

# The Aftermath of Combat-Related PTSD

## Toward an Understanding of Transgenerational Trauma

Melissa Pearrow

Lisa Cosgrove

*University of Massachusetts, Boston*

The number of military personnel who are involved in combat situations continues to increase. As a result, researchers have identified risk factors associated with the development of combat-related posttraumatic stress disorder (PTSD). The authors of this article review some of the characteristics of military personnel involved in these conflicts, factors unique to the current military actions, and symptom presentation and prevalence rates of PTSD among those serving in Iraq and Afghanistan. They discuss mechanisms for the transgenerational transmission of trauma symptoms and identify strategies for interventions.

**Keywords:** *post-traumatic stress disorder; transgenerational trauma; veterans with PTSD*

Veterans who have returned from combat have been exposed to extreme circumstances that can have a profound impact on family functioning. Veterans' exposure to heightened levels of stress—resulting from combat and associated threatening and catastrophic events—can markedly disrupt their functioning, not only while on the front lines but also upon their reentry into civilian life. Exposure to combat can lead to excessive anxiety and disabling symptoms that present not only in the veteran but that can be transmitted to persons close to him or her such as partners, children, and friends. It is critical for school-based service providers to become aware of the transmission of trauma because the available statistics clearly demonstrate that the number of individuals affected by combat-related stress is on the rise. As of mid-2008, there were more than 1.3 million men and women on active duty and another 1.1 million serving in the National Guard and Reserve forces (Department of Defense, 2008). Recent military operations in Iraq and Afghanistan have resulted in the majority of military personnel experiencing high-intensity guerilla warfare, and these efforts represent the most sustained ground combat operations and hazardous security duty involving American forces since the Vietnam era (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). The vast majority of combat deaths and wounds are the result of roadside bombs and improvised explosive devices, and more wounded survive than ever before (Friedman, 2005; Gates, 2008; Hoge et al., 2004). These covert war

strategies heighten the state of arousal of military personnel, making them vulnerable to increased anxiety upon return to their family life, thus making readjustment from the war zone to the home front a complicated process (Friedman, 2006).

In this article we describe issues unique to military personnel returning from combat duty in Afghanistan and Iraq and we discuss the intergenerational impact of combat-related posttraumatic stress disorder (PTSD). Diagnostic characteristics and prevalence rates of PTSD are reviewed and factors that contribute to secondary transmission of trauma symptoms to children are examined. Ecologically and school-based strategies that foster resilience in families and communities are identified.

### The Stress of War: PTSD

To date, much of our understanding of PTSD in war-zone veterans has come from the Vietnam era, and many of these studies examined the impact of combat on mental health years after their military service ended (Jordan et al., 1991, 1992). Research with war-zone-related PTSD has primarily been derived from male Vietnam veterans, exploring commonly experienced interpersonal difficulties

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**Authors' Note:** Please address correspondence to Melissa Pearrow, Department of Counseling and School Psychology, Boston, MA 02125; e-mail: [melissa.pearrow@umb.edu](mailto:melissa.pearrow@umb.edu).

and the impact on family life. These difficulties included problems with domestic/partner violence, hostility, intimacy, sociability, anger, expressiveness, and disclosure (Byrne & Riggs, 1996; Carroll, Rueger, Foy, & Donahue, 1985; Jordan et al., 1992; Marshall, Panuzio, & Taft, 2005; Roberts et al., 1982; Taft et al., 2005). More recent research has examined the impact of family functioning of female Vietnam veterans (Watkins, Taft, Hebenstreit, King, & King, 2008), which is important because women now comprise roughly 15% of active military (Department of Defense, 2004). The ramifications of combat exposure on veterans and their families from the Vietnam era has resulted in ongoing methods to examine mental health problems, including PTSD, for those returning from military conflicts (Hoge et al., 2004). However, there are still many gaps in our understanding of the psychosocial effect of combat, particularly with regard to the demographics that are unique to today's soldiers.

In terms of current demographics, recent data suggest that those returning from Iraq had higher rates of engaging in a firefight, as well as combat experiences and more frequent contact with the enemy, when compared to those returning from Afghanistan (71% vs. 31%; Hoge et al., 2004). For both groups, there was a stronger relationship between "combat experience, such as being shot at, handling dead bodies, knowing someone who was killed, or killing enemy combatants, and the prevalence of PTSD" (Hoge et al., 2004, p. 17). In addition, the youngest veterans (age 18–24 years) demonstrated a significantly higher risk of obtaining a PTSD diagnosis compared to veterans older than the age of 40 (Seal et al., 2007). Interestingly, military personnel serving in the reserves (e.g., National Guard) required mental health treatment at a higher rate than those in active duty (42.4% vs. 20.3%) and rates of PTSD were also higher at 6 months after return for those in the reserves (24.5% vs. 16.7%; Milliken, Auchterlonie, & Hoge, 2007). Individuals serving in this capacity are civilians whose daily lives are outside the community of full-time military personnel; they are not living among families who are experiencing similar issues. Because they "are [not] embedded within full-time military culture . . . they have much less access to the social support and family services available to full-time active-duty troops" (Friedman, 2006, p. 591).

Hence, it is important to ask if the original definition and conceptualization of PTSD is an adequate representation of what veterans actually experience when they return to their families. PTSD was officially included in psychiatric taxonomy in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1980 as "a response to the lobbying efforts of distressed Vietnam veterans and their psychiatric

allies" (Linder, 2004, p. 25). PTSD was initially defined and continues to be characterized in the *DSM-IV-TR* (American Psychiatric Association, 2000) as an anxiety disorder. The main symptomatology includes persistent reexperiencing of the traumatic event, avoidance of stimuli associated with the trauma, numbing of general responsiveness, and/or increased arousal that causes significant distress or impairment in functioning (American Psychiatric Association, 2000). Although these symptoms are relevant to contemporary soldiers, current conceptualizations of PTSD fail to address more contextual, systemic, and structural issues. Specifically, the focus on intra-individual factors undermines health care providers' ability to attend to the intergenerational impact of combat-related trauma.

### **Intergenerational Transmission of Trauma to Children**

The transition of homecoming for most families is an extremely stressful period, and the experiences of child rearing can act as a delayed stressor for the combat veteran (Figley, 1993; Haley, 1984). Although many studies have documented interpersonal difficulties of veterans with war-zone-related PTSD, the study of transmission of trauma from survivor to offspring, which has been referred to as vicarious, empathic, and secondary traumatization, is a more recent line of inquiry (Samper, Taft, King, & King, 2004). A complex aspect of trauma transmission to children is that there are higher rates of partner violence for war-zone PTSD veterans (Taft et al., 2005) and children exposed to family violence can develop PTSD (Margolin & Vickerman, 2007) as well as imitate the behaviors of parents with PTSD (Cosgrove, Brady, & Peck, 1994). The term *secondary traumatic stress* has been used to refer to the stress that results from caring for, helping, or wanting to help a traumatized person, and they may "experience considerable emotional upset and may, over time, become indirect 'victims' of the traumatic event" (Figley, 1993, p. 59).

Clearly, the impact of the war-related trauma is not limited to the veteran but also extends to the children and partners who are negatively affected as they surround and care for the war veteran (Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005; Rosenheck & Fontana, 1998). Research has shown that wives of veterans with PTSD have increased psychiatric symptoms, impaired social relations, and more negative emotions and inner feelings of loneliness (Mikulincer, Florian, & Solomon, 1995; Solomon et al., 1992). In addition, researchers have begun documenting the ways in which veteran parents who have PTSD have unique

challenges. Children of veterans with war-related PTSD have higher levels of behavior problems. Specifically, veterans who participated in combat-related violence and abusive violence, such as acts of injury or destruction regarded as unnecessary upon return (e.g., terrorizing civilians, torturing prisoners, etc.), have children with significantly lower self-esteem, higher levels of disruptive behaviors, difficulties in academic performance and peer relations, and emotional and psychiatric disturbances (Caselli & Motta, 1995; Davidson & Mellor, 2001; Galovski & Lyons, 2004; Jordan et al., 1992; Rosenheck & Fontana, 1998). Bessel van der Kolk (1987), a leading expert in PTSD research, poignantly described how children are impacted by a parent's PTSD:

Children in such families [with a traumatized father] invariably grow up with distorted ideas about their roles in family conflicts: they are likely to blame themselves and carry around a core of self hatred that is difficult to undo later in life. These children often develop difficulties in emotional involvement with others; their object relations frequently are characterized by withdrawal and caution lest the wounds of emotional betrayal once again be opened, or by intense involvements and repeated disappointments as nobody is found who can compensate for the sense of loss and betrayal they have carried since childhood. (p. 181)

Moreover, it appears that the tendency to rely upon strategies such as emotional numbing—however unconscious such strategies may be—exert a “particularly detrimental effect on veteran-child relationship quality” (Samper et al., 2004, p. 311). The characteristics of emotional numbing, such as unavailability, detachment, and disinterest as well as difficulty experiencing positive emotions, are more closely linked to interpersonal impairment and decrease a parent's ability to participate in and enjoy interactions with his or her children, thus diminishing the ability to develop a meaningful relationship (Ruscio, Weathers, King, & King, 2002). Replicated in studies of veteran and nonveterans with PTSD, the numbing was predictive of increased parent-child aggression (Lauterbach et al., 2007). The crucial role of emotional expression breaks down and communication invariably suffers as the veteran has difficulty connecting with his or her children and family members, with an eventual and vicious cycle of frustration and further withdrawal as family members find themselves feeling increasingly disconnected from each

other (Cosgrove et al., 1994; Galovski & Lyons, 2004). The emotional withdrawal prohibits the development of real communication, and often these periods of avoidance and withdrawal follow episodes of dramatic reexperiencing of trauma cues or angry outbursts (Emdad & Sondergaard, 2005; Frederikson, Chamberlain, & Long, 1996; Rosenheck & Fontana, 1998).

Although it is of course impossible to identify exactly what “causes” intergenerational trauma, four possible mechanisms have been identified by Ancharoff, Munroe, and Fisher (1998). These mechanisms include silence, where the child, in sensing the parent's fragility, is taught to avoid stimuli that might upset the parent and the child's anxiety increases as he or she is unable to seek out help or comfort from the parent. Overdisclosure is the process where the parent overwhelms the child as he or she explains the trauma in graphic detail, leaving the child terrified. Identification occurs when the child, who is constantly exposed to the posttraumatic symptoms, begins to identify with and mimic the symptoms as a way to connect with the parent. Finally, reenactment is the final mechanism of transmission and occurs when the child is engaged in or participates in reenacting some aspect of the traumatic experience.

As the conceptual and clinical understanding of secondary trauma continues to evolve, systemic, contextual, and ecologically based strategies need to be developed. The following section describes general approaches and specific interventions that may help clinicians, teachers, and related service personnel in their work with children of veterans.

## **Implications for Interventions and Treatment**

Children who experience primary or secondary trauma can present with characteristics of general PTSD, including hypervigilance, dissociation, difficulty concentrating, sleep disturbances, irritability, and behavioral outbursts (National Institute of Clinical Excellence, 2005). Hence, most of the intervention and treatment strategies for children with PTSD can also be used with children experiencing secondary trauma, particularly cognitive-behavioral treatment (CBT) adapted to suit the child's age, circumstances, and level of development. CBT is a psychotherapeutic strategy that examines the individual's cognitions and behaviors with the goal of altering maladaptive coping methods by training the individual, through skill-based learning, to use more adaptive strategies. The recommendation to use CBT intervention strategies is based on a large base of literature on the treatment of childhood PTSD, though the traumatic event leading to the symptom presentation comes

from exposure to events such as school shootings, sexual abuse, and other trauma (Galovski & Lyons, 2004). Evidence from CBT based on these traumatic events suggests that at least some of the elements of CBT can be effective in treating PTSD symptomatology, particularly elements such as direct discussion of the trauma, desensitization and relaxation techniques, cognitive reframing, and contingency reinforcement programs for problematic behaviors (Cohen & Mannarino, 1993; Deblinger & Heflin, 1996).

The child with secondary trauma may demonstrate significant difficulties within the school and learning environment, and a comprehensive evaluation may provide information on particular needs and services. The classroom setting should be designed to maximize the child's learning potential by creating a safe and structured environment where rules and expectations are clearly delineated. The school environment is thus uniquely designed to minimize fears by providing consistency and predictability, making it the optimal setting to normalize the recovery process (Pynoos & Nadar, 1993). Issues of containment and structure are critical because children suffering from secondary trauma often have coexisting learning problems. For example, many children exhibit decreased attention and memory, have difficulty concentrating, and present with inconsistent responses and poor organizational skills (Cosgrove et al., 1994).

Within the school setting the strategies and interventions can be tailored to address the unique symptoms of the child. For example, if the child has significant difficulty with organizational skills, graphic organizers and organizational notebooks can generate achievement. In a similar vein, if the child demonstrates difficulty with memory tasks, additional repetition using audio recordings or peer supports can support positive learning. Any accommodation or learning strategy of techniques, principles, or rules that enables a student to solve problems and complete tasks independently can assist the child with PTSD to become successful in the school setting. However, what complicates the development of effective interventions is that children demonstrating trauma-like symptoms may appear to be quite similar to children diagnosed with attention-deficit disorder (ADD); comorbidity rates indicate that 23% to 37% of children with PTSD also have attention-deficit/hyperactivity disorder (ADHD; Famularo, Fenton, Kinscherff, & Augustyn, 1996). Yet, proper diagnosis and treatment are imperative because the recommended course of treatment for PTSD differs from that for ADHD (Weinstein, Staffelbach, & Biaggio, 2000). In terms of psychopharmacological interventions, for example, children with PTSD who experience heightened states of arousal and anxiety may not experience the same benefits from the

use of stimulant medication as do youth with ADHD (Husain, Allwood, & Bell, 2008).

As this brief review suggests, school-based service providers need to pay greater attention to the child's family dynamics and communication patterns when children are referred for a psychological assessment for ADHD. Incorporating questions about the presence of parental PTSD into children's psychological assessments is a necessary first step in terms of developing more systemic interventions. If systemic changes within the family do not occur, then it is difficult for the children to sustain the emotional and behavioral benefits of individual-level treatment (Cosgrove et al., 1994). When working with veteran families, it is critical to teach children and families more effective communication and conflict resolution skills while building the family's social supportiveness and increasing the quality and quantity of family communication (Figley, 1993). Also, from a larger systems perspective, children with secondary trauma can benefit from educational and mental health service integrated between these two systems (Forness, 1988). The consequences of fragmented systems leave gaps in service delivery that place an undue burden on families and caretakers already stressed by the veteran's war-zone-related trauma. Yet, the provision of integrated services requires the schools to be accountable for more than learning outcomes to include outcomes for the social, emotional, and behavioral dimensions of the child (Forness, 1988).

## Summary and Future Directions

In order to more effectively work with families affected by combat-related PTSD, mental health professionals and school personnel need to be aware of the limits of traditional psychological interventions that rely predominately on intraindividual approaches (i.e., relying only on pharmacological treatment or individual therapy). For example, although CBT strategies can assist the individual child coping with primary or secondary trauma, such strategies must be implemented with care because they may inadvertently depoliticize and decontextualize PTSD. In so doing, they may reinforce victim blame. As Summerfield (1995) astutely noted, "PTSD symptoms are not just a private and individual problem but they are also an indictment of the social contexts which produce them" (p. 24). However, incorporating more systemic and contextual interventions is not an easy task because of the barriers that veterans face when trying to deal with the aftermath of combat-related stress; a disclosure of PTSD and other psychiatric problems can be documented in medical records and lead to

difficulties obtaining security clearances and subsequently, military advancement (Friedman, 2006; Hoge et al., 2004). Other barriers for accessing mental health care are concerns for being seen as weak and that unit leaders and fellow troops will have less confidence in the soldier (Hoge et al., 2004). Recent changes in postdeployment assessments allow troops to overcome some of these impediments by indicating that mental health treatment was “strictly related to adjustments from service in a military combat environment;” yet, this does not solve the larger barrier to treatment in that the comorbidity of PTSD and at least one other psychiatric disorder is 80% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

In addition to being cognizant of the barriers, there must also be an increased awareness of the risk factors for developing combat-related PTSD. Specifically, those who served in the National Guard and Reserves and veterans displaying numbing of general responsiveness or avoidant reactions to their experiences are statistically more likely to develop PTSD (Hoge et al., 2004; Milliken et al., 2007; Seal et al., 2007). Professionals having the most contact with these veterans and their families are usually community providers, such as primary care physicians and ultimately, school personnel. Thus, there is need for continuing medical and professional education workshops on secondary traumatization and the intergenerational transmission of trauma for these service providers. Also, family therapy, group counseling, and support services with other veteran children are essential. Systemic approaches such as these also can help reduce isolation and help children to develop the skills needed to communicate their affective experiences. These interventions can help repair a sense of community and connection that is often lost as family members struggle with aftermath of war. Indeed, perhaps one of the most useful questions both researchers and service providers can ask is “How can we support our veterans struggling with PTSD to be the most effective and nurturing parent they can be?”

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**Melissa Pearrow**, PhD, is an assistant professor in the Department of Counseling and School Psychology at the University of Massachusetts, Boston. After working as a school psychologist for ten years, she completed doctoral training at Northeastern University where she trained in hospital, community, and school-based settings. In addition to her focus on youth empowerment programs, her scholarship focuses on issues of urban education, prevention program implementation, and school-based mental health services.

**Lisa Cosgrove**, PhD, is a clinical psychologist and associate professor in the Department of Counseling and School Psychology at the University of Massachusetts, Boston. In addition to her empirical research, she has published articles and book chapters on theoretical and philosophical issues related to clinical practice and research. She is co-editor, with Dr. Paula Caplan, of *Bias in psychiatric diagnosis* (Rowman & Littlefield, 2004). Her most recent research focuses on conflict of interest in the psycho-pharmaceutical industry.

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