MILITARY-RELATED POSTTRAUMATIC STRESS DISORDER AND INTIMATE RELATIONSHIP BEHAVIORS: A DEVELOPING DYADIC RELATIONSHIP MODEL

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The protracted conflict in Iraq and Afghanistan and an all-volunteer military has resulted in multiple war zone deployments for many service members. While quick redeployment turnaround has left little time for readjustment for either the service member or family, dealing with the long-term sequelae of combat exposure often leaves families and intimate partners ill-prepared for years after deployments. Using a modified Grounded Theory approach, digitally recorded couple interviews of 23 couples were purposefully selected from a larger sample of 441 couples to better understand the impact of war zone deployment on the couple. The Veteran sample was recruited from a randomly selected cohort of men in treatment for posttraumatic stress disorder (PTSD). Over-all it was found when Veterans experiencing deployment related PTSD re-enter or start new intimate relationships they may bring with them a unique cluster of inter-related issues which include PTSD symptoms, physical impairment, high rates of alcohol and/or drug abuse, and psychological and physical aggression. These factors contributed to a dynamic of exacerbating conflict. How these couples approached relationship qualities of mutuality, balanced locus of control and weakness tolerance across six axes of caregiving, disability, responsibility, trauma, communication and community impacted the couple’s capacity to communicate and resolve conflict. This dyadic relationship model is used to help inform implications for clinical practice.

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The wars over the past decade have produced more and more service members returning from one or more deployments in Iraq and Afghanistan. With each homecoming, attention shifts to reintegration into the full range of family and community life. With increasing multiple deployments, the shift from war zone back to family and community leaves little time or motivation for adequate adjustment. The impact of war zone deployments on wives and families of service members may also be overlooked or even avoided, resulting in a silencing of military-wives’ experiences (Davis, Ward, and Storm, 2011). The challenge of reintegrating into family and community life does not end when military service ends. For Veterans, especially those with war zone related injuries or mental health problems such as depression and posttraumatic stress disorder (PTSD), reintegration can be a lifelong process. Family members, and intimate partners in particular, often carry the primary responsibility for that reintegration and caregiving.

This article describes some of the relationship dynamics between Veterans in treatment for PTSD and their intimate partners, through qualitative analysis of data selected from the overall Relationships and PTSD Study: Detection of Intimate Partner Violence (NRI: 04-040). In the overall study, a randomly selected sample of 441 male Veterans in treatment for PTSD and their female intimate partners completed relationship interviews, questionnaires, and assessment with the first author’s study team. Quantitative analyses then examined variables including PTSD severity, substance abuse, relationship behaviors, and intimate partner violence. Subsequently, qualitative analysis was conducted on interview transcripts from 23 of these couples in order to further examine two salient questions: 1) What is the impact of the Veteran’s PTSD symptoms on the relationship behaviors of these couples? and 2) How do these couples handle conflict and how has it changed over the course of their relationship? Based on the narratives provided by these couples, a developing model of dyadic functioning is offered.
BACKGROUND

Most research on PTSD focuses on individual trauma symptoms of the survivor and the secondary impact on the family. There is little research that focuses on the dyadic functioning of couples with traumatic stress experiences, and even less that describes couple functioning when both care giving for disabilities and intimate partner violence (IPV) are present (Goff, Crow, Reisbig, and Hamilton, 2007; Henry, et al., 2011; Melvin et al., 2012).

Social support, especially that of the spouse or intimate partner, may counteract or reduce some of the symptoms of war zone related PTSD (King, et al., 1998; Sautter, Armelie, Glynn, and Wielt, 2011). However, this positive effect may be time limited, as the impact of living with someone with PTSD starts to erode the benefits of social support and begins to have a deleterious effect on the caregiver and family (King, et al., 2006). Partner distress, in association with the impact of war zone related PTSD, may be more related to the perceived care giver burden than the Veteran’s impairment (Dekel, Solomon, and Bleich, 2005).

When partner distress is identified, the question arises as to the antecedent of this distress. Is this partner distress and possible PTSD secondary to the impact of living with and caring for someone with war zone-related physical and/or psychiatric disabilities (Monson, Taft, and Fredman, 2009; Solomon, Dekel, Zerach, and Horesh, 2009) or related to their own prior trauma experiences (Melvin, Gross, Hayat, Jennings, and Campbell, 2012) or secondary to their victimization at the hands of their loved one for whom they are also the care giver? In a study by Manguno-Mire and colleagues (2007), over 60% of the partners studied reported that their partner (male combat Veterans with PTSD) “demonstrated a physical threat to their well-being” (pg.76).
The avoidance symptom cluster of PTSD, through numbing/withdrawal, appears to have an impact on communication and partner distress that the other PTSD symptom clusters do not (Renshaw and Campbell, 2011). Wives and partners also become caught in avoidance behaviors as they try to accommodate the Veteran with PTSD, reduce the PTSD symptoms, protect the Veteran, and make their own life more manageable. These behaviors may unintentionally reinforce PTSD symptom expression and dependence on the intimate partner (Monson, et al., 2009). Partners of combat Veterans report experiences of being caught in a damned if you do/damned if you don’t duality where their efforts to help their partner are met with his anger and resentment (Grimesey, 2009).

The impact on intimate partners is even more pronounced when the Veteran with PTSD is also intimately violent. Veterans with PTSD have consistently been found to have a higher incidence of IPV perpetration than Veterans without PTSD (Kulka, et al., 1988; Orcutt, King, and King 2003; Taft, et al., 2005). For example, in the frequently cited National Vietnam Veterans Readjustment study (Kulka, et al., 1990), 64% of the combined sample of Veterans with and without PTSD reported committing acts of physical violence towards their partner in the past year. However, when comparing the male Vietnam Theater Veterans with PTSD (n = 122) to those without PTSD (n = 250), 24.1% of the Veterans with PTSD were rated (by the spouse/partner) as perpetrating moderate to high violence compared to only 6.5% of Veterans without PTSD. Among active duty military and military Veterans in treatment for IPV perpetration (known batterers), the severity of IPV perpetration was significantly correlated to their PTSD severity (Gerlock, 2004). Published research on the link between intimate partner violence (IPV) and war zone deployments goes as far back as the Vietnam War (Strange and Brown, 1970). While the research on the link between combat exposure and IPV perpetration is
mixed, the link between the development of PTSD symptoms secondary to combat exposure and IPV perpetration is well established (Lasko, et al., 1994; Prigerson, Maciejewski, and Rosenheck, 2002; Taft, et al., 2007). When comparing the three symptom clusters (re-experiencing, avoidance, and hyper-arousal) of PTSD, the hyper-arousal symptom cluster (anger/irritability, hyper-awareness, and startle response) has been found to have the strongest positive association with aggression (Taft, et al., 2007).

METHODOLOGY

The protocol for the overall Relationships and PTSD study was reviewed and approved by the University of Washington, Seattle, Institutional Review Board (IRB). Informed consent was obtained for each research participant separately (Veterans and wives/partners).

A modified grounded theory methodology was used for qualitative analysis of the previously collected data set to identify both dyadic and individual processes associated with Veteran PTSD. The goal of grounded theory is the development of theory derived from the data, which explain the meanings of human behavior from the perspective of the participants (Glaser and Strauss, 1999). Grounded theory is founded on symbolic interaction (Blumer, 1969) where interactions, actions and processes are reviewed through meaning, thought (introspection) and language (Milliken and Schreiber 2001).

Participants

The qualitative data (audio recordings and transcripts from previously collected interviews) was drawn from the overall random sample of military Veterans reflecting war or conflict zone deployments from Iraq and Afghanistan to WWII; sometimes multiple deployments during multiple war zone eras. Male Veteran participants, already in treatment,
were randomly selected from a number of PTSD treatment programs at a VHA (Veterans Health Administration) Health Care System and Vet Center in the Northwestern United States. Veterans in a heterosexual committed intimate relationship (married or partnered) for at least one year, and whose partner was also willing to participate, were eligible for the study. The sample consisted entirely of military Veterans (no longer on active duty) and their wives/partners. Of the 441 couples who participated in the larger overall study, 190 (44%) of the Veterans were identified as perpetrating IPV, and 251 (56%) were not. The IPV/non-IPV determination was made based on couples’ responses to research questionnaires, the behavioral interview, and team consensus regarding whether the couple met the research definition for IPV Yes or No. The subset of 23 couples used in the qualitative analysis reflects both IPV ($n=13$) and non-IPV($n=10$).

Couple interviews were purposely selected for secondary qualitative analysis by members of the study team, who listened to all of the recorded interviews to determine: 1) was the sound quality of the interview adequate to allow for transcription, 2) was the length of the responses to the questions appropriate for analysis i.e. detailed descriptions vs. 'yes/no' answers, and 3) did the interviewee produce concrete examples that would be meaningful to a qualitative analysis. The study team made notes of their impressions and prioritized the evaluation of each. The study coordinator reviewed the recommendations and selected the most highly recommended interviews for the qualitative sample, ensuring that both IPV-yes and IPV-no couples were represented. The transcriptionist and qualitative analyst were blinded to the demographics and IPV status of the couples throughout the process.

The use of a predetermined sample size rather than on an open-ended approach was a modification of grounded theory method necessitated by the grant funding requirements. In
Table 1. Veteran and wife/partner descriptive information represented in qualitative sample.

<table>
<thead>
<tr>
<th></th>
<th>Veteran reports</th>
<th>Wife/Partner reports</th>
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</thead>
<tbody>
<tr>
<td><strong>Age Span</strong></td>
<td>27 – 83 years</td>
<td>24 – 71 years</td>
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<tr>
<td></td>
<td>Median age 61</td>
<td>Median age 56</td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
<td></td>
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<tr>
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<td>• 18</td>
</tr>
<tr>
<td>Partnered</td>
<td>• 2</td>
<td>• 3</td>
</tr>
<tr>
<td>Divorced</td>
<td>• 1</td>
<td>• 2</td>
</tr>
<tr>
<td><strong>Time in relationship (years span)</strong></td>
<td>1 – 47.75 years</td>
<td>2 – 45 years</td>
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<tr>
<td><strong>Currently living with:</strong></td>
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<td></td>
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<td>• 7</td>
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<tr>
<td>Children only</td>
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<td>• 3</td>
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<tr>
<td>Roommate or friend</td>
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<td>• 0</td>
</tr>
<tr>
<td>Alone</td>
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<td>• 1</td>
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<tr>
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<td>• 0</td>
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<td>• 3</td>
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<tr>
<td><strong>Employment</strong></td>
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<td></td>
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<tr>
<td>Employed full time</td>
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<td>• 0</td>
</tr>
<tr>
<td>Retired</td>
<td>• 11</td>
<td>• 4</td>
</tr>
</tbody>
</table>

Male Veteran military and deployment information

| **Branch of service**          |                 |
|                                | 14              |
| Army                           | 5               |
| Marines                        | 2               |
| Navy                           | 1               |
| Air Force                      | 0               |
| Coast Guard                    | 14              |
| Served in more than one branch | 0               |

| **First war zone deployment**  |                 |
|                                | 1               |
| WWII                           | 0               |
| Korea                          | 14              |
| Vietnam                        | 3               |
| Persian Gulf                   | 5               |
| OIF/OEF                        | 5               |
grounded theory research, sample sufficiency is determined not by size, but rather by reaching “saturation”, the point at which new data no longer contribute new categories or understanding of those categories (Strauss and Corbin, 1998). The predetermined sample of 35 transcribed couple’s interviews was well within the typical range of grounded theory studies (Thomson, 2006). Saturation was reached at 19 couples. The interviews used were both sufficiently rich and open ended to provide sufficient material for well-grounded theory development. Four more couples were included to ensure comprehensive analysis, as well as theoretical verification, resulting in a final qualitative sample of 23 couples.

*Procedures*

To facilitate open disclosure for each participant, especially when IPV is present, couples were interviewed separately using a semi-structured interview. The interview, developed by the first author, was structured in order to capture responses necessary for the quantitative analysis, but sufficiently open to allow themes to emerge through narrative. Interviewing couples separately allows them to describe their relationship behaviors, over the span of their relationship, in their own voice. The data collection and qualitative interviews were conducted using a team-based approach (including the first and second authors). The interview addressed a range of issues in the relationship, from basic demographic information about their living situation, how long they have been in a relationship, to how they handle conflict, whether there has ever been any physical force used during those conflicts, to questions about substance use, injuries secondary to any violence, general violence, weapons in the home, etc. Both the Veteran and wife/partner were asked questions related to conflict and fighting: “Do you ever fight? Does it ever get physical between you? How do you handle conflict?” And, if they have ever talked about the Veteran’s war zone experiences: “Has your husband/partner ever talked about his
military or war zone experiences?” (partner) Or, “Have you ever talked about your military or war zone experiences with your wife/partner?” (Veteran) Both were also given a chance to talk in general about the impact of war zone experiences and disabilities related to those experiences, on their relationship. On average the Veterans’ interviews were 49 minutes, and partners’ interviews were 39 minutes.

Data analysis

Strauss and Corbin’s (1990, 1998) coding paradigm of open, axial and selective coding was applied. The initial data analysis processes performed by the third author utilizing Atlas.ti (version 6) qualitative data analysis software for tracking codes, memos and visual category mapping. For each dyad the two interviews were combined into a single unit and analyzed together as a dyad with each dyad comprising a single data unit.

For the initial coding, the interview recordings and transcripts were listened to and read simultaneously in order to capture inflection, tone, etc. During this initial reading of the transcripts in vivo codes were highlighted. In vivo codes are “catchy terms that immediately draw our attention to them” (Strauss and Corbin, 1998, p. 115). Based on these codes, a preliminary analysis was completed. Single meaning units, discrete sections of texts or speech that reflect a specific meaning, often fell into multiple categories.

These analyses yielded 36 categories based on a total of 2,227(open coding) meaning units. Re-reading the transcripts these categories were then organized around common themes creating 16 second-order categories that included PTSD symptoms, trauma, disability, substance abuse, sub-cultural norms (Veteran), stressors, conflict behaviors and patterns, roles, relationship structure, communication patterns, caregiving, communication, community, felt responsibility,
mutuality locus of control, weakness tolerance, distress and IPV. All three authors participated in the continued analysis processes of grounded theorizing. As this process continued, salient categories consistent with contemporary grounded theory and principles (Clarke, 2005) were constructed to characterize the experience of couples coping with Veteran PTSD. Reflecting a social ecology (Bronfenbrenner, 1976) perspective the attitudes, perspectives and behaviors contained in these categories were understood together as constituting relationship roles. A visual concept map connecting categories was used to identify complex dynamic relationships amongst the various roles and categories. These relationship patterns were considered to be molar activities. According to Bronfenbrenner, a molar activity is “an ongoing behavior possessing a momentum of its own and perceived as having meaning or intent by participants in the setting” (1979, p. 45).

**FINDINGS**

Over-all, it was found that when the Veterans suffering from deployment related PTSD re-enter existing or start new intimate relationships they may bring with them a unique cluster of inter-related issues. These issues include specific PTSD symptoms, physical impairment, high rates alcohol abuse and a specific set of sub-cultural norms. These issues are not only experienced as stressors for the relationship, but taken together they contribute to the development of a unique relationship pattern/structure. Thus, the impact of PTSD cannot be understood simply by looking at each factor in isolation, but rather at the relationship’s dynamic response to these stressors. The conflict and relational patterns expressed in the narratives clearly illustrate a convergence of factors unique to the relationships of Veterans suffering from PTSD. These factors contribute to a particularly problematic dynamic in that they exacerbate
conflict and distress while simultaneously minimizing the couple’s capacity to communicate and resolve conflict.

The terms distressed and non-distressed are not dichotomous but used to reflect a broad continuum across a spectrum of relationship axes and qualities. The relationship behaviors described by these couples were not static, but moved across this spectrum. Within any dyad, a range of functioning may be described whereby they are more or less distressed in one axis compared to another. However, also within each dyad relatively consistent patterns emerged that contributed to relatively consistent levels of distress. Although couples described both positive and negative patterns (across the distressed/non-distressed spectrum), the qualitative sample selected included slightly more IPV Yes than non-IPV couples.

Out of these narratives the two distinct categories of relationship functioning emerged that facilitated understanding of the dynamic patterns that the couples described; relationship axes and relationship qualities. Relationship axes refer to the intertwined areas in which PTSD emerged as impacting the couple’s relationship functioning; caregiving, communication, community, responsibility, trauma and disability. Relationship qualities refer to those dyadic characteristics that emerged as salient to the degree of distress associated with PTSD, specifically: mutuality, balanced locus of control and weakness tolerance.

Case Examples

Narratives reflecting both distressed and non-distressed examples are given for each axis. The caregiving axis has two examples that reflect this movement across the spectrum of distressed and non-distressed. Both narratives are from women who have been in long standing relationships with Veterans with PTSD. The distressed example reflects significant loss and
sacrifice in the role of caregiving. This women describes the loss of aspects of herself that define who she is. The women in the second example has also been a caregiver to her husband for many years. She describes what happens when a person is thrown into a caregiving role without knowledge of the condition or needs for which they are providing care. In contrast to the distressed narrative, she has not loss her sense of self in her role as a caregiver.

*Relationship Axes*

**Caregiving** was a common theme for these couples. In some couples the dynamic of care giver/care recipient is exacerbated by the presence of PTSD symptoms and/or IPV such that what should be a source of support that brings couples closer becomes a source of turmoil that keeps couples at a distance. Partners expressed a very high felt need to care for or manage the Veteran’s wellbeing, motivated by empathy (concern for the other) but also by anxiety (concern for self). Some partners described poor self-care and an overall sense of losing themselves in the relationship. Veterans experienced the partner’s caregiving as much needed support, but also as a threatening reminder of their own diminished capacity. These tensions, paired with minimal information about PTSD, left some partners feeling helpless, incompetent, and frustrated and some Veterans feeling belittled, controlled, and thereby triggered. Being able to participate in the Veteran’s VA care, at some level, and receiving education about PTSD symptoms and other co-occurring problems was identified as helpful by some partners.

*Distressed:*

“Well…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, 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’s all about them.” (partner)
Non-distressed:

“I was not assertive enough, and I think of the things that he did and it just...kills me, you know what I mean? Well, yeah, advantaged of, but ashamed that I didn’t do something sooner.” (partner)

PTSD symptoms such as emotional numbing, avoidance, need for control, and depression are serious impediments to communication. These factors were often experienced by the partners as resistance, led to frustration and anger toward the Veteran, and contributed to the partner herself sometimes adopting a more assertive style of relating to the Veteran and others. In this way, partners’ attempts to communicate could be experienced by Veterans as aggression, or as “triggers.” In the absence of communication from the Veterans, partners often became hyper-vigilant in an attempt to anticipate the Veterans’ moods and wishes. Indeed, a sense that the partner held responsibility for the Veteran’s emotional expression as well as any aggression or violence in the relationship was shared by both members of the couple. Another factor in the communication dynamics is the Veterans’ need to withhold information about the traumas experienced during combat, a withholding that was understood by Veterans as necessary for relationship security and self-protection, but experienced by partners as further lack of intimacy and a demonstration of mistrust.

Distressed:

“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...” (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.” (Veteran)

Non-distressed:

“And, and things that happened while in the infantry, you know? But, they we—they were all very, very light. No, nothing descriptive, you know, gory,
nothing of that nature because our love was having no business knowing about those things.” (partner)

This lack of effective communication was exacerbated by the Veteran’s military experience and culture in which secrecy can be necessary and is sometimes vital for survival. A strong, unifying distinction between soldier/civilian is formed that translates to a general us/them mentality, ultimately fostering a sense that partners, as civilians, cannot understand. This exclusive belief system extends beyond the home into the larger family and the community overall, effectively isolating both the Veteran and the partner from social contacts or outside sources of support. Society and community are, of course, necessary to modern life; however, unstructured social interaction was also regarded by Veterans with suspicion and perceived as threatening. Even if friendship and human connection was desired, it was often avoided out of fear of rejection or survivor guilt, including the avoidance of intimacy with and love of one’s partner. Both Veterans and partners spoke of how connections with other Veterans were an important part of not only PTSD awareness, but also served as one vital source of social support for Veterans when other forms of support were not possible as they choose security through isolation.

*Distressed:*

“A lot of it was job related, because it was nothing for me to put in a 90 hour week, which meant we never saw each other or anyone else. 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 of information from me, which became just intolerable for her.” (Veteran)

*Non-distressed:*

“Well, it—we’re in a couples PTSD group right now. And, hearing some of the other couples, what they say, I just feel so fortunate to have my
husband. …We’re friends. We go almost everywhere together. We just talk a lot…We were both military when we met and, so that was a bonus. And, wherever he went, wherever he was assigned, I managed to get assigned there too…” (partner)

Both Veterans and partners tended to implicitly or explicitly speak of the partner as responsible for the Veteran, in terms of daily routine, health status, and emotional state. The partners’ statements reflected an experience of attending closely to the symptoms, states, and wellbeing of their Veteran: a dynamic most clearly expressed around the themes of anticipating, avoiding, or coping with the Veterans’ “triggers.” Unfortunately, the partner’s actions in this regard were experienced by the Veteran both as caring and required but also as controlling and resented, and the partners’ actions thereby became potential triggers in and of themselves. In contrast, non-distressed narratives reflected setting limits or boundaries around responses to triggers.

*Distressed:*

“But, yeah, I could definitely have a lot of pent-up rage that I can’t – don’t know how to get rid of instantly. And, that’s where there’d be a hole in the wall from… And, that happened a few times. I don’t know. It, it easily pops up at situations. Sometimes, I don’t even know where it comes from, honestly.” (Veteran)

*Non-distressed:*

“…we check in with each other to find out what that trigger is before reacting, really, for me anyway, when I’m feeling like I’m being triggered, now I want to decide how much I want to invest in this particular thing. I de-escalate it, I just let it go. If it’s a high priority, then I’ll say something like ‘We need to talk about this when I’m less angry.’” (Veteran)

Central to our topic is the trauma experienced by the Veteran with PTSD and how they continue to experience the aftermath of trauma. Some Veterans referenced their trauma through a sense of entitlement such as “You owe me, because of what I’ve been through.” Veterans justified their actions as well as their impotence in this way. Aggression and control as well as
weakness and vulnerability were tied to trauma suffered, such that others felt compelled to “deal with” the Veteran and give them leeway. Trauma experience is intensified by the knowledge that the Veteran has killed/could harm actively or passively, and can thus be both a victim and perpetrator of trauma. Veterans’ significant need for control often manifested in heightened aggression, both verbal and physical as well as full blown IPV. In these cases, the Veterans’ need for control was described by partners as inducing neither empathy nor concern, but fear and anxiety. Knowledge of the Veteran’s capacity to harm, noted in reference to his size, strength, or past history, military or previous IPV, created significant partner fear and anxiety. This was true in both an active and a passive sense. For example, many participants described physical explosiveness or assaults that occurred during nightmares or sleep, generally without the Veteran’s awareness. In addition, the possession of weapons was common with the Veterans and became a recurrent theme among the more distressed couples with IPV, becoming the focal point of the Veteran’s capacity to harm.

The non-distressed couples, by contrast, acknowledged PTSD symptoms such as nightmares as an indication of the Veteran’s level of stress; providing an opening to communicate.

**Distressed:**

“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)

“I think she’s scared of me, because of what she knows of my, my military past.” (Veteran)

**Non-distressed:**

“I know when he has bad nightmares, I smell – I wake up smelling. To me, he smells like rancid maple syrup. That’s the smell when I know, and even I
can get up and say, “Oh, you had a bad night.” And, he goes, Yeah, I did.” …And, and him and I’ll talk about it, you know.”

Veterans and partners described a wide variety of physical and cognitive limitations or disability that the Veterans suffered as a result of their military deployments, including diabetes, hearing loss, chronic pain, erectile dysfunction, loss of mobility, and problems with attention and memory impairment. A history of alcohol and/or substance abuse, usually described in terms of ‘self-medication’, was also described in this vein as ultimately exacerbating both PTSD and medical issues. The presence of these physical symptoms was woven throughout the couple’s descriptions of their conflicts, communication, and overall relationship. Physical illness and disability on the part of the Veteran was one more factor that inhibited the partner’s attempts to confront problems or make change in the relationship, and served to reinforce the other axes discussed herein.

**Distressed:**

“He felt I was intruding. He felt that I was treating him like a child. He felt I was asking of him things that were unreasonable. And, really, what I was concerned about was making sure that he was safe and that he was going to get home OK and on time.” (partner)

**Non-distressed:**

“I don’t even think we’ve had a disagreement because he’s been in such a medical state and all, so many dynamic levels of needing to take care of himself that I didn’t want to add to that.” (partner)

**Relationship Qualities**

The participants’ descriptions of their relationships expressed not only specific axes, but also reflected overarching qualities/characteristics of their relationships. The relationship qualities that emerged are mutuality, balanced locus of control and weakness tolerance.
Both implicitly and explicitly participants described various degrees of mutuality. **Mutuality** is defined as the bi-directional movement of feelings, thoughts, and activity between persons. The dimensions of mutuality include empathy, engagement, authenticity, zest, diversity and empowerment (Genero, Milller, Surrey and Baldwin, 1992). Mutuality is reflected in the couples’ narratives as they talk about engaging in mutually enjoyable activities and attending to the emotional state of each other.

**Locus of control** comes out of social learning theory, and is the extent to which an individual believes they can control the events that affect them (Rotter, 1960). Basically, a person may perceive their life events as either within (internal locus) or beyond their control (external locus). An internal locus of control is expressed as both Veterans and partners describe activities they engage in (either as a couple or individually) to lessen the impact of the PTSD symptoms. An example of external locus of control is expressed by a Veteran as he talks about his “pent-up rage” and then “there’d be a hole in the wall…”

For this sample, **weakness tolerance** was paradoxically powerful depending on the degree to which it is accepted and integrated or used to exploit or demean. As previously noted by Kunz (1998) an individual’s weakness can exert significant power over others. A tolerance of weakness is described when Veterans are aware of their need for assistance and accept assistance from their partner and others. On the other hand, an intolerance of weakness was also expressed by Veterans and partners as they talked about the Veteran’s reluctance or refusal to get help, and anger and annoyance towards partners’ attempts to help.
Toward a model

Reflecting the relationship between the three relationship qualities, a tentative theoretical model was constructed (Figure 1) for this sample. The theory development process included reflecting on the resonance of the categories with the findings of the larger quantitative study, related existing literature and presentations at a national family therapy conference and interactive Webinar as part of theory development (access online at: http://www.bwjp.org/webinar_recordings_military.aspx). The conference and webinar did not contribute to the data but the feedback from experienced professionals provided a degree of trustworthiness during the process (Charmaz, 2006).

The theory contends that the functioning of these Veteran PTSD relationships manifests across the six intertwined axes on a continuum ranging from “tension free” - ”tension” – “double-bind.” By double bind we mean an emotionally distressing dilemma in which a partner or couple has two or more conflicting tasks or roles in which one task or role negates the other. Double bind theory originated from the work of Gregory Bateson and colleagues, and refers to an emotional distressing dilemma in communication where there are two or more conflicting messages (Bateson, 1972). Each message negates the other, so in this situation an attempt to fulfill one role or task results in a failure to fulfill the other. Double binds are anxiety producing. For distressed relationships characterized by multiple on-going double binds, the anxiety becomes chronic.

The model reflects a continuum across the three relationship qualities that intersects each relationship axis. These relationship qualities (mutuality, locus of control and approach to weakness) predict how these axes will be experienced. High mutuality, balanced locus of control
and tolerance of weakness allow these couples to experience the trauma of deployment related PTSD (both first hand and secondary) in a manner that transcends the tension (the outer most aspect of the sphere). These couples are able to mitigate the negative impact of PTSD. By contrast, the couples with low mutuality, unbalanced locus of control and poor tolerance of weakness describe the distress associated with deployment related PTSD as part of a perpetually escalating cycle of chronic anxiety, isolation, and distress that frequently leads to separation and/or IPV (central aspect of the sphere).

**DISCUSSION**

This research, and the developing model of dyadic functioning for Veterans with war zone related PTSD, demonstrates the complexity these couples face in managing the day-to-day sequelae of war zone deployments and efforts to re-establish pre-deployment family and social activities. These efforts are frequently thwarted by the compounding interactions among PTSD symptoms and the couples’ attempts to cope and adjust. Among the distressed couples, partners contend not only with PTSD symptoms (e.g., nightmares, social isolation, and anger and aggression), but find themselves protecting the Veteran from PTSD symptom triggers as part of their caregiving role. In doing so, they themselves become an identified trigger and are resented for it as the Veteran describes this behavior as controlling. Some of these distressed couples describe clear patterns of psychological abuse and physical violence towards the partner.

The non-distressed couples, on the other hand, describe communicating directly about the PTSD symptoms and the impact of those symptoms on the relationship and the partner. This communication often included discussions about the war zone trauma experiences, thus tackling both PTSD-related avoidance and the secrecy that can be part of the warrior ethos--military vs. civilian dynamic. Partners in non-distressed relationships also describe setting clear boundaries
Figure 1. Military-related PTSD dyadic relationship model from Distressed to non-Distressed across relationship axes and qualities.
around their responsibilities and self-care. These less distressed couples not only described specific coping strategies, they more frequently spoke in terms of “we.”

Treatment that effectively addressed PTSD and related symptoms (e.g., depression) and/or alcohol abuse was identified as helpful in several of the couples, especially around overt physical violence (but not always in regards to ongoing IPV patterns). Several participants reported being in some form of anger management, or “DV” (domestic violence) treatment, but did not speak of it in detail or attribute any specific behavioral change to it. The Veterans who had more open communication with their partners about PTSD and their emotional state experienced less relational distress. This was sometimes directly attributed to an outcome of treatment. The partner’s involvement in the Veteran’s treatment as a couple was also described as very beneficial, as were connections with other Veterans.

**Clinical Implications**

This research helps to inform clinical interventions for providers working with Veterans with war zone related PTSD. While both partners and Veterans reported that substance abuse and PTSD specific treatment helped to reduce the overt physical violence in these relationships, it did little to reduce the psychological abuse. And, while both reported that involving partners in the Veterans’ VA treatment, and educating partners about PTSD symptoms were also helpful, Veterans were paradoxically dependent on and resented partners for their care giving efforts in the distressed couples.

While these findings cannot be generalized beyond this clinical sample they do highlight the importance of screening and assessing for patterns of psychological abuse and physical violence when working with couples with PTSD-related war zone trauma (Gerlock, Grimesey, Pisciotta, and Harel, 2011a; 2011b). In this sample, educating partners about PTSD symptoms
and coaching them on their caregiving role is not enough and potentially sets partners up as a target of abuse when there is also IPV. Providers should clearly communicate the difference between PTSD symptoms and IPV behaviors and address each separately. Partners in non-distressed couples describe setting clear boundaries. Providers can assist these couples in supporting the Veterans in more independent behavior in PTSD symptom management. Providers can also educate both Veterans and partners about the importance of setting boundaries and responsibility, and encourage self-care. As trauma material inevitably surfaces, providers can coach these couples on addressing this material in a manner that is mutually acceptable to Veteran and partner.

Limitations and Future Research

This research specifically addresses couple’s issues for Veterans in PTSD treatment at VA locations in the Northwestern U.S. While the themes that emerged resonated with previous research on similar couples and for treatment providers nationally, the findings cannot be generalized beyond the sample and the site. However, this research provides critical foundational information that contributes to the national dialogue on how to respond to Veterans and families at VA, military, and community settings. By including a focused discussion on violence and abuse in these relationships we were able to identify the interaction between PTSD symptoms, IPV behaviors, the impact on the partner, and relationship dynamics. Future research on couples and families with a member with war zone related PTSD should differentiate between PTSD symptoms and IPV behaviors.

REFERENCES


