

## **Chapter 7: Secondary traumatization among wives of war veterans with PTSD**

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I'm afraid for myself, of what I've become since the war. Our entire life is lived under pressure. I feel I'm in a war day in day out to keep my sanity. I married a man who was happy, sociable, and diligent....Today he's impatient, tired, depressed, anxious, and vulnerable; he can't hold a job, yells at the kids, and is indifferent towards me. I feel rejected and socially isolated. I'm angry. Sometimes I feel that I don't want to live.

This statement describes some of the feelings and experiences of the wife of a traumatized Israeli veteran of the Lebanon War. They are typical of many wives of traumatized veterans. Along with other manifestations of distress, they make the wives of traumatized veterans indirect victims of their husbands' traumatic experience.

In this, wives of traumatized veterans are one of various groups of persons who have been identified as suffering psychological consequences of traumatic events which they did not experience at first hand, but through their close proximity to a direct victim. These groups include family members of Holocaust survivors (e.g., Danieli, 1986; Lev-Wiesel & Amir, 2001), children of combat soldiers (e. g., Rosenheck & Nathan, 1985), and therapists (e.g., Azar, 2000; Iliffe & Steed, 2000; McCann & Pearlman, 1990; Schauben & Frazier, 1995), rescue workers (e. g., North et al., 2002) and others who come into intimate contact with victims of natural and man made disasters.

This chapter reviews the literature on the secondary traumatization of wives of traumatized combat veterans. Secondary traumatization is one of several terms, including: “compassion stress,” “compassion fatigue,” and “secondary victimization” (Figley, 1983), “co-victimization” (Hartsough & Myers, 1985), “traumatic countertransference” (Herman, 1992), and “vicarious traumatization” (McCann & Pearlman, 1989), that have been used to label the manifestations and processes of distress reported by persons in close proximity to victims of traumatic events that they themselves did not actually experience.

The term is used in this chapter, as in the literature, in both its narrow and broad sense. In the narrow sense, it refers to the transmission of nightmares, intrusive thoughts, flashbacks and other symptoms typically experienced by traumatized individuals, to persons close to them. In the broad sense it refers to any transmission of distress from someone who experienced a trauma to those around him or her and includes a wide range of manifestations of distress in addition to those that mimic PTSD (Galovski & Lyons, 2004).

Some 15% to 40% of war veterans develop PTSD. By its nature, this is a disorder that puts tremendous difficulties in the way of the injured veteran's personal relations and functioning (Solomon, 1993). The avoidance symptoms of psychic numbing, withdrawal, detachment, constricted affect, and loss of interest in previously enjoyed activities are symptoms that undermine the individual's ability to maintain the intimacy of family life (Riggs et al., 1998). The hyper-arousal symptoms include heightened irritability and hostility, which would make it difficult for the afflicted veteran to control his aggression. In addition, many PTSD casualties experience reduced sexual drive and problems in sexual functioning (Letourneau, Schewe, & Frueh, 1997; Kotler et al., 2000). Many have difficulty in functioning outside the

home, both socially and at work, resulting in unstable employment and high unemployment rates (Solomon, 1993).

The first two sections of this chapter briefly summarize some descriptive accounts of being married to a PTSD veteran and the empirical findings on the wives' secondary traumatization. The third section deals with separation and divorce among these couples. The fourth and fifth sections deal respectively with factors that have been found to predict secondary traumatization and with theoretical explanations of the phenomenon. The sixth section discusses treatment. The last section summarizes what is and is not known to date and makes recommendations for further study.

The chapter confines itself to what happens to the wives after their husbands return from service and does not address their experiences or state of mind when their husbands' are away. It does not discuss the possible secondary traumatization of men whose wives served in the military and suffer from PTSD. Nor does it discuss the consequences of PTSD for partners of persons whose PTSD stems from other traumatic events, ranging from the Nazi Holocaust, through natural disasters, mass displacements, or personal traumas such as rape. Although all these issues are important, they are beyond the scope of this chapter.

#### Descriptive accounts of living with traumatized veterans

The first accounts of the secondary traumatization of wives of traumatized veterans were clinical descriptions of living with veterans of the Vietnam War published in the 1980's. These accounts do not use the term secondary traumatization and do not mention PTSD, which was not well known yet. They do, however, provide clear testimony of the great distress the women suffered.

Williams (1980), based on group therapy sessions with veterans' wives, relates

the "spread of effect" of the traumatized veterans' symptoms; the distress the women suffered as a result of their husbands' distancing and violence; and the "compassion trap" in which they found themselves when they sacrificed too many of their own needs in their efforts to improve their husbands' situation and to preserve their family life. Maloney (1988) describes six wives of Vietnam veterans with clear PTSD symptoms, including dreams of the war and panic attacks triggered by the same triggers as their husbands', such as the buzz of helicopters, sudden noises, gunfire, and the smell and sound of spring rain. In similar vein, Matsakis (1988) relates that the women in her support groups for veterans' wives told of dreaming of Vietnam, of suffering from insomnia and startle reactions, and of being hyper-vigilant around their potentially violent husbands, and of feeling isolated and helpless in their marriages.

Mason's (1990), in a detailed and vivid book about life with her traumatized husband, describes , along with her PTSD symptoms, her fear of her husband's erratic explosions, her sense of "walking on eggshells," the effort and energy she invested in trying to keep her husband from getting upset and flying into a rage; as well as her struggle to fulfill multiple roles: of cook, provider, and housekeeper; of only parent to her children and her husband's only friend and rescuer.

These accounts convey a good sense of what living with a traumatized veteran can be like and the difficulties and distress it can cause. The details of these accounts are familiar today. At the time they were written, however, there was little awareness that trauma could be transmitted to someone who did not actually experience the traumatic event. Their importance for us today lies in the fact that they opened the door to the systematic research that followed.

Empirical findings of secondary traumatization in wives of PTSD veterans

The empirical studies of secondary traumatization of wives of PTSD veterans examine the wives' emotional distress and their perceptions of their marital relationships.

*The Wife's Distress:* The first large systematic study that examined the impact of PTSD on the emotional life of veterans' wives was Kulka et al.'s (1990) national epidemiological study of the impact of PTSD on the families of Vietnam War era veterans. The study reports indications of secondary traumatization in both the wife and children, though it does not identify it as such. In a sub-sample of 466 families, the authors found that the wives of PTSD veterans had lower subjective well-being and a greater sense that they were on the verge of a nervous breakdown than the wives of non-PTSD veterans. In a further analysis of this sub-sample, Jordan et al. (1992) found that the wives of PTSD veterans reported significantly lower happiness and life satisfaction and higher demoralization than the wives of veterans without PTSD.

In tandem, a more specific study was carried out by Solomon et al. (1992a) on 205 wives of Israeli combat veterans of the 1982 Lebanon war. This study, which focused solely on veterans' wives, examined a range of psychiatric symptomatology and social effects. The findings show that the wives of PTSD veterans reported significantly higher levels of somatization, depression, obsessive-compulsiveness, anxiety, paranoid ideation, interpersonal sensitivity, hostility, and somatic complaints, than the wives of non-PTSD veterans, as well as greater loneliness and dissatisfaction with their wider social network. These findings, obtained six years after the war, provide further evidence of heightened emotional distress among wives of PTSD veterans. Similar findings were obtained on another sample of wives of Israeli war veterans of the Lebanon war some twenty years after (Ben-Arzi, Solomon, & Dekel, 2000).

Further evidence of secondary traumatization of the wives of traumatized veterans is provided by Dirkzwager, Bramsen, Ader, and van der Ploeg's (2005) study of 708 partners of Dutch peacekeepers. Their findings showed that the partners of peacekeepers with PTSD reported more sleep problems, somatic problems, and negative social support than partners of peacekeepers without PTSD, and judged their marital relationship less favorably.

In addition, these authors linked the wives' distress specifically to the marital situation. For the purpose of comparison, the authors also examined the responses of 332 of the peacekeepers' parents. No evidence of secondary traumatization was found among the parents, and no differences were found between parents of peacekeepers with and without PTSD. These findings suggest that it is the intimate nature of the marital relationship that makes the wife more vulnerable to secondary traumatization than members of the extended family.

***The Marital Relationship:*** The first studies of the impact of PTSD on the marital relationship were carried out on the veterans themselves. These studies showed that the PTSD veterans reported less marital satisfaction, less intimacy, and less self disclosure and expressiveness than non-PTSD veterans and more hostility and physical violence (e.g., Carroll, Rueger, Foy & Donahoe, 1985). While these findings point to difficulties in the marital relationships of PTSD veterans, it took another few years for researchers to realize that it was important to query the wives as well as their husbands.

The studies of the wives and couples provide evidence both of heightened marital distress among women married to veterans with PTSD and more dyadic problems in the couple relationship. Studies of wives of veterans of the Vietnam (Wilson & Kurtz, 1997) and Lebanon war veterans (Solomon et al., 1992b; Mikulincer, Florian,

& Solomon, 1995) show that wives of PTSD veterans report greater spousal conflict, less intimacy, less cohesion, and less marital satisfaction than wives of non-PTSD veterans, as well as more verbal and physical violence by their husbands (Frederikson, Chamberlain, & Long, 1996; Jordan et al., 1992; Rosenheck & Thomson, 1986). With respect to dyadic problems, Riggs et al. (1998) found that over 75% of Vietnam veterans with PTSD and their partners had Dyadic Adjustment Scale scores in the clinically significant range of marital distress, in contrast to 32 % of couples where the veteran did not have PTSD. Using a different measure, Dirkzwager et al. (2005) found that 24% to 39% of the partners of peacekeepers with PTSD symptoms scored in the range of a clinically problematic relationship, compared with 16% of those whose man did not have PTSD symptoms. These findings suggest that heightened marital distress and impaired dyadic relationships are also manifestations of secondary traumatization.

These empirical findings were obtained with respect to different wars, at different times, and in different countries, including the United States, Israel, Australia, and Holland. They provide solid evidence of the existence of secondary traumatization among veterans' wives. They also raise important questions: What keeps these women in their troubled marriages? What predicts which women are most likely to develop secondary traumatization and which ones are less likely? What treatment is available for the victims of secondary traumatization?

The remainder of this chapter discusses the answers that the literature to date provides to these questions.

### Separation and Divorce

The chronic strain that PTSD places on both partners in the marriage and on the

relationship between them might lead us to expect heightened divorce rates among such couples. This expectation was well borne out in the aftermath of the Vietnam War. Reports on Vietnam veterans indicate much higher rates of divorce than among the rest of the population (Center for Policy Research, 1979). The expectation has not been borne out among Israeli couples, however. Data from in Israel indicate no upsurge in separation and divorce among traumatized veterans, whose divorce rates are no different from those of other Israelis.

Two questions arise. One is why women who remain married to PTSD veterans stick it out, despite their great distress and the problems in the relationship. The other is what enables them to stay in their troubled marriages. To our knowledge, the only study that has addressed these questions to date is a qualitative study of nine wives of Israeli veterans with PTSD (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005a).

With regard to the first question, most of the women who participated in the study told the researchers that they had considered divorce and some that they had even discussed the possibility with her husbands but decided not to go through with it. As they explained it, they were stopped by a strong sense of moral commitment, stemming mainly from personal loyalty and internalized social norms, but, in some cases, also from fear for their husband's lives. Most of the women told of a good marital relationship prior to their husband's developing PTSD. They described living happily with men who had been healthy, strong, and supportive. This, they said, reinforced their commitment to their husbands and their moral obligation to weather the difficult times with them. Their general sense was that one does not dump a man in time of hardship. For most of the women, this sense of obligation was reinforced by the conviction, strongly held throughout Israeli society, that one does not abandon an injured soldier in the field. As one put it:

For me it's like abandoning an injured soldier on the battlefield or abandoning someone sick... We created a family together; our relationship was established before; it's not like I'd break up the whole package because he's not pulling his weight. It doesn't work like that.

Some of the women who wanted to leave told that they were locked in their marriages by explicit threats their husbands made to commit suicide if they did. These women felt that they could not take the responsibility if their husband acted on his threat. All in all, the women who participated in the study did not feel that they really had the option of leaving their husbands. Boss (1999) noted a similar lack of choice for spouses of persons with other emotional or physical disabilities.

With regard to the second question, the women attributed their ability to cope with the many difficulties arising from their husband's PTSD to several sources. One was the reservoir of good feelings they had from when their husbands were vibrant, healthy individuals and their marriages were happy. Another was watching their husband struggle with his PTSD day in and day out. This deepened their appreciation of his courage and determination, as well as their love for him, and also served as an example which encouraged them to struggle on as well. A third source of strength, reported by a few of the women, was an increased sensitivity on the part of their husbands. These women reported that their husband's difficulties and vulnerabilities seem to have made him more aware than he had previously been of the emotional difficulties that she and their children experienced. Finally, most of the women told that they gained a sense of strength and empowerment from their own struggle to help their husbands and to keep the family together. These initial observations suggest that there is some compensation or redress for the many difficulties and burdens of living with a PTSD husband.

The observations are consistent with the concept of post-traumatic growth proposed in recent literature (e.g., Tedeschi & Calhoun, 1996). This concept maintains that exposure to traumatic events may result not only in psychological distress but also in psychological and spiritual growth. The claim is that the struggle with the distress attendant on the traumatic exposure issues, among other things, in a heightened sense of power and mastery and a greater valuation of life and sense of meaning. These outcomes are very close to those described by the nine wives.

The question remains, however, of how generalizable the experiences of this small group of Israeli wives are to the wives of PTSD veterans elsewhere. In contrast to traumatized Vietnam War veterans, Israeli veterans with PTSD are not prone to self-medicate with alcohol and drugs, and are no more prone than other Israeli men to abuse their wives physically. These factors probably made living with the traumatized Israeli veterans less unbearable than living with their American counterparts. Moreover, despite rising divorce rates, Israeli society remains a traditional, family-oriented society, in which family unity is a central value (Cohen, 2003). We know that how families cope with a member's disability is affected by the unique social, historical, and cultural context of the society in which they live (Boss, 1987; Tubbs & Boss, 2000).

#### Predictors of Secondary Traumatization among Wives of PTSD Veterans

The literature shows considerable variance in the adjustment of wives of PTSD veterans. Jordan et al. (1992), for example, found that although 42% of the wives of PTSD veterans reported feeling demoralized, 24% reported that they were satisfied with their lives. Such variability, which has been found in other studies of wives of PTSD veterans (Riggs et al., 1998; Solomon et al., 1992a), gives rise to the question

of what predicts the different outcomes.

Broadly speaking, three main sets of predictors have been examined in the literature: predictors pertaining to the husband's PTSD, predictors pertaining to the wife, and predictors pertaining to the couple relationship.

***Predictors pertaining to the husband's PTSD:*** These predictors include the severity of the PTSD, the avoidance symptoms, and the husband's violence.

*PTSD severity:* Not surprisingly, several studies show that the more severe the husband's PTSD, the more severe the wife's distress (Beckham, Lytle, & Feldman, 1996; Riggs et al., 1998), and also that changes in the husband's PTSD severity predicted analogous changes in the wife's psychological distress and dysphoria (Beckham et al., 1996). Of particular interest is a study by Bramsen, van der Ploeg, and Twisk (2002), which suggests that the wife's distress is not only a function of her husband's PTSD, but also impacts on it. These authors examined the long term psychological adjustment of 444 elderly Dutch couples drawn from a community sample some 50 years after the end of World War II. Both members of the couple had been exposed to the ravages of the war. These authors found that the level of each spouse's PTSD symptomatology was predicted not only by his or her own wartime experiences, but, beyond this, also by the severity of their spouse's PTSD. This finding brings home the spiralic inter-relationship of post-traumatic distress in married couples. If the finding can be generalized to couples where only the man had direct exposure to the traumatic event, it suggests that the wife's secondary traumatization could exacerbate his PTSD, which in turn would exacerbate her own secondary traumatization.

*Avoidance symptoms:* Several researchers went beyond the severity of the PTSD to examine the contribution of the three symptoms clusters to the quality of the

marital relationship. These studies show that, of the three clusters, the avoidance symptoms make the greatest contribution to the quality of the marital relationship and, moreover, that within the avoidance cluster, symptoms of involuntary emotional numbing (e.g., emotional restriction, detachment from others) are more strongly related to the quality of the relationship than symptoms of effortful avoidance (e.g., attempts to avoid reminders and attempts to avoid thoughts and feelings) (Cook, Riggs, Thompson, & Coyne, 2004; Evans, Mchugh, Hopwood, & Watt, 2003; Riggs et al., 1998). Riggs et al.,(1998) attribute the damage caused by emotional numbing to the marital relationship to the deficit it entails in the experience and/or expression of positive emotions (Litz, 1992). Since emotional expression plays an important role in the intimate exchanges integral to well functioning relationships, the absence of or inability to express positive feelings toward a partner would diminish the quality of the relationship.

*Husband's Violence:* Several studies also show that the more frequent the PTSD husbands' violence towards his wife, the higher the wife's distress (Calhoun, Beckham & Bosworth, 2002) and the lower her martial satisfaction (Dekel & Solomon, In press). These findings are similar to those found in the general population (Daniels, 2005; Woods, 2005). They are of special concern here because of the relatively high level of spousal violence perpetrated by men with PTSD (Byrne & Riggs, 1996; Jordan et al., 1992; Kulka et al., 1990).

*Predictors pertaining to the wife:* Two predictors pertaining to the wife have been examined: her caregiver burden and her separation-individuation.

*Caregiver burden:* Caregiver burden is defined as the perception that one's emotional or physical health, social life, or financial status is adversely affected by caring for a relative who is ill or has special needs (Zarit, Todd, & Zarit, 1986).

Hankin, Abueg, Gallagher-Thompson, and Murphy (1992) describe PTSD as a long-term condition that places a heavy burden on the caregiving partner, similar to that borne by partners of other persons suffering from chronic impairments. Findings in Israel (Bleich, Solomon, & Dekel, 1997) show that the burden borne by wives of PTSD veterans is similar in its intensity and components (Novak & Guest, 1989) to that borne caretakers of the elderly (Caserta, Lund & Wright, 1996). In both cases, the most onerous components of the overall burden were the time pressures stemming from the demands of caretaking and the sense that the caretaker's personal development was sacrificed to the needs of the person being cared for. These were followed by chronic fatigue and physical effort attendant on caretaking. In both groups, the conflicts between the obligations of caretaking and other obligations (e.g., to children, work) and the negative feelings (e.g., frustration, resentment) evoked by the caregiving ranked at the bottom of the scale.

Several studies conducted on American and Israeli wives of PTSD veterans found that the greater their sense of caregiver burden, the greater their emotional distress (Beckham et al., 1996; Ben Arzi, Solomon, & Dekel, 2000; Calhoun et al., 2002). Calhoun et al. (2002) also found that changes in the wives' sense of burden over time predicted analogous changes in their psychological distress, dysphoria, and state anxiety. The role of caregiver burden in wives' secondary traumatization is further highlighted by findings that this variable completely mediated the associations between veterans' psychiatric symptoms and their wives' symptoms, and between veterans' functioning and wives' marital adjustment (Dekel, Solomon, & Bleich, 2005b).

It is also of note that findings also show that wives' sense of caregiver burden was associated both with the severity of their husband's PTSD (Beckham et al., 1996)

and with the degree of impairment in his day to day and occupational functioning (Dekel, et al., 2005b).

*Wives' separation-individuation:* Separation-individuation refers to the establishment of a distinct sense of self, through the achievement of emotional autonomy and independence from the mother (Mahler, Pipe, & Bergman, 1975). Findings show that individuals with high levels of separation-individuation enjoy a good sense of mastery, increased coping ability, and reduced anxiety and inner conflict, which facilitate their coping with difficulties in the marital system (Blos, 1979; Bowen, 1978). The importance of separation-individuation to the emotional adjustment of wives of PTSD veterans is suggested by the qualitative study discussed above of nine Israeli women married to such veterans (Dekel et al., 2005a). These women described a constant struggle to lead a life of their own even as they were drawn into fusion with their needy husbands. They described the struggle to set boundaries and maintain individuation, as their care-giving encroached on their private space. Those women who did not succeed in maintaining a degree of autonomy and independence from their PTSD husband reported feeling that they were drowning in his experiences and demands.

Only one study to date has empirically examined the relationship between the adjustment of wives of PTSD veterans and their separation-individuation (Ben-Arzi, Solomon, & Dekel, 2000). This study shows that women with higher levels of separation individuation reported lower sense of burden and less psychological distress. The explanation may lie in Bowen's (1978) claim that high levels of separation-individuation enable one to maneuver between intimacy and autonomy in the family system. If this is the case, high levels of separation-individuation might enable wives of PTSD veterans to act as caregivers and supportive partners without

being emotionally overwhelmed or losing their autonomy and identity in the process.

***Predictors pertaining to the marital relationship:*** The association between the marital relationship and the secondary traumatization of women married to PTSD veterans has been examined in several ways. Solomon, Waysman, Avitzur, and Enoch (1991) examined the contribution of the wives' relationships with key members of their family and social networks. Their findings show that of all the relationships examined – between the wife and her father, mother, mother-in-law, siblings, husband, and children, and friends -- the only one that made a significant contribution to reducing the wives' distress was their relationship with her husband. In particular, a good marital relationship contributed significantly to reducing the wives' depression, anxiety and hostility.

Waysman, Mikulincer, Solomon, and Weisenberg (1993) examined the role of family environment. Their findings showed that wives in 'conflict oriented families' reported the highest levels of psychiatric symptomatology and loneliness, while those in 'expressive families' reported the lowest levels of both. Further evidence of the emotional benefits of expressiveness come from Solomon et al., (1991) findings that high expressiveness, defined as the degree to which the marital relationship allowed for open and direct expression of feelings, was significantly associated with positive psychological adjustment among wives of traumatized combat veterans, whereas marital cohesion, intimacy, and conflict were not.

These findings all point to the key role that the nature and quality of the marital relationship plays in the wife's secondary traumatization. They indicate that a good marital relationship, and especially an expressive one, can mitigate the wife's distress, while a poor relationship, especially a conflicted one, can exacerbate it.

The findings are problematic in two respects, however. None of the studies cited

controlled for the severity and manifestations of the husband's PTSD. This makes it impossible to distinguish between the impact of the PTSD and the impact of the marital relationship on the wives' secondary traumatization. As pointed out above, findings show a close relationship between PTSD severity and the quality of the marriage.

Moreover, since the studies are cross sectional, we cannot be sure that the wife's secondary traumatization does not affect the quality of the marriage more than the quality of the marriage affects her secondary traumatization. Indeed, several scholars have suggested that there is a bi-directional impact (Fals-Stewart & Kelly, 2005)

#### Theoretical explanations

The literature offers a variety of theoretical explanations of secondary traumatization among wives of traumatized men. The explanations vary in the quality and amount of empirical support they have.

*Identification and empathy:* The first theoretical explanation was offered by Maloney (1988) in an effort to understand the resemblance of the symptoms reported by wives of traumatized veterans and those of the veterans themselves. Maloney suggested that the resemblance may stem from the wives' tendency to identify with their husbands, to internalize their experiences, and to experience in fantasy the same kinds of traumatic events that they had experienced.

Figley (1989; 1995; 1998) uses the term "empathy" rather than identification; but, in essence, his account seems to be an attempt to explain how and why these wives come to identify with their traumatized husbands. As Figley (1998) relates it, the process starts with the wife's efforts to emotionally support her troubled husband, which lead her to try to understand his feelings and experiences and, from there, to empathize with him. In the process of gathering information about his suffering, she

takes on his feelings, experiences, and memories as her own – and hence his symptoms.

Some support for these explanations may be found in two of the studies discussed above. The extensive talk of the women in the Dekel et al. (2005a) study of their efforts to set boundaries, to maintain their individuality, and not to be drawn into fusion with their PTSD husbands provides some qualitative support for these explanations. Indirect quantitative support is provided by Ben-Arzi, Solomon, and Dekel's (2000) findings that wives of PTSD veterans with higher levels of separation individuation reported lower sense of burden and less psychological distress than their counterparts with lower levels of separation-individuation. For more solid support, however, studies would have to be carried out using identification and empathy as independent variables.

The empathy and identification explanation is qualitatively different from next two explanations, chronic stress and ambiguous loss. While the chronic stress and ambiguous loss explanations attribute the wife's secondary traumatization largely to the hardships of living with the traumatized veteran, the empathy and identification explanation attribute it more to processes within the wife herself.

*Chronic stress produced by close and prolonged contact with a malfunctioning partner:* Living with a PTSD husband is a chronic stressor, which, like other chronic stressors, may lead over time to somatic and psychiatric difficulties. This explanation is consistent with findings of heightened distress among spouses of persons suffering from a variety of chronic physical or mental disabilities, such as depression (Krantz & Moos, 1987), schizophrenia (Hatfield & Lefley, 1987), and brain injury (Lezak, 1986), among others. It gains more specific support from subsequent studies showing the contribution of caretaking burden to the wives' secondary traumatization.

*Ambiguous loss:* The term "ambiguous loss" was coined by Boss (1987, 1999) to describe situations in which a person is present psychologically but absent physically (e.g., in prison, kidnapped, missing in action) or present physically but absent psychologically, as is the case when the person suffers from a debilitating mental disorder, of which PTSD is one of many examples. According to Boss (1999) there is considerable un-clarity regarding the role and responsibility of the person with the mental disorder in the family. The lack of clarity immobilizes other family members: decisions are put on hold, and the boundaries of the relationship are unclear. The ambiguity often becomes as debilitating as the illness itself. The person experiencing the ambiguous loss struggles to reduce this ambiguity and to improve the clarity in the relationship. Due to the persistent nature of the loss, however, the effort becomes physically and psychologically exhausting, with attendant symptoms of depression, anxiety, guilt, and distressing dreams.

This explanation is consistent with qualitative findings on spouses of Alzheimer sufferers (Caron, Boss, Mortimer, 1999; Kaplan & Boss, 1999) as well as dementia (Boss, Caron, Horbal, & Mortimer, 1990). Somewhat more specific support regarding the wives of PTSD veterans may be gleaned from the findings of Dekel's qualitative study cited above. The women in the focus group spoke extensively of their confusion about the husbands' roles and the great strain that this caused them:

It's as if I'm living alone. I have to do everything alone. If I want to go out, he tells me "go by yourself" or "go and I'll join you later. What am I? Am I a widow? Divorced? I'm not divorced and I'm not a widow. I have a husband.

*Upset in world assumptions:* Gilbert (1998) proposes a more cognitive explanation. This is that just as the basic world assumptions of direct victims of trauma are often upset (Janoff-Bulman, 1992), so too are the assumptions of indirect

victims. The partner of a traumatized man learns, just as he had, that the world is unsafe and chaotic and that being a good person does not protect one from harm. Her basic assumptions about the relationship are also upset. Gilbert implies that it is these cognitive upsets, along with the great difficulty of understanding the behavior of the traumatized husband, that lead to the wife's secondary traumatization.

Gilbert (1998) supports her claims with clinical evidence. Some empirical support is provided by studies showing that negative world assumptions contribute to the distress of persons directly exposed to traumas (e.g., Magwaza, 1999); that relatives of crime victims report more negative world assumptions than relatives of non-victims (Denkers, & Winkel, 1995); and that children of PTSD veterans report both more negative world assumptions and greater distress than children of veterans without PTSD (Dinshtein & Dekel, 2005). None of these studies, however, has been carried out among wives of PTSD veterans.

*Assortative mating*: Finally, various authors claim that the heightened distress of women married to men with PTSD may be attributed to assortative mating – the tendency to choose a partner similar to oneself. The argument here is that the wives' distress stems from prior vulnerabilities which led her to be attracted to and marry a vulnerable man. This claim is supported by findings of high levels of depression in both spouses in a marriage (Merikanages, Bromet & Spiker, 1983).

While this explanation cannot be ruled out, there are grounds for questioning it. For one thing, a study of Israeli PTSD veterans and their wives indicates that many were married before the men developed PTSD, meaning that the women had not chosen partners with emotional difficulties (Solomon et al., 1992a). Furthermore, there is reason to believe that most combat veterans, at least in Israel, where army recruits must pass stringent examinations of their physical and mental health, were

psychologically healthy prior to their traumatization. Jordan et al. (1992), in their study of secondary traumatization following the Vietnam War, refutes the assortative mating theory on the grounds that they found no significant differences in socio-demographic and other background characteristics among wives of PTSD veterans and wives of non-PTSD veterans.

### Treatment

Despite the considerable distress of wives of PTSD veterans, there is little discussion in the literature about how to help them to alleviate or cope with it. Most of the accounts of interventions with veterans' wives are embedded in accounts of marital and/or family therapy focused on the needs of the psychologically injured veteran. In a review article, Riggs (2000) divides these therapies into two broad types, systemic treatments and support treatments. In both, the trauma is at the center. Systemic treatment involves the use of marital and family therapy models to reduce relationship distress caused by PTSD. Its aim is to alleviate conflict, improve communication, and otherwise bring about better family functioning. Support treatment aim to enhance familial and other social support for the identified patient. It views the wife as an important source of support for the traumatized veteran, and focuses on her role in helping him recover.

Neither of these approaches focuses on the needs of the secondary victims themselves. To our knowledge, there are only a small number of accounts of direct clinical work with veterans' wives. Williams (1980), cited above, and Coughlan and Parkin (1987) give accounts of group therapy she conducted with wives of Vietnam veterans. More recently, Remer and Ferguson (1998) offers a detailed, six-stage model for treating veterans' wives suffering from secondary traumatization. The model, however, is based on working with partners of sexual assault victims and

seems is more suitable for acute crises than to chronic conditions. None of the suggested treatments has been evaluated empirically.

Our review highlights the need for direct therapeutic intervention with the veterans' wives, focused on the women's own needs. At this stage, we have no way of knowing what kinds of intervention would be most efficacious. However, we would like to suggest that the following points be taken into consideration in planning interventions for wives suffering from secondary traumatization:

1. PTSD is a chronic disorder, whose severity and manifestations are affected by both inner and outer events and vary over time, and which is highly resistant to treatment. This means that wives of PTSD veterans have to cope with the problems created by the PTSD over and over again. With respect to intervention, this means: a) that one-time intervention, of whatever type, may well not be adequate, especially for women whose husbands are severely impaired by their PTSD; and b) that different interventions may be appropriate at different stages of the disorder and at different points in the life cycle. Hence 2, 3, and 4:

2. A range of interventions should be available for the wives of veterans, which will address the changes in their husband's situations and their own.

3. Depending on the needs of the women at any particular time, the intervention can be individual or group, and employ any and all of a range of methods: psycho-educational, stress reduction, behavioral-cognitive, psycho-dynamic, and so forth.

4. A strength-oriented perspective aimed at empowering the wives to seek, recognize, and use their strengths to deal with the long term and ever changing consequences of their husband's traumatization may be particularly useful (Cowger, 1994).

5. Intervention need not be limited to sessions with a professional. In addition or

instead of such sessions, it may be helpful to offer wives of traumatized veterans a range of cultural and leisure activities, with and without their husbands and children. Such activities may help to recharge their batteries; may help make up for some of the social deficits from which they suffer as a result of their husbands' PTSD; and may increase their social support by bringing them into contact with other women in situations similar to their own.

6. In addition, it should be kept in mind that intervention with wives of PTSD veterans, is plagued by low participation rates. Studies show that while veterans' wives may often seek treatment for their husbands and even transport them to the therapy, they themselves often do not engage (Lyons & Root, 2001). Judging from our experience at a clinic that provides mental health services to Israeli Defense Force veterans and their families, wives of traumatized veterans face numerous obstacles to engagement. These include the distance and cost of travel to counseling sessions, difficulties in arranging child care, constraints on their time, and, sometimes, the objections of their husbands. Efforts must thus be made to reach out to wives of veterans and to lower the barriers to their participation.

#### Summary and recommendations for further study

This review points to substantial evidence of secondary traumatization among wives of war veterans, of different wars and in different countries, even decades after the war's end. Their traumatization is marked both by specific trauma symptoms identified in the DSM and by general psychological distress, including depression, anxiety, heightened hostility and other symptoms. Various explanations have been offered for the development of secondary traumatization, but only some of them have been examined empirically. The key predictors for which there is empirical evidence

include the severity and avoidance symptoms of the veteran's PTSD and his violence against his wife; and the wife's caregiver burden and degree of individuation separation. In addition, the quality of the marital relationship has been treated both as a manifestation and predictor of the wife's secondary traumatization. With this, data on divorce rates in the United States and Israel suggest that the degree to which these marriages founder varies with the culture. In addition, our own qualitative findings on an admittedly small group of Israeli women suggest that being married to a PTSD veteran may have its compensations, which enable the women to stay in their troubled marriages.

A great deal remains to be learned about the secondary traumatization of veterans' wives, however. Perhaps the most crucial gaps in our knowledge stem from the fact that, with very few exceptions, almost all the studies to date have been cross sectional. The findings simply do not allow us to speak with much certainty about the directionality of the various associations that have been found. As Fals-Stewart & Kelly (2005) ask: "Does a partner who returns home with PTSD lead to relationship problems and lack of social support, setting the stage for the onset of secondary trauma, or are couples who have preexisting relationship and social support problems more vulnerable to the development of PTSD and secondary trauma?" Or are the associations perhaps bi-directional?"

Similar questions can be asked with respect to the wife's personality and disposition. Longitudinal studies, which might help answer some of these questions, are very much needed. Prospective studies, which would enable comparing behaviors "before" and "after" the traumatic experience would also, be in order. While prospective studies might be feasible in peacekeeping missions and planned armed operations, however, they would be very difficult to conduct in unplanned military

engagements.

Our understanding of how secondary traumatization develops is also very limited. How much is it a result of the transmission of the traumatic experience – as Maloney (1988) and Figley (1989) imply? How much is it a consequence of the stresses and burdens of living with the traumatized veteran? All of the theoretical explanations – empathy and identification, ambiguous loss, and upset to world assumptions – require further examination. Such studies might give us a better idea of how trauma is actually passed on from the direct victim to the indirect one.

In addition, we would like to know considerably more about factors that predict or moderate secondary traumatization. In addition to examining more personal variables and features of the marriage, environmental factors should also be considered. These might include such things as the society's view of the war, the status of women in the society, and the social, psychological, and instrumental support available to the woman.

Further research is also recommended on the marriages of PTSD veterans. In addition to clarifying the direction of the relationship between secondary traumatization and marital problems, we would also like to learn about factors involved in the stability and dissolution of marriages to PTSD veterans. What role is played by the society's views of marriage and of the status of woman? What, if any impact, does the family's economic status have? What personal factors enter into decisions about divorce of women married to veterans with PTSD? In addition, we would like to learn more about how women cope with their difficult marriages to PTSD veterans. How do they handle the various tasks they perform? What gives them the strength to struggle day in and day out with the consequences of their husband's PTSD? How do they preserve their own emotional stability? Recent

literature points to post-traumatic growth among survivors of a range of distressing and traumatic events (e.g., Tedeschi, & Calhoun, 1996). One direction for research would be to examine whether the partners of these survivors, among them the wives of traumatized veterans, also experience post-traumatic growth.

Also of scholarly interest are the implications of the wife's secondary traumatization on her functioning in other roles, especially as a mother. A study of children of traumatized veterans suggests that warm and protective mothers are able to temper the negative impact of the father's PTSD on their children (Dinshtein & Dekel, 2005). However, there is no research to date on how the mother's secondary traumatization affects her parental functioning.

A great deal also remains to be learned about matters that were not addressed in this chapter. Today, when increasing numbers of women serve in the armed forces, both in U.S.A and elsewhere, the question of how their service related PTSD impacts on their husbands or partners, as well as on their children, becomes increasingly pressing. The uncertainties and other difficulties experienced by women whose husbands are away in war also merit research attention, and all the more so now that U.S. forces are in Iraq. Moreover, since combat is only one of the many sources of traumatization, there is a need to learn more about how traumatization from other sources may affect those living with the traumatized individual. That is, we would like to know whether different types of traumatic events would affect families in different ways and, if so, how.

Finally, a great deal of work remains to be done to develop, publish, and evaluate interventions for wives of traumatized veterans. To date, no interventions focused on the needs of the secondary victim have been published in the literature. This does not mean that such interventions do not exist. There is probably much more intervention

going on with wives of PTSD veterans than is reported. We urge that clinicians report what they are doing in this sphere. We also urge evaluative studies of interventions with wives suffering from secondary traumatization. We hope that the advances in our understanding of the causes and processes of secondary traumatization will help to develop effective interventions to alleviate distress of the secondary victims of traumatic events.

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