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Spouse Support and Vietnam Veterans’ Adjustment to Post-Traumatic Stress Disorder*

Constance L. Shehan**

It has been estimated that as many as 50% of the 800,000 combat veterans from the Vietnam conflict still suffer from unresolved war experiences. A recent government study, however, concluded that veterans who have a supportive marital relationship are considerably more likely to be able to successfully adjust to the delayed stresses of combat. This paper presents a conceptual model of the role of spouse support in Vietnam veterans’ adjustment to post-traumatic stress syndrome and discusses the implications of the model for therapeutic intervention.

Several major studies have concluded that today, more than a decade after the peak years of the Vietnam war, the 800,000 Vietnam veterans who were engaged in combat are plagued by significantly more problems than their peers (Card, 1983; Egendorf, Kadushin, Laufer, Rothbart, & Sloan, 1981; Hogancamp & Figley, 1983). The after effects exhibited by many of these veterans appear to constitute a syndrome identified as post-traumatic stress disorder (PTSD), which is defined as a delayed but persistent malaise characterized by nightmares, loss of control over behavior, emotional numbing and withdrawal from the environment, hyper-alertness, and anxiety and depression (DSM-III, 1980, p. 238).

It has been estimated that 20% of all Vietnam era combat veterans are formally diagnosable, but that 50% show signs of troubling, unresolved war experiences. Although the difficulties may spring initially from memories of disturbing war events, they usually have been elaborated over the years until they color a wide range of issues affecting everyday life (Egendorf, 1982). For instance, Vietnam veterans have a greater propensity for marital breakup and living alone. They also have lower educational attainment, higher unemployment and absenteeism at work, relatively heavy drug use, and relatively more frequent hospitalization for psychological problems (Card, 1983; Egendorf et al., 1981).

In spite of these major difficulties, however, research commissioned by the Veteran’s Administration to study the adjustment of Vietnam veterans offers an optimistic appraisal of the potential for adjustment. The research stresses that the majority of Vietnam veterans lead stable lives and have learned, in various degrees, how to cope with the subclinical malaise they experience. The existing data show that those who have made the most progress in working through the legacy of the war have not only reflected on their experiences but have talked about them considerably with supportive others—most notably a spouse or intimate friend (Egendorf, 1982). The veterans who have made only limited progress are those who have failed to confront the combat issues, either privately or in communication with others. Their difficulty may be attributed largely to the failure of their family and friends to facilitate disclosure of painful memories associated with combat (Egendorf, 1982; Egendorf et al., 1981; Hogancamp & Figley, 1983). Thus, a major conclusion of the existing research is that there are naturally occurring elements in the veterans’ interpersonal environment that may modify the problems associated with the delayed stresses of combat (Egendorf et al., 1981). Being married, or more precisely, having a supportive relationship with one’s spouse, considerably reduces the negative impact of combat and greatly aids in the recovery and healing process. Combat veterans who are low on spouse support are four times as likely to be demoralized and to exhibit various stress symptoms (Egendorf et al., 1981).

Unfortunately, the existing research on adjustment to PTSD does not define spouse support or describe supportive marital relationships. It provides no detailed information about the specific behaviors of their wives that Vietnam veterans find supportive. And, it fails to present information from veterans’ wives concerning their attempts to help their husbands deal with the enduring stresses of combat.

The objectives of this paper are to present a conceptual model of the role of spouse support in Vietnam veterans’ adjustment to PTSD and to discuss the implications of this model for therapeutic intervention. Spouse support is defined here in terms of the marital communication system. A particular emphasis of the conceptual model is the identification of barriers to open communication that are created by PTSD. The discussion attempts to illustrate how difficult it can be for individuals to be supportive of a spouse who suffers from PTSD.

Post-Traumatic Stress Syndrome

The Trauma of Combat

The DSM-III (1980) describes a "traumatic stress" as something which is generally outside the range of usual human experience, and which, as such, would evoke significant symptoms of distress in nearly everyone. Traumatic stressors include natural disasters, such as floods and earthquakes, plane crashes and auto accidents, and violent personal assaults such as rape, as well as warfare. There are four aspects of military combat that make it particularly traumatic (Hogancamp & Figley, 1983). First, it is perceived as highly dangerous by the combatant, who fears for his life and for the lives of his comrades. Death is ever present. In Vietnam, the fear of death was even more insidious than in previous wars.

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because the enemy was “hidden” in many respects. Because it was a civil war, the enemy was often indistinguishable from the ally to the American GIs. Because it was a guerilla war, ambushes were common. Wire-trapping and booby-trapping were frequently employed combat techniques. Tom Hagel, a Vietnam veteran quoted in MacPherson (1984, p. 176) recalls this aspect of that war:

Half the time you didn’t even see anything. . . . Until you’d find the bodies. They could booby-trap everything. A cigarette package—anything—and leave it around. There was unbelievable terror of everything booby-trapped. Sometimes the terror is so deep-set you simply cannot remember. It comes back in nightmares.

Second, individuals in combat experience a profound sense of loss—of lives, and of youth and innocence. Third, the soldier feels a sense of helplessness. He has no control over his own fate from moment to moment (Hogancamp & Figley, 1983). One veteran’s remembrances vividly illustrate this feeling (MacPherson, p. 119):

At night, he lit a cigarette—flash—right . . . where we could just be blown away. I panicked and yelled . . . (and) blew out the match. “When it’s time, it’s time,” he said. I believed him, too. I’d seen so many guys who took precautions and still got blown away.

Finally, the soldier is faced with destruction and disruption—defoliated land, burned buildings, and corpses. Tales told by combat veterans, such as the following one by Wayne Feld, reprinted in MacPherson (1984, pp. 194–195), vividly illustrate these elements of stress:

The woods were on fire from napalm. You could smell the burned bodies. . . . Come daylight, the fighting was over. We had to pick up pieces of our guys to send home. Arms and legs and three-quarters of a whole person.

**Characteristic Symptoms of PTSD**

Figure 1 summarizes four major types of symptoms characteristic of PTSD: (1) depression; (2) residual guilt and grief; (3) reexperiencing the trauma; and (4) detachment and anger. Each of these will be discussed in detail.

<table>
<thead>
<tr>
<th>Factor I. Depression</th>
<th>Factor II. Residual Guilt or Grief</th>
<th>Factor III. Reexperiencing the Trauma</th>
<th>Factor IV. Detachment and Anger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble concentrating</td>
<td>Guilt about what I did in Vietnam</td>
<td>Nightmares</td>
<td>Feeling angry or irritable</td>
</tr>
<tr>
<td>Low interest in job or other activities</td>
<td>Guilt for surviving Vietnam</td>
<td>Violent dreams or fantasies</td>
<td>Losing temper easily</td>
</tr>
<tr>
<td>Feeling worthless or unsure about self</td>
<td>Grief or sorrow</td>
<td>Reacting when surprised, using military training</td>
<td>Difficulty in relating to others</td>
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<tr>
<td>Difficulty keeping a job</td>
<td>Feeling emotionally distant from family and others</td>
<td></td>
<td>Mistrust of others or government</td>
</tr>
<tr>
<td>Depression</td>
<td>Feeling emotionally distant from family and others</td>
<td></td>
<td>Jumpiness or hyperalertness</td>
</tr>
<tr>
<td>Suicidal feelings or attempts</td>
<td>Feeling emotionally distant from family and others</td>
<td></td>
<td>Feeling separated from others, from country or society</td>
</tr>
<tr>
<td>Problems with memory</td>
<td>Anxiety</td>
<td>Anxiety</td>
<td>Fear of loss of control</td>
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<td></td>
<td>Difficultly feeling emotions</td>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Painful moods and emotions</td>
<td></td>
<td>Having arguments with others</td>
</tr>
</tbody>
</table>

**Depression.** Suicidal depression is common among PTSD victims. Tom Hagel, a Vietnam veteran and law professor, quoted in MacPherson (1984, p. 180), recalls his life after Vietnam:

*My modus operandi* was to sit by myself in a bar, get drunk, and if anyone said anything to me, I’d just go crazy. I was functioning only in school and then, later, at work. It was my way to escape.

Hagel also remembers constantly thinking of ways to commit suicide to make it look like an accident so that his family could collect insurance benefits.

**Residual guilt and grief.** One counselor who works with Vietnam veterans describes the intense survivor guilt and grief experienced by a soldier who accidentally shot and killed his best buddy as he was attempting to pull him out of a river during an ambush (MacPherson, 1984, p. 207):

For fourteen years he’s been driving forty-two miles out of his way around the town to work. He refuses to drive through it. After he comes into therapy, he suddenly remembers. The guy he killed was buried in that town. He felt so guilty that he had totally blocked that from his mind.

**Reexperiencing the trauma.** Most PTSD sufferers reexperience the trauma of their combat experiences through recurrent dreams or nightmares and/or intrusive recollections. John Ketwig, a Vietnam veteran, describes one of his recurring nightmares (1985, pp. 295–296):

I dream I am leaning over the bed to kiss a forehead goodnight, and there is a stir, and a beautiful, trusting face has been transformed into the bubbled, flaking, disfigured black horror of the kid I once saw in the hospital.

**Detachment and anger.** The DSM-III notes that sporadic and unpredictable explosions of aggression are particularly characteristic of combat veterans with PTSD. One veteran describes a violent episode he had while looking at his photographs of Vietnam with his wife and next door neighbor (Baker, 1981, p. 308):

We started looking at the album and I just flipped out. I started throwing shit everywhere. I beat my wife over the head with a full quart bottle of beer. I had a handful of butcher knives in each hand and I was threatening to cut them.

Vietnam veterans with PTSD can become overcontrolled aggressors because of their fear of letting out the anger and rage they feel. According to Joseph Gelsomino, a counselor who works with Vietnam veterans (quoted in MacPherson, 1984, p. 275), “Part of their identity is being seen as someone who can kill and one of their fears comes from the unleashing of that.”

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**Figure 1: Symptoms of PTSD among Vietnam Veterans (adapted from Silver and Iacono, 1984, page 8).**
The comments of a veteran's wife who was interviewed by MacPherson (1984, pp. 267–268), illustrates this:

"My husband will take a seat by the kitchen in a restaurant, ask for a steak rare and get it well done, and never complain. (His explanation for this is:) "I am so afraid to let go—because I think I would go completely out of control."

In addition to the combat related stress that is ever present, veterans must also cope with the normal stresses of everyday life. They may often be living on the verge of exploding with no way of communicating their stress and letting it out in healthy ways. So, they displace this stress and anger onto the people who are closest to them—their wives or girlfriends. "This has a very battering effect on their women" (Gelsomino, quoted in MacPherson, p. 276).

Another wife, also interviewed by MacPherson (1984, pp. 260–261), clearly shows the strain of living with a combat veteran:

An undercurrent of angry futility seems to permeate Phyllis. "Vietnam ruined our lives. I keep remembering the Alan of before. He was affectionate, considerate, kind. When he returned, he had a quick temper, no patience, could not concentrate . . . right now I do not like him."

Veterans' Wives: Also Victims of PTSD

In support groups, veterans' wives characteristically describe their husbands as erratic and unpredictable, extremely demanding and self-centered, isolated, and unable to express or share feelings, or to handle frustrations. They report that their husbands push them away with a blatant "leave-me-alone" attitude. Thus, the wives and girlfriends of Vietnam veterans are also victims of PTSD. Living with men who seldom speak of their troubles, fly into rages, drink too much, are verbally abusive, and cannot keep their jobs, leaves many of the female partners of Vietnam veterans with PTSD to turn bitter, defensive, and hostile. Yet, those women stand by, tolerating behavior that is often abusive, staying in a relationship that is, in few respects, a traditional companionate one, and continuing to provide beneficial "support." They are "bystanders to disaster, still trying to comprehend a war that happened 13,000 miles away" (MacPherson, 1984, p. 266). Many feel that they have failed to get results with their nurturing and caring. Yet the veterans, themselves, often say they could not have made it through the past decade without their wives or girlfriends. "Few of the men and women can articulate the intangible and deeply personal emotional benefits of such relationships. Mostly it is a sense of being there, of not giving up hope, of standing by" (MacPherson, 1984, p. 265).

Spouse Support Defined

What is spouse support, then? What helping behaviors do these wives provide, often unknowingly, to their troubled husbands? How can these helping behaviors be systematically built into intervention programs? The previous discussion suggests that the supportive spouse of the Vietnam veteran who is suffering from PTSD is one who facilitates his process of working through the delayed stress associated with combat. For this reason, spouse support is conceptualized here in terms of the marital communication process. Socioemotional spouse support is information, provided by one spouse to the other, that causes the other to believe he or she is cared for and loved, that he or she is esteemed and valued, and that he or she belongs to a network of communication and obligation (Cobb, 1976, p. 30).

The Difficulties of Providing Support

Women who have lived under the conditions described above may find it difficult to provide the type of support that is so critical for veterans' adjustment to the stresses of combat. First, they may not realize that PTSD is the cause of their husbands' negative behavior. Thus, they may blame themselves for the problems in their relationships and attempt to change their own behavior rather than to seek help for their husbands. Second, even if they do realize that Vietnam is at the root of their husbands' problems, they simply may not know how to respond in a supportive way. When they've been awakened by their husbands' nightmares of Vietnam or have watched their husbands retreat even more into themselves when the subject of the war is mentioned in a conversation, they may ask themselves whether support consists of continued probing to elicit more of the painful memories, or of granting permission to remain silent and becoming silent, themselves. Finally, they simply may not feel that they can be warm, optimistic, and loving to husbands who are sullen, abusive, and aloof. When these difficulties arise, the families of individuals suffering from PTSD may tend to respond with dysfunctional coping strategies, such as attempting to control the person's environment so as to prevent additional stress, filling the individual's time with meaningless activities to pass time, and never mentioning the traumatic experience (Burge, 1983). It is clear that good intentions and loving concerns are not enough to guide wives in providing effective types of support to husbands who suffer from PTSD.

The Model: PTSD, Marital Communication, and Socioemotional Spouse Support

Obstacles to Marital Communication Caused by PTSD

Open communication is the key to success in all close relationships (Derlega & Chaikin, 1977; Hawkins, Weisberg, & Ray, 1980), yet it may be extremely difficult to accomplish in marriages where one spouse suffers from PTSD. While husbands, in general, have greater difficulty communicating their feelings than wives (Notarius & Johnson, 1982), Vietnam veterans who suffer from this disorder far exceed the level of inexpressiveness typical of males in our society. PTSD inhibits the marital communication system in several ways. First, it greatly reduces the veteran's self-disclosure, beyond the typically low levels characteristic of men, in general. This has profound negative implications for the marital relationship. Second, it increases the veteran's use of defensive communication behavior. And third, the husband's hostility and low levels of disclosure cause the wife to develop communication apprehension, which leads her to respond defensively, and decreases her ability to provide him with feedback that he is loved and cared for, esteemed and valued, and part of a relationship that he can count on, thus perpetuating the dysfunctional communication patterns. These links between PTSD, marital communication, and spouse support are summarized in Figure 2, which is discussed in more detail below.

PTSD and Self-Disclosure. Self-disclosure, the process through which one person expresses his/her feelings, perceptions, fears, and doubts to another, allowing relatively private and personal information to surface
(Jorgensen & Gandy, 1980), is a prerequisite for developing intimate relationships. The feeling of estrangement and mistrust characteristic of PTSD victims leads the veteran to closely guard or monitor the amount of information about himself that he provides to others. PTSD victims want to maintain the personal distance between themselves and others because they fear they will be condemned and rejected by others who become aware of their war deeds. The following comment from a combat veteran illustrates this point (Baker, 1981, p. 314):

There are things that you’re afraid to talk about because you don’t know what’s going to happen if you say something about it. Like going kicking ol’ pregnant women in the stomach and blowing babies away... and blowing away papa-san because he was dying and helping him a little.

The veteran may also attempt to maintain the distance between himself and his wife through his nonverbal communication—by avoiding prolonged eye contact with her, by hesitating to touch her, by responding to her attempts at conversation with menacing or threatening facial expressions, stances, and postures, and by standing further away from her than is typical for intimate relationships.

**PTSD and Defensive Communication.** PTSD, which is characterized by extreme interpersonal hostility, causes its victims to exhibit defensive communication behavior, which consists of verbal and nonverbal behaviors that are threatening or punishing to others, including judgmental and dogmatic responses, attempts to control the other, and expressions of indifference and of superiority (Gibb, 1961). MacPherson (1984, pp. 275-276), describes one incident characteristic of this that was told to her by a veteran’s wife:

One night she and the children had started a barbecue. Her husband came home from work and flew into a rage because someone had forgotten to set the fork and spoon at his place. “He thought we did that on purpose, that we didn’t want him there!”

**PTSD and Wife’s Communication Apprehension.** Communication apprehension is defined as an enduring syndrome in which one’s fear of communicating with one’s spouse outweighs the gains that one anticipates from doing so. It affects communication behavior by reducing the amount of self-disclosure, the degree of trust in the other’s communications, and the amount of communication in general (Powers & Hutchinson, 1979). It is reasonable to expect that after experiencing primarily negative responses from her husband and finding her attempts at meaningful communication with him met only with expressions of indifference and/or superiority, the wife of the PTSD victim may reach the point where she dreads speaking to him even to ask straightforward, nonpersonal questions about everyday life.

As a result of the husband’s Vietnam related PTSD, then, the marital communication system becomes characterized by defensive rather than supportive behavior. This not only lessens the veteran’s chance of successfully working through the trauma of the war, but also reduces his wife’s satisfaction with the marital relationship (Derlega & Chaikin, 1977; Jorgensen & Gaudy, 1980).

**Implications for Therapeutic Intervention**

Most intervention strategies designed for use with veterans’ war related psychological problems focus almost exclusively on the individual veteran with a blatant ignorance of his family ties (Hogancamp & Figley, 1983). As this paper demonstrates, however, wives of veterans must also be included in intervention strategies not only because they can be crucial elements in the successful adjustment of their husbands but also because they, too, are victims of PTSD. Thus, PTSD intervention programs based on spouse support must take a two pronged approach. They must, first, address the psychological problems the wives may have developed (e.g., low self-esteem, communication apprehension, loss of self-disclosure skills, anger and disappointment at their husbands’ inability to fulfill the traditional companion role expected of spouses in our society, and fear of their husbands’ anger). Second, they must assist wives in effectively performing the therapeutic spouse role; that is, they must instruct wives on how to facilitate husbands’ disclosure of painful combat memories and feelings. Basic issues that therapists need to consider when designing intervention strategies for treatment of Vietnam veterans that are based on spousal support are enumerated and discussed below.

**Intervention Issues**

1. Vietnam veterans’ wives need to be educated about PTSD. They may have no idea that their husbands’ erratic and hostile behavior is related to their Vietnam combat experiences. Many wives blame themselves for their husbands’ emotional
distance and feel tremendous guilt as a result.

2. Wives need to be informed about the key role they and their marital relationships can play in their husbands’ successful adjustment to PTSD. This information will effectively motivate veterans’ wives to listen carefully to their husbands’ personal accounts of their combat experiences.

3. Veterans’ wives must be desensitized to the horrifying details of the Vietnam combat experience (to the extent that this is possible), so that they are spared some of the shock and trauma that could accompany their husbands’ disclosure of war memories. Accordingly, they should be encouraged to read some of the personal accounts of the war written by Vietnam veterans.

4. Veterans may be hesitant to discuss their combat experiences for fear of rejection. Thus, they may be very sensitive to any responses that appear to be judgmental or condemning. Wives must be trained to provide empathetic responses that will facilitate their husbands’ disclosure of painful war-related thoughts and feelings. Several existing therapeutic programs (such as the program developed by Silverman, 1978, for use with the families of rape victims) could be modified for use in this regard. Additionally, wives must be taught not to reinforce the traditional masculine stereotype of nonexpressivity (Hogancamp & Figley, 1983). Veterans will feel more comfortable in expressing their emotions if their wives and families can demonstrate their ability to tolerate this nontraditional male behavior (Figley & Srenkle, 1978).

5. Wives of Vietnam veterans need to be encouraged to attend the recently emerging support groups for the women who live with these men as a way of further reinforcing the idea that the confusing behavior they experience is common to most sufferers of PTSD.

6. Veterans’ wives should be informed about the beneficial effects to their husbands of informal contact with other Vietnam veterans. Such relationships have also been identified as critical elements in the successful adjustment of Vietnam veterans to PTSD (Engendorf et al., 1981). Additionally, they should be informed about existing treatment programs for Vietnam veterans that are funded by the federal government, such as the Veterans Administration’s Operation Outreach, which consists of storefront programs operated primarily by Vietnam veterans. “Those who share the injuries are major sources of reassurance, strength, encouragement, guidance, and counsel” (Figley & Salison, 1980, p. 139).

7. Wives whose husbands refuse to participate in support groups or to work with a private therapist should undergo a caregiver centered support development activities program (Gottlieb, 1983). Programs such as the one developed by Cowen (1982) for use with hairdressers, divorce attorneys, bartenders, and foremen, or the Community Helpers Project, developed by D’Augelli, Vallance, Danish, Youth, and Gerdes (1981), for rural communities in Central Pennsylvania where residents are reluctant to use formal mental health services, could be modified for use with wives of Vietnam veterans.

8. Because of the operation of the principle of reciprocity in communication, wives of Vietnam veterans suffering from PTSD may need to relearn self-disclosure skills. Several existing programs could be adapted for use in this regard: Ginsberg and Vogelsong (1977), Guernery (1977), and Miller, Corrales, and Wackman (1975).

9. Finally, veterans’ wives need to be encouraged to be as flexible as possible in the role expectations they apply to their husbands. They need extra tolerance and understanding if their husbands need more time alone, are especially irritable at the end of work days, and are less vocal in their interactions.

Intervention strategies based on the wife’s provision of socioemotional support, then, would focus on the wife’s reciprocation of defensive rather than supportive communication behavior. The wife needs to be aware of the reciprocity principle so that she does not perpetuate the defensive pattern. She has to be taught how to resist the impulse to withdraw and to return her husband’s hostile and inattentive responses with tolerant and engaging responses so that she can begin to chip away his resistance to open communication.

Conclusion

Effective intervention strategies designed to teach veterans’ spouses to provide socioemotional support must be based on identification of specific verbal and nonverbal communication behaviors that are “supportive.” Yet the existing research literature on social support is virtually mute on this point (Barrera, 1981). Ideally, one could look to existing definitions of the concept for a key to delineating the substance of social support. Unfortunately, the extent body of research on the ameliorative impact of social support is limited by profound conceptual chaos. Indeed, use of the concept is so inconsistent across researchers and substantive problems that Gottlieb (1983) has described social support as a “protean concept.”

Even the more comprehensive definitions of social support do not provide detailed information about the substance of supportive behavior. Investigations of social support have largely focused on the structure of support systems rather than on what the providers of support actually offer to others. Cowen (1980, p. 53) has frequently called attention to the need for more explicit behavioral accounts of support (Gore, 1978; Lieberman & Mullan, 1978). Gottlieb (1978) appears to have been the first, and is still one of the few, to assess the perceived behavioral activities involved in the receipt of informal help (Barrera, 1983). The paramount task that researchers who study the ameliorative impact of social support must undertake immediately is to begin to identify specific behaviors that are perceived as helpful by recipients.

END NOTE

1. According to Thoits (1982), there are two basic types of social support: socioemotional (i.e., affection, sympathy and understanding, acceptance, and esteem from others) and instrumental (i.e., advice and help with work and family responsibilities).

REFERENCES


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