Veteran’s Administration
Spotlight on Women Cyberseminar Series
January 23, 2012

Moderator: And we are just about at the top of the hour. I would like to take this opportunity introduce our two presenters. We have Dr. April Gerlock. She is a research scientist, and Dr. Jackie Grimesey. She is a project manager. And both are joining us from the VA Puget Sound Health Care System where the HSR and D Center of Excellence is located.

So I would like to thank both of you for taking the time to present for us today. And I’m ready to turn it over to you now. Do you have the screen set to go?

April Gerlock: Yes, we do.

Moderator: Excellent. There you go.

April Gerlock: Okay, all right. So folks should be looking at the slide, the very first slide that says from highly distressed to thriving, a qualitative analysis of relationship behaviors in veterans with Post-Traumatic Stress Disorder.

And this is April Gerlock. I’m here with Jackie Grimesey. Unfortunately Dr. George Sayre had to teach a class this morning and he is not with us, but Jackie and I can handle this so—well we to thank you all for joining us again today.

For those of us on the West Coast it’s still morning, but good afternoon to those of you in Central Time and on the East Coast. We’re going to pick up a little bit from where we left off last November.

Those of you who joined us in November for the cyberseminar were able to hear a little bit about the quantitative results that came out of this study. Today we’re shifting to the qualitative results, and I’m going to go to the next slide. For those of you who just have the slides we’re on slide number two.

I’m going to start out by giving you a little background on looking at this study from a qualitative analysis and looking at relationship behaviors in didactic functioning in Veterans and their wives or partners. If you remember from back in November I focused on the intersection of Post-Traumatic Stress Disorder and intimate partner violence.

The shift is a little different today because I am going to be talking about relationship behaviors about veterans with Post-Traumatic Stress Disorder. And those of you who work with Veteran’s with posttraumatic stress you are very well aware of how important social support is, especially from the spouse or intimate partner, and how that support in and of itself may counteract or reduce some of the PTSD symptoms.

However, with more research and there’s a really a very nice body of research looking at couples’ behaviors with veterans with PTSD. That positive affect may be time limited because of the impact of living with someone with PTSD.

It starts to erode some of those benefits and it starts to have an impact on the caregiver and the family. And in fact there is a body of literature that really looks at partner distress of these partners who are living with someone with PTSD, and looking at their distress whether it is secondary traumatization in terms of living with someone with PTSD, or a maybe primary trauma themselves secondary to their victimization at the hands of the loved one for whom they
are also often a caregiver.

I am going to switch to slide number three now. Oops. Okay, now we’re switching to slide number three. I think we’re going to have to use the little arrows instead.

This is the funded study. It was the relationships and PTSD study and focusing on detection of intimate partner violence. And as you could see this is our research team. Jackie and I are going to be talking about some of the results of the qualitative analysis and some opinions around that. Those opinions are ours and do not reflect VA policy or VA opinions.

Moving on to next screen number four, just an overview of the project, the qualitative analysis that we are talking about today was part of a larger, that larger project, the PTSD and relationships study. And in that sample we had 441 male veterans who were randomly selected from PTSD treatment programs at VA Puget Sound Health Care System. And that also included Tacoma Vet Center.

And then we had 441 wives or partners. Someone—a partner was defined as someone who had been in an intimate committed relationship with the veteran for at least one year. And we had some rigorous criteria around identifying whether there was intimate partner violence. We were looking at intimate partner violence perpetration on the part of the male veteran. And so what we focused in on was whether the veteran was intimately violent.

And in our sample we had 190 or forty-four percent of the male veterans we considered were being intimately violent with their female partner or wife. The majority, fifty-six percent, which was 251 men, were not intimately violent.

However, within this group within our IPV no group because we were really looking at the veterans’ variable for yes or no on IPV here we had three women who we consider primary aggressors. And within our yes group we had two couples where we considered that there was mutual violence where both were acting as aggressive towards each other and no one in particular was the primary aggressor or primary victim in those couples.

The veterans’ ages ranged from twenty-two to eighty-eight and that reflects also a range of war zones from Operation Iraqi Freedom, Enduring Freedom to World War II. Most of them had been deployed to a war zone or conflict area. Others were there, had Post-Traumatic Stress Disorder for reasons other than exposure to a war zone or a conflict area, and moving onto slide number five now.

We had two primary research questions for the qualitative analysis. And they were what is the impact of the veterans’ PTSD symptoms on the relationship behavior of this couple and how do the couples handle conflict?

Moving on to slide number six we used a grounded varied method for analyzing the couples. And I will talk a little bit more about how we selected the couples for the grounded theory, but just for those of you who are not familiar with qualitative methods, a grounded theory method is a systematic methodology for generation of theory from data.

So from the data collected there are key points that are identified and marked with a series of codes. Those are extracted from the text and then the codes are grouped into similar concepts in order to make them more workable.

And then from these concepts categories are formed. And from those categories you create a theory. What we’re going to talk about today is an emerging theoretical model, but within grounded theory you continually check back to the data to make sure that the model that is emerging and developing is well grounded.

Slide number seven this slide we’re here we’re talking about how we identified the couples that we did the qualitative analysis for. From that original random sample we purposely
selected twenty-three of the couples. And we had done digital recordings on all 441 couples. We just analyzed twenty-three of the recorded couples. The data started to emerge around nineteen couples. We continued to sample a few more and were able to come up with the model that we’re going to talk about today with twenty-three couples.

This qualitative analysis represents both IPV yes and IPV no couples. And there are also couples who gave us rich descriptions of their relationship issues.

Moving on to slide number eight, our overall finding was that care giving, communication, community and responsibility are all key components to lasting, intimate relationships for these veterans. However, the presence of intertwined disability and trauma that is part of PTSD created this unique and complex and potentially highly problematic dynamic for these couples.

Moving on to slide number nine, we created a dyadic tension model. And we’re going to talk about that today. It’s a model that moves from function to dysfunction across the spectrum of PTSD veterans’ couples.

They experience these tensions within their relationships. And we identified six primary tensions, disability, care giving, responsibility, trauma, communication and community.

So those were the six primary tension areas. And across these tensions, depending on how the couple were functioning there were these three axes that really captured that dynamic of from dysfunction to functional or distress to thriving.

And those three axes were mutuality, locus of control and approach to weakness. And it was how the couples responded on these three axes that really determined where they were at on that distress to highly to thriving continuum.

Going on to slide number nine, mutuality for our study was defined as a bidirectional communication, mutual back and forth communication. These couples had respect. They supported each other’s decisions and life goals, and in general these were couples who were enjoying each other.

Locus of control is the person’s tendency to either perceive their life events as within their control or beyond their control, which is an external, internal versus external locus of control.

And the concept of weakness was we really looked at this as how the couples approached to dealing with weakness. And it can be paradoxically powerful depending on the degree to which weakness is accepted and integrated or if it’s used to exploit or demean.

Going on to number, slide number eleven, this is our emerging model. And as you can see the six areas of six tensions are there. You can see that we have this dynamic under care giving of caring versus self-protection, self-care versus other care, caring or being a trigger.

And each one of these areas of tension is not a standalone area. There is a lot of overlap among the six tensions. So you will see some of the themes demonstrated in different ways as we go around this circle and look at disability, how couples handle disability, how responsibility was handled, how trauma emerged and was handled in these couples, how communication was handled and how they approached community.

And as you can see those three intersects being axes on locus of control, weakness and mutuality intersect all of these areas. And depending on how the couples approached those three axes really depended on how they functioned, whether they were very distressed or thriving couples.

And Jackie is going to take over from here and talk and give you some examples of how
these couples expressed these dynamics in their relationships. And we’ll move on to slide number twelve.

Jackie Grimesey: Good morning. This is Jackie Grimesey. And I’m going to go through the six areas that April just outlined and give you a little bit more detail about what we heard from the veterans and their partners in this study.

In the slide set you have a very rich and large amount of information. And so in the interest of time I’m going to pick and choose what I talk about here, but I encourage you to go back to the slide set later and take a look at the other examples that we don’t have time for today.

Let me start with disability. Both veterans and their partners described the following PTSD symptoms and related issues as having significant impact on their relationship. And these symptoms are familiar to most of you who do PTSD work, avoidance, emotional numbing, depression, a heightened need for control, hypervigilance, self-harm and risk taking, aggression and self-medication.

Now many of the participants did specifically identify these as PTSD related symptoms, but moving on to the second point, they also described a wide variety of physical and cognitive impairments or limitations that the veterans suffered in relation to their deployment. Now this is not directly related to PTSD symptoms in particular.

Those are things like diabetes, hearing loss, medication related erectile dysfunction, loss of mobility, cognitive problems like attention and memory impairment. And then the bottom point here, the majority of veterans and their partners described the veterans’ history of alcohol and/or substance abuse as a use, whoops, as a use for self-medicating in a manner that exacerbated both PTSD and medical issues.

The presence of these symptoms was woven through their descriptions. We heard this again and again from partners and veterans. They described it in terms of conflict communication and overall relationships.

Moving on, slide thirteen I’m not going to spend a lot of time on the slides that outline the tensions in particular because I’d like to focus more on the examples that gave rise to these tensions.

Let’s move on to slide fourteen. Here are some examples of things we heard from veterans and partners in terms of disability. Let me read the first one. We heard from a partner, “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.”

So the partner there is saying he’s had all this medical and psychological struggle. I don’t want to get into our relationship problems with him. I don’t want to add to his plate.

Moving on to slide fifteen, let’s take a look at the second example here. Again this is with disability. “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 okay and on time.”

Now here is a partner describing how she’s attempting to care for the veteran and in terms of his disability, but that’s not really being taken up in the manner in which she hoped. So it can become an area for resentment. And we’re going to talk about that more in the other slides as well.

Let’s move on. Slide sixteen discusses the next area of tension and that’s around care giving itself. It’s a vicious cycle in which caring for the symptoms of PTSD is received, but it’s also experienced as a source of PTSD symptoms. So in that way the partner’s attempts to care
for the veteran can be both a support and a trigger for PTSD. We’ll see more about that as we go on.

Second point, in these couples care giving, normally a phenomena experience grounded and concern for the other has been transformed, is simultaneously a state of self-concern. What we mean by that is the partner’s care giving for the veteran in any, well in many couples care giving is the natural, normal part of the relationship and is something to be desired. However, for some of our partners they felt they had no choice but to care for the veteran, and in a way that was taking care of themselves, and their families and their relationship in a broader sense.

Moving on, reflecting the combination of a very high felt need to manage the veteran’s wellbeing, motivated by both empathy, concern for the other, and anxiety, concern for the self, and minimal information regarding PTSD resulted in being minimally effective at either supporting the veteran or managing their aggression. Partners expressed self-blame a sense of helplessness, incompetence and frustration.

Partners described poor self-care and overall sense of losing themselves in the relationship. So in terms of this area we saw many comments around helplessness, wishing they had more information about PTSD and really just not knowing how to respond.

Moving on, when discussing the volatile and sometimes violent behavior of the veterans partners expressed anxiety regarding his emotional state and a desire to avoid the triggers, but these descriptions were marked by self preservation. They were protective and defensive language rather than concern.

So let’s move on to slide seventeen. Again here are some of the tensions around care giving. I’ll not spend much time on that. Let’s talk about some of the examples, slide eighteen.

Care giving, the second comment here is quite telling. The partner here says, “Well, I also did them for me but, you know, I was secondary. And, that’s another thing. 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.” And by that she means PTSD. “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.”

Okay, moving on to slide nineteen, another good example of this care giving area, let’s talk about the first one here, care giving depends on a trigger. The veteran here says, “If she hits a trigger, like she sometimes, let’s see, when, when I have the feeling she’s nagging, when you get the feeling that she’s nagging, and then all of a sudden, it’s like bam, bam, bam. I can’t be specific, but it’s pretty much what happens.” So the veteran there is trying to describe how the partner is trying to care for him, but sometimes it hits a point that it feels like nagging and that becomes a trigger.

Let’s look at the third example on this page, slide nineteen. The partner says, “I try and figure out what triggered him. I come at it from a different direction.” So the partners are in a way hyper vigilant themselves. They’re always trying to figure out what the triggers are. They’re trying to figure out the best way to approach things with the veteran. And that demands a heck of a lot of energy.

Let’s move on to slide twenty. This is the third area of tension that we found: responsibility. Both veterans and partners tended to implicitly or explicitly speak of the partner as responsible for the veteran’s emotional state. This dynamic was most clearly expressed around the themes of triggers.
Partners tended to be acutely aware of, and frequently more articulate and detailed than the veterans themselves. Their descriptions reflected an experience of attending closely to the symptoms, states, and wellbeing of their veteran partner. So as I said a minute ago the partners were really doing everything they could to understand and stay on top of this.

Let’s move to slide twenty-two, so I’m going to skip slide twenty-one. We’ll look at some examples here for responsibility.

Let’s look at the first example where the partner says, “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. 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 get it before it gets really bad, but if I’m not there then there’s nothing I can do about it.”

And let’s look at the last example on this slide twenty-two. “So, and then after awhile I got to thinking, boy, I was really stupid. You know I felt stupid and humiliated, ashamed that I didn’t catch it, that I didn’t do something.” So this partner is expressing her lack of action or putting herself down for not understanding and not being able to respond.

Okay, moving to slide twenty-three let’s just continue to trauma slide twenty-four of the next area. I apologize for skipping so much, but I’m watching the clock.

The next area of tension is trauma. We heard from many of the veterans the sense of entitlement. It was like you owe me because of what I’ve been through. Actions as well impotence were justified in this way.

Weakness and vulnerability turned back so others had to deal with them. Again triggering we’ve talked about that a fair amount. Moving to the third point, veterans’ significant need for control and level of aggression was described as inducing neither empathy nor concern, but fear and anxiety on the part of the partners and family.

The fourth point, an awareness of the veteran’s capacity to harm, noted in reference to his size, his strength, or past history, military or previous IPV history, this created significant partner fear and anxiety. We’ll see a couple of examples about that in a minute.

The fifth point, assaults during sleep added to the knowledge that the veteran has killed, could harm either actively or passively. We spoke to many, many veterans and partners who discussed assaults during sleep or during nightmares. And we did not code that as active IPV in and of itself. However, that did add to the knowledge that the veteran had the capacity to harm and it was a very, very frightening event for both the veteran and his partner when that would happen during sleep.

And then the last point on this page, possession of weapons, now if you work with veterans I don’t have to tell you this is common, 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.

Okay, I’m going to move to slide twenty-six, some of the examples of trauma. I’d like to share with you the first two examples on this page. The first one, here’s a veteran that’s saying—he’s trying to describe his experience of trauma. He says, “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 wasn’t a pretty sight.”

Now reading between the lines of what this veteran said he’s describing going through triggering things so his PTSD symptoms were activated for whatever reason. He says he got the
thing for domestic violence. We can assume that refers to some kind of report or arrest. And then preclusion to it with my dad we did talk to them about their own family history of witnessing IPV growing up on the part of their parents. So he’s saying everything was going on for this veteran, the PTSD symptoms, the domestic violence, the family history. He says it was a perfect storm.

Let’s take a look at another example on this page, the second one. Here’s a partner and she says, “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?” In this statement the partner is really outlining how that knowledge of the veteran’s experience and the fact that he may have killed before what that does to a couple where they may be intimate partner violence.

Let’s take a look at one of our next categories. I’m going to skip through this very long example and let you read that on your own, slide twenty-seven, and move to slide twenty-eight which is communication.

This is the fifth of the six tensions, communication, PTSD symptoms, again emotional numbing, avoidance, need for control and depression. These are all impediments to communication as you can imagine.

Partners have to develop hypervigilance in the absence of communication. We had one partner talk about how she could actually smell his nightmares. She knew if he’d had a nightmare by the way he smelled. And that was her communication. She didn’t get it directly. She didn’t have the discussion. She had other cues that she read.

Partners may already know the secrets. The tension lies in disclosure. So the partner may already know something is going on, but for the couple the tension is in the disclosure and actually discussing what’s happening.

The third point, when describing their partners attempts to communicate or manage their triggers, the veterans tended to express annoyance or resentment at being controlled. Many described a diminished sense of self, being treated like a child, passivity or compliance. In this way, partner’s attempts to manage their veteran are themselves experienced as triggers. The partner was perceived as responsible for both the veteran’s emotional experience and their aggression or violence. We’ve talked about triggers a fair amount during this presentation, and as Dr. Gerlock said, these areas do all overlap one to the other.

And the fourth point here, 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 more powerful or assertive methods or style of relating. And what this means is sometimes the partner would feel compelled to become more assertive, to become more powerful when that may not be their previous mode of relating to the veteran or other people.

And then finally at the bottom of the page, both identified partners as highly talkative, expressive, communicating, initiating, and pursuing of connection. This was often framed as either complimentary to or compensatory for the veteran’s lack of communication. So again the partner is somewhat forced to change their way of engaging the world.

Let’s look at a few examples for this. I’m going to move to slide number thirty, examples for communication. Let’s look at the first example on this page from the partner.

And she says, “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.” So this poor partner is
pretty exasperated and this statement reflects many of the things we’ve covered so far, the disability, care giving responsibility, trauma, and communication. It’s all there.

If you look at the second point on this page the veteran says, “Well she’s heard more details when me and my buddies have been flapping our gums and she just happened to be overhearing what was going on.” Well this veteran is expressing, yeah, I don’t really tell her directly what’s going on with me, but she might overhear it.

Okay, I want to move to slide thirty-one. One more example for communication is the third one on this page where the veteran says 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.”

So the veteran here is expressing how he’s aware of what’s going on in the relationship. He’s aware of the problems, but yet he—there’s a blockage there. There’s a blockage in communication and in becoming a couple again with the partner.

All right, let’s look at the sixth of the six tensions. Slide number thirty-two is community. That is the last of the six tensions we found.

Community, this lack of effective inter-relating was worsened by the veteran’s military experience and culture in which secrecy and security is valued and sometimes necessary. There is a strong sense of distinction between soldiers and civilians, leading to a sense that partners cannot understand. So for many of the partners unfortunately they fell into the civilian camp. And it was kind of an us and them mentality and communication and in becoming a couple again with the partner.

Second point we found this interesting that some of the veterans talked about their service dogs and how the dogs were really liked and allowed to help and protect, whereas some of the partners were resented for doing those things. And the service dog got to succeed at what the wife was punished for.

The third point, hypervigilance, motivated by caring or love and/or by pathological fear, self-protectiveness, and the last point on this page, partners spoke of how connections with other veterans were an important part, not only of PTSD awareness but also a vital support system for the veteran. Yes, we heard again and again from partners how that connection with other veterans was so critically important both to them and to their veterans.

Let’s look at a couple examples of community. I’m going to move to slide thirty-four. Let’s look at the first example here. So this is a veteran and he’s talking about how he has escaped through work. He said, “A lot of it was job related, because I was working. It was nothing to put in a 90 hour work 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 just became just intolerable for her.”

Okay, let’s look at slide thirty-four and the second example on this slide. Here’s a partner who says, “I couldn’t even go to the grocery store by myself. 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?” So the partner in this situation her own social activity became curtailed through this difficulty interacting with the community.

All right, I am through the six tensions and now I’m going to turn it back over to Dr. Gerlock who’s going to talk for a few minutes about some implications for treatments.

April Gerlock: Yes. We’re on slide number thirty-six and we’re going to take a few minutes just to finish up with this so that we’ll have some time for comments and questions.

What you’ll see on slide thirty-six is a triangle. And we call it the triangle of healing, but it just picks up the themes that Dr. Grimesey was talking about in terms of what the veterans and their wives and partners talked about in terms of what was helpful for both the veterans seeking help from the VA as well as staying with the VA or working with as wife, partner and other vets in the community and getting that help.

And as you can see the wife and partner was identified as very important. The veteran and wife also identified VA staff were very important in that, as well as other veterans and the community in general in terms of the support that vets and other communities gave in helping support these veterans getting help.

Moving on to slide thirty-seven we have some comments here about what the veterans and the wives talked about in terms of PTSD treatment and healing. And I’m just going to go through these because I think those of you who are listening who are treatment providers in PTSD settings may be interested in this.

Treatment that effectively addressed PTSD and related symptoms and/or alcohol abuse was identified as helpful in several of the couples, especially around overt physical violence, but not in regard to ongoing IPV patterns. Some of those threats that we heard Jackie talking about some of the intimidation, that sort of thing didn’t seem to target that. And while several of the participants talked about being in some form of anger management or even DV treatment, none of them spoke of it in detail or attributed any specific behavioral change to it.

The veterans who had more open communication with their partners regarding the Post-Traumatic Stress Disorder and their emotional state experienced less relational distress. And that’s part of that mutuality that we were talking about in terms of the back and forth communication between the veteran and his partner.

And then the partner’s involvement in veteran’s treatment as a couple is also described as very beneficial. Some of those examples that were given by some of the partners where they felt really left out or they felt as though they didn’t know what was going on that getting more involved in the veteran’s care and more included by the VA was something that was helpful.

Partners in the less distressed couples expressed having created boundaries and communicated with the veteran about the effects of PTSD that it was having on them. So and these partners they had created boundaries for themselves about themselves. They communicated with the veteran about what the impact of his PTSD symptoms were having on them. They often spoke in terms of we, so they talked about themselves as a couple when describing both conflict, support and resolution.

And partners spoke of how connections with other veterans were an important part of not only PTSD awareness, but also an important part of a vital support system. Okay, slide thirty-eight.

Here are just some examples and I’ll maybe I’ll just pick a couple of these. The first one is a partner is talking about it. She says, “I think that the healing didn’t really start to take a
deeper road until he started coming to the VA and doing the work with other veterans. That was really a huge shift. I can’t emphasize how much that changed him.”

And then I think I’ll go to the last one where this partner is talking about how she approached this with her husband or partner. She said, “You need help. But he was so much in denial where he doesn’t want to get help. And he’s telling me, ‘Don’t get me in trouble because I’m you know I’m not doing anything you know.’ He felt like he was crying for help. He felt he was crying for help- that crying for help was trouble for him.”

Okay, let’s go to the next slide, number thirty-nine. This is a very, very long one, but it’s a wonderful description and I’m hoping that you all will take some time just to read through this as this wife talks about the struggle she went with, with her husband in trying to get him engaged in PTSD treatment.

Moving on to slide forty you have our contact information in case you have questions or would like to get in touch with us. And I think the rest of the slides are the references for the presentation today. And now we can take some time for questions and comments.

Moderator: Excellent. Thank you both very much. For those of you that joined us after the top of the hour and are trying to figure out how to submit a question or a comment just go to your go to webinar panel on the right hand side of your screen. You’ll see a plus sign next to the word questions. Just go ahead and click that to expand the box and then you can type your question or comment into the bottom box and press send. And we’ll happily pass it along to the presenters.

We do have a couple of questions that have come in thus far, the first one. Did participants self-identify as involved in IPV? If not how did you identify them?

April Gerlock: Yes, actually both partners and veterans. And this speaks to a little bit of the methodology that we used in identifying IPV. We did individual interviews with both the veteran and the wife or partners separately.

It was a protocoled interview that asked about relationship behaviors including how they handle conflict as well as whether there was any physical violence or psychological abuse. Both the veteran and the wife or partner was asked these questions.

In addition they were given a questionnaire called the abusive behavior inventory, which had the veteran self-identify any physical violence or psychological abuse that he had been using in this relationship. We also gave one to the wife or partner where she identified any physical violence or psychological abuse that he had acted against her.

And this was one of the most stable and coherent variables that we had and that our couples, the percentage of reported of them, whether there was physical violence in this relationship or previous relationships, was very close and very consistent for the veteran both in the current relationship as well as in a past relationship. So it was from four different methods of capturing that data. And if anybody, either the veteran or the partner identified it we identified it as IPV yes.

If there was any doubt and there were some couples where we had some question about who’s the primary aggressor and whether there was intimate partner violence or not, all of us in the study team listened to the digitally recorded interviews and all came to a consensus decision around whether the couple was IPV yes or no.

Moderator: Excellent. Thank you. We do have a request to back up to that last slide that had the very long quote on it if you could do that.
April Gerlock: Okay. Let’s see. Can we still do—okay, hang on just a minute.

Moderator: And no problem. Take your time.

April Gerlock: We just to get out of the other screen, okay.

Moderator: There you go.

April Gerlock: That would be slide thirty-nine for those of you who just have the slides.

Moderator: Great. Thank you. And let’s see the next question; are there plans to attempt this study with female veterans and their spouses or with any sex veteran and their children?

April Gerlock: We have a number of researchers out there in the VA who are doing this type of research and working with women veterans. And some of these elements I believe are going to be picked up and by some other researchers. And we’re hoping that we may also have some more analysis of this particular data set from VA researchers coming out of the VA in maybe the next couple of years or so. So I think the question is that it’s something that is under development by a number of people right now.

Moderator: Great. Thank you for that question. The next one, are you seeing any differences when the coupleship both individuals are veterans and have been deployed compared to just one individual in the coupleship being a veteran?

April Gerlock: That’s a really good question because the whole issue of when the wife/partner was also a veteran emerged in this study because the wife/partner may be dealing with her own PTSD symptoms secondary possibly to a war zone deployment or military sexual trauma. The largest sample in our study was Vietnam veterans and so a number of these Vietnam veterans are married to women who were also Vietnam veterans.

And so we had some couples that were dually deployed. They both had been deployed to a war zone. We did not analyze that as a separate thing or as a point of analysis, although I also know of some other research that is out there in the Army that is going to be looking at dually deployed couples, so hopefully you all have some information coming soon on that as well.

Moderator: Thank you. The next question we have, are you seeing any differences, oh, I’m sorry. Were any of your couples court involved? And if so could you describe anything about the court that was either helpful or harmful?

April Gerlock: Well that’s a good question as well. We had a number of the veterans who had been court involved. And I’m not sure that any of them were currently while they were in this study were currently court involved.

I just know that from my previous research looking at veterans in active duty military who were in treatment for batterers intervention treatment and who also had, some of them had Post-Traumatic Stress Disorder that the court involvement in terms of the responding to probation and responding to court, having to report monthly in terms of how they’re doing and
having reports go into the court was one of the significant variables in terms of keeping the veterans as well as the service members in battered intervention. Now that was from a previous study. It was not a focus of this particular study and so we don’t know how it presented for this particular sample.

Moderator: Thank you for that response. The next question we have, what was the percentage of the veterans sampled who were identified as receiving domestic violence counseling?

April Gerlock: I don’t think I could answer that right now. Jackie, do you know?

Jackie Grimesey: Yeah. I am not able to answer it off the top of our head. However, we did capture that data. If the person would like to email us that question I’d be happy to respond to that. It was a small number though I can tell you just from my recollection.

Moderator: Thank you. The next question, where can I access the abuse behavior inventory?

April Gerlock: Why don’t you email me? I can let you know where you can access that. It’s an abusive behavior inventory is an instrument that has—it’s a both an identified perpetrators does a self-evaluation of their physical and psychological abuse and then an identified victim of IPV, also does an evaluation of the level of violence of psychological abuse perpetrators to them. So why don’t whoever asked that question just go ahead and email me and I can give you access to that information.

Moderator: Thank you. Maybe this would be a good time to scroll back down to the contact page. Great, thanks. Well that is the final question that was written in. We’ll give people another minute or two to submit any last minute questions. And here comes one now. Were there specific questions asked about other treatments such as domestic violence treatment?

April Gerlock: Yes. We asked both about domestic violence treatment as well as anger management whether the veteran had been in anger management classes and whether the veteran had attended any domestic violence treatment. We have that data. We just don’t have it available here to present today.

Moderator: Thank you for that.

April Gerlock: We can ask—email Jackie on that.

Moderator: Sounds great.

Jackie Grimesey: I just make a comment.

Moderator: Mm-hm.

Jackie Grimesey: I was saying, this is Jackie. And I’d just like to say how grateful we are to the veterans and partners who participated in this study who were so forthcoming in discussing their relationship with us in great detail. It was really amazing to see how open they were and how
willing they were to discuss the relationship when they were asked in a respectful and direct way.

And also I’d like to thank the clinic providers who helped us connect with the veterans who were in our study. Without those providers this study would not have been successful as it was. Thank you.

Moderator: Thank you for those comments. We are getting some comments rolling in. Well done webinar I thank you very much, great presentation. So there is a lot of appreciation for this research being done.

And we also do have one more, or I’m sorry, two more questions that have come in. The first one, do you think there will be significant changes with only OIF, OEF, OND predominant groups since the Vietnam era was when marriage was valued more?

April Gerlock: I don’t know. I’m not really sure how to answer that question based on this research. Obviously our research here spanned from young couples who some of them were married. I would say that most of the couples in this study were married. They were the largest samples were of married couples.

And some of the veterans had been married multiple times. And those were Vietnam veterans and veterans from other conflict areas. So I don’t really know how to answer that based on this research. Sorry that I can’t give you a very coherent answer for that. Can you, Jackie?

Jackie Grimesey: Well I would just have to point out how some of the dynamics are going to change between the groups. Some of the Vietnam veterans were not in a relationship or married when they were deployed. However, today we see many young families where the soldier is going off to deployment and then returning.

So we’re going to see some changes. I don’t know that we can tell you what those will be yet, but the nature of the family and the veteran and deployment that is all changing. So hopefully more researchers will pick this up and continue to look at it.

Moderator: Excellent. Thank you. We do have more questions that have come in. Okay, do you think your findings apply to active duty families as well?

April Gerlock: Yes. Remember our second largest group, though the Vietnam vets were the largest group, but the second largest group were OIF, OEF. So we had a pretty good number of veterans who were deploying to Iraq and Afghanistan during when this study was conducted. And so they were, and many of them were National Guard and reservists.

So they were shifting from active duty status to civilians, back to their civilian jobs and in and out. And we captured them as they were transitioning sometimes from they had just recently been activated in active duty and now they were a civilian again. And some of them then got activated again.

So I think that there’s certain elements of the study that absolutely resonate for active duty military as well, especially around the issues around the couples handling things like post-deployment issues, talking about war zone or conflict zone experiences, handling the residuals of having been deployed, whether there’s mental health issues or physical issues, and how they as a couple work in managing handling those symptoms and accessing care.
Moderator: Great. Thank you. You did just briefly touch on this, but maybe you could specify what branch was the largest, Army, National Guard, et cetera.

April Gerlock: Army was our largest group. We had representation from all branches of the service, Army, Marine Corps, Navy, Air Force, Coast Guard. And our largest group was the Army, I think followed by Marine Corps.

Moderator: Thank you. You discussed briefly some people that had service dogs. Did service dogs make things better or worse for those with PTSD?

Jackie Grimesey: Oh well again we didn’t focus on that point in particular. It was just a comment that we picked up as interesting in those veterans who did have service dogs talked about them in very, very high terms. So I could speculate I suppose. My speculation would be that it’s helped a great deal, but there are people doing research on service dogs. And I would encourage you to take a look at what they are finding.

Moderator: Great. Thank you. Well that was the final question. Would either of you like to give any concluding comments or final thoughts?

April Gerlock: I just want to thank everyone for joining us again today. And if you haven’t -if you weren’t able to join us in November, I don’t know if the quantitative is still available. Is that still one the people can access?

Moderator: Yes. It is posted on our website archive catalogue so they can just go to the HSR&D webpage and then look to the left navigation bar.

April Gerlock: Okay. And so anyone who is interested in hearing some of the quantitative findings go ahead and access that from November, but otherwise thank you very much and appreciate those of you who called in.

Jackie Grimesey: Thank you very much.

Moderator: Thank you both for presenting for us. We did have a large group join us today and lots of positive comments already coming back in. So we appreciate you taking the time and thank you to all of our attendees for joining us. And this does formally conclude today’s HSR&D cyberseminar. Have a nice day.

[End of Recording]