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The Legacy of Combat Trauma

Clinical Implications of Intergenerational Transmission

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INTRODUCTION

Posttrauma symptoms can have a profound effect on the manner in which a trauma survivor relates to others, including, perhaps most significantly, family members. Survivors are markedly changed by their experiences. The psychological impact of trauma is well established in a variety of survivor populations (e.g., Burgess & Holmstrom, 1974; Davis & Friedman, 1985; Figley, 1978; Foa, Rothbaum, Riggs, & Murdock, 1992; Kilpatrick, Veronen, & Best, 1985; Koopman, Classen, & Spiegel, 1994; Laufer, Frey-Wouters, & Gallops, 1985; Titchner, Kapp, & Winget, 1976). These posttrauma symptoms include (1) experiencing the trauma through flashbacks, nightmares, and persistent thoughts; (2) cognitive and phobic avoidance of trauma-related stimuli; (3) hyperarousal symptoms of irritability, startle response, and sleep disturbance (American Psychiatric Association, 1994). It is easy to understand how survivors' numbing of responsiveness, social withdrawal, and irritability, with episodic outbursts of rage, can make it difficult for them to maintain interpersonal relationships. In turn, children of traumatized patients may be affected directly or indirectly by their parents' posttrauma symptoms. For example, Rosenheck and Nathan (1985) described a child of a combat veteran with posttraumatic stress disorder (PTSD) as having insomnia; headaches; tearfulness; feelings of helplessness; fears of being kidnapped, shot, or killed; attention problems at school; and fantasies similar to his father's flashbacks. These authors coined the term *secondary traumatization* to describe this phenomenon. Others have referred to this as transgenerational transmission of trauma (Harkness, 1993). Although the terminologies differ, common to these descriptions is the notion that children are affected by their parents' posttrauma sequelae. Despite a plethora of descriptive information, intergenerational transmission of trauma is a poorly defined empirical construct, and one that is not well understood within the professional community. We do not know the extent to which parental trauma affects the next generation or how many generations may be influenced. One of the best predictors for PTSD is the intensity and duration

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of exposure to traumatic events (Gleser, Green, & Winget, 1981; van der Kolk, 1988). We can speculate that one of the best predictors for secondary trauma in children may be the intensity and duration of trauma exposure of their parents. Combat veterans are a group that has been exposed to extensive trauma and, therefore, represent a population in which intergenerational transmission is likely. The objectives of this chapter are to describe the legacy of combat trauma on the children of Vietnam veterans and identify the mechanisms through which these cognitive, affective, and behavioral patterns are handed down. In addition, this chapter explores issues of how to determine if, when, and how to intervene.

BACKGROUND

Anecdotal Literature

Holocaust Survivors. Intergenerational transmission of trauma was first described among the children of Holocaust survivors (e.g., Freyberg, 1980; Krystal & Niederland, 1968; Rakoff, Sigal, & Epstein, 1966; Sigal & Rakoff, 1971). Some authors noted pathological symptoms in children and families of Holocaust survivors (Rakoff, 1966; Trossman, 1968). In contrast, other authors observed no specific behavioral disturbances in this population (Klein, 1971), except a tendency to avoid separations from parents, overt expressions of anger, and the desire to protect their parents from emotional pain. In addition, these children manifested a low tolerance toward hearing parental trauma memories (Klein, 1971; Prince, 1985). Other authors noted that children of survivors were apathetic and uncertain about career goals (Krystal & Niederland, 1971), manifested neurotic and psychotic symptoms similar to or symbolic of their parents' trauma (Kestenberg, 1983; Krell, 1982; Link, Victor, & Binder, 1985; Rodin & Rodin, 1982), and experienced what appears very similar to dissociation and emotional numbing (Epstein, 1979). Similarly, Epstein (1979) reported episodes of daydreaming the content of which bore a striking resemblance to the traumatic experiences of the parents. Finally, Danieli (1985) and Wardi (1992) suggested that children of Holocaust survivors seemed to have special significance for their parents. Danieli described a constant psychological presence of the Holocaust in the homes of survivors and their children and how this presence was absorbed through "osmosis" (Danieli, 1985, p. 299). Neither Epstein nor Danieli found these children to be a pathological population. Rather, these children seemed to struggle silently with war-derived messages from their parents, including belief that the world is not a secure place, the future is uncertain, evil exists in the world, and their parents were fragile, despite outward appearances (Epstein, 1979). The anecdotal descriptions suggest that these children demonstrate a range of emotions and behaviors that may be associated with their parents' traumatic experiences.

Internees. Descriptions of children whose parents were interned in Japanese Civil Internment Camps in the Dutch East Indies during World War II (Doreleijers & Donovan, 1990) document survivor parents' massive denial of trauma, the communication of trauma-related messages to children, and the subtle encouragement of children's aggression. These authors postulated that the traumatized parents equipped their children with the same defenses that were useful to them during their internment. Similarly, internment of Japanese Americans in the United States has been found to impact survivors and their children (Nagata, 1991). Nagata described inhibited communication about the trauma in these families that heightened a sense of foreboding and awareness of parental trauma in the children. Also, these children experi-

enced a greater sense of vulnerability than those whose parents were not interned, and in psychotherapy they manifested rootlessness, emotional constriction in the family, feeling burdened by the silence in the family, low self-esteem, vocational concerns, problems with assertiveness, and identity issues.

Vietnam Veterans. Intergenerational transmission of trauma has also come to the attention of clinicians working with combat veterans. Figley (1985) referred to this as a chiasmal effect (p. 410) whereby traumatic symptoms are transferred to supporters. In a case report, Rosenheck and Nathan (1985) documented symptoms of a young boy that mimicked those of his combat-veteran father. They hypothesized that PTSD can disrupt the psychosocial and academic functioning of children through direct exposure to parents' traumatic material, and through parental repetitions of the trauma. Many latency-age children of Vietnam veterans were observed to manifest significant levels of psychopathology during the course of group therapy (Jacobsen, Sweeney, & Racusin, 1993), particularly in the areas of affect modulation, coping with stress, and the ability to elicit help from adults. Harkness (1991) also reported that children of veterans manifested difficulties in academic performance, peer relations, and affective coping. Similar to some descriptions of children of Holocaust survivors, she did not report extremely severe symptoms in children of Vietnam veterans but, rather, described general deficits in psychosocial functioning. Vietnam veterans are often observed, according to Harkness, to maintain an extremely close, overprotective, and overcontrolling relationship with their children. Jurich (1983) observed that families of Vietnam veterans have enmeshed parent–child ties between the veteran and his children. Adolescence appears to be a time of great difficulty for both the veteran and his children in terms of identity development in the child and the resurrection of identity foreclosure (p. 356) in the parent. The risk of intergenerational transmission is high at this time.

Although the literature is compelling in its rich and comprehensive description of intergenerational phenomena, most observations are made by clinicians working with families with identified psychopathology that may not accurately reflect the true heterogeneity of the population. There is no consensus among authors about the specific symptoms experienced by the children of survivors, and adequate empirical support for conclusions has not been provided. Until the 1980s, the literature on children of Holocaust survivors presumed existence of psychopathology, and the prognosis was considered poor. Later accounts focused more on the meaning of the parental trauma to the child and the role this played in the development of adaptational styles, vocational choices, and relationships (Danieli, 1981).

Empirical Literature

Holocaust Survivors. A recent review of the literature found a very mixed picture of children of survivors (Ancharoff, 1994). Clinical observations of psychopathology of children of Holocaust survivors have not been substantiated by research results (Baron, Reznikoff, & Glenwick, 1993; Keinan, Mikulincer, & Rybricki, 1988; Leon, Butcher, Kleinman, Goldburg, & Almagor, 1981; Rose & Garske, 1987), although they may be vulnerable to stress responses subsequent to trauma in adulthood (Solomon, Kotler, & Mikulciner, 1988). Unique styles of defensive functioning have been reported, most likely related to the meaning of the expression of certain types of affect (i.e., aggression, anger, anxiety; Lichtman, 1984; Nadler, Kav-Venaki, & Gleitman, 1985). No specific style of family interaction or structure has been found to be linked directly to parents' survivorship status; however, children of survivors do appear to struggle more with independence and autonomy than children of nonsurvivors (Rose &

Garske, 1987). There exists a high degree of affective avoidance and feelings of parental responsibility in children of Holocaust survivors (Nadler *et al.,* 1985; Rose & Garske, 1987; Zwerling *et al.,* 1984); however, parental communication was found to be significantly related to personality variables rather than survivorship status (Lichtman, 1984). Cultural variables and immigrant status may also influence emotional expressiveness in families (Rose & Garske, 1987). Child-rearing practices do not appear significantly different in families of Holocaust and non-Holocaust survivors (Halik, Rosenthal, & Pattison, 1990; Weiss, O'Connell, & Siites, 1986).

Many of the empirical studies suffer from methodological weaknesses that may have resulted in their failure to detect true differences between groups of Holocaust survivors and nonsurvivors, and their children. For example, studies examining child-rearing practices did not consistently use comparison groups to control for the effects of parental trauma on child rearing. Conclusions about the impact of parental trauma on child rearing in families of Holocaust survivors, are, therefore, difficult to reach. Examination of children of Holocaust survivors was based on the retrospective accounts of these adult children, and in many studies, objective indices of psychological status and functioning of the children were not obtained. Parental diagnoses were also not obtained, so the relationship between the psychological states of these parents and their children is unclear. There is insufficient evidence to conclude that psychopathology is common in the children of Holocaust survivors, and the population appears to be more heterogeneous than people originally thought (Danieli, 1985).

Vietnam Veterans. Although symptoms have been described in children of Vietnam veterans that appear to be directly related to their fathers' war experiences, few controlled studies have been conducted to test these observations. Harkness (1993) examined the effect of fathers' combat-related PTSD and violent behaviors on their children. Results revealed that parents viewed their children as depressed, anxious, somatized, schizoid, uncommunicative, hyperactive, aggressive, and delinquent. Boys were viewed by parents as being more disturbed than girls. Additionally, lower levels of family functioning, paternal combat experience, and paternal violence were significantly associated with child behavior problems, academic difficulties, and poor social competence. Harkness's study, however, evaluated outcome based on the presence or absence of violence in fathers with PTSD. Harkness suggests that violence in the family may be more influential in the development of child psychopathology than either the fathers' PTSD or the level of family functioning, but she did not include a non-PTSD comparison group. Since outbursts of anger, however, can be considered a PTSD Criterion D symptom of increased arousal, and violence may be incorporated into traumatic reexperiencing (particularly in Vietnam veterans), the study can still be considered to lend support for the hypothesis of intergenerational transmission of trauma. Parsons, Kehle, and Owen (1990) also found that combat-veteran fathers perceived their children to manifest dysfunctional behavior, including aggression, hyperactivity, delinquency, and social difficulty.

Davidson, Smith, and Kudler (1989) evaluated family histories of psychiatric illness in Vietnam, Korean, and World War II veterans with PTSD, nonpsychiatric controls, depressed patients, and alcohol-abusing individuals. Their results revealed that more children of PTSD patients received psychiatric treatment than did those of nonpsychiatric controls and manifested significant psychiatric and developmental problems such as attention deficit disorders, anxiety, behavioral and academic difficulties, and anorexia nervosa. A study of 1,200 Vietnam veterans (out of 3,016 veterans who had engaged in interviews as part of the National Survey of the Vietnam Generation, a component of the NVVRS study (Kulka *et al.,* 1990), found that veterans with PTSD were more likely to report martial, parental, and family adjustment prob-

lems (in terms of adaptability and cohesion, and family violence) than veterans without PTSD (Jordan, Marmar, Fairbank, & Schlenger, 1992). Overall, the results of empirical studies of Vietnam combat veterans and their children are consistent with clinical observations of this population. There is some evidence to suggest that psychopathological responses may be transmitted to children by their fathers.

Wives of combat veterans also incur secondary trauma in the relationship with their husbands. Verbosky and Ryan (1988) found increased levels of stress, feelings of worthlessness, poor self-esteem, and ineffective coping in wives of veterans with PTSD. Many have also been battered in their relationships with these combat veterans (Maloney, 1988; Matsakis, 1988; Williams, 1980) and have been found to show psychiatric symptoms (Solomon, 1988, 1990). Factors that have been found to contribute to wives' mental health include the degree of expressiveness in the marital relationship (Solomon, Waysman, Avitzur, & Enoch, 1991). DeFazio and Pascucci (1984) observed common interpersonal patterns between Vietnam veterans and their wives which appeared to influence the marital relationship and, one can speculate, the potential for transmission of trauma.

Traumatic events impact survivors along a continuum of psychological functioning. Not every child of a trauma survivor will become a dysfunctional adult. Conversely, a parent does not necessarily have to meet criteria for PTSD to communicate traumatic beliefs and assumptions about the world. Children receive trauma-related communications about beliefs and assumptions that may result in emotional and behavioral problems, or more subtle disruptions in psychosocial functioning and adjustment.

DEFINITIONS AND CONSTRUCTS

The information-processing theories of Janoff-Bulman (1992) and McCann and Pearlman (1990a) provide a theoretical framework for understanding the traumatic beliefs and assumptions that survivors communicate to their children. Janoff-Bulman (1992) uses the concept of schemata to explain how trauma influences the development of these beliefs and assumptions about the world. A schema is a mental structure that represents organized knowledge about a given concept or type of stimulus. Based upon early interactions with caregivers, individuals develop a set of beliefs, assumptions, or internal representations of the self and others that guide subsequent interactions with others. According to Janoff-Bulman, fundamental assumptions are generally the grandest schemata, the most abstract, generalized knowledge structures. Individuals tend to perceive and understand the world in schema-consistent ways. Once basic assumptions develop, they are usually resistant to change except when trauma is experienced.

The psychological sequelae of trauma stem from the shattering of three fundamental assumptions about the world and the self: (1) the world is benevolent, (2) the world is meaningful, and, (3) the self is worthy. Differential responses to trauma arise, in part, from the nature of the traumatic event and the basic assumption most threatened by it. The world is no longer considered safe and secure; thus, a new worldview is constructed. According to Janoff-Bulman (1992), the breakdown of any one assumption is sufficient to disrupt a victim's feeling of personal safety and security in the world.

In constructivist self-development theory, McCann and Pearlman (1990a) also utilize these concepts to explain the impact of trauma on the survivor. They postulate the self as the basis for an individual's identity and inner life that develops as a result of (1) reflection, (2) interactions with others, and (3) reflection upon these interactions. The self is composed of

four elements: (1) basic capacities to maintain inner identity and self-esteem, (2) ego resources that regulate interactions with the world, (3) psychological needs that motivate behavior, and (4) cognitive schemata, which are beliefs, assumptions, and expectations through which an individual interprets his or her experience. These components of the self are affected by trauma interdependently, and the individual's dominant needs determine his or her psychological response to events. Early experience with others creates particular patterns of salient needs within each individual. The needs hypothesized to be most affected by traumatic experience include (1) frame of reference, (2) safety, (3) trust and dependency, (4) esteem, (5) independence, (6) power, and (7) intimacy. Trauma disrupts the individual's salient needs; schemata are the cognitive manifestations of these needs.

It is these disrupted schemata of the traumatized parent that are transmitted to the children, influencing their basic assumptions, worldviews, and beliefs. Transmission of trauma has been observed in other populations as well, including therapists who work with trauma survivors (Chrestman, 1994; Danieli, 1988a; McCann & Pearlman, 1990b; Munroe, 1991; Schauben & Frazier, 1995). Intergenerational transmission of trauma may occur in children whose parents are survivors of trauma. It refers to thoughts, feelings, and behaviors that parallel those of the trauma survivors, are generated from the survivors' experiences, and are transmitted to them from the survivors (Munroe, Shay, Fisher, Zimering, & Ancharoff, 1993).

The distinction between primary and secondary trauma is not necessarily clear. A child who is the victim of violence is being primarily traumatized. A child who learns the parent's traumatized worldview in the context of the relationship might more accurately be described as being secondarily traumatized. Both can occur simultaneously, and the distinction between the two is more academic than real. They may be difficult to separate or label in practice.

Children who have been primarily traumatized, as well as those who have been secondarily traumatized, may manifest intrusions of traumatic material in the form of daydreams and fantasies. Both groups may also manifest behavioral change in response to environmental and/or ideational stimuli symbolic of the trauma. Directly traumatized children may encode the trauma in visual memory, subsequently replaying the image in their minds. Similarly, children of traumatized parents may experience recurrent visual images of parental trauma that they have constructed from fantasy and information acquired from parents or other sources. In response to intrusions, both directly traumatized children and those who have experienced secondary trauma may remain in a state of anxious arousal or hypervigilance. Finally, both groups of children, without words sufficient to describe or process the traumatic material, may act it out through play or develop trauma-related fears.

Conceptual models to understand secondary traumatization or intergenerational transmission are less clear than the theories on the impact and effects of primary trauma. We hypothesize the following as variables influential in the transmission of traumatic beliefs: the severity of parental trauma; the degree to which beliefs and assumptions have been disrupted, the degree to which a parent has integrated the traumatic event and restored meaning to life, and the number and frequency of stimuli that may trigger traumatic recollections and reexperiencing.

It is important for clinicians to remain aware of the functional utility of the messages that are transmitted from traumatized parents to their children. Not all messages, beliefs, or assumptions are necessarily pathological in the context of the imperfect society in which we live. Aspects of a traumatized parent's worldview may, at times, be helpful. Although a combat veteran, for example, remained vigilant for any sign of ambush even after Vietnam, it may not be maladaptive for his child to be moderately cautious while walking along city streets. The most malignant component of the transmission is the raw, unintegrated affect that has never been

processed in the parents and, consequently, becomes internalized in the children in another place and time. The goal of treatment is not necessarily to restore a "Pollyannaish" worldview in children and families of survivors, but to help them integrate the traumatic experiences of the parent's past and create a worldview that incorporates realistic considerations and maintains an overall feeling of safety, meaning, and value in the present.

Perhaps adaptive or maladaptive consequences of transmission are not the central issue. What is more important is the nature of the transmission and the degree of choice regarding behavior. Transmission of trauma implies that trauma, in some way, narrows the choices one has with regard to behavior, based upon beliefs and assumptions that have been shattered. When children of survivors feel compelled to reenact parental traumatic experiences, their choices are, by definition, narrowed. Choice is based upon messages communicated by parents about the world in which the child never lived, except, perhaps, vicariously.

MECHANISMS OF TRANSMISSION

The mechanisms of transmission (secondary, as opposed to primary) described herein should be regarded as simplified working models. They are not mutually exclusive and, in practice, show considerable overlap. They are neither good nor bad. They can transmit healthy or maladaptive messages. These mechanisms are silence, overdisclosure, identification, and reenactment.

Silence

Silence can often communicate traumatic messages as powerfully as words. Danieli (1984) wrote about a "conspiracy of silence" in society, in general, and in therapists working with Holocaust survivors, in particular, that she found maintained and exacerbated the effects of trauma. From a systemic perspective, silence communicates rules, myths, and metamessages to which the family may unquestioningly adhere. Silences in the family may develop in one of two ways. First, family members may be empathically attuned to the survivor parent's emotional distress. To avoid arousing further distress, they may work hard to shun issues they believe may trigger discomfort and further symptomatology in the parent. This is especially relevant for children of survivors, who sense that something terrible must have happened to their parent and that he or she is fragile as a result. Second, the parent's behavior may inhibit discussion about sensitive issues. For example, a combat veteran may react to issues that trigger recollections of combat trauma with extreme anxiety, outbursts of rage, or a flashback. Children learn quickly to avoid discussion of events, situations, thoughts, or emotions they believe may provoke such behavior. Families collude to maintain these silences to protect themselves and the survivor from posttrauma reactions. The breach of silence may precipitate the use of diversionary tactics or crises in the family to maintain distance from the traumatic material. These may include simply changing the subject, scapegoating a child, or a marital argument. As a result, the focus of the family interaction changes from the father's trauma to relatively more benign issues. Subsequent anxiety in the children may be related to the anticipation of their parent's symptoms and to fantasies about the uncommunicated material.

A variant of silence is underdisclosure. When only partial details of the parents' trauma are known, children may struggle to complete the story and gain closure. In an effort to know and feel closer to their parents, children may fantasize or imagine the trauma their parents experienced, which can be as horrifying, or more horrifying than accurate information.

Overdisclosure

Bearing witness to traumatic experience can challenge even the most firmly held beliefs that the world is a safe place, that there is a meaning to what happens to us, and that we are worthy. Sharing the process with another person has therapeutic value in terms of alleviating the intense isolation of a trauma survivor. It is problematic if the other is not equipped to share the intensity of the experience in its raw form.

Children of trauma survivors vary with respect to awareness and knowledge about their parents' traumatic experiences. Frequently, trauma survivors want to protect family members from the emotional pain of their memories. However, direct disclosure does occur and may traumatize the children. Traumatic information relating to parents' experiences must be conveyed to children in age-appropriate ways and in doses that permit children to listen to the experiences and receive appropriate parental support. The ability of parents to confide appropriately about their trauma, however, is a function of the degree to which they can cope with their symptoms, and perhaps the extent to which their assumptions have been altered. Trauma survivors who have not sufficiently integrated their experiences often have difficulty choosing how much to disclose and modulating associated affect. It is difficult to hear and empathize with the emotional pain of those we care about. It is also distressing to hear traumatic details without concomitant affect. The impact of such direct disclosure on children may be horror, particularly when delivered in a flat, nonchalant way. This has also been noted in psychotherapists working with trauma survivors (Danieli, 1988a). Graphic disclosures of trauma-related information may be made by parents with urgency to prepare their children to survive in a world in which they believe there is no trust and danger is omnipresent.

Identification

Children who live with a traumatized parent may be continually exposed to posttrauma reactions, which can be unpredictable and frightening. Children tend to feel responsible for their parents' distress and feel that if they could just be good enough, their parents would not be so sad or angry. Thus, the child makes extreme efforts not to disturb them further. Children of trauma survivors are similar to the frequently parentified children of depressed or alcoholic mothers (Gizynski, 1983; Greenfield, Swartz, Landerman, & George, 1993; Harkness, 1993). These roles may arouse significant anxiety in children who are not prepared to handle the functions and demands of adulthood. This anxiety may parallel, for example, the inexperienced combat veteran suddenly placed in the middle of a firefight.

Children seek out their parents' acceptance and recognition. Children of combat veterans identify with their father's experience to know him better and attempt to feel what he feels, possibly leading to the development of parallel symptomatology (Harkness, 1993). Additionally, PTSD intrusion and avoidance cycles may be particularly confusing and disruptive for children. Survivors may be unpredictable and explosive during intrusions, unable or unwilling to explain what is happening to them. Subsequently, they may feel guilty for having put the family through this experience, and may isolate themselves and feel emotionally numb and unable to connect with their children. The child may manifest the same feelings and behaviors.

The survivor's propensity for hypervigilance may be conveyed to children through observation and modeling as well. A child of a Vietnam combat veteran may observe the father angrily insisting on sitting in the far corner of a restaurant to have a full view of the room, so no one can surprise or ambush him. The child may learn to manifest similar hypervigilance on the playground, believing there are dangers in the world against which he or she must be

perpetually on guard. Emulating parental behavior is also a way to gain acceptance from a parent who has difficulty with intimacy because of trauma.

Survivor guilt has been an associated with PTSD (American Psychiatric Association, 1987), perhaps reflecting the need of trauma survivors to maintain a view of the world as meaningful (Janoff-Bulman, 1992) and reverse the helplessness associated with their traumatic experience, while maintaining loyalty to the dead (Danieli, 1985). Children of trauma survivors may also experience a type of survivor guilt. They may ruminate about their behavior to make sense of what appear to be arbitrary, random parental reactions to common events. This behavior may also facilitate the child's ability to maintain a connection with the traumatized parent. Without this connection, severely traumatized parents may be absorbed in their own traumatized world and be unreachable in many ways to their children.

Reenactment

Trauma survivors tend to reenact their trauma. Traumatic experiences, however, may not be reenacted alone. Others may be engaged or induced to participate in relationships based on this worldview and to act out various roles that vary in accordance with the specific dynamics of the original trauma (Munroe *et al.*, 1995). Affect is aroused in others that parallels the survivors' original trauma experience by their participation in the reenactment. These interactions repeatedly test the validity of the traumatized worldview in a way that tends to confirm it. People close to trauma survivors can find themselves thinking, feeling, and behaving as if they, too, had been traumatized or were perpetrators. Although the content of the interaction may vary, the themes and the affect it generates in others remain the same. Essentially, what is created is an isomorph of the survivor's experience in another person, a relationship that generates a pattern or structure parallel to the survivor's trauma experience and produces feelings, thoughts, and behaviors common to that experience.

Behavioral isomorphs engage children directly in the traumatized world of their parents. Engagement in scenarios that are thematically reminiscent of the parent's trauma forcefully transmit the parent's worldview. For example,

> A Vietnam veteran who had experienced severe combat exposure, disillusionment with his superiors in Vietnam, and with the government upon his return, took his 3-year-old son to the playground. His son wanted to ride down the slide but was afraid and repeatedly asked his father to catch him at the bottom of the slide. The father agreed. However, when the child reached the bottom of the slide, the father broke his promise and deliberately did not catch him. When asked why, the father said his child needed to learn to distrust what people told him. (J. F. Munroe, personal communication, November 18, 1993)

This message of distrust is exactly what the father learned in Vietnam. Superiors often made lethal decisions, stating they had the best interest of their men at heart, decisions that cost the lives of friends and innocent civilians. In the aforementioned interaction with his father, the little boy experienced a betrayal parallel to the one his father experienced in his unit. In essence, this man was teaching his son how to survive in an unsafe world. The father did not need words or reference to Vietnam to teach this lesson, yet the content of the message was powerfully transmitted, as Danieli (1985) has noted in children of Holocaust survivors.

Reenactments transmit trauma by setting up participatory isomorphs that produce in others parallel but perhaps less intense trauma experiences of the survivor. These may be produced intentionally, but often involve unconscious acting out of the trauma worldview. When participants experience this, they are being secondarily traumatized. The affective experience

of this participation is described by others as projective identification (Catherall, 1992b) or countertransference (Wilson & Lindy, 1994). The isomorphic reenactment produces parallel thoughts and behaviors, as well as feelings.

> An intoxicated, suicidal Vietnam veteran was found in the basement of his home by his adolescent son, who had just come home from school at the regular hour. The father, reliving a combat experience in a fit of rage, was crying, and holding a revolver to his head. Having seen his father's rages before, the son experienced each one to be as anxiety provoking as the first. He felt responsible for his father's life, both powerful and helpless, as well as angry. (J. F. Munroe, personal communication, February 25, 1994)

This situation paralleled the overwhelming helplessness the veteran felt in the middle of a firefight and the intense feeling of power that often accompanies the combat experience. The child's anger may have also paralleled the veteran's rage at having been forced into a situation with which he was ill-equipped to cope.

As described earlier, all of these mechanisms may overlap. For example, while watching television with his 8-year-old son, something he saw triggered a memory of the war for a combat veteran, who began to talk about his experiences, which soon led to describing atrocities. As if attacked by his own horror, the father made up some excuse and left the house quickly in an attempt to contain his feelings. The son had been exposed to the horror of wartime atrocities (overdisclosure). His father's abrupt departure left him without closure and with having to speculate on what else happened, and what it meant (silence). With no one to talk to, he went outside and played basketball to try to force the information out of his mind (identification). He was left with the parallel feelings of knowing about the horrors of war but not being allowed to speak about them, and perhaps thinking that nobody would believe him anyway (isomorphic reenactment). A portion of the father's combat experience had been transmitted to the son to be incorporated into his worldview.

CASE EXAMPLES

The following are some examples of the messages Vietnam veterans can pass on to their children. They illustrate a range of negative and positive behaviors that might occur, but do not imply that all or most children of Vietnam veterans will experience such problems.

Case 1

> Laura was 16 when she attempted suicide by an overdose of street drugs and medications prescribed for her mother. Prior to her suicide attempt, her grades had slipped from a B average to failing all her courses. Her steady boyfriend also used drugs, and she hung out with an older group of friends.
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> Her parents had separated $2^1/_2$ years earlier, but they still maintained intermittent contact. Laura, her old brother, and younger sister lived with their mother but had contact with their father. Laura was described as her father's favorite. He would often take her for walks when she was little, and she was the one who could coax him out of his "moods." She remembered her father saying to a family therapist that he had been in the woods with a loaded gun to his head, but he could not pull the trigger because he saw Laura's face.
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> Laura's father, Mike, served as a field medic in Vietnam. Following his return, he reported constantly seeing the faces and bodies of soldiers he could not save. Although he had been a promising student and athlete before Vietnam, Mike was not able to "get it together" when he got

back. While his three brothers went on to successful professional careers, Mike had a long history of alcohol and heroin addiction. He would be able to maintain sobriety for 6 months to 2-year periods. During these clean-and-sober periods, he would become very involved with work. As sleep, negative images, and relationships at work worsened, he would gradually go back to using substances. After his last relapse, he and Laura's mother separated.

Gail, Laura's mother, said, "Laura is always the one who seems to take things most seriously."

Laura was a quiet, sweet child. She was often the family peacekeeper and the one who tried to make everyone happy. She would prepare dinner for the family when Gail worked late and make little cards and gifts for Mike to cheer him up. Mike and Gail said that this made it even more confusing when she started running around with an older crowd and getting into trouble.

Laura was, at first, extremely reticent to talk in sessions. She alternated between anger and silence. Shortly after her suicide attempt, she told the emergency-room physician, "I made a mess out of everything, and now I just want to die!"

Case 2

Kevin, a 12-year-old boy, was brought in by his father, Jake, to his Veterans Affairs therapist for evaluation after a motorcycle accident from which Kevin still suffered nightmares. Jake was being seen at Veterans Affairs because his PTSD symptoms from Vietnam combat interfered with his job advancement and social functioning. Kevin was a soft-spoken, pleasant young man who often looked to his father for direction, and he stated a preference that his father remain with him during the first session.

Jake was a 46-year-old Vietnam combat veteran. He completed 2 years of community college before being drafted and sent to Vietnam. Because of his intelligence, greater maturity, and physical abilities, he soon became a squad leader. Although he performed admirably and received medals and commendations, many of the men in his squad were killed in an ambush that he felt he should have been able to prevent. After coming home, Jake took a job with the telephone company but persistently turned down promotions and had difficulty getting along with his bosses.

Kevin and Jake described the accident in which an older man and his wife turned out of a driveway in front of the motorcycle Kevin and his father were on. Kevin said that his father tried to swerve away from the car, but the car kept coming, and they hit it anyway. Kevin's leg was badly scraped and bleeding. He remembered how angry his father was, threatening to kill the driver. They kept shouting at each other. Finally, the police arrived, and Kevin was taken to the hospital and released the same day.

Jake was worried that the accident had traumatized Kevin. He was surprised when he heard the content of Kevin's dream. In his dream, the accident was about to happen and Kevin could not warn his father. Jake got so angry over his son's injury that he pulled out a gun and shot the man in the car, and the police took Jake away. Kevin was then able to tell his father that he was more afraid of his father's anger (and his being the cause of it) than he was bothered by the accident or the injury.

Kevin said that he often felt he caused his father's upsets. With some prompting, Jake was able to tell his son that, as a squad leader, he had felt very responsible for his men and sometimes still reacts today the way he did then. At the therapist's urging, he gave a few examples of how this happened at work as well. He reassured his son that he was not the cause of his anger.

IDENTIFICATION OF INTERGENERATIONAL TRANSMISSION OF TRAUMA IN CLINICAL PRACTICE

There is no single answer to the question of what we should look for in the child of the survivor of combat trauma. The legacy of trauma is complex. It depends on the initial trauma, the ways in which it is handed down, the mediators in the child's environment, and his or her

makeup. Sometimes the symptoms may mirror those of the parent's PTSD, but the legacy may manifest itself in other forms. Green (1993) described the category of trauma, individual factors, and the recovery environment as the three factors relevant to the presentation of a traumatized person. These factors are also relevant for the child of a traumatized combatant. It is important to remember that the effects are not always only negative. Since these children are often still living in an environment influenced by the traumatized parents, assessment is neither static nor easily standardized. Asking the right questions does not mean drawing standardized conclusions for a child.

The degree to which transmission of traumatic beliefs will affect children cannot be presently predicted, because no tools exist to measure adequately the construct and the differential impact of primary and secondary trauma. But risk factors, based on historical and interpersonal data, can be identified. A comprehensive assessment should include a thorough evaluation of the child's cognitive, affective, and psychosocial functioning. The assessment extends to an evaluation of the parents' psychosocial and marital functioning (as traumatic reenactments occur within the entire family). To uncover the family's worldview, the clinicians must be alert to family myths, common themes and assumptions, beliefs, as well as patterns of engagement.

The child who is having problems may be identified through the school, the parents, or a treatment or social service agency, as in the case examples. Harkness (1993) pointed out that the child may not behave or be perceived the same way in all situations. A child who appears to pose few problems at home or school may come to the attention of a treatment or social service agency because of the parents' behaviors. There are many ways to assess a child's behavior (e.g., child behavior checklists filled out by parents, teachers, or observers; educational core evaluations; parent interviews; direct observations).[1] The place in which the child is identified often determines how the child is assessed. Some of the symptoms found in children of Vietnam veterans include impaired self-esteem, poor reality testing, trouble following rules, hyperactivity and aggressive behavior, difficulty coping with feelings, intrusive thoughts, and nightmares (Harkness, 1993; Rosenheck & Nathan, 1985). Because these are also found in many other disorders, knowledge of the parent's primary trauma and the interaction patterns in the family are important in determining if secondary trauma is a factor. Understanding the behavioral context is equally important in terms of identifying ways in which trauma may be reenacted and ascertaining the degree to which the reenactment is impinging upon daily functioning. Examining behavior patterns seen in other children of combatants with PTSD [e.g., Harkness's (1993) descriptions of the vicariously traumatized child, the nurturant rescuer, and the emotionally isolated child] may also be helpful in determining the existence of secondary trauma. Psychoeducation and trust building, discussed in the interventions section below, may need to precede data gathering in many instances.

Beyond the nature of the parent's trauma, how it has been communicated to the child (overtly, covertly, or by reenactment), its behavioral manifestations in the father and its parallel in the child, exploring the family dynamics is extremely important. Mason (1990) poig-

[1]Krinsley and Weathers (1995) reviewed assessment measures for trauma and emphasize that the definition of trauma, the dimensions of trauma (subjective and objective), and the examination of a broad range of stressful events are important. Some of the measures they reviewed include the Familial Experiences Inventory (Ogata *et al.*, 1990) and the Retrospective Assessment of Traumatic Experiences (Gallagher, Flye, Hurt, Stone, & Hull, 1992). Similarly, McNally (1996) reviews assessment tools for evaluating PTSD in children. Pynoos *et al.*'s (1993) description of age-related behaviors in traumatized children, and developmental models of childhood traumatic stress (Pynoos, Steinberg, & Wraith, 1995) might also apply to children of traumatized parents as a result of either primary or secondary traumatization. Pynoos and Eth's (1988) interview for traumatized children might also be adapted to those suffering the legacy of trauma. In these cases, it would be assumed that the child's behavior is parallel with, or reactive to, the traumatized parents' behaviors.

nantly described the role that wives often take in families of traumatized veterans: selfless, enabling, pacifying, and, usually, depressed and angry. Wives may experience primary as well as secondary traumatization in their leadership with their husbands and may transmit aspects of both within the context of their relationship with the children. Figley (1989) suggested exploring issues related to functioning in families in which one or more members has PTSD, such as their understanding of how the stress affects them, their inclination to conceptualize their difficulty as a family problem versus identification of the traumatized parent as the damaged member, flexibility of family roles, and the level of intrafamily violence. Ben-David and Lavee (1992) described and categorized family reactions to outside stressors as being secure, indifferent, cautious, or anxious. Measures such as the Family Environment Scale (Moos & Moos, 1986) assess various dimensions of family relating. Danieli (1985) identified specific categories of adaptational styles in families of Holocaust survivors. She described victim families, fighter families, numb families, and families of "those who made it." These patterns may also emerge in families of Vietnam veterans as clinicians and researchers continue to study Vietnam veterans with regard to the specific nature of the combat experience, as well as the homecoming they received. For example, the child of a combat veteran, who was taught that life was expendable and its value low, might show the aforementioned symptoms of low self-worth. Children of veterans who saw authority as incompetent and had negative homecomings are not likely to see the world as benevolent and may have a very difficult time following rules that society has set. A rigid pattern may affect behavior and self-esteem over time. A traumatic family pattern that may work moderately well when children are small (e.g., allies and enemies) may fall apart in their adolescent and young adult years, when the child desires a degree of independence and autonomy. A father who had been uninvolved in a child's early years may identify and become more engaged with his or her adolescent rebellion.

The social context is also very important in assessing the legacy of trauma. When the environment is dangerous (e.g., war zone, certain inner-city neighborhoods), teaching survival behaviors may be quite adaptive. The cultural context must be evaluated as well. The child may come from a group of people that has been persecuted or traumatized in addition to the war experiences of the combatant parent. The family may be one that has experienced generations of trauma and sees this as the norm. Contextualizing the story in an integrated fashion is crucial. Messages communicated within a family can relate a history or a legacy such that important aspects of their past are not forgotten. Within this communication, however, there must be a context or a place within which the affect may be held, so that it does not overwhelm the family as a whole, or any of its members. There is usually an element of truth in the anxiety communicated within the family of a trauma survivor. Evaluative skills must be taught to help families ascertain the probability of the traumatic event occurring in the present. Families of trauma survivors, and children more specifically, have difficulty accurately assessing the risk of the past repeating itself.

Mediating variables are also extremely important. Sources of support outside the immediate family can often provide an alternative worldview. Unique strengths the child may have should be assessed and utilized appropriately. Socioeconomic factors may also be involved.

INTERVENTION

Combat-veteran status, alone, does not automatically imply the necessity for clinical intervention. Neither are the problems that children may manifest automatically attributable to the father's combat experience. Combat experience may, instead, serve as a framework for

intervention if it is warranted. It is important to identify the behavior of the child, the context in which it occurs, and whether it is related to the father's combat trauma. A child who has difficulty reading and does not get along with teachers may have a learning disability and subsequent problems with teachers, or may be acting out the father's difficulty with authority in a subsequent lack of attention to reading. Interventions on both levels may be appropriate.

When the child's behavior does seem clearly related to secondary trauma, it is important to avoid blaming the father. He may already be suffering a great deal of guilt; moreover, he may be worried that he is harming his child. Blaming the victim of the combat trauma is unlikely to increase the possibility for effective intervention with either the father or the family. Involving the father as part of the solution is more likely to produce results that will benefit both generations. Engaging the mother is equally important. The wife, a recipient of secondary trauma, may also need help, but the parental team is, by far, the most powerful influence on addressing transmissions. There is no clear guideline on when to intervene. In general, intervention should be considered when the worldview transmitted by the trauma generates thoughts, feelings, and behaviors that may be inappropriate for the current environment.

Interventions are either preventive or reactive. Preventive responses are appropriate when awareness of the father's traumatic experience exists and he and his family can be informed of the possible impact of intergenerational transmission. Reactive responses are called for when problems in the children of veterans become apparent. The relationship between these difficulties and paternal combat trauma should be explored. If the child's problems surface in school, the staff may not know whether the father is a veteran and if he has been traumatized by combat. Since transmission is not limited to combat trauma, it would be wise to take a full trauma history from both parents.

Intervention strategies can be either informative or interactive. Similar to the mechanisms of transmission that they address, these strategies overlap considerably and the differences may be more conceptual than actual. Informative strategies are essentially psychoeducational and include pamphlets, books, video- or audiotapes, lectures, and presentations. Many veterans who suffer from PTSD do not know what it is. They often assume that they are crazy or inadequate, and that nobody else experiences the world the way they do. And even those who are aware of the influence that trauma can have on individuals may be totally unaware of the process of such transmission. Framing PTSD as a normal response to abnormal experiences can relieve a great deal of pressure on both the veteran and his or her family. The explanation should include effects on loved ones and families of those traumatized. Transmission does not require a diagnosis of PTSD. Once some of the effects of trauma are identified and explained, family members can begin to consider some control over their behaviors. These are fairly passive activities for the clinician, in that the family determines what actions are to be taken. Material may be presented on the formal definitions and symptoms of PTSD, as well as on the less formal effects (e.g., where the veteran will sit in a restaurant, the avoidance of family social gatherings such as weddings and holidays). The mechanisms of transmission described earlier, of how those who are close to the combat veteran can begin to think, feel, and behave as if they were in combat, may also be explained. Strategies might include a family information meeting that is followed by questions and answers, a spousal support group, or a workshop that included both parents and children. Family members can learn how trauma influences their own lives. Recommendations for further information should be provided. The specific content and style of such an intervention will vary according to the needs of the participants the clinicians assess throughout the meeting.

Interactive strategies consist of the active involvement by mental health professionals, directed at the mechanisms of transmission, in the process of therapy. They help identify the mes-

sages, the specific means of transmission, and alternative communication patterns. To succeed, therapeutic interventions must rely on first having established and maintained trust. Trauma involves the betrayal of basic trust. Moreover, in combat veterans, the loss of trust in authority is crucial (Munroe *et al.,* 1995). This mistrust may be an integral part of what is transmitted to other family members, including children. Therapists who rely on the role of "professional authority" may be quickly rejected. A successful interactive strategy requires attention to the ongoing tests of trust that the traumatized veteran and his or her family may pose.

The mechanisms of transmission are problematic when they cannot be identified or discussed. Transmitted messages, once elucidated, can be evaluated for their current appropriateness. Silence and overdisclosure do not allow opportunity for discussion. Identification and reenactments are essentially nonverbal exchanges. It may be very hard to decipher the messages on a conscious level. In the example in which the father allowed his son to fall off the slide, the messages and worldview were not open to discussion or analysis. The girl whose father did not shoot himself because he saw her face could neither articulate her sense of being thrust into the impossible responsibility for life and death, nor know how it may have paralleled her father's experience of being thrust into combat. Therapy focuses on the mechanisms in order to verbalize the resultant transmitted messages.

Ideally, it would be most efficient if the entire family were available and interested in therapy, but this is quite frequently not the case. Also, since trauma disrupts the ability to trust or negotiate relationships, a broad definition of what constitutes a "family" may be necessary. Interventions can be targeted to the parents, partners, children, relatives, friends, or other therapists. The trauma survivor may be the person least receptive to outside influence as a result of the deep violation of his or her sense of trust. The veteran who is in treatment may resist involving the family out of the wish to protect them. Veterans are frequently concerned that therapy will result in overdisclosure that may harm the family or cause them to reject him or her. It is crucial to allow the family to have some degree of control over the process. It is also important to tailor the therapy to the needs of the recipients to prevent further traumatization. For example, the amount and nature of information about war should differ when disclosed to a school-age child and to a grown child who is considering enlisting in the military.

Recovery from trauma is enhanced when trauma is viewed as a family problem rather than an individual problem (Catherall, 1992a; Danieli, 1988b, 1993; Figley, 1988). The objective of interventions directed at intergenerational transmission is to help family members examine the appropriateness of the various components of their current worldview in light of past traumatic events. Once the problems with silence or overdisclosure are identified, families can begin to talk about what questions need to be asked and how detailed the answers need to be. Once family members are aware of identifications or isomorphic reenactments, they can begin to distinguish between reactions to the past and responses to the present. A worldview that is dominated by trauma restricts the ability to respond to changing world conditions. The objective of any intervention is an expanded worldview that allows all family members a greater range of responses.

CLINICAL IMPLICATIONS

There is little doubt that combat trauma can have devastating and long-lasting effects on those directly exposed to it. It is important to recall, however, that prior to 1980, the diagnosis of PTSD did not exist, and the view held by the clinical community was that people should recover from combat exposure within 6 months. Those who did not recover were presumed to

have a premorbid condition. The field has developed and revised the criteria for PTSD to evaluate the impact of primary trauma, but secondary effects are not well understood. Similarly, there may be a tendency to deny the legacies of combat trauma on successive generations.

The extent of the damage that transmitted trauma can incur is yet unclear. The number of generations affected remains ambiguous, as is the specific nature of the transmissions and the differential vulnerability of family members. There is some evidence that children's symptoms may parallel those of the combat-veteran father, but additional consequences are unknown. Children of combat veterans may be more likely to exhibit parallel symptoms of PTSD, but they may also be more likely to exhibit symptoms of other disorders of childhood. Combat veterans received a wide variety of inappropriate diagnoses prior to 1980, and it is possible that many of the diagnoses given to their children have been similarly inaccurate. There is clearly much research to be done, but clinical experience demonstrates the need to address secondary effects. Clinicians must address it or become part of the "conspiracy of silence" (Danieli, 1981, 1984, 1988a).

Bloom (1995) has proposed a germ theory of trauma. Following Pasteur, she suggests that, just as bacterial agents external to an individual cause infection, traumatic experience external to the survivor cause PTSD symptoms. Similarly, one can speculate that such an infection may be contagious to successive generations. Pasteur's discoveries led to direct interventions on causal agents and the mechanisms of infectious transmissions. With respect to the legacies of combat trauma, the causal agent is known. Techniques for addressing it in those directly exposed are continually being refined. If trauma has an infectious aspect, we should not treat just the traumatized individual.

As stated earlier, silence does not prevent the transmission of trauma but, on the contrary, acts as a mechanism of its transmission. Many combat veterans, their spouses, as well as their therapists, are understandably reluctant to expose children to the horrors of war. Age and developmental level of children are crucial in determining the nature of what and how much they can process. The messages, however, are transmitted even if the content of the trauma is not. A portion of the raw affect of the original trauma may be transmitted without processing its meaning. Any effort to prevent the potential damage of transmission necessitates a careful analysis of just how much of the traumatic detail is disclosed and when. Full disclosure is not an objective of treatment. Allowing the family greater control over disclosure and transmitted messages is a more appropriate goal. Understanding the mechanisms of transmission allows therapist and family members to examine the messages conveyed, with or without disclosure of details of the trauma.

The implications of transmission should be an immediate concern for clinicians working with combat veterans. Therapists working with children should be sensitive to the possibility that the behavior observed may be related to the symptoms of a combat veteran father. A thorough assessment should include a trauma history, and should not be limited to combat trauma. A family history of exposure to traumatic events should be taken to identify potential "contagions," as extrapolated from the germ theory. Interventions should focus on the family whenever possible. The mechanisms provide clinicians with expanded choices about how to address intergenerational transmission.

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