “It has made me more confident. I feel I relate with people easier and get along with almost anybody” |
| **Difficulty with Emotions** | Difficulty processing, expressing, relating, or regulating emotions | 1 | 1. “Always angry. I had trouble interacting with people. Constantly changed jobs” |
| **Difficulty Trusting** | Difficulties believing others have your best interest at heart. | 10 | 1. “Very difficult to form close personal friendships. Have less than five close friends. I am very guarded”  
2. “I don't let ANYONE get close”  
3. “I do have a hard time initially forming relationships due to my hard crust nature” |
| **Negative Connection with Others** | Experiencing a negative relationship or connection with others. | 36 | 1. “I don’t feel on the same level with others my own age”  
2. “I am only friends with people who have been in the military or are still in, or have experienced dealing with PTSD in a partner like I have. If a person does not know anything about the military its hard to be friends with them. I feel as thought they are ignorant”  
3. “I do not relate to others or develop relationships any more” |
### Code:

Relationships Q3: How has serving in the United States military impacted the way you relate to others and develop relationships?

<table>
<thead>
<tr>
<th>Definition</th>
<th>n</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meaning Making</strong></td>
<td></td>
<td>Finding purpose and value out of experiences taken away from serving in the military</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1. “Serving in the military has made me more disciplined, and helped me develop a philosophy of continuous improvement. So, my ability to develop relationships has enhanced, since the last day of my military service”</td>
</tr>
<tr>
<td><strong>Positive Connection with Others</strong></td>
<td></td>
<td>Experiencing a positive relationship or connection with others.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>1. “Improved to accept others without judging”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. “It has allowed me to develop deeper more trusting relationships with other. While in the military these are the relationships that you foster with your comrades”</td>
</tr>
<tr>
<td>TOTAL</td>
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<td>65</td>
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</tbody>
</table>
## Trauma Memory

<table>
<thead>
<tr>
<th>Code: Trauma</th>
<th>Definition</th>
<th>( n )</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Personal Loss** | Death or threat of death or injury to someone known personally            | 32     | 1. “Held my best friend in my arms as he died”  
2. “I watched 12 of my friends crash in a helo [helicopter] off the back of a ship and drown while doing a VBSS exercise”  
3. “The most traumatic experience I had in the military was when four of my coworkers died in a helicopter crash” |
| **Removed Loss** | Death or threat of death or injury to someone not known personally        | 20     | 1. “Poverty in many locations”  
2. “I witnessed suicide bombers detonate, saw traumatic bodily injury and death to both military members and civilians”  
3. “I pulled hundreds of bodies out of the water in New Orleans after Hurricane Katrina” |
| **Prolonged Exposure** | An extended amount of combat exposure                                     | 3      | 1. “Flew over 1,000 combat hours in Vietnam”  
2. “Infantry combat tour for 13 months”  
3. “Stress of combat over seven days per week for one year” |
| **Threat to Self** | The perceived existence of risk of injury or death to own person          | 56     | 1. “I was 17 years old and I was abducted and raped by 5 high ranking military personnel”  
2. “I had to jump in a hole with a Marine whose head was blown off to get him out of the hole. I was wounded by a hand grenade blast to the face”  
3. “I was wounded in the arm after a rocket went through my room in Iraq” |
<table>
<thead>
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<th>Examples</th>
</tr>
</thead>
</table>
| Threat to Others  | The perceived existence of risk of injury or death to other persons known or unknown | 30  | 1. “Hostile forces threatened to overrun the detachments position”  
2. “War, death, dismemberment, rape, torture, etc.”  
3. “During my deployment to Somalia it was extremely unsettling to see the children that were affected by the wars” |
| Adjustment        | The process of altering behaviors and beliefs that are more harmonious or congruent to the current environment. Processing difficult emotions. | 13  | 1. “Everyday I woke up about an hour before my alarm went off because I dreaded going to work. I got hooked on online videogames because it was an escape from reality”  
2. “Alcohol abuse, relationship problems, PTSD”  
3. “Hyperactivity. Never able to relax. Used to the high stress level of combat and was unable to turn it off” |
| TOTAL             |                                                                             | 154 |                                                                                                                                          |