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The Effect of Combat-Related Posttraumatic Stress Disorder on the Family

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THIS paper reviews literature on the detrimental effect of combat-related posttraumatic stress disorder on the family. The literature indicates that guilt feelings, emotional withdrawal and elevated levels of aggression in the returning veteran make it difficult, perhaps even impossible, for him to fully resume his former roles of father, husband and breadwinner. Wives and children of veterans show psychiatric symptoms. Despite these hardships, the families are generally reluctant to seek professional help. The clinical implications are discussed and suggestions are made for intervention and outreach.

A considerable body of research has demonstrated increased psychopathology in combatants following participation in battle (e.g., Grinker and Spiegel 1945; Stauffer et al. 1949; Titchener and Ross 1974; Mullins and Glass 1973). Such war-related stresses may of course have a detrimental effect on general health and social functioning (Kardiner 1941; Kardiner and Spiegel 1947). In addition to the immediate effects observed on the battlefield, delayed effects can appear at any later point. Battle stress, in and of itself, can produce severe disturbances regardless of predisposition. It can also unmask latent disease processes in vulnerable individuals (Solomon et al. 1985). Posttraumatic stress disorders are both of high prevalence and of long duration. Many veterans are left with severe emotional scars and are disturbed by stress residues for long periods following battle (Figley 1978; Solomon et al. 1985).

The psychological problems of veterans also affect their families. The war-related emotional disorders from which veterans suffer put pressure on family relationships and may cause family disintegration and exacerbation of family members' emotional problems (Hogancamp and Figley 1983). Yet in contrast to the many studies that have investigated posttraumatic disorders in veterans, little attention has been paid to the disorders' potentially detrimental effects on veterans' families.

The toll of war on women and children is immense, but while families of prisoners of war have received considerable attention and recognition of their problems, families of veterans, including veterans suffering from combat-related psychopathology, have been consistently overlooked (Hogancamp and Figley 1983). This paper will attempt to fill in some of the gaps. Specifically, it will review the nature of combat stress and its impact on the family and will discuss possible clinical implications.

Stresses of Combat

Participation in combat exposes a soldier to a surfeit of stress, the worst of which is undoubtedly the palpable risk of

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injury or death. Other combat-related stresses include the loss of friends, and significant physical discomfort due to lack of sleep, food or water or to extremes of temperature. Ghastly scenes of injury and exposure to death are commonly accompanied by feelings of loneliness, lack of social support and lack of privacy (Stauffer et al. 1949).

Combat stress can produce both acute and chronic reactions characterized by psychological and somatic pathology. The two most common and conspicuous manifestations of combat psychopathology are combat stress reaction (CSR) and posttraumatic stress disorder (PTSD). As used in this paper, CSR refers to reactions occurring during or shortly after battle; PTSD refers to stress reactions after the war has ended. CSR is characterized by labile polymorphic manifestations, such as overwhelming anxiety or total withdrawal, resulting in marked polarization of behavior and impaired functioning (Kardiner and Spiegel 1947). The enduring symptoms of PTSD entail considerable suffering, such as recurrent intrusive recollections of the traumatic events, recurrent related dreams, and sudden acting or feeling as if the traumatic events were happening again. Additional disturbing symptoms include hyperalertness, sleep disturbance, survivor guilt, and memory or concentration difficulties. The suffering individual is unable to control these painful experiences. Intensification of PTSD symptoms as a result of exposure to later events that symbolize the trauma is often observed (American Psychiatric Association 1980). Mundane stimuli such as sonic booms, sudden loud noises or the color red deeply affect many veterans and lead to avoidance and severe restriction of activity.

Combat-related trauma is often described as a multistaged process (Kardiner and Spiegel 1947; Titchener and Ross 1974). Initially, when the individual is faced with extreme threat and feels unable to marshal effective means for coping with it, CSR is aroused. Later, with the alleviation of the actual threat, emotional balance is restored in some cases while in others profound and prolonged sequelae in the form of PTSD ensue. Sometimes there is no recognizable emotional damage during or immediately after combat, but delayed PTSD may appear at any later time.

The Family in Wartime

The pressures of war are not restricted to the combatants, however. Families left in the rear also are exposed to severe stress. In many countries at war, the risk of death or injury in the civilian population is very real. Even when there is no immediate danger to civilians, family members have good reason to be extremely worried about their loved one on the front. Is he dead? injured? missing in action? taken prisoner? Such uncertainty leads to a reluctant but inevitable anticipation of loss (e.g., McCubbin et al. 1976). The family's anxiety is exacerbated by media coverage, which with technological developments has become increasingly extensive with every war (Solomon et al. 1985). Yet, while it is inundated with general information of a most frightening kind, the family has no direct communication with the soldier on the front and usually does not even know where he is. The result is that the mood of family members tends to oscillate rapidly and erratically between hope and despair.

Another major source of stress is the fact that while the husband/father is on the front, the family necessarily undergoes changes. Roles shift to compensate for the missing member (McCubbin et al. 1976). The mother tends to take upon herself both parental roles. The children tend to assume more responsibilities. Moreover, the typical pressures of family life are often increased by the absence of the husband and father (Hill 1949).

In short, wartime is a period in which the family is required to cope with vastly increased stresses. Furthermore, these difficulties do not end when the war is over and the man of the family returns.

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Homecoming and Reintegration

When the soldier returns home, he enters a household that has changed in order to accommodate his absence. Inevitable tensions arise as the family members negotiate the redistribution of roles and responsibilities (Hogancamp and Figley 1983). For example, the husband may find that his wife has become more independent and assertive and has replaced him as the head of the household. His attempts to reassume his former role may well lead to marital conflict (McCubbin et al. 1974). In many cases the wife may be reluctant to return to her former position (Hill 1949). At the same time, there may be pressure on the veteran to quickly resume his former responsibilities to his family, including the responsibility of providing economic support. These conflicts take place within a short period. There is little spare time for the veteran to decompress and digest his war experiences. The time pressure exacerbates the other tensions. To complicate matters, the returning veteran often feels that his wife and children do not understand what he experienced during the war, while they in turn consciously or unconsciously feel angry with the veteran for deserting them at a time when they most needed him. The resultant anger and resentment is apparent on both sides.

PTSD and the Family

Of the host of PTSD symptoms, those that have direct negative effects on social relations are particularly significant for the veterans' families. These symptoms include numbing of responsiveness and reduced involvement with the external world, as seen by diminished interest in significant activities, feelings of detachment or alienation, and constricted affect. These symptoms make it very difficult for veterans to fully reintegrate themselves into society (Figley 1978).

Especially problematic is the task of resuming the more demanding and intimate social roles of husband and father. Polner (1971), in a study based on interviews with veterans' families, reports that family members perceived significant impairments in the veterans' emotional stability. In a study of 200 Vietnam veterans who received treatment, Lumry et al. (1970) found that a high percentage of their sample suffered from severe interpersonal problems, especially in their marital relationships. Haley (1974, 1978), from her extensive clinical experience with Vietnam veterans, concludes that veterans who continue to mourn the death of close friends or who suffer survivor guilt are often unable to become involved in or maintain close personal relationships. Lifton (1973) and Figley (1976) reach similar conclusions about Vietnam veterans.

Difficulties veterans have in maintaining intimate relationships with their wives may often be compounded by sexual problems. The veterans' sexual drive is frequently diminished, with a resulting drastic curtailment of sexual activity (Haley 1978). Wives, in turn, may feel rejected and unloved and may suffer frustration (Williams 1980).

The veteran's elevated levels of hostility, too, can have severe psychological repercussions on his wife and children. Haley (1974) has found that combat veterans, especially those who were involved in atrocities, suffer from guilt and fear over their violent impulses. By the same token, Horowitz and Solomon (1978) suggest that as guilt-provoking as the violence is, many veterans have learned to regard violence as a viable and often pleasurable solution to problems. Conflicts between aggressive impulses and the attempt to control them may affect the veteran's functioning as both father and husband.

Fatherhood may overtax the veteran's ability to resolve this conflict, as many points of the child's development impinge on it. The natural exuberance and aggres-

siveness of a growing child, especially a son, may reawaken memories of wartime aggression and provoke excessive rage or guilt over sadistic impulses. The veteran's attempts to control his child's aggressiveness may be out of proportion (Haley 1975). The intensification of conflicts over aggression that are brought about by combat experience hinders the veteran's ability to create an atmosphere that fosters the growth and proper development of his children.

The veteran's elevated level of anger and his increased susceptibility to acting on it may also result in violent outbursts toward his wife. In a study of wives of veterans, Williams (1980) found that 50% of the veteran couples who sought professional help with her reported wife-battering. The battering behavior, however, did not conform to the usual pattern. In most cases, battering is a vicious circle that is not easily broken. In veteran families, in contrast, there were usually one or two extremely violent, frightening episodes, which were not repeated and were followed by the couple's seeking professional help. This difference in behavior indicates that wife-battering in veterans' families has a motivation and dynamic of its own, apparently linked to the veteran's combat experience.

In wars that involve guerrilla activity, such as the Vietnam War and the 1982 Lebanon War, the enemy can be anyone, including children. A veteran who has engaged in actions against women and children may find the transition to the role of husband/father particularly difficult. Clinical observations demonstrate that intimacy with a woman, the birth of a child, and the more common fatherly chore of comforting a crying child may all increase stress in such veterans (Haley 1978; Christenson et al. 1981). These and other symbolic representations of the veteran's wartime aggression may lead to a further reduction of his involvement with his family, especially the amount of child care in which he participates. A married man who suffers from war-related PTSD is unlikely to engage in affectionate, supportive relationships or to fulfill his responsibilities toward his family.

Children of veterans pay a high personal price for their father's PTSD. Rosenheck and Nathan (1985) coined the term "secondary traumatization" to describe the strong transgenerational effects of the syndrome. As a consequence of intimate exposure to their father's rage, depression, guilt and general affective dyscontrol, children of PTSD veterans experience "considerable distress, depression and self-doubts," plus guilt and uncontrolled rage. Some of them have been found to act out violent war-related schemes, such as getting into fights, in order to prove that they would be able to survive the kinds of trials their fathers had come through. Veterans' wives who seek professional help often complain that their husbands returned home "changed men" (Tarsh and Roystone 1985). These changes not only have a direct impact on the quality of the marriage but frequently result in its break-up. The Center for Policy Research (1979) indicates that the divorce rate among Vietnam veterans is higher than that of the rest of the U.S. population, while the President's Commission on Mental Health (1978) presents figures showing that 38% of the marriages of Vietnam veterans broke up within 6 months of their return from Southeast Asia.

Where the marriage does hold together, the wife's well-being may be sacrificed in the process. Instead of the husband and the family rapidly resuming their prewar mode of functioning, as the family members all expect, the veteran's condition forces a redistribution of roles and the redivision of labor. Where the husband suffers from PTSD, the wife takes on all or almost all of the responsibility for child care, for maintaining the psychological well-being of her husband and children and, often enough, for the family finances as well. The wife is required to make drastic changes to adjust to her new situation, and so are the children.

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husband's PTSD, yet she feels responsible for his well-being. The result is that she may well find herself caught in an extremely frustrating "compassion trap," in which she sacrifices too many of her own needs for the rest of the family. Her self-sacrifice leads to a build-up of frustration and strong aggressive feelings. Clinical evidence suggests that women tend to find it difficult to express their aggression overtly (Bar-Tur 1977). In this situation expression is especially difficult because it clashes with internalized social expectations of the gratitude and compassion due to men who sacrificed themselves for their country, particularly if the veteran is a close relative. The only solution open to the wife is to displace her aggressive feelings from her husband to a less threatening target – her children or herself. In the latter instance, the wife's aggression takes the form of depression and guilt feelings. Although no systemic investigation has been published, clinical observations show that the wives of veterans with PTSD tend to suffer from guilt, anger, alienation and mistrust – symptoms that are similar to their husbands' (Williams 1980).

The distress of veterans' families is especially striking in a country such as Israel, where the army is generally respected and viewed as a necessary tool for survival. In such cases, the society consciously feels in debt to those wounded in action. These attitudes impose a heavy burden on the already distressed women and children. The women are expected to carry the burden, sacrificing many of their own needs, without sharing their conflicts with others. The children are torn between loyalty to their father and anger at having been emotionally and physically abused (Rosenheck and Nathan 1985). Such binds can have devastating consequences, including lowered self-esteem, loss of identity, demoralization, severe depression and child abuse. Because large segments of society participate in war, these detrimental sequelae may have a disintegrating effect on the entire social fabric.

Clinical Implications

Armies and veterans' administrators generally take responsibility for their injured soldiers. They usually ignore the considerable hardships of the wives and children of their psychiatric casualties. Yet it seems quite clear that it is really impossible to properly address the PTSD of veterans in isolation from their families. The husband's disorder starts a vicious circle, creating disturbances in his wife and children, which in turn may augment his own illness. Such an intertwined complex of problems cannot be solved by intervention focused only on the PTSD casualty himself. What is needed is a series of activities, which include psychotherapy for the veteran, help for his family, involvement of his social network, and changes in the attitudes of the society at large toward PTSD.

To be effective, family intervention should be adapted to the specific nature and needs of every family where PTSD is a problem. Because of the many problems of the wives in such families, Williams (1980) suggests initially treating the wives separately and then involving the couples in group therapy at a later stage. However, given the very large variety of family interactions – from enmeshed families to disengaged ones – it seems inappropriate to prescribe the same treatment mode or sequence for each.

Nor is it enough simply to wait for PTSD veterans and their families to show up at a clinician's office or mental health clinic. Despite their very real hardships, they are notably reluctant to seek or accept psychological help. Research on combat veterans found a high prevalence of untreated PTSD (Solomon et al. 1987; Solomon 1987; Kadushin 1985). In Israel, soldiers who had diagnosable PTSD and who could have received treatment free of charge simply did not ask for it. Similarly, Fried (1985), who attempted to organize therapy groups for wives of veterans with combat-related PTSD, reported that the women were reluctant to participate. The women described a process of social con-

striction that isolated their families from extended family, friends and helping institutions alike. The process would start with the veterans suffering from PTSD feeling ashamed of what they considered their weakness or cowardice and preferring not to expose their discomforts. Soon enough the embarrassment would affect the wife as well, and the family became a tightly closed off, somewhat fortified unit. This isolation both intensifies the problems of the family and contributes to its unwillingness to seek help. Clinical impressions (Hogancamp and Figley 1983) suggest that for all its suffering, the family fears that any change would simply lead to further trauma. Tarsh and Roystone (1985), in their work with families of people who contracted PTSD as a result of accidents, found that many of these families believed that only a miracle could save them.

All planning of clinical intervention for families of PTSD casualties should surely take into account both the problems of such families and their attitudes toward the illness, themselves and the social establishment. An attempt must be made to change these features of the PTSD family that prevent help-seeking. Outreach services for the veteran and his family would seem an essential first step. Information on PTSD—its symptoms, prevalence, impact on the family—should be made available to veterans and to the public at large, both to facilitate the identification of the illness and to eliminate any stigma. Moreover, the veteran's natural social network, friends, companions at work and relatives should be activated on his behalf. In short, PTSD should be taken out of the closet. People should be made aware of what it is and of the contribution they can make toward the recovery of any of their family and friends who have it.

REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. *Diagnostic and Statistical Manual of Mental Disorders (DSM-III).* APA, 1980.

BAR-TUR, L. *Aggression and Guilt Feelings of Wives of Veterans of the I.D.F. Who Are Physically Disabled.* MA thesis, Tel-Aviv University, 1977.

CENTER FOR POLICY RESEARCH. *The Adjustment of Vietnam Veterans to Civilian Life.* New York: Center for Policy Research, 1979.

CHRISTENSON, R. N., WALKER, J. I., ROSS, D. R., and MALTBIE, A. A. Reactivation of traumatic conflicts. *American Journal of Psychiatry* (1981) 138: 984-85.

FIGLEY, C. R. Combat-related stress disorders: Family therapy implications. Presented at annual meeting, Association of Marriage and Family Counselors, Philadelphia, October 1976.

FIGLEY, C. R. Psychosocial adjustment among Vietnam veterans: An overview of the research. In C. R. Figley, ed., *Stress Disorders Among Vietnam Veterans: Theory, Research and Treatment.* Brunner/Mazel, 1978.

FRIED, B. Family therapy for wives of combat stress reaction casualties of the 1982 Lebanon War. Fieldwork report presented to School of Social Work, Tel Aviv University, July 1985.

GRINKER, R. R., and SPIEGEL, J. P. *Men Under Stress.* Blakiston, 1945.

HALEY, S. A. When the patient reports atrocities. *Archives of General Psychiatry* (1974) 30:191-96.

HALEY, S. A. The Vietnam veteran and his preschool child: Child rearing as a delayed stress in combat veterans. Presented at American Orthopsychiatric Association, Washington DC, March 1975.

HALEY, S. A. Treatment implications of post-combat stress response syndromes for mental health professionals. In C. R. Figley, ed., *Stress Disorders Among Vietnam Veterans: Theory, Research and Treatment.* Brunner/Mazel, 1978.

HILL, R. *Families Under Stress: Adjustment to the Crisis of Separation and Reunion.* Harper, 1949.

HOGANCAMP, V. E., and FIGLEY, C. R. War: Bringing the battle home. In C. R. Figley and H. I. McCubbin, eds., *Stress and the Family.* Vol. 2, *Coping with Catastrophe.* Brunner/Mazel, 1983.

HOROWITZ, M. J., and SOLOMON, G. F. Delayed stress response syndromes in Vietnam veterans. In C. R. Figley, ed., *Stress Disorders Among Vietnam Veterans: Theory, Research and Treatment.* Brunner/Mazel, 1978.

KADUSHIN, C. Social networks, helping networks, and Viet Nam veterans. In S. M. Sonnenberg, A. S. Blank, Jr., and J. A. Talbott, eds., *The Trauma of War: Stress and Recovery in Viet Nam Veterans.* American Psychiatric Press, 1985.

KARDINER, A. *Traumatic Neurosis of War.* Hoeber, 1941.

KARDINER, A., and SPIEGEL, H. *War Stress and Neurotic Illness.* Hoeber, 1947.

LIFTON, R. J. *Hom*
1973.

LUMRY, G. K., CE
BRAATZ, G. A.
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Veterans Admi
Psychiatry, Hou

MCCUBBIN, H. I.,
Family Separat
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nion. Harper, 1949.
C. R. War: Bringing
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amily. Vol. 2, *Coping*
Mazel, 1983.
N. G. F. Delayed stress
ıam veterans. In C. R.
Among Vietnam Vet-
Treatment. Brunner/

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S. M. Sonnenberg, A.
ott, eds., *The Trauma*
in Viet Nam Veterans.
1985.
rosis of War. Hoeber,

War Stress and Neu-

LIFTON, R. J. *Home from the War.* Simon & Schuster, 1973.

LUMRY, G. K., CEDARLEAF, C. B., WRIGHT, M. S., and BRAATZ, G. A. A further look at the Vietnam-era veteran. Presented at 15th Annual Conference, Veterans Administration Cooperative Studies in Psychiatry, Houston, April 1970.

MCCUBBIN, H. I., DAHL, B. B., METERS, P., et al., eds. *Family Separation and Reunion: Families of Prisoners of War and Servicemen Missing in Action.* U.S. Government Printing Office (D-206.21:74-70), 1974.

MCCUBBIN, H. I., DAHL, B. B., LESTER, G., et al. Coping repertoires of families adapting to prolonged war-induced separation. *Journal of Marriage and the Family* (1976) 38:461-71.

MULLINS, W. S., and GLASS, A. J., eds. *Neuropsychiatry in World War II.* Vol. 2, *Overseas Theaters.* Medical Department, U.S. Army, 1973.

POLNER, M. *No Victory Parades.* Holt, Rinehart & Winston, 1971.

PRESIDENT'S COMMISSION ON MENTAL HEALTH. *Report to the President.* Vol. 3, *Mental Health Problems of Vietnam-era Veterans.* U.S. Government Printing Office, 1978.

ROSENHECK, R., and NATHAN, P. Secondary traumatization in the children of Vietnam veterans with posttraumatic stress disorder. *Hospital and Community Psychiatry* (1985) 36:538-39.

SOLOMON, Z. Combat-related posttraumatic stress disorder among Israeli soldiers – a two-year follow-up. *Bulletin of the Menninger Clinic* (1987) 51:80-95.

SOLOMON, Z., SCHWARZWALD, J., and WEISENBERG, M. *Mental Health Sequelae Among Israeli Soldiers in the 1982 Lebanon War.* Medical Corps, Department of Mental Health, Israel Defense Forces, 1985.

SOLOMON, Z., WEISENBERG, M., SCHWARZWALD, J., and MIKULINCER, M. Posttraumatic stress disorder among frontline soldiers with combat stress reaction: The 1982 Israeli experience. *American Journal of Psychiatry* (1987) 144:448-54.

STAUFFER, S. A., LUMSDAINE, A. A., LUMSDAINE, N. H., et al. *The American Soldier.* Vol. 3, *Combat and Its Aftermath.* Princeton University Press, 1949.

TARSH, M. J., and ROYSTONE, C. A follow-up study of accident neurosis. *British Journal of Psychiatry* (1985) 146:18-25.

TITCHENER, J. L., and ROSS, W. D. Acute or chronic stress as determinants of behavior, character and neuroses. In S. Arieti and E. B. Brody, eds., *American Handbook of Psychiatry.* Vol. 3, *Adult Clinical Psychiatry.* Basic Books, 1974.

WILLIAMS, C. M. The veteran system – With a focus on woman partners: Theoretical considerations, problems and treatment strategies. In T. Williams, ed., *Post Traumatic Stress Disorders of Vietnam Veterans.* Cincinnati: Disabled American Veterans, 1980.