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Marital Adjustment, Parental Functioning, and Emotional Sharing in War Veterans

Zahava Solomon¹, Shimrit Debby-Aharon¹, Gadi Zerach², and Danny Horesh¹

Abstract
The current study aimed to examine the implications of posttraumatic stress disorder symptoms and emotional sharing in marital adjustment and parental functioning among Israeli veterans of the 1982 Lebanon War. The sample consisted of combat stress reaction (CSR) veterans (n = 264) and non-CSR veterans (n = 209). Results show that traumatized veterans reported lower levels of marital adjustment and more problems in parental functioning. Furthermore, higher levels of posttraumatic symptoms, especially avoidance symptoms, were related to a decrease in marital adjustment and parental functioning. Most important, emotional sharing was found to moderate the relation between posttraumatic stress disorder severity and parental functioning. Possible explanations, limitations of the current study, and recommendations for future research are presented.

Keywords
PTSD, emotional sharing, marital adjustment, parental functioning

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It is now well established that the experiences of war often cause emotional distress. Some pathological reactions to war are acute and occur on the battlefield or in the immediate aftermath of combat. The most common of these reactions is combat stress reaction (CSR), which is characterized by various symptoms such as paralyzing fear of death, emotional and physical numbness, and severe depression (Kormos, 1978). Previous studies have shown that veterans who experienced an acute traumatic reaction to combat may be at increased risk for more chronic disabling implications that endure for many years, most notably posttraumatic stress disorder (PTSD; Solomon & Mikulincer, 2006).

Beyond the mental distress experienced by trauma survivors, studies have consistently shown the detrimental effects of trauma on the survivor’s family (e.g., O’Donnell, Cook, Thompson, Riley, & Neria, 2006). The majority of studies suggested that posttraumatic stress symptoms largely account for the relationship between war exposure and familial and marital maladjustment (e.g., Dekel, Enoch, & Solomon, 2008). Studies indicate that trauma survivors often experience difficulties in intimacy and marital communication (Cook, Thompson, Riggs, Coyne, & Sheikh, 2004), outbursts of rage and aggression (Beckham & Moore, 2000; O’Donnell et al., 2006), as well as reduced sexual desire and difficulties in sexual functioning (e.g., Johnson & Williams-Keeler, 1998). In addition, studies have found that trauma victims report lower marital satisfaction (Nelson Goff, Crow, Reisbig, & Hamilton, 2007), lower stability (Schumm, Bell, & Gade, 2000), intention to end their marriage (Riggs, Byrne, Weathers, & Litz, 1998), and higher divorce rates (Kulka et al., 1990).

Most studies, however, focused on PTSD victims and only rarely examined CSR casualties. In a previous study, the families of Israeli CSR veterans suffering from PTSD were characterized by low cohesiveness and expressiveness and high conflict as compared with CSR veterans without PTSD (Solomon, Mikulincer, Fried, & Wosner, 1987). Furthermore, although it is assumed that trauma affects the victim’s relationships with the entire family, victims’ functioning as parents has received less empirical attention, and most studies on this topic were limited in scope and based on clinical observations.

Various studies have found that posttraumatic symptoms compromise the veteran’s ability to function as a father (Davidson & Mellor, 2001). It was also found that the relationship between the traumatized veteran and his child is often characterized by entanglement, control, excessive closeness, and overprotectiveness. This, in turn, might lead to various psychopathologic symptoms among victims’ offspring, a phenomenon known as “secondary traumatization” (Harkness, 1991, 1993; Jordan, Marmar, Fairbank, & Schlenger, 2001).
Few explanations were suggested for the difficulties experienced by the traumatized in parental functioning. Among those are difficulties in controlling aggressive impulses, which lead to emotional outbursts and result in an atmosphere of fear, guilt, and caution (Rosenheck, 1986).

Over the years, studies have attempted to examine the relationship between various posttraumatic symptom clusters and both marital and parental functioning. Only one study found an association between symptoms of intrusion and marital difficulties (Hendrix, Jurich, & Schumm, 1995). Several studies have found associations between hyperarousal symptoms and the use of physical and verbal violence in marital relations (Riggs et al., 1998; Taft, Schumm, Panuzio, & Proctor, 2008). However, the link between avoidance symptoms and family functioning is, for now, the most documented in the trauma literature (Cook et al., 2004; Evans, McHugh, Hopwood, & Watt, 2003; Ford, Shaw, & Sennhauser, 1993). Furthermore, studies found that within the avoidance cluster, emotional numbing significantly contributes to problems in marriage and parent–child relationships, independently of other symptoms and of syndrome severity (Cook et al., 2004; Ruscio, Weathers, King, & King, 2002; Taft et al., 2008).

As opposed to avoidance and emotional numbing, self-exposure and emotional sharing were found to be positively related to intimate relationships. Both reflect a process of emotional sharing of thoughts, feelings, and attitudes (Finkenauer & Hazam, 2000). This process is multifaceted, consisting of numerous modes of expression, from sharing simple facts to sharing the most significant intimate personal experiences (Purves & Philip, 2004). It was found that emotional sharing increases closeness and establishes a sense of caring, empathy, and intimacy among family members (Caughlin, 2003; Matsakis, 1996; Vogel, Wester, & Heesacker, 1999). Lack of sharing, on the other hand, makes it hard for both spouses to share their feelings and is related to detachment, distancing, isolation, and conflict among couples (Frederikson, Chamberlain, & Long, 1996). Clark and Phares (2004), for example, found that in families where fathers exhibited more emotional numbing and withdrawal, both the prevalence and the severity of parent–child conflicts were higher.

As opposed to the above findings, there is a controversy in the trauma literature regarding the effects of emotional sharing on one’s mental distress. On one hand, several studies argue that expressiveness plays an important role in the process of recovery (Allen, 1995; Rosenheck & Thomson, 1986). Studies of American veterans from the Vietnam War (Green, Grace, Lindy, Gleser, & Leonard, 1990) or from Somalia (Bolton, Glenn, Orsillo, Roemer, & Litz, 2003) found that those who talked about their military service with
supportive significant others (family member, partner, friend) were at a lower risk of developing PTSD. On the other hand, other researchers claim that sharing traumatic experiences with others is not effective in reducing posttraumatic symptomatology (Kinzie & Boehnlein, 1989; Rime, 1995). A study of soldiers who fought in the Gulf War found no connection between soldiers’ sharing of war experiences with family and friends and the severity of their posttraumatic symptoms (Southwick, Morgan, & Rosenberg, 2000).

The interrelations between PTSD, emotional sharing, and family functioning have been rarely studied. Two studies of ex-prisoners of war found that self-disclosure mediated the relation between PTSD and marital adjustment (Dekel et al., 2008) and between PTSD avoidance symptoms and marital intimacy (Solomon, Dekel, & Zerach, 2008). Another study found that depression, which was characterized by loss of interest and social withdrawal, moderated the relation between PTSD and marital aggression (O’Donnell et al., 2006). To the best of our knowledge, no other study has examined the possible moderating role of emotional sharing with a family member in the relationship between veterans’ PTSD and marital and parental functioning.

The aims of the present study are

1. to assess marital adjustment and parental functioning among veterans who suffered from psychological breakdown (CSR) during the First Lebanon War, with and without current posttraumatic symptomatology, and comparable control veterans;
2. to examine the relative contribution of posttraumatic symptom clusters (intrusion, avoidance, and hyper arousal) to marital adjustment and parental functioning; and
3. to examine the moderating role of emotional sharing in the relationship between posttraumatic symptoms and (a) marital adjustment and (b) parental functioning.

Method

Participants

The sample included 473 male Israeli veterans who took part in active combat in the 1982 Lebanon War. Two groups participated in the study:

a. The combat stress reaction (CSR) group \( (n = 264) \) was sampled from the population of soldiers who fought in the Lebanon War and were diagnosed with CSR and referred for psychiatric intervention
by their battalion physicians on the battlefield during the war (for
details, see Solomon, Shklar, & Mikulincer, 2005).
b. The combat control group with no CSR (n = 209) included veterans
who had fought in the same combat units as the CSR group but had
not shown CSR symptoms. For each CSR casualty, a matched con-
trol participant was randomly selected from among eligible soldiers
who had similar sociodemographic characteristics (age, education,
and military rank and assignment). The difference in the number
of participants between the CSR and non-CSR groups is due to the
differential rate of participation in each group.

There were no significant differences between the two groups in age, level
of education, religiosity, and marital status. Mean age was 46.9 years (SD =
5.76) for the CSR group and 47.59 years (SD =5.40) for the controls. The
level of education was also similar: 20.6% of the CSR group and 17.2% of
the controls had elementary school education, 55.3% of CSRs and 52.2% of
controls had high school education, and the remainder had higher education.
Most participants were married, and this was their first marriage (89% of
CSRs and 91.4% of controls).

It is worth noting that all the veterans in the CSR group had received
immediate treatment on the battlefield. Furthermore, as for postwar therapy
assignment, 59.8% of the CSR group veterans and 10% of the control group
veterans assigned for therapy in the years following Lebanon War until 2002
(for full details, see Solomon, Shklar, & Mikulincer, 2005).

Recruitment and Procedure
Participants were recruited from a pool of participants of a previous study
conducted in 1983. The former study included 360 CSR and 307 controls.
After updating addresses and phone numbers, potential participants were
contacted by telephone, and the aim of the current study was explained. In
the CSR group, 323 veterans were located and 286 of them agreed to par-
ticipate in the current study (88.5%). In the control group, 258 veterans were
located and 218 of them agreed to participate (84.5%). Those who agreed to
participate in the study were offered to meet in their homes or in another
preferred location to complete the questionnaire. Participants signed an
informed consent form before they filled in the questionnaires. Data were
collected in 2002.
Measures

CSR diagnosis during the 1982 Lebanon War was obtained from official military records. PTSD symptoms, emotional sharing, marital adjustment, and parental functioning were obtained from self-report questionnaires in the current study, 20 years after the end of the Lebanon War.

The PTSD Inventory. This inventory (Solomon et al., 1993), a 21-item self-report scale based on the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 1994) criteria, was used to assess the extent of posttraumatic symptomatology (number of symptoms) and the severity of posttraumatic symptoms. The questionnaire consists of statements tapping the DSM-IV symptom criteria. Participants were asked to indicate, on a 4-point scale ranging from never to often, the frequency with which they experienced the described symptom. Cronbach’s alpha for symptom intensity in the current study was .96. Cronbach’s alphas for the symptoms subscales were .93 for the intrusion subscale, .90 for the avoidance subscale, and .91 for the hyperarousal subscale. Concurrent validity of the entire scale is also high, compared with other self-report measures and with a clinical diagnosis of PTSD (Solomon, 1993; Solomon & Horesh, 2007).

Dyadic Adjustment Scale (DAS). The DAS (Spanier, 1976) consists of 31 items that tap four domains of marital adjustment: marital consensus, conflict, cohesiveness, and satisfaction. Participants were asked to indicate the extent to which each item describes their current marital interaction on a Likert-type scale ranging from 1 (very low) to 6 (very high). We calculated the total marital adjustment score by summing up the ratings of the 32 items. The scale has very good convergent validity and discriminant validity (Heyman, Sayers, & Bellack, 1994). Based on a comparison of a community group and a clinical group, the cutoff score between normative and problematic marital relations was set to 98 (Eddy, Heyman, & Weiss, 1991). The scale has been widely used among Israeli populations (e.g., Horesh & Fennig, 2000). Cronbach’s alphas in the current sample ranged between .88 and .89 for the four marital adjustment domains and .95 for the total marital adjustment index.

Emotional sharing. To assess the level of emotional sharing among war veterans, we constructed a short self-report scale based on themes that were drawn from previous interviews we conducted with Lebanon War veterans (Solomon, 1993). The scale consists of the following six statements: “I would rather not show others how I feel inside”; “I feel uncomfortable opening myself to other people”; “I feel comfortable sharing my private thoughts and
feelings with other people”; “I tell everything to the people who are close to me”; “I usually discuss my problems and concerns with people who are close to me”; and “I turn to others for many things, including comfort and approval”. For each statement, participants were asked to rate from 1 to 7 the degree to which they agree with it (1 = not agree at all, 7 = agree very much). Reliability of this scale was α = .79.

**Parental functioning.** A self-report scale was constructed for the purpose of the present study, based in part on the Questionnaire for Assessing Social Impairment (Dekel, Solomon, & Bleich, 2004). The scale includes five items: father’s involvement in the raising of his children, cooperation between both parents in raising their children, meeting the physical and emotional needs of the children, and physical and verbal violence toward the children. This measure was constructed in collaboration with professional social workers who specialize in family therapy among posttraumatic veterans. Furthermore, this measure was constructed using empirical data regarding family life among war veterans. The items were derived from standardized and validated questionnaires (e.g., the “father caring involvement questionnaire”; Levy-Shiff & Israeliashvili, 1988). Respondents were asked to what extent each item described them on a scale of 1 to 4 (not at all, low, medium, high). This measure was previously piloted in a study by Dekel et al. (2004) and provided good Cronbach’s alpha (=.81). Cronbach’s alpha in the current study was .79.

**Life Events Questionnaire.** Life events after the war were measured using Solomon and Flum’s (1988) Life Events Questionnaire, which comprises 23 life events tapping four domains: family (e.g., divorce), work (e.g., dismissal), health (e.g., major disease, hospitalization), and personal events (e.g., accident). Participants were asked whether they had experienced any of the events since the 1982 Lebanon War (yes/no). They were also asked to indicate whether the experienced events were perceived by them as being positive or negative. The sum of negative life events after the war was used for analysis.

**Sociodemographic factors.** Sociodemographic factors measured include age, years of education, marital status, and religiosity (secular, traditional, orthodox).

**Results**

**Marital Adjustment and Parental Functioning**

Table 1 shows the means, standard deviations, and multivariate $F$-test results of the study variables for three comparisons: (1) CSR/non-CSR groups, (2) PTSD/non-PTSD groups, and (3) CSR with and without PTSD/
Table 1. Means and SD of Marital Adjustment and Parental Functioning According to Groups: Combat Stress Reaction (CSR vs. Non-CSR) and Current Posttraumatic Stress Disorder (PTSD vs. Non-PTSD)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Non-CSR (n = 207), M (SD)</th>
<th>CSR (n = 260), M (SD)</th>
<th>F Test, F(1, 472)</th>
<th>Non-PTSD (n = 350), M (SD)</th>
<th>PTSD (n = 123), M (SD)</th>
<th>F Test, F(1, 468)</th>
<th>Non-PTSD (n = 181)a, M (SD)</th>
<th>PTSD (n = 28)b, M (SD)</th>
<th>F Test, F(3, 473)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adjustment</td>
<td>4.93 (0.88)</td>
<td>4.61 (0.94)</td>
<td>14.42***</td>
<td>5.02 (0.76)</td>
<td>3.97 (0.93)</td>
<td>153.68***</td>
<td>5.07 (0.79)</td>
<td>4.02 (0.89)</td>
<td>51.63***</td>
</tr>
<tr>
<td>Parental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>functioning</td>
<td>3.44 (0.48)</td>
<td>3.21 (0.51)</td>
<td>24.91***</td>
<td>3.42 (0.41)</td>
<td>3.00 (0.64)</td>
<td>66.36***</td>
<td>3.49 (0.37)</td>
<td>3.07 (0.81)</td>
<td>26.32***</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .00.
non-CSR with and without PTSD. We performed an analysis of variance (ANOVA) test to examine group differences on marital adjustment and parental functioning. The ANOVA yielded a significant effect for group (CSR/non-CSR), $F(1, 473) = 14.42, p < .00$. An ANOVA test for parental functioning also yielded a significant effect, $F(1, 466) = 24.91, p < .00$. As can be seen in Table 1, the CSR group reported lower levels of marital adjustment and parental functioning than the non-CSR group.

Similarly, we performed a second set of ANOVA tests to examine group differences between the PTSD and non-PTSD groups. The ANOVA test for marital adjustment yielded a significant effect for group (PTSD vs. non-PTSD), $F(1, 473) = 153.68, p < .00$. An ANOVA test for parental functioning also yielded a significant effect, $F(1, 466) = 66.36, p < .00$. As can be seen in Table 1, the PTSD group reported lower levels of marital adjustment and parental functioning than the non-PTSD group.

We performed a third set of ANOVA tests to examine group differences among the four groups: CSR with and without PTSD and non-CSR with and without PTSD. The ANOVA test for marital adjustment yielded a significant effect for group, $F(3, 473) = 51.63, p < .00$. Post hoc Scheffé tests showed that the CSR with PTSD and non-CSR with PTSD groups reported lower levels of marital adjustment and parental functioning as compared with the CSR without PTSD and non-CSR without PTSD groups.

**PTSD Symptom Clusters, Marital Adjustment, and Parental Functioning**

Three-step hierarchical regression analyses were conducted to examine the unique contribution of each posttraumatic symptom cluster to marital adjustment and parental functioning. The two outcome variables were regressed on three symptom clusters: intrusion, avoidance, and hyperarousal.

In the first step of each regression, we entered three demographic variables: age and number of both negative and positive life events. We used these variables to statistically control for intervening effects. In the second step, we entered the group variable (CSR vs. controls). In the third step, the symptom clusters (intrusion, avoidance, and hyperarousal) were entered into the regression equation.

As can be seen from Table 2, although all three symptom clusters made a significant contribution to marital adjustment, the avoidance cluster was found to be the most powerful predictor. Avoidance explained 11% of the variance in marital adjustment, beyond the variance explained by the covariates. It is also important to note the significant contribution of negative life events ($\beta = -.39$, ...
Table 2. Regression Effects of PTSD Symptom Clusters on Marital Adjustment and Parental Functioning

<table>
<thead>
<tr>
<th>Variable</th>
<th>Marital Adjustment</th>
<th>Parental Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model 1</td>
<td>Model 2</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>Age</td>
<td>.08</td>
<td>.07</td>
</tr>
<tr>
<td>Positive life events</td>
<td>.17**</td>
<td>.02</td>
</tr>
<tr>
<td>Negative life events</td>
<td>-.40***</td>
<td>.05</td>
</tr>
<tr>
<td>Group (CSR/ non-CSR)</td>
<td>.07</td>
<td>.07</td>
</tr>
<tr>
<td>Intrusion</td>
<td>-.10</td>
<td>.02</td>
</tr>
<tr>
<td>Intrusion R²</td>
<td>29.6%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Intrusion F change</td>
<td>65.79***</td>
<td>.83</td>
</tr>
<tr>
<td>Avoidance</td>
<td>-.16</td>
<td>.08</td>
</tr>
<tr>
<td>Avoidance R²</td>
<td>40.5%</td>
<td></td>
</tr>
<tr>
<td>Avoidance F change</td>
<td>84.30***</td>
<td></td>
</tr>
<tr>
<td>Hyperarousal</td>
<td>-.13</td>
<td>.01</td>
</tr>
<tr>
<td>Hyperarousal R²</td>
<td>34.7%</td>
<td></td>
</tr>
<tr>
<td>Hyperarousal F change</td>
<td>35.45***</td>
<td></td>
</tr>
</tbody>
</table>

Note: PTSD = posttraumatic stress disorder; CSR = combat stress reaction.
*p < .05. **p < .01. ***p < .00.
$p < .00$). Overall, the total set of variables (including group and posttraumatic symptom clusters) accounted for 32.9% of the variance in marital adjustment, $F(5, 467) = 45.71, p < .00$; 40.5% of the variance with avoidance as predictor variable, $F(5, 467) = 63.54, p < .00$; and 34.7% of the variance with hyperarousal as predictor variable, $F(5, 467) = 63.54, p < .00$.

A similar pattern was observed with regard to parental functioning. As can be seen in Table 2, all three symptom clusters were found to be significant predictors of parental functioning, with the avoidance cluster being the most powerful predictor. Avoidance explained 5% of the variance of parental functioning, beyond the variance explained by the covariates. Overall, the total set of variables (including group and posttraumatic symptom clusters) accounted for 23.2% of the variance in parental functioning, $F(5, 461) = 27.29, p < .00$; 27.8% of the variance with avoidance as predictor variable, $F(5, 461) = 35.53, p < .00$; and 25.1% of the variance with hyperarousal as predictor variable, $F(5, 467) = 30.84, p < .00$.

The Moderating Role of Emotional Sharing

To examine the moderating role of emotional sharing on the relation between PTSD severity and marital adjustment and parental functioning, a series of hierarchical regressions was performed in accordance with procedures described by Baron and Kenny (1986); see Table 3. Because none of the interaction effects were significant for the total marital adjustment score, we will present only the results concerning parental functioning.

The total set of variables explained 31% of the parental functioning variance, $F(6, 460) = 34.41, p < .00$. As can be seen in Table 3, negative and positive life events variables were found to significantly contribute to parental functioning. Posttraumatic severity and emotional sharing made a significant contribution. The more posttraumatic symptoms one endorsed, the lower one’s level of parental functioning; and the higher one’s level of emotional sharing, the higher one’s level of parental functioning.

The interaction between PTSD severity and emotional sharing was significant, ($F$ change = 4.5, $p < .05$). We used Aiken and West’s (1991) recommendations for exploration of interactions in multiple regressions. First, we created two groups by dividing the total sample according to high and low emotional sharing (1 SD below and above the median). Second, PTSD severity was regressed on parental functioning, separately for the high and low emotional sharing groups. In the low emotional sharing group, we found that PTSD severity significantly contributed to parental functioning ($\beta = -.30, p < .01$). In the high emotional sharing group, we found a lower
and nonsignificant contribution ($\beta = -.08$, $p =$ nonsignificant). These results demonstrated the moderating role of emotional sharing. Veterans with more posttraumatic symptoms reported lower levels of parental functioning, and this negative association was stronger among participants with low levels of emotional sharing.

**Discussion**

The results of this study indicate that 20 years after the war, veterans suffering from posttraumatic symptoms, with and without antecedent CSR, report lower levels of marital adjustment and more problems in parental functioning compared with veterans without posttraumatic symptomatology. It was also found that the level of posttraumatic symptoms is negatively associated with marital adjustment and parental functioning and that avoidance, more than intrusion and hyperarousal, contributes to this association. In addition, it was found that emotional sharing moderates the relationship between PTSD severity and parental functioning, but not between PTSD severity and marital adjustment.
These findings are in line with previous studies, in which posttraumatic war veterans reported low marital satisfaction (Caselli & Motta, 1995), difficulties in marital communication and intimacy (Cook et al., 2004), dissatisfaction with marital relations (Riggs et al., 1998), ineffective patterns of communication and familial conflict resolution (Ford et al., 1993), a more negative perception of marital interactions, and a stronger will to end their marriage (Riggs et al., 1998). Similarly, in a previous study, CSR veterans of the Lebanon War who have also endorsed posttraumatic symptoms reported lower levels of social and familial functioning compared with CSR casualties without PTSD (Solomon & Mikulincer, 2007). In addition, the family environment of CSR casualties with PTSD was characterized by less cohesiveness and expressiveness and more conflict (Solomon et al., 1987).

The research literature suggests several possible explanations for problems in marital adjustment among traumatized war casualties (Jordan et al., 1992; Solomon et al., 1987). Traumatized soldiers returning from the battlefield are sometimes left with feelings of anger and rage that might erupt and lead to aggressive behavior toward one’s family. Empirical studies of war veterans consistently reveal anger, hostility, aggressiveness, violence, and abuse in their families (Evans et al., 2003; Herman, 1997; Williams, 1980). Many traumatized veterans also report avoidance of social relations and emotional numbness (e.g., Galovski & Lyons, 2004) that inhibit their capacity for intimacy. These difficulties are manifested in a number of ways, including in the couple’s sexual relations. Traumatized veterans tend to report a significant decline in sexual activity and interest, sometimes to the degree of complete sexual abstinence (e.g., Litz, Keane, Fisher, & Marx, 1992). As a result of the decline in sexual desire and sexual functioning, spouses often feel rejection, frustration, and low self-worth (Williams, 1980).

The findings of the present study also indicate that PTSD casualties reported poorer parental functioning, as reflected in the level of involvement in child rearing, cooperation with one’s spouse, the degree to which one satisfies the physical and emotional needs of one’s children, and the level of physical and verbal violence aimed at them.

These findings are in line with previous studies (Davidson & Mellor, 2001; Ruscio et al., 2002). The literature points to several possible processes that are involved in PTSD casualties’ parental dysfunction. One process has to do with victims’ difficulties in controlling their aggressive impulses. This makes it hard for them to create a positive atmosphere in which their children may develop (Rosenheck & Fontana, 1998). In addition, the pressures of
child rearing may themselves be particularly difficult for veterans with PTSD, and therefore exacerbate their distress (Haley, 1984).

The problems in marriage and in parenting were found to be more strongly associated with avoidance than with either intrusion or hyper arousal. As for marital adjustment, these findings are in line with previous studies, in which symptoms of posttraumatic avoidance were found to be related to problems in marital functioning (e.g., Cook et al., 2004; Riggs et al., 1998). Similarly, the effect sizes and explained variance of avoidance symptoms were found to be relatively equivalent to other studies (Evans et al., 2003; Taft et al., 2008). These findings support the idea that avoidance symptoms play a crucial role in veterans’ family life. Frederikson et al. (1996), for example, have found that posttraumatic avoidance is the symptom most significantly associated with spouses’ wish for separation or divorce. In an attempt to explain these findings, Rosenheck and Thomson (1986) have argued that the veteran’s avoidance creates a vicious circle, where his reluctance to talk about past experiences only strengthens his feelings of uncertainty and his wife’s apprehension. The tension expressed by the wife, in turn, is experienced as intolerable by the veteran and thus pushes him toward further withdrawal.

As for parental functioning, studies have shown that detachment, emotional unavailability, and lack of interest that characterize posttraumatic avoidance and emotional numbing may undermine the traumatized father’s ability to properly interact with his children and to establish a meaningful relationship with them (Ruscio et al., 2002). In a study by Samper, Taft, King, and King (2004), for example, avoidance and emotional numbing were found to be major predictors of low parental satisfaction among men suffering from PTSD. In addition, the difficulties trauma casualties have in controlling their impulses may lead to emotional outbursts, thereby creating a constant atmosphere of fear among their children (e.g., Hosin, 2001). Consequently, victims may have strong feelings of guilt for hurting their children and for not functioning properly as fathers and as role models. Under such family circumstances, traumatized fathers may resort to the possibility of emotional avoidance.

Finally, it was hypothesized that emotional sharing will moderate the connection between the severity of posttraumatic symptoms and both marital adjustment and parental functioning. This hypothesis was supported only with regard to parental functioning but not vis-à-vis marital adjustment. More specifically, a significant negative relation was found between the severity of posttraumatic symptoms and parental functioning, and this association was particularly strong among veterans with low levels of emotional sharing.
This finding underscores the importance of openness and emotional sharing in parent–child relationships, particularly among traumatized individuals (Caughlin, 2003; Clark & Phares, 2004; Ruscio, 2002; Samper et al., 2004). Similarly, Clark and Phares (2004) found that fathers who exhibited low levels of emotional availability experienced more intense and frequent conflicts with their children. Findings such as these highlight the importance of emotional sharing in improving the relationship between trauma victims and their children. They also suggest that even when posttraumatic symptoms are severe, emotional sharing may enable parents to sustain a positive relationship with their children.

Previous studies have shown that wives of posttraumatic casualties perceive the level of communication and emotional sharing between them and their husbands as important (e.g., Dekel, Goldblatt, Kiedar, Solomon, & Polliack, 2005). However, emotional sharing was not found to moderate the adverse effects of PTSD on marital adjustment in the present study. Nonetheless, it did moderate the effect of PTSD on parental functioning. This difference may have to do with the fact that marital relationships are fundamentally different from one’s relationship with one’s children. One’s wife is the main witness to the personal changes one goes through following combat (Figley, 1978). These changes are often accompanied by great difficulties in the couple’s relationship. Thus, it may be that the veteran’s expressiveness—although important—is simply not sufficient for reducing the high levels of marital conflict.

In addition, it was already noted that the implications of emotional sharing largely depend on the environment’s reaction to it (Ullman & Filipas, 2001). Because marital relations are often severed following trauma, the veteran’s wife might not respond positively to his attempts to share his experiences. The lack of support from one’s spouse might then exacerbate one’s distress and intensify posttraumatic symptoms, which in turn augment marital conflict.

The present study has several methodological limitations. First, the questionnaires assessing emotional sharing and parental functioning were constructed especially for the purpose of the present study and therefore need to be further validated by other studies. Second, our study focused on a very specific population—Israeli male war veterans. Therefore, the possibility of generalizing our findings to a female population, or alternatively to victims of trauma that is not war related, may be somewhat limited. Finally, the present study—like most trauma studies—is correlative in nature and therefore cannot directly point to causality.
Despite these limitations, however, this study has both empirical and practical importance. Empirically, it provides further support to previous studies investigating the family relations of posttraumatic casualties. Our findings show that 20 years after the Lebanon War, posttraumatic symptoms—and especially avoidance symptoms—have significant negative implications for casualties’ family relations and parental functioning. Also, this study suggests a complex perspective on the effectiveness of emotional sharing vis-à-vis parental functioning and marital adjustment. We have suggested here that the level of effectiveness may be related to factors such as the nature of expressiveness, its timing, and the listener’s reaction to it. Future studies are encouraged to conduct a more comprehensive examination of factors related to the effectiveness of expressiveness following trauma.

This study provides further evidence that trauma affects not only its direct victims but also those surrounding them. It also shows the important contribution of emotional sharing to trauma survivors’ interpersonal relations. On a practical level, the results of this study encourage family treatment interventions, especially ones that aim to improve the ability for emotional sharing among PTSD casualties and their families. These interventions should target both the traumatized and their family members. Thus, they should help victims develop effective ways of expressing their thoughts and feelings and at the same time promote more tolerance and understanding on the side of family members. Only under these conditions will trauma casualties and their families benefit from emotional sharing.

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