THE EFFECT OF PTSD AND COMBAT LEVEL ON VIETNAM VETERANS' PERCEPTIONS OF CHILD BEHAVIOR AND MARITAL ADJUSTMENT

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This study empirically investigated the effects of post-traumatic stress disorder (PTSD) and combat level on Vietnam veterans' perceptions of their children's behavior, as well as its effects on their marital adjustment. Results indicated that the predictor variables of PTSD and combat level together explained 33.6% of the variance in perceived child behavior problems ($p < .001$) and 51.8% of the variance in marital adjustment ($p < .001$). In addition, PTSD and combat level, when observed together, reliably predicted internalizing and externalizing behavior problems in addition to four specific areas of marital adjustment. When observed individually, however, it was shown that child behavior problems and marital adjustment were predicted primarily by PTSD, rather than combat level.

Post-traumatic stress disorder (PTSD) was acknowledged as a valid clinical entity with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980). This disorder represents the development of characteristic symptoms that result from a traumatic event that is outside the range of normal human experience (Pearce, Schauer, Garfield, Ohlde, & Patterson, 1985) and that would be likely to elicit symptoms of distress in most people (McCaffrey & Fairbank, 1985). Current descriptions of PTSD include recurrent and intrusive recollections of the event; recurrent distressing dreams; markedly diminished interest in usual activities; and increased arousal, including sleeping difficulty, difficulty concentrating, and hypervigilance (DSM-III-R; American Psychiatric Association, 1987).

The Center For Policy Research (1979; Figley, 1978; Green & Berlin, 1987) has estimated that the Vietnam war continues to impact 20 to 50% of the 2.8 million veterans of that war. Other estimates go as high as 60% (Barrett & Mizes, 1988). Vietnam veterans continue to seek assistance from mental health professionals for war-related disturbances that include combat-related thoughts and images, sleep disturbances, nightmares, survival guilt, interpersonal conflicts, social alienation, and memory difficulties (Barrett & Mizes, 1988; Green & Berlin, 1987). Individuals who experience these symptoms are diagnosed frequently with post-traumatic stress disorder (PTSD) (DSM-III-R; American Psychiatric Association, 1987).

In contrast to the abundant research on the individual effects of PTSD, there has been a dearth of research on the effects of war and other traumatic experiences on family members of the survivor (Solomon, 1988). The present study focused on Vietnam War veterans who had a diagnosis of PTSD and those who did not, with respect to marital adjustment and reported behavior problems of their children.

Clinical accounts suggest that the Vietnam veteran with PTSD may have great difficulty in the area of interpersonal relationships. DeFazio and Pascucci (1984) state that "the symptoms which tend to be most troublesome and often bring the veteran to the attention of a mental health professional are those which revolve around feelings of detachment and estrangement from others and the general interpersonal difficulties

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experienced by the veteran and his family" (p. 77). Specifically, the veteran with PTSD may have an especially difficult time fulfilling the roles of husband and father (Rosenheck & Thomson, 1986; Solomon, 1988). For instance, the veteran often experiences difficulties with the control of aggressive impulses (Haley, 1984; Motta, 1990; Solomon, 1988) and with involvement in specific tasks and routines of family life (Maloney, 1988; Solomon, 1988). Self-absorption; isolation; the inability to express emotions or share feelings (Rosenheck & Thomson, 1986); and overprotective, overcontrolling relationships with their children (Jurich, 1983) all appear to be characteristic of Vietnam veterans' difficulties in functioning within the family system.

Empirical research that has examined the family members of the Vietnam veteran, and his relationships with them, is scarce, but offers consistent findings. Vietnam veterans with PTSD show more difficulty with intimacy (Roberts et al., 1982; Wilson, 1978). They indicate difficulties with emotional expressiveness, anger control, trust, and they experience marital problems (Penk et al., 1981). In addition, empirical research has indicated that Vietnam veterans with PTSD report more difficulties with sociability, score higher on measures of social maladjustment, and report more family problems than veterans without PTSD (Roberts et al., 1982). Less expressiveness and self-disclosure, higher levels of hostility and physical aggressiveness, and greater maladjustment in dyadic relationships are all characteristic of the Vietnam veteran who experiences PTSD (Carroll, Rueger, Foy, & Donahoe, 1985).

Findings from the small group of empirically based studies on the marital adjustment of veterans with PTSD point to the need for further research. Researchers and clinicians alike have stated that there is a need for more empirical investigations in this area (Carroll et al., 1985; Maloney, 1988; Roberts et al., 1982). In addition, many of the interpersonal variables that distinguish Vietnam veterans with PTSD from other veterans raise the question of the effects on the functioning of their children. Researchers and clinicians have noted the need for research in this area, as well (Maloney, 1988; Solomon, 1988).

Combat level has emerged as an important variable in the study of Vietnam veterans. Research has demonstrated a relationship between PTSD and combat level (Foy, Carroll, & Donahoe, 1987; Foy, Sipprelle, Rueger, & Carroll, 1984; Green & Berlin, 1987; Pearce et al., 1985; Penk et al., 1981). Furthermore, combat level has been demonstrated to be related to other types of personal functioning difficulties (Carroll et al., 1985; Casella & Motta, 1990; Roberts et al., 1982).

The present study investigated empirically the effects of the Vietnam veteran's PTSD, level of combat exposure, and associated interpersonal difficulties on his perception of primary relationships, namely, those with his spouse and children. Specifically, do veterans with more PTSD symptomatology and greater combat exposure perceive their marital relationships as less well-adjusted than the marital relationships of veterans with fewer symptoms and less combat experience? Second, does the degree of PTSD and combat level directly relate to veterans' perceptions of their children's behavior and functioning? It was hypothesized that PTSD and combat level would explain a significant amount of variance in child behavior problems (Rosenheck & Nathan, 1985; Rosenheck & Thomson, 1986). Similarly, it was predicted that PTSD and combat level would explain a significant amount of variance in marital adjustment (Carroll et al., 1985; Penk et al., 1981; Roberts et al., 1982). In addition, comparisons were made between veterans' ratings of child behavior problems and similar ratings completed by their wives in an effort to validate the veterans' perceptions. Further exploration investigated the relationship between more specific child behavior problems (i.e., internalizing and externalizing problems), as measured by the Child Behavior Checklist (Achenbach & Edelbrock, 1983), and the predictor variables of PTSD and combat level. Similarly, the relationship between more specific areas of marital adjustment and the predictor variables of PTSD and combat level also was examined.
Method

Subjects

The subjects of this study were 40 male Vietnam War veterans, who ranged in age from 39 to 67 years, with a mean age of 44.70 and a standard deviation of 4.59. These subjects were married and fathers of at least one child between the ages 4 and 16 at the time of the study. Of 40 children who were referenced and analyzed, 17 were male and 23 were female. Their mean age was 12.73 years with a standard deviation of 3.43 years. In addition to the veterans themselves, the wife of each subject was asked to participate subsequent to the veteran’s involvement in the study. Of 40 requests made to veterans’ spouses by mail, 24 were completed and returned, which represents a 60% response rate. The veterans were recruited from several Vietnam War veteran centers and service organizations on Long Island, NY, the VA Hospital located in Northport, NY, an advertisement in a veterans’ organization newsletter, and through word of mouth.

Materials

Mississippi Scale for Combat-Related PTSD. The Mississippi Scale for Combat-Related Posttraumatic Stress Disorder (MSCRPTSD), developed by Keane, Caddell, and Taylor (1988), is a 35-item, self-report scale derived from DSM-III criteria for the diagnosis of PTSD. Items are rated on a 5-point Likert scale and summed to yield a total score that ranges from 35 to 175. A score of 107 or more was used to indicate a diagnosis of PTSD because it was found to classify correctly 93% (of 92) of the Vietnam veterans with PTSD (Keane et al., 1988).

Military Stress Scale. The Military Stress Scale (MSS; Watson, Juba, & Anderson, 1989) was used to measure level of combat exposure. This 6-item measure contains 3 items rated on a Likert scale that reflect length of time in combat, seriousness of wounds, and exposure to the deaths of comrades. Three additional dichotomous items reflect involvement in atrocities, hand-to-hand combat, and being taken prisoner.

Demographic information. This questionnaire contained items that concerned the veterans’ family constellation, history of psychological treatment, and family members’ involvement in psychotherapy. Several pertinent demographic variables were analyzed in order to determine whether there were differences between the reports of PTSD and non-PTSD subjects in terms of employment, history of divorce, current involvement in therapy, history of therapy, substance abuse, and veterans’ reports of wives’ current involvement in therapy.

Achenbach Child Behavior Checklist. Child behavior problems were measured with the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983). This scale contains a list of behavioral problems and competencies of children who range in age from 4 to 16 years. The oldest child, between the ages of 4 and 16, born to the Vietnam veteran and his current wife was rated individually by both parents. A 3-point scale is used to rate the frequency and/or degree of specific problematic behaviors on 113 items. The CBCL provides a total problem score; a profile of behavioral deviancy (8 or 9 scales, depending on age and gender), such as aggressiveness; and two broad-band factors, namely, internalizing and externalizing. Externalizing problems refer to a general tendency to act-out, such as aggressiveness and delinquency, while internalizing problems are reflected in disorders such as depression and withdrawal.

Dyadic Adjustment Scale. Marital adjustment was measured by the Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS assesses the quality of marriage and similar dyads. It is a 32-item paper-and-pencil measure for use with either married or unmarried cohabiting couples. In addition to an overall measure of adjustment, the scale provides an assessment of four components of adjustment. These components were labeled dyadic consensus, dyadic satisfaction, dyadic cohesion and affectional expression.
Dyadic consensus refers to the extent of agreement between partners on matters important to the relationship, such as money, religion, recreation, friends, household tasks, and time spent together. Dyadic satisfaction measures the amount of tension in the relationship, as well as the extent to which the individual has considered ending the relationship. The individual's satisfaction with the expression of affection and sex in the relationship is measured by the subscale entitled affectional expression, while dyadic cohesion refers to the common interests and activities shared by the couple.

Procedure

Veterans' treatment facilities and service organizations located in the New York area were contacted by telephone to explain the purpose of the study and to request permission to recruit prospective subjects. Subjects typically were assessed individually or in small groups. Ten subjects' (25%) materials were obtained by mail or through a third party.

Upon completion of the veterans' participation, their wives were sent one questionnaire and an informed consent form. If their husbands had been recruited from the VA Hospital, a second consent form was required. Wives were encouraged to complete the questionnaire independently from their spouses. A self-addressed, stamped envelope was provided in order to return materials by mail to the researchers. Subjects were requested to return the completed questionnaire within 2 weeks after receipt of the materials. At the end of the 2-week period, a follow-up letter was sent to subjects who had not returned the materials asking them to complete them as soon as possible. Two follow-up letters were sent as necessary (after 2 to 3 consecutive weeks with no response from the subject). All information was anonymous and confidential, and subjects were advised that the findings of the investigation would be made available to them if requested.

Design

The degree of PTSD symptomatology reported by the subjects and the degree of reported combat experienced by the subjects while in Vietnam provided the predictor variables in this study.

The criterion variables were dyadic (i.e., marital) adjustment and perceived behavioral problems of their children. The data were evaluated by multiple regression and correlation analyses.

Results

Multiple regression analyses were performed with combat level and post-traumatic stress disorder (PTSD) as the predictor variables and child behavior problems and marital adjustment as the criterion variables, separately. When examining the relationship between the predictor variables and child behavior problems, it was found that the multiple correlation coefficient, \( R = .58 \), which explained 33.6% of the variance, was significant, \( F(2,37) = 9.31, p < .001 \). This indicates that the variables of PTSD and combat level when taken together were related significantly to child behavior problems, as hypothesized.

Zero-order coefficients revealed that there was a significant correlation between the independent variables of PTSD and combat level \( (r = .30, p < .05) \). However, only PTSD was correlated significantly with child behavior problems, \( r = .58, p < .001 \), and explained 33.6% of the variance. Therefore, of the two simple correlations (each of the predictor variables with the criterion variable), only PTSD was related significantly to child behavior problems.

It is important to note that although a significant multiple \( R \) was obtained, closer inspection revealed that only one of the two predictor variables contributed uniquely
and significantly to the prediction of child behavior problems. That is, the semipartial correlation coefficients for PTSD and combat level, respectively, were \( sr^2 = .31 \) \((p < .001)\) and \( sr^2 = .0003 \) \((p = .907)\). This indicates that \( R^2 \) would decrease .03% if combat level were removed from the regression equation. Altogether, 33.6% of the variability in child behavior problems was predicted by both independent variables. However, the one significant predictor (PTSD) that contributed unique variability explained 31% of the total variance. Child behavior problems, then, were found to be predicted reliably by PTSD and not by combat level.

In the analysis that examined the relationship between the predictor variables and marital adjustment, it was found that the multiple correlation coefficient, \( R = .72 \), which explained 51.8% of the variance, was significant, \( F(2,37) = 19.55, p < .001 \). This indicated that PTSD and combat level when observed together were related significantly to marital adjustment, as was hypothesized.

Both predictor variables were correlated significantly with marital adjustment. That is, PTSD was correlated significantly with marital adjustment, \( r = -.71, p < .001 \), and explained 50.4% of the variance. Combat level also was correlated significantly with marital adjustment, \( r = -.32, p < .05 \), and explained 10.2% of the variance. Therefore, both PTSD and combat level were related significantly to marital adjustment.

A closer inspection of the semipartial correlation coefficients revealed that only one of the two predictors (PTSD) contributed uniquely and significantly to marital adjustment. That is, the semipartial correlation coefficients for PTSD and combat level, respectively, were \( sr^2 = .41 \) \((p < .001)\) and \( sr^2 = .01 \) \((p = .34)\). This indicates that \( R^2 \) would decrease 1% if combat level were removed from the regression equation. Altogether, 51.8% of the variability in marital adjustment was predicted by both independent variables together. However, the one significant predictor (PTSD), which contributed unique variability, explained 41% of the total variance. Marital adjustment, then, is predicted reliably by PTSD.

In order to determine the extent to which wives’ assessments of their children’s behavior were related to veterans’ reports of child behavior problems, correlation coefficients were computed. Veterans’ and wives’ reports of child behavior problems were correlated significantly, \( r = .71, p < .001 \), an indication that there was moderately strong agreement between husbands’ and wives’ perceptions of their child’s behavior.

**Results for Internalizing and Externalizing Child Behavior Problems**

The relationship between child behavior problems and the predictor variables of PTSD and combat level was evaluated by multiple regression analyses that used the externalizing and internalizing subscales of the child behavior checklist, separately. The multiple correlation coefficient, \( R = .60 \), which explained 36% of the variance, was significant, \( F(2,37) = .10.26, p < .001 \). This indicates that PTSD and combat level when taken together were related significantly to internalizing behavior problems.

For externalizing behavior, the multiple correlation coefficient, \( R = .56 \), was significant, \( F(2,37) = 8.26, p < .01 \). This indicates that PTSD and combat level when taken together were related significantly to externalizing behavior problems and together explained 31.4% of the variance in externalizing behavior problems. Inspection of zero-order correlation coefficients revealed that, in the case of both internalizing and externalizing behavior problems, PTSD was related significantly to the criterion variable, while combat level was not. Inspection of the semipartial coefficients revealed that PTSD contributed uniquely and significantly to the prediction of externalizing and internalizing behavior problems. PTSD explained 34.7% of the variance in externalizing behavior problems and 24.4% of the variance in internalizing behavior problems.

**Results for Specific Areas of Marital Adjustment**

An additional analysis was performed in order to explore further the relationship between the predictor variables and more specific areas of marital adjustment. A multiple
regression analysis was performed to investigate the relationship between the predictor variables and dyadic consensus, which is indicative of the extent of agreement between partners on matters important to the relationship, such as money, religion, recreation, friends, household tasks, and time spent together. The multiple correlation coefficient $R = .69$, which explained 47.6% of the variance, was significant, $F(2,37) = 16.34$, $p < .001$. This result demonstrates that the variables PTSD and combat, when taken together, were related significantly to dyadic consensus.

The second subscale, dyadic satisfaction, measures the amount of tension in the relationship, as well as the extent to which the individual has considered ending the relationship. Multiple $R = .59$, which was significant, $F(2,37) = 9.76$, $p < .001$. Therefore, when these variables were observed together, they were related significantly to dyadic satisfaction and together explained 34.8% of the variance. An additional multiple regression analysis was performed to investigate the relationship between the predictor variables and the third subscale, affectional expression, which indicates the individual's satisfaction with the expression of affection and sex in the relationship. The multiple correlation coefficient, $R = .57$, was significant, $F(2,37) = 9.01$, $p < .001$. Thus, PTSD and combat level when observed together were related significantly to affectional expression and together explained 32.5% of the variance in affectional expression. A final multiple regression analysis was performed to investigate the relationship between the predictor variables and dyadic cohesion, or the common interests and activities shared by the couple. The multiple correlation coefficient, $R = .61$, which explained 37.2% of the variance, was significant, $F(2,37) = 10.85$, $p < .001$. This indicated that PTSD and combat level when taken together were related significantly to dyadic cohesion.

PTSD was related significantly to dyadic consensus, satisfaction, affectional expression, and cohesion. Combat level alone, however, was related only to dyadic consensus. In addition, inspection of the semipartial correlation coefficients revealed that only one of the two predictor variables (PTSD) contributed uniquely and significantly to the prediction of each of the four criterion variables. That is, the semipartial correlation coefficients between PTSD and the four criterion variables were: $sr^2 = .40$ for dyadic consensus, $sr^2 = .31$ for satisfaction, $sr^2 = .28$ for affectional expression, and $sr^2 = .31$ for cohesion. Combat level, however, did not explain a significant amount of unique variance in any of the criterion variables.

**Results for PTSD and non-PTSD Subjects**

In order to determine whether those subjects with PTSD would differ significantly, in terms of marital adjustment and perceived child behavior problems, from those subjects without such a diagnosis, separate one-way analyses of variance were conducted. Subjects were divided into a PTSD and a no-PTSD group based in scores obtained on the MSCRPTSD. As previously noted, a score of 107 was used to separate the groups. The results revealed significant differences in child behavior problems between the PTSD group ($n = 10, M = 62.4, SD = 10.31$) and the no-PTSD group ($n = 30, M = 52.5, SD = 10.11$), $F(1,38) = 7.12$, $p < .02$. $Eta^2 = .158$ indicated that 15.8% of the variance in child behavior problems could be explained by presence or absence of PTSD. In addition, significant results were obtained in marital adjustment between the PTSD group ($n = 10, M = 24.1, SD = 7.2$) and the no-PTSD group ($n = 30, M = 41.7, SD = 8.9$), $F(1,38) = 31.9$, $p < .001$. The strength of association between marital adjustment and presence or absence of PTSD indicated that 45.6% ($eta^2 = .456$) of the variance in marital adjustment is explained by the presence or absence of PTSD. Significant differences, therefore, were obtained between the PTSD group and the no-PTSD group on both dependent variables.

Chi-square tests were conducted for each of several relevant demographic variables. The analyses examined the number of subjects who reported being employed, divorced, having a problem with substance abuse, being in therapy, having a history of psychological
treatment, and subjects' reports that their wives were in therapy. Subjects in the PTSD group were compared to subjects in the no-PTSD group. When subjects in the PTSD group and the no-PTSD groups were compared, results revealed that there were significant differences in the number of subjects who reported present employment, substance abuse, current psychological treatment, and a history of psychological assistance. Inspection of cell frequencies revealed that the PTSD group was significantly more likely to report being unemployed, currently receiving psychological treatment, current abuse of alcohol and/or drugs, and a history of psychological treatment than was the no-PTSD group.

Significant differences were not found when the PTSD group and the no-PTSD group were compared in terms of reported history of divorce or reports of their wives' involvement in therapy.

**Discussion**

Contrary to the expectation that both PTSD and level of combat would emerge as significant predictors of both child behavior problems and marital adjustment, only PTSD emerged as an important consideration in the prediction of either of these two criterion variables. Past research has demonstrated a strong relationship between level of combat exposure and PTSD symptomatology (Green & Berlin, 1987; Pearce et al., 1985). It has been stated that combat exposure is the primary etiological variable of PTSD (Foy et al., 1987; Foy et al., 1984). Researchers have demonstrated that heavy combat experiences are related to a greater frequency of PTSD symptomatology than light combat experiences (Penk et al., 1981).

The present study is in agreement with previous research in demonstrating a significant relationship between combat level and PTSD. It is important to note, however, that the combat scale used here has been shown to be highly sensitive to combat history and less correlated with PTSD than previously used measures of combat (Watson et al., 1989).

The present study is in agreement with previous research that has demonstrated that veterans with PTSD report more interpersonal adjustment difficulties than do veterans without PTSD. PTSD emerged as a more potent variable than level of combat in terms of marital adjustment and perceptions of child behavior problems. PTSD was shown to be an important variable in the prediction not only of overall marital adjustment, but also in several of the specific areas of adjustment to marriage: amount of agreement in marriage, amount of tension in the relationship, satisfaction with sex and affection, and common interests and activities shared by the couple. It is noteworthy that subjects with PTSD were found to report, on average, marital adjustment that would be considered "very much below average" according to standardization data. Subjects without PTSD, however, also evidenced below-average marital adjustment, according to standardization data, an indication that the present sample may represent subjects whose marital adjustment, as a whole, is below average.

In addition to the original finding of the present study with regard to specific areas of marital adjustment, the present study contributes to the literature with the finding that veterans with PTSD report more problematic behaviors with their children than do veterans without PTSD. As a group, subjects in the present study perceived their children's behavior as falling in the normal range. However, when divided into PTSD and no-PTSD groups, PTSD subjects perceived their children's behavior as more problematic than subjects in the no-PTSD group.

According to Motta (1990), veterans who are experiencing war-related problems can pass them on to their children, such that their children may exhibit maladaptive behaviors. This is consistent with clinical publications that have indicated that children of Vietnam veterans with PTSD are likely to develop symptoms like their fathers', but
to a lesser degree, and may become preoccupied with events that were traumatic for their fathers (Rosenheck & Nathan, 1985; Rosenheck & Thomson, 1986). The term "secondary traumatization" was coined by Rosenheck and Nathan (1985) to emphasize that a relationship exists between a Vietnam veteran's experience of PTSD and the problems faced by his children. Some clinicians also have asserted that Vietnam veterans with PTSD may have difficulty providing an environment that fosters the growth and development of their children (Haley, 1984; Solomon, 1988). These clinical reports highlight the difficulties experienced by children of Vietnam veterans with PTSD, findings that were supported empirically in the present study.

While the findings from prior research on combat level may seem inconsistent with the present results, a closer examination of both the samples and the methodology utilized in some of these studies may clarify discrepant outcomes. In the literature, combat frequently has been viewed as a dichotomous variable and analyzed in terms of presence vs. absence of combat (e.g., Penk et al., 1981; Roberts et al., 1982; Wilson, 1978) or high vs. low combat (e.g., Carroll et al., 1985). When subjects were placed into distinct groups in these studies, the varying range of combat experience may have been ignored. This may be especially true when subjects were divided into high and low combat groups. In the present study, a clear distinction between levels of combat does not exist. Rather, all subjects reported some combat experience, with absolute (i.e., "high" or "low") levels of combat unknown. More importantly, in the present study veterans may not have represented a broad enough range of combat experience to detect the effects of combat. Perhaps combat would have emerged as a significant predictor had there been a larger range of combat experience, including subjects who ranged from high absolute combat level to low (or no) combat level. Nevertheless, the present sample was seen as representative of Vietnam veterans in that subjects were obtained from multiple sources. It may be important in the future to include a wider range of combat experiences and to analyze combat as a continuous variable.

It is important to note that the present group of subjects scored somewhat low, overall, on measures of combat and PTSD. That is, on the scale used to measure combat level, it is possible to obtain a total possible score of 28. However, the mean of the sample was 7.83, the median was 7.00, the mode was 5.00, and the scores ranged from 3 to 16. This indicates that the subjects in the present sample, on average, report fairly low levels of combat experience, and this also may explain in part the weak predictive effects of combat. In addition, the mean, median, and mode of the sample on a scale used to measure PTSD all fall below the cut-off score for presence of PTSD. That is, with a score greater than 107 indicating the presence of PTSD, the mean of the present sample was 89.88, the median was 84.50, and the mode was 55.00. Therefore, overall the subjects in the present study may be considered to have a low level of PTSD.

Despite the relatively low levels of combat exposure and PTSD, the present study clearly shows that veterans such as those in this sample are experiencing both marital problems and are viewing their offspring as having behavioral difficulties. Family interventions apparently are needed to enable these veterans to achieve more stable relationships with their wives and to help their children. Further research may be needed to identify specific areas of concern among the children and wives of the Vietnam war veteran.

REFERENCES


