

Experiences of Wives of Veterans Suffering from Combat-Related Post-Traumatic Stress Disorder: A Qualitative Content Analysis

Masoud Sirati Nir¹, PhD; Abbas Ebadi², PhD; Masoud Fallahi Khoshknab³, PhD; Abbas Tavallaie⁴, MD

¹Behavioral Sciences Research Center, Department of Psychiatric Nursing, Baqiyatallah University of Medical Sciences, Tehran, Iran;

²Behavioral Sciences Research Center, Department of Psychiatric Nursing, Baqiyatallah University of Medical Sciences, and Janbazan Medical and Engineering Research Center (JMERC), Tehran, Iran;

³Department of Nursing, University of Social Welfare and Rehabilitation Sciences (USWR), Tehran, Iran;

⁴Behavioral Sciences Research Center, Baqiyatalla University of Medical Sciences, Tehran, Iran

Corresponding author:

Abbas Ebadi, PhD; Behavioral Sciences Research Center, 4th Floor, Department of Nursing, Baqiyatallah University of Medical Sciences, P.O. Box: 19575-174, Tehran, Iran

Tel: +98 912 2149019; Fax: +98 21 26127237; Email: ebadi1347@bmsu.ac.ir

Received: 21 May 2013 Revised: 15 June 2013 Accepted: 26 June 2013

ABSTRACT

Background

War as a cause of psychological trauma can lead to unfortunate events in human life. Trauma experienced by one of the family members can affect other members of that family as well. Family members, especially spouses, experience trauma due to permanent encounter with signs of Combat post-traumatic stress disorder (PTSD). This study was conducted to investigate the experiences of the veterans' wives.

Methods

The present qualitative study was conducted on 12 veterans' wives aging 37-50 years. The subjects were selected through purposeful sampling from Bonyad Consultancy Center from early April to late September, 2012.

Data were collected using focused group discussion and analyzed through conventional content analysis approach.

Results

The participants' experiences were categorized into two main themes and 5 sub-themes. The extracted themes included "disease and family reaction" and "coping with the disease" and the sub-themes included "negative emotions", "living together but not intimately", "reprehension and disease stigmatization", "support motivation", and "dual role-play".

Conclusion

The results of this study demonstrated that Combat PTSD had a negative effect on family members, especially wives. Thus, eliminating this problem requires health and educational interventions.

KEYWORDS: Combat post-traumatic stress; Veteran; Qualitative research; War; Mental health

Please cite this article as: Sirati Nir M, Ebadi A, Fallahi Khoshknab M, Tavallaie A. Experiences of Wives of Veterans Suffering from Combat-Related Post-Traumatic Stress Disorder: A Qualitative Content Analysis. *IJCBNM*. 2013;1(3):147-155.

INTRODUCTION

Post-Traumatic Stress Disorder (PTSD) is a severe, chronic, and weakening anxiety disorder¹ which occurs following severe traumatic events and harmful experiences² and facing accidents, such as war, flood, earthquake, car accidents, bombing, horror, and living in war camps.³ Long term negative effects of Combat PTSD on families have been shown in previous studies; such a way that wives demonstrated the symptoms of this disease in the long run which is called secondary traumatization.⁴ Overall, 30% of the veterans' wives had secondary traumatization⁵ and 39 Croatian soldiers' wives suffered from this trauma.⁶ Moreover, other studies have reported existence of problems in the families and social relations of Danish and British soldiers.⁷ Also, in comparison to healthy people, more disorders were found in the veterans' personal relationships.⁸ Veterans' misbehavior with their family members has been reported, as well.³

This disorder affects the quality of life of the veterans, their families, and society. The victims' families suffer from more mental problems.⁹ This disorder has severe negative and permanent impacts on marital adjustment, general family function, and spouse's mental health, which in turn leads to aggression, violence, sexual problems, divorce, and inappropriate parenting.⁹ Also, compared to normal wives, marital satisfaction has considerably decreased among these wives.⁴

There are many cases of this disorder among the Iranian veterans who are resistant to therapy while facing serious harm in their family and social relationships.¹⁰ Zaribi et al. showed that the wives of Iranian veterans suffering from this trauma have more unsatisfactory feeling and problems in their relationships and have a lower level of mental health compared to the healthy wives.¹¹

From the beginning of the Iran-Iraq war, the Janbazan and Isargaran Affairs Foundation (JIAF) was established to provide the war victims with physical and psychological services. However, it was only

until recently that all the patients received adequate attention from the Foundation because, at the beginning, the majority of the problems the patients faced were not predictable. Now, the social services available to the affected patients have increased.¹²

Regarding the cultural and religious context of the Iranian society and the existing gaps in research on the experiences among the war victims, conducting such qualitative studies may provide valuable information to healthcare providers¹³. Thus, the present study was performed to acquire general understanding of the experiences of the veterans' wives.

MATERIALS AND METHODS

Participants and Procedure

In this qualitative study, twelve Iranian veterans' wives were purposefully selected from Bonyad Consultancy Center by the cooperation of Janbazan Medical and Engineering Research Center from early April to late September, 2012. Due to making use of the purposive sampling method, well informed participants were selected. In other words, this sampling provided important information that could not be obtained through other alternatives. The inclusion criteria of the study were the veterans' wives suffering from chronic PTSD along with depression disorder and not having any physical injuries and substance abuse. Also, they had got married before their husbands' illness.

All the participants were Persian speakers, either junior high-school or pre-university graduates, and homemakers. In addition, the subjects' age ranged from 37 to 51 years and their mean age was 43.3 years. The participants' characteristics are summarized in table 1. The participants' selection was based on their experiences and involvement with the topic of this study.¹⁴ The study data were collected using focused group discussion. At the beginning of the first session, the objectives of the study, its method, role of each participant, and confidentiality

Table 1: Demographic characteristics of study participants (N=12)

Participant N	Age (year)	Level of Education	Number of Children	Lifetime together (year)
1	46	Lower-secondary	3	26
2	45	Lower-secondary	4	23
3	41	Upper-secondary	2	21
4	51	Primary Education	5	32
5	38	Pre-University course	3	20
6	43	Upper-secondary	2	25
7	50	Primary Education	3	30
8	39	Upper-secondary	3	22
9	45	Pre-University course	3	18
10	40	Lower-secondary	3	21
11	39	Pre-University course	0	8
12	43	Lower-secondary	1	12

of the information were discussed. Then, written informed consents for participating in the study and also recording their sessions were obtained. The group discussion started with open questions, such as “What is your experience with your husband?” and continued with exploratory questions. The purpose of asking these open questions was to make the participants easily talk about their problems. At the end of every session, the recorded materials were transcribed word by word and then, they were coded. The next session was held after analyzing the data obtained from the previous session. During the third session, no new data were obtained due to data saturation.¹⁵ The *focus group* lasted for 90 minutes every session and involved twelve participants.

The researcher, as a coordinator, controlled and guided the sessions carefully to prevent any orientation and off-the-topic information. During the sessions, the participants avoided group thinking while exchanging their experiences. The focus group discussions were audio-recorded, transcribed verbatim, and analyzed concurrently with data collection. Coding was performed line by line, and comparative analysis of the excerpts was carried out. The researcher took notes of the general ideas through examination of the data and the original codes were then extracted. In doing so, particular words, phrases, and highlights

stated by the participants were identified in the form of meaningful units. In the next step, the initial codes were categorized as classes and/or major and minor themes.

To ensure the accuracy of the data, Guba and Lincoln criteria including credibility, confirmability, dependability, and transformability were used.¹⁶ To confirm credibility, prolonged engagement, immersing in the obtained results, and reading the manuscripts for several times were done in order to recognize the correct analysis unit.¹⁷ The researcher gained better understanding by close interaction with the participants and review was done by the participants, colleagues, and supervisors to ensure the conformity of understanding. To analyze the data, conventional qualitative content analysis approach in which the categories are directly extracted from the context data was utilized.¹⁸

Ethical Considerations

The ethics committee affiliated to the Baqiyatallah University of Medical Sciences and the Janbazan Medical and Engineering Research Center approved the study. The participants were informed about the study both orally and in writing and assured of confidentiality and anonymity. They were informed that participation in the study was voluntary and that they could refuse to participate or withdraw from the study without

being penalized. Moreover, the participants were reassured that their responses would be kept confidential and their identities would not be revealed in the research reports or publication of the findings. Finally, informed consents according to the provisions of the Declaration of Helsinki were obtained from the participants who agreed to participate in the study.

RESULTS

The results obtained from the participants' experiences were categorized into two main themes called "disease and family reaction" and "coping with the disease" and five sub-categories including "negative emotions", "living together but not intimately", "reprehension and disease stigmatization", "support motivation", and "dual role-play". Figure 1 shows the themes and subthemes extracted from the study.

First Theme: Disease and Family Reaction

This theme contained three sub-themes of "negative emotions", "living together but not intimately", and "reprehension and disease stigmatization".

1.1 Negative Emotions

Based on the participants' description, they experienced anger, depression, fear, and worry in interaction with the veterans. They also observed some disorders in their children. For example, they said:

"His disease has transferred to us like a contagious disease; we always live with worry. My husband is not a wife-beater nor does he have fun. He is always silent. When he mixes up, he beats himself. These behaviors have negative effects on me and my children's life. My 15-year-old son has nightmares, sleepwalks and grinds teeth at night. My little child has no friends at school, he is isolated." [Participant 2]

"He has transferred his negative energy to us. I am mentally weak, nervous, and sensitive. I even take psychiatric medication. When he is discharged from the hospital, our worry and stress starts again. He picks on fight with me and my children at home. He has beaten our little daughter many times for making noise. Then, he starts to cry. My son cannot even approach him. My children are also nervous. We are always living with fear and worry." [Participant 1]

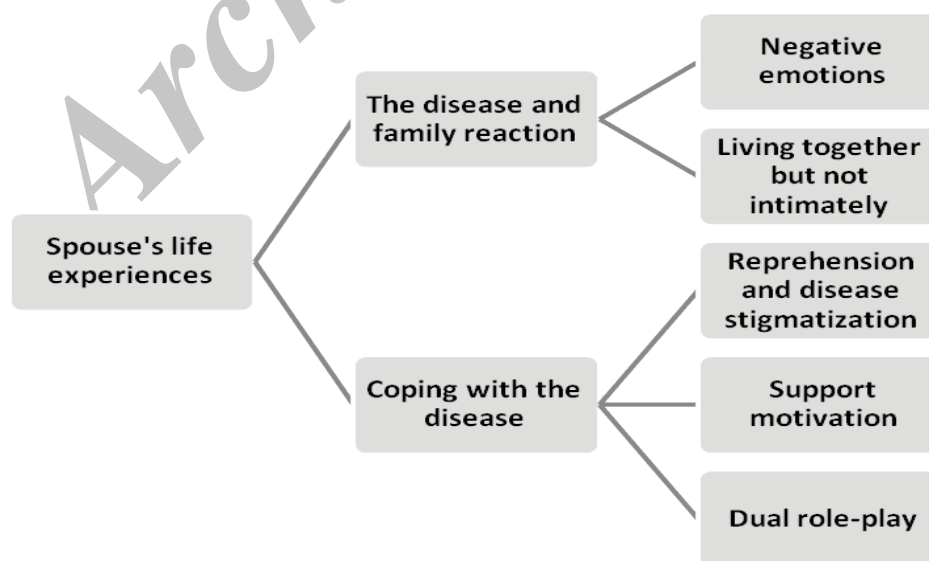


Figure 1: Themes and subthemes extracted from the study.

1.2 Living Together but not Intimately

One of the main experiences of the participants was having problems in making communications and being emotionally different from their husbands in spite of living together for several years. In this regard, they said:

“We have been living together for 25 years. He was at war for 5 years and was not also present in my life for the remaining 20 years. He might have been beside me, but he has been distant from me for many years. He has had no proper relationships with me. It is a long time that he does not talk to me. He does not talk to anybody. Our relationship is limited to giving his medicines and eating food when he is hungry or visiting the doctor.” [Participant 6]

“My husband is not living in this world at all. He always wants to be alone. We cannot talk to him and he does not have any feelings toward us. He even does not have any relationships with me as his spouse. His nervousness has affected me. His behaviors has made everyone in the family angry.” [Participant 3]

1.3 Reprehension and Disease Stigmatization

Most of the participants experienced jest, sarcasm, mental disease stigmatization, and others' getting distant from the patient supposing that they are insane and this issue had negatively affected their wives and children. They also mentioned:

“Most people jokingly say that all the national facilities belong to the families of martyrs and veterans and a huge amount of money is spent for them. They have no worry; all comfort and facilities belong to the veterans and their families. Even some relatives resent us by jest and sarcasm.” [Participant 10]

“Some people say he (the veteran) is mentally ill and is keeping his head above the water by medication. They think they are facing a crazy guy; their look and sarcasm hurt us. Our children are also embarrassed and become upset. This issue has negatively

affected their spirit.” [Participant 5]

Second Theme: Coping with the Disease

This theme was categorized into two sub-themes of “support motivation” and “dual role-play”. The wives under study were flexible in coping with the veterans' disease and had experienced the responsibility of managing the family.

2.1 Support Motivation

Due to their interest in national values, their husbands, their children's future, and destiny, the participants have resisted the consequences resulting from the disease and have continued their lives with support motivation. As an example, they said:

“In addition to my husband's mental problem, relationship problem, sleep disorder, unemployment, and staying at home, he is older now and his problems have become more. I have coped with all these problems because of him and I will stand up to the end.” [Participant 3]

“Living with a veteran was my own choice. It was a kind of pride for me and my family. I always think that my child would grow up and would be proud of his father. I resist all the problems for the sake of my child's future. I tolerate him because he is the father of my child.” [Participant 9]

2.2 Playing Dual Role-Play

Due to the inadequacy or limitations of their husbands in playing their roles in life, the participants had to take the responsibilities of managing the house in addition to their own maternal duties. For instance, they said:

“Our life is under the influence of my husband's disease and our life is really different from the lives of other non-veteran wives. Their life responsibilities are on the shoulders of their husbands. All the problems of the family are on my shoulders because of my husband's disease. I am the mother and the father of the family; meanwhile, his responsibilities are not easy to handle.” [Participant 7]

“Due to his disease and its related problems, the responsibilities of managing our life are on my shoulders, whether economically or spiritually. All the house affairs, all the children’s responsibilities in life, expenditures, family economy, receiving salary, and paying installments are on my shoulders.” [Participant 4]

DISCUSSION

According to the results of the present study, the veterans’ wives experienced negative emotions, such as anger, aggression, depression, and anxiety, resulting from the negative effects of PTSD. Experiences of the veterans’ wives in other societies have also indicated that this disorder can have negative effects on the mental condition and family relations because the wives often face problems coping with their husbands’ symptoms such as illogical requests, physical violence, and their emotions, which cause mental pressure for the wives.¹⁹

Based on the studies conducted on the issue, violence and physical and verbal aggression is quite more common against the spouses of the veterans with PTSD.^{20,21}

Consequently, the direct contact of the soldiers with violence can affect the relationships and mental performance of the family members, as well.²² Previous studies have reported stress resulting from living with the patient,²³ high frequency of depression and other mental disorders,²⁴ and low level of mental health among the wives of the veterans suffering from PTSD compared to the wives of physically-injured veterans.^{25,26} That is because the patients always warn the family about the possible risks; therefore, they are always exposed to excitability and aggression which would frighten them.⁹

In general, the veterans with mental diseases are at a higher risk due to the following reasons. First, the symptoms of this disorder are naturally deleterious. Second, their healthy appearance causes such behaviors and symptoms not to be

attributed to their disease. Therefore, the spouses feel upset or oppressed instead of feeling pity and, as a result, their mental health is more threatened. But why do the wives of the veterans with both physical and mental injuries have better mental health compared to those of the veterans with only mental problems? Cognitive definition may explain the reason. Probably, understanding and accepting the limitations or at least feeling pity for the veteran with physical problems is higher because the disabled body of the veteran makes the spouse attribute the violent and disturbing behavior to the physical problem not PTSD. Thus, it cannot increase the wives’ mental pressure. On the other hand, if the veteran looks healthy, the symptoms of PTSD, which have emotional and behavioral form, are less attributed to the disease. Furthermore, the veterans with physical disability have less ability to hurt their families compared to those without physical disabilities. Of course, further studies are required to be performed on this assumption.

Another experience of the participants was problems in communication and improper relationships with the spouses. Despite having a married life, they are always in a permanent struggle between keeping their own personal privacy and getting too much close to their husbands’ lives. Even though their husbands are physically present, they are mentally absent. Responsibility motivation and ethical commitment of wives toward their spouses make them inseparable. They believe that this family relation is the result of the negative effects of combat PTSD.

The findings of a qualitative study based on the phenomenological approach showed the negative effects of the disorder on family relations and the effect of family relations on the veterans’ therapy process. This is due to the fact that emotional numbness and anger have negative effects on the family relations as well as the quality of the relationships with spouse, children, and other family members. Also, the wives struggle to maintain the control of their personal space and family

while dealing with a partner who is physically there but psychologically absent.²⁷ Furthermore, they encounter problems in intimate relationships and family roles.²⁸ Many studies have reported more marital dissatisfaction among the veterans' wives compared to the normal group.^{4,29} Also, weak marital relationship has been shown to be correlated with emotional insentience.³⁰

The participants of the current study were ridiculed and discriminated because of this disorder and also felt humiliated because some people think that the veterans suffering from PTSD are insane and avoid them. This has a negative effect on the family spirit. Unfortunately, mental disease stigmatization has not been investigated in Iran. Nevertheless, stigmatizing views toward mental diseases exist in many societies causing a large number of problems for the patients and their families.³¹

Support motivation was among the other sub-categories of coping with the disease in this study. Due to their interest in national values and feeling of responsibility toward their children's destiny, the participants resisted the unfortunate events and had positive adaptation while facing the patients' condition. Of course, people's adaptation in confronting stress was not the same.³² In general, individuals make use of cognitive and behavioral approaches to cope with stressful situations in order to reach adaptation.³³

If continuing living with a person with combat PTSD is mandatory due to the cultural and social reasons, it can increase the negative effects on the wives' mental health. Besides, we should not ignore the Iranians' spiritual and religious beliefs in this regard. Thus, further studies are recommended to be conducted on the issue.

Although the participants of this study required mental support, they had to take their husbands' role and manage the family issues in life in addition to their own responsibilities. Therefore, paying attention to the needs of the veterans' wives is an essential part of the intervention for the

individuals suffering from combat PTSD.²² Iranian veteran families deserve receiving special medical and social services at higher levels than what is provided now.¹⁰

Moreover, it is very important for the nurses and other healthcare specialists to be aware of the destructive effects of combat PTSD on the family relationships so that they can consider better intervention methods.²⁷ In fact, executing educational programs for the veterans and their families lead to improvement of health and admission of self-care,³⁴ sense of well-being of the family and spouses, and satisfaction with the relationship.⁴

In general, suffering from a chronic condition is associated with a relative decrease in health utility scores, a relative increase in mobility limitations, dexterity problems, pain, emotional problems (i.e. decreased happiness), cognitive limitations, decline in productivity and financial status, and disruption of the family and social life.¹²

Similar to the previous studies, the results of the present study showed that emotional status and anger of the patients negatively affected their relationships with spouses, children, extended family members, and the family unit as a whole.²⁷ It is obvious that education and support of the veterans' family members are vital. Therefore, their family members are recommended to keep permanent relations with psychologists, psychiatrists, and social workers, especially psychiatric nurses. Also, it is essential to design qualitative studies in order to investigate the experiences of the children of the veterans suffering from PTSD. One of the limitations of this study was that only one group of the veterans' wives was considered.

CONCLUSION

Based on the results of this study, the participants had the role of main care-provider and supporter of the patient. However, living with combat PTSD patients had negative effects on the mental condition of the family members, especially their wives, and they

suffered from psycho-social problems. Solving their problems requires social support. Also, preventing the recurrence of the symptoms is of great importance and resolving the issue of disease stigmatization depends on promoting the awareness level of the society.

ACKNOWLEDGMENT

The authors sincerely acknowledge the participants of the study and financial support of Veterans' Medical Sciences and Engineering Research Institute and Baqiyatallah University of Medical Sciences. They are also grateful for Ms. A. Keivanshekouh at Research Improvement Center of Shiraz University of Medical Sciences for improving the use of English in the manuscript.

Conflict of interest: None Declared

REFERENCES

- 1 Kozarić-Kovačić D, Pavelić K, Filipac V, Cindrić M, Vučinić S, Kraljević Pavelić S. Proteomics and Posttraumatic Stress Disorder (PTSD). Coping with Posttraumatic Stress Disorder in Returning Troops, Wounds of War II. K. W: Brenda. Amsterdam, IOS Press; 2010.
- 2 Joseph S, Linley PA. Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review*. 2006;26:1041-53.
- 3 Koenen KC, Stellman SD, Sommer Jr JF, et al. Persisting posttraumatic stress disorder symptoms and their relationship to functioning in Vietnam veterans: A 14-year follow-up. *Journal of Traumatic Stress*. 2008;21:49-57.
- 4 Catherall DR. Handbook of stress, trauma, and the family. New York, NY: Routledge Press; 2004.
- 5 Prpić J. Chronic pain and secondary traumatization in wives of Croatian war veterans treated for post traumatic stress disorder. *Acta clin Croat*. 2002;41:295-306.
- 6 Frančišković T, Stevanović A, Jelušić I. Secondary traumatization of wives of war veterans with posttraumatic stress disorder. *Croat Med J*. 2007;48:177-84.
- 7 Schnurr PP, Lunney CA, Bovin MJ, et al. Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan. *Clinical Psychology Review*. 2009;29:727-35.
- 8 Engelhard IM, Van Den Hout MA, Weerts J, et al. Deployment-related stress and trauma in Dutch soldiers returning from Iraq. *The British Journal of Psychiatry*. 2007;191:140-5.
- 9 Calhoun PS, Beckham JC, Bosworth HB. Caregiver burden and psychological distress in partners of veterans with chronic posttraumatic stress disorder. *Journal of Traumatic Stress*. 2002;15:205-12.
- 10 Shabani A. Postwar Stress disorder in literature of Iran. *Iranian Journal of Psychiatry and Clinical Psychology*. 2010 15:323-6. [In Persian]
- 11 Zarrabi H, Najafi K, Shirazi M, et al. The impact of post-traumatic stress disorder on partner of Iranian veterans. *Acta Medica Iranica*. 2008;46:120-4. [In Persian]
- 12 Ebadi A, Ahmadi A, Ghanei M, Kazemnejad A. Spirituality: A key factor in coping among Iranians chronically affected by mustard gas in the disaster of war. *Nursing and Health Sciences* 2009;11:344-50.
- 13 Sirati Nir M, Ebadi A, Fallahi Khoshknab M, Tavallae A. Spiritual Experiences of War Veterans Who Suffer from Combat-Related Post-Traumatic Stress Disorder: A Qualitative Study. *Journal of Religion and Health*. 2013;52:719-29.
- 14 Wong L. Focus group discussion: a tool for health and medical research. *Singapore Med J*. 2008;49:256-60.
- 15 Corbin JM, Strauss AL. Basics of qualitative research: Techniques and procedures for developing grounded theory. California: Sage Publications, Inc; 2008.
- 16 Speziale HJS, Streubert HJ, Carpenter DR. Qualitative research in nursing:

- Advancing the humanistic imperative: Lippincott Williams & Wilkins; 2010.
- 17 Cunningham G, Slevin E. Community psychiatric nursing: focus on effectiveness. *Journal of psychiatric and mental health nursing*. 2005;12:14-22.
 - 18 Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qualitative health research*. 2005;15:1277-88.
 - 19 Nelson BS, Wright DW. Understanding and treating post-traumatic stress disorder symptoms in female partners of veterans with PTSD. *Journal of Marital and Family Therapy*. 1996;22:455-67.
 - 20 Jordan BK, Marmar CR, Fairbank JA, et al. Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*. 1992;60:916-26.
 - 21 Byrne CA, Riggs DS. The cycle of trauma: Relationship aggression in male Vietnam veterans with symptoms of posttraumatic stress disorder. *Violence and Victims*. 1996;11:213-25.
 - 22 Galovski T, Lyons JA. Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*. 2004;9:477-501.
 - 23 Jackonis MJ, Deyton L, Hess WJ. War, its aftermath, and US health policy: Toward a comprehensive health program for America's military personnel, veterans, and their families. *The Journal of Law, Medicine & Ethics*. 2008;36:677-89.
 - 24 Kronmüller KT, Backenstrass M, Victor D, et al. Expressed emotion, perceived criticism and 10-year outcome of depression. *Psychiatry research*. 2008;159:50-5.
 - 25 Al-Turkait FA, Ohaeri JU. Post-traumatic stress disorder among wives of Kuwaiti veterans of the first Gulf War. *Journal of anxiety disorders*. 2008;22:18-31.
 - 26 Dekel R, Enoch G, Solomon Z. The contribution of captivity and post-traumatic stress disorder to marital adjustment of Israeli couples. *Journal of Social and Personal Relationships*. 2008;25:497-510.
 - 27 Ray SL, Vanstone M. The impact of PTSD on veterans' family relationships: An interpretative phenomenological inquiry. *International Journal of Nursing Studies*. 2009;46:838-47.
 - 28 Sayers SL, Farrow VA, Ross J, Oslin DW. Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*. 2009;70:163-70.
 - 29 Dirkzwager AJE, Bramsen I, Adèr H, van der Ploeg HM. Secondary traumatization in partners and parents of Dutch peacekeeping soldiers. *Journal of Family Psychology*. 2005;19:217-26.
 - 30 Cook JM, Riggs DS, Thompson R, Coyne JC, Sheikh JI. Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. *Journal of Family Psychology*. 2004;18:36-45.
 - 31 Papadopoulos C, Leavey G, Vincent C. Factors influencing stigma A comparison of Greek-Cypriot and English attitudes towards mental illness in north London. *Social Psychiatry and Psychiatric Epidemiology*. 2002;37:430-34.
 - 32 Angermeyer MC, Kilian R, Wilms HU, Wittmund B. Quality of life of spouses of mentally ill people. *International journal of social psychiatry*. 2006;52:278-85.
 - 33 Campbell-Sills L, Cohan SL, Stein MB. Relationship of resilience to personality, coping, and psychiatric symptoms in young adults. *Behaviour Research and Therapy*. 2006;44:585-99.
 - 34 Damron-Rodriguez JA, White-Kazemipour W, Washington D, et al. Accessibility and acceptability of the Department of Veteran Affairs health care: diverse veterans' perspectives. *Military medicine*. 2004;169:243-50.