

The impact of Veterans' posttraumatic stress disorder on intimate partner relationships

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The Relationships and PTSD Study: Detection of Intimate Partner Violence (NRI-04-040)

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Overview of Project

- 441 male Veterans randomly selected from PTSD treatment programs at VA Puget Sound HCS.
- 441 female wives/partners.
- Yes IPV 190 (44%) No IPV 251 (56%)
 - Within IPV NO group: 3 women primary aggressors;
 - Within IPV YES group: 2 mutual violence couples
- Veterans' ages ranged from 22 – 88 years old.
- Most (96%, 432) had deployed to a war zone.

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Method - Grounded Theory

- A systematic qualitative methodology for the generation of theory from data.
- From the data collected, the key points are marked with a series of codes, which are extracted from the text. The codes are grouped into similar concepts in order to make them more workable. From these concepts, categories are formed, which are the basis for the creation of a theory.
- The emerging theoretical model is continually checked against the data to make sure it is well grounded.

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Procedures

- 23 digitally recorded couple interviews were purposely selected from the larger study sample and transcribed.
- Couples were selected for the qualitative analysis based on a representative sample of IPV Yes and NO, and who gave rich descriptions of their relationship issues.

Research Questions

- "What is the impact of the Veteran's PTSD symptoms on the relationship behaviors of this couple?"
- "How do the couples handle conflict?"

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Overall Finding

Caregiving, Communication, Community, and Responsibility are key components to lasting intimate relationships.

However the presence of intertwined **Disability and Trauma**, that is part of PTSD, create unique, complex, and potentially highly problematic dynamics.

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Disability

- Participants described the following PTSD symptoms and related issues as having significant impact on their relationship: **avoidance, emotional numbing, depression, a heightened need for control, hypervigilance, self-harm & risk taking, aggression, and self-medication.**
- They also described a wide variety of physical impairments / limitations suffered in relation to deployment, but not directly related to PTSD symptoms: **diabetes, hearing loss, medication related erectile dysfunction, loss of mobility, and cognitive problems such as attention and memory impairment.**
- The majority described the Veterans' **history of alcohol and/or substance abuse and use for self medicating** in a manner that exacerbated PTSD symptoms, medical issues, conflict, communication, and overall relationship.

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Examples: Disability

- *I don't even think we've had a disagreement because he's been in such a medical state on all, so many dynamic levels of needing to take care of himself that I didn't want to add to that. (Partner)*
- *"I felt very abandoned. (Veteran)
What kind of response would you hope for? (Interviewer)
Understanding. (Veteran)
You mean, in terms of listening, and trying to understand? Or, getting information on their own? Or, what, what could have helped, do you think? (Interviewer)
Understanding at a level where the other person would know that I was weak, and vulnerable, because of certain incidents. And, I was having a hard time adjusting to it. I needed their ability to deal with me as I coped with those issues. So, not the ability to relate, but a little lower level." (Veteran)*

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CareGiving

- A vicious cycle in which caring for the symptoms of PTSD is **received/ experienced as a "trigger" or source of PTSD symptoms.**
- In these couples, caring / caregiving, normally an experience grounded in concern for the other, has been transformed and is **simultaneously performed from a state of anxiety and self concern.**
- When discussing the volatile and sometimes violent behavior of the Veterans, **partners expressed anxiety regarding his emotional state, and a desire to avoid triggers**, but these descriptions were marked by protective and defensive language as well as concern.
- The combination of a **very high felt need to manage** the Veteran's well being, motivated by both empathy (concern for the other) and anxiety (concern for self) and **minimal information about PTSD** results in being minimally effective at either supporting the Veteran or managing their symptoms. Partners expressed **self-blame, a sense of helplessness, incompetence and frustration.** Partners also described **poor self care** and an overall sense of **losing themselves** in the relationship.

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Examples: Care Giving

- *Well, I also did them for me but, you know, I was secondary. And, that's another thing that I would like it known is that the family and the spouse become secondary to everything. And, you, kind of, get lost in the shuffle. Everything is focused on it, everything. And, in some ways, rightfully so, but, also, the - my emotions, my feelings, my medical care, my physical care, my sexual desires, my life desires, you know, work, everything falls to the wayside. And, it all is about them. (Partner)*
- *...depends. If she hits a trigger, like she's, sometimes - let's see, when, when I have the feeling that she's nagging, when you get the feeling that she, she's nagging, and, then, all of a sudden, it's, like, bam, bam, bam. ... - I can't be specific, but that's pretty much what happens. (Veteran)*

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Responsibility

- Both Veterans and partners tended to implicitly or explicitly speak of the **partner as responsible** for the Veterans emotional state. This dynamic was most clearly expressed around the themes of eliminating, avoiding, or producing "triggers."
- Partners tended to be acutely aware of, and frequently more articulate and detailed than the Veteran's themselves. Their descriptions reflected an experience of **attending closely to the symptoms, states, and well being** of the Veteran.

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Examples: Responsibility

- *And, the fact that it fell on me all the time to be responsible for making sure that he got the medical help that he needed. It was a huge responsibility. And, the majority of which I didn't know enough it - I mean, I've worked in and out of medical hospitals and clinics, and I know enough about it to ask the right questions and get it just before it gets really bad. But, if I'm not there, then there's not anything I can do about it. (Partner)*
- *I just go by whatever she feels. I just try to make her life easy, you know? "Do what you need...It's easier for me, I don't have to deal with it...I don't do anything, myself. Like, I put myself in a little cage. (Veteran)*

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Trauma

- Participants described the Veterans' sense of entitlement, i.e. **"you owe me"** because of what I've been through". Volatile actions as well as impotence were justified in this way. Weakness and vulnerability were sometimes presented so that "others have to deal with me".
- An **awareness of the Veteran's capacity to harm**, noted in reference to his size, strength, military history, or previous violence, created significant partner fear and anxiety.
- **Assaults during sleep** added to the knowledge that the Veteran has killed/could harm actively or passively.
- **Possession of weapons** was common with the Veterans and a recurrent theme among the more distressed and violent couples, becoming the focal point of the Veteran's capacity to harm.

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Examples: Trauma

- *"So I was going through this triggering thing. And I got the thing for domestic violence anyway. And – you know, the preclusion to it with my dad and everything. So, everything just hit just right, you know? It was like the perfect storm of domestic violence, with the anger, the guilt, and everything just meshed. And, it, it wasn't a pretty sight." (Veteran)*
- *And, you try to sympathize with him, and you say, you know, "I can't imagine that. I feel so bad for you." And, then, he gets real defensive, and, "You can't possibly understand what it was like." (Partner)*
- *"He says, 'I killed people in Vietnam'. Now, what does that make you think? If you're yelling at somebody and they say 'I killed before.'" (Partner)*

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Communication

- **PTSD symptoms** (emotional numbing, avoidance, need for control, and depression) **impede communication**.
- Partners described developing their own kind of hypervigilance in the absence of Veterans' communication. Partners may already **"know" the Veterans' secrets**, the tension lies in the lack of discussion.
- **Partners were identified as highly talkative**, expressive, and pursuing of connection. This was often framed as either complimentary to, or compensatory for, the Veteran's lack of these qualities.
- The **lack of communication** was experienced by partners as resistance and led to frustration and anger toward the Veteran and contributed to the partner sometimes adopting a more assertive or blunt style of relating.
- When describing their partners attempts to communicate or manage their triggers, **Veterans tended to express annoyance or resentment at being controlled**. Many described a diminished sense of self, being treated like a child. In this way, partner's efforts were themselves experienced as "triggers".

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Examples: Communication

- *"I mean, he has secrets. He would withhold stuff from me. He wouldn't tell me where he was, what he was feeling, what he needed, what he wanted. He would not go to the doctor, he wouldn't schedule appointments. He wouldn't write down his meds – he would rely on me to remember what his meds are, even if they'd changed." (Partner)*
- *We ended up being two strangers in the same house. She didn't recognize that I'd come back a different person and that there were a lot of things that I couldn't talk to her about, that I can't talk to her about. She knew I wasn't sleeping at night. If a needle fell on the carpet I could hear it, you know? She was very critical of the fact that I just wasn't the same person. I was depressed. (Veteran)*

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Community

- The Veteran's **lack of effective inter-relating** was worsened by the military experience & culture in which secrecy and security is valued and, sometimes necessary, and there is a strong sense of distinction between soldiers/civilians leading to a sense that partners (if civilians) cannot understand.
- Just as Veterans were **hypervigilant in social situations**, partners also became hypervigilant when the couple was in public, motivated both by caring/love for the Veteran and by self-protectiveness/fear over what could happen.
- Partners spoke of how **connections with other Veterans** were an important part of not only PTSD awareness, but also became a vital support system for the Veteran.

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Examples: Community

- *A lot of it was job related, because I was working – it was nothing to put in a 90 hour week, which meant we never saw each other. I was trying to put her through school to get her master's degree, but, basically, I was hiding. I didn't want to have to be out in public. I didn't want to have to relate with people. If you work the night shift, you don't do those things. It just got to the point that there was no room left for anyone or anything. She wasn't receiving any feelings or information or anything from me, which became just intolerable for her. (Veteran)*
- *I couldn't even go to the grocery store by myself, and, I mean, it got to the point where my friends no longer liked him. They despised him because all he did was call. It got to the point to where I stopped going and seeing my friends. I stopped going out and being social, you know?" (Partner)*

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Recap: Overall Finding

Caregiving, Communication, Community, and Responsibility are key components to lasting intimate relationships.

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