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Re-Integration Stress for Desert Storm Families: Wartime Deployments and Family Trauma

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Because the war was relatively brief, casualties relatively light, and the Nation sanctioned the war socially, veterans of Desert Shield/Storm and their families were not anticipated to suffer symptoms of trauma or re-entry stress beyond that expected in routine peacetime military deployments. However, the authors argue that the stress imposed on families by Desert Shield/Storm was not analogous to that of routine deployments. The call to duty was unexpected, disruptive, and "hazardous" (i.e., highly dangerous) which places it in the category of a "catastrophic" stressor as defined by McCubbin and Figley (1983). The deployment was a call to war, which creates unique stress beyond those experienced during peacetime deployments. The deployment also carried with it prolonged "anticipation of trauma." For these reasons, the authors argue, the deployment to Desert Shield/Storm created a situation of "family trauma" for veterans and their families. Suggestions are offered for education, prevention and treatment for families undergoing unexpected wartime military deployments.

KEY WORDS: Desert Storm; families; trauma; war; deployment.

INTRODUCTION

Between August 1990 and March 1991, 500,000 American military personnel were called to duty in the Persian Gulf. Early on there was concern about potentially high incidence of Combat Stress Reactions (CSR) and PTSD, as American military were expected to find themselves involved in trench warfare on the magnitude of that encountered in World War I. However, in the end, it was argued that a number of factors would mitigate against large scale stress reactions among the returning troops and their

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families back home. First, the war was relatively brief. It is true that the first troops were sent over the first week of August, 1991; that by October, close to 300,000 were already in the theatre of operations; and that during the summer of 1991, there were still between 50,000 and 100,000 left in and around Iraq. However, in the public eye, the actual *war* lasted only 6 weeks (and to some, it only lasted five days): Five and a half weeks of air strikes followed by five days of a ground war. Second, the war was also seen as having relatively few American casualties. Slightly over one hundred of our men and women died, and of these, less than half died from enemy fire.

Third, the war had strong social sanction from the people of the United States. Having learned from the Vietnam War that social censure of that war and its veterans contributed to the chronicity of subsequent PTSD reactions, the country worked hard to support the troops serving in the Persian Gulf war. From television promotional spots, to yellow ribbons, to flag stickers on car windows, to the thousands of tons of packages and letters that literally jammed the mail-ways, Americans by and large sought to demonstrate their support of the people called to duty. Even those strongly opposed to the war and demonstrating for peace were always careful to clarify that they supported the *people serving in the war*, despite opposition to the war itself. This show of national support culminated in a nationally televised homecoming celebration in June, 1991, for the Desert Shield/Storm Veterans. Thousands attended and many more millions watched on TV. Clearly, the country bestowed a sense of honor on the Desert Shield/Storm veterans and embraced them with emotional support.

Fourth, perhaps because of the factors listed above, the war had relatively few psychiatric casualties. Few cases of Combat Stress Reaction were diagnosed from August of 1990 through March, 1991, and even fewer cases of Post-traumatic Stress Disorder were cited.

Finally, working from lessons learned during the Vietnam war, Mental Health and Social Work departments, across the country, on military bases and in civilian settings, tried to reach out psychiatrically to the families left behind. The belief underlying this outreach was that education and emotional support for family members during the deployment would emotionally shore up the family system, which in turn would help the morale of the deployed troops, thus serving to diminish the numbers of psychiatric casualties from the war. Support groups for families were established; educational literature was distributed; information networks were set up; and publications were produced ("Post-traumatic stress disorder (PTSD)," 1991; "Guide to A Mentally Healthy Reunion," 1991) to help with the re-entry process.

These factors—the relative brevity of the war, the limited number of physical and psychiatric casualties, the overwhelming social sanction that its troops received, and the focused support for families of military personnel during the deployment—led to the expectation that separation and re-entry stresses for the troops and their families should be mild, and analogous to the predictable and workable separation and reentry stresses seen in military families undergoing peacetime deployments as a part of tours of duty. Unfortunately, this expectation was not realized. Symptoms described by about 10% of Desert Shield/Storm personnel during deployment (percentages reflect second author's informal estimates generalized from approximately 200 clinical field interviews) included hypersomnia/insomnia, appetite changes, psychic numbing, increased irritability, fearfulness, and sadness. Symptoms described by an estimated 10-20% of Desert Shield/Storm personnel upon returning home from the deployment, even up to 6 months following the return home, included lingering sleep disturbances and bad dreams, mild irritability, mild concentration difficulties, somatic complaints, problems readjusting to work, preoccupation with relationships or experiences during the deployment, a wish to avoid such people and memories, and a re-examination of one's values/goals/direction in life with a push toward doing something different. These symptoms did not exist prior to the deployment and were prolonged in their occurrence, lasting in some cases months (rather than the predicted weeks) subsequent to return. Many family problems did not emerge until several months after the deployed member's return. As much as a year post-return, some families were reporting a recurrence of the affects associated with the deployment, and the concurrent symptom manifestations, at times of family transition or heightened family stress. Two years postreturn, a Veterans Affairs' data bank reported about 700 Gulf War veterans had been screened for war-related problems as part of a national Gulf War treatment outreach effort (Anderson, 1993). Unfortunately, the prediction of minimal wartime and post-war stress led, at times, to puzzlement and even censure when Desert Storm troops and their families showed these postdeployment symptoms of disruption.

The authors will address the importance of having a conceptual framework, or "name," for the kinds of symptoms (that belied prewar expectations) shown by Desert Shield/Storm troops and their families during and after the war. The tenet will be offered that the stress of this deployment was qualitatively different than that of a peacetime deployment, since (1) the nature of the deployment met the criteria for a "catastrophic" stressor (McCubbin and Figley, 1983); (2) wartime brought anxieties unlike those experienced during peacetime deployments; and (3) the prolonged anticipation, by troops and their families, of physical or psychological

trauma, brought its own unique stresses. As such, the Desert Shield/Storm deployment stress qualified as "family trauma." Making this conceptual shift offers insight into models of education, prevention, and treatment for wartime families—models that the authors hope will be applicable to wartime deployments in general, beyond the relevance to Desert Shield/Storm in particular.

In a recent paper, Scurfield (1992) raised questions about the national collusion to sanitize and silence the residua of Operation Desert Storm, making it difficult for distressed veterans and their family members to identify, much less receive help for, their lingering post war adjustment difficulties. The authors hope in this paper to give conceptual articulation to one such area of distress shown by the Desert Shield/Storm veterans and their families.

The data from this paper are drawn from the second author's experience interviewing approximately 200 military personnel during and following the Desert Shield/Storm deployment. In his role as the staff psychologist assigned to the Hospital Ship, USNS COMFORT, from August 1990 to March 1991, he interviewed crew members from the ship itself, crew members from other ships, and troops from ground-based facilities, referred to the Hospital Ship for evaluation and treatment. Subsequently in his role as staff psychologist at the National Naval Medical Center in Bethesda, Maryland, he interviewed returned military personnel who had served aboard the Hospital Ship. Data are also drawn from the first author's experience working as a psychologist in the field of trauma (Peebles and Fisher 1987a; Peebles and Fisher, 1987b; Peebles, 1989a,b; Peebles-Kleiger, 1989; Peebles-Kleiger *et al.,* 1992), and from her experience talking with wives and families of deployed service members during and after the war deployment. These talks occurred both one-on-one, and in military-sponsored support groups, in her role as spouse of a deployed service member. In addition, focused, in-depth interviews were conducted in her role as psychologist, as part of a data-gathering process for the educational videotape, *Families, Trauma and Stress* (Peebles-Kleiger *et al.,* 1992).

PEACETIME DEPLOYMENT/REENTRY

The emotional cycle of peacetime deployment was the model used at most military bases for family education and intervention prior to, during, and after the Desert Shield/Storm deployment. This model is well known. There are two versions. One describes seven phases of adjustment, from the anticipation of the loss to the final re-integration and stabilization of relationships within the family upon reunion (Logan, 1987). A second

describes four emotional stages of adjustment adapted from the stages of grief (Kubler-Ross, 1969): Anger/Protest, Sadness/Despair, Coping/Detachment, and Return/Reunion (Emotional Stages of Deployment, 1990). The two versions are similar in thrust; thus, we will integrate the two in a composite description below.

1. Both versions describe a one to two week period of tension, protest and anger as news of the impending deployment is released and the family begins making preparations for separation. People are described as "on edge" and "slight irritations can grow to major proportions" (Emotional Stages of Deployment, 1990, p. 27). This is the "Anger/Protest" stage.

2. The final few days before the departure bring the second stage of "Detachment and Withdrawal" (Logan, 1987), in which family members, frightened by the impending loss, typically distance from each other.

3. Beginning at the time of departure itself, as the buses are pulling out, is the phase of "Emotional Disorganization" (Logan, 1987) or "Sadness/ Despair" (Emotional Stages of Deployment, 1990). In this phase, tension and/or detachment are replaced by sadness and loss. Symptoms of depression can set in, with problems sleeping, periods of tearfulness, and difficulty eating. This period is described as lasting about two to 6 weeks.

4. At about the sixth week, the phase of "Recovery and Stabilization" (Logan, 1987) or "Coping/Detachment" (Emotional Stages of Deployment, 1990) begins. The sadness drifts away, and what supplants it is "a state of relative calm and confidence in handling day-to-day living" (Emotional Stages of Deployment, 1990, p. 8). Although the occurrence of a major crisis can temporarily upset the psychological equilibrium, for the most part the calm is described as lasting the bulk of the deployment. This phase involves settling into a comfortable routine, making community and group connections and maintaining communication with the deployed service member.

5. About 6 weeks before deployment ends, "Anticipation of Homecoming" (Logan, 1987) begins. Activity, tension, and even loss and despair emerge again as the family rushes to prepare themselves and their home for the return of the deployed service member. Fears and hopes run high as the family's conflicting expectations of reunion vs. change, and fulfillment vs. disappointment, are stirred.

6. The actual stage of "Reunion" (Logan, 1987) is described as beginning reunion day and lasting about 6 weeks. In this stage the family tries to become a family again, to get re-acquainted, to negotiate changes in old roles, and to respond to the changes in each other. The marital couple works to re-establish intimacy, and children and parents work to reestablish familiarity and connectedness.

7. Finally, according to Logan (1987), about 6 to 12 weeks after reunion, "Reintegration and Stabilization" set in, with the family resuming their coherence as a functioning unit again.

Within the model of peacetime deployment, allowance is made for difficulties negotiating certain stages. In addition, much is also written in the peacetime deployment literature about stresses encountered at reunion (Guide To a Mentally Healthy Reunion, 1991; McCall, 1981). However, in general, the peacetime deployment literature describes the deployment separation as a circumscribed family challenge that, if prepared for and managed in an optimal way, can enhance the quality of a relationship:

> If such changes are accepted cheerfully, they can make a marriage more stimulating. "Separation enhances our relationship," says one Navy wife. "It's like we've been lovers for 17 years." (McCall, 1981, p. 7)

HOW DESERT SHIELD/STORM WAS DIFFERENT: FAMILY TRAUMA

The education on deployment adjustment offered to the families of Desert Shield/Storm was invaluable. Even more notable were the efforts made by contingency planning personnel on bases around the country to reach out and make their availability known to families left behind. However, these educational efforts, based on peacetime deployment experience, proved insufficient for Desert Shield/Storm families for three reasons: (1) Desert Shield/Storm was not an anticipated, routine deployment; it was an unexpected, wartime deployment considered Hazardous Duty. This moved it from the category of "normative" life stressor to the category of "catastrophic" life stressor (McCubbin and Figley, 1983), with the ensuing emotional reactions typical of "catastrophic" life stressors. (2) The state of war in and of itself brings family stresses unique to that state, both during the war and during the subsequent re-integration process (Hobfoll *et al.*, 1991; McCubbin *et al.*, 1976; Solomon, 1988; Solomon *et al.*, 1991a; Solomon *et al.*, 1991b; Solomon *et al.*, 1992). (3) The prolonged anticipation of trauma (such as that experienced by military and their families during Operation Desert Shield) brings additional unique stress and emotional sequelae (Terr, 1991). These three conditions (described below in more detail) rendered the Desert Shield/Storm deployment a situation of potential family trauma. As such, the application of peacetime deployment knowledge to the Desert Shield/Storm deployment was limited in its potential efficacy.

"Catastrophic" Stressor

In writing about stress and the family, McCubbin and Figley (1983) differentiate between "Normative" family stress and "Catastrophic" family stress. The more the stressful event is anticipated; the more there is time to prepare; the more participants have had some previous experience with such events; the more there is a sense of control over the event; the more the event has been experienced by others and there is guidance from others on how to get through the event; then the more it is a Normative family stress. In contrast, the more time in actual "crisis"; the more there is a sense of helplessness, loss, disruption, and destruction; and the higher the degree of dangerousness, the more it is a Catastrophic family stress. Normative family stresses might include events such as the birth of a first child or the death of an aged parent. Catastrophic family stresses might include the death of a spouse or the diagnosis of life-threatening illness in a child.

As can be seen from this model, routine peacetime deployments would fall into the category of Normative stresses, while the Desert Shield/Storm deployment would fall into the category of Catastrophic stress. The peacetime deployment is expected; there is time to prepare (both pragmatically in terms of supplies and household arrangements, as well as emotionally); although disruption is involved, the threat of danger and destruction is usually minimal; and the sense of "crisis" is most often minimal too, particularly if the family prepares emotionally for the deployment. In contrast, troops deploying for Desert Shield/Storm sometimes had no more than 48 hr notice. Personnel were sent over who had no prior deployment experience and no anticipation of deployments built in to their job duties. For the first time, more than 40,000 women (about seven percent of the war-time force) were deployed, thousands of whom were mothers, with dependent children ranging from only 6 weeks old to adolescence. In some families both mother and father were called to duty, necessitating rapid-fire childcare arrangements. Powers of Attorney, wills, the purchasing of supplies all had to be accomplished within hours, and all was done within an atmosphere of crisis and fear. There was little sense of control: No one knew how long the deployment would be, how lethal the situation could become, or how much manpower would eventually be needed. Some personnel were told manpower needs precluded rotation plans, and that the deployment could conceivably last for years. The degree of dangerousness was high: Chemical and biological warfare were real possibilities; nuclear warfare was speculated; Scud missile attacks, burning trenches, bombing of innocent targets, hostage-taking, terrorist acts, and environmental destruction were already in place. For these reasons, the Desert Shield/Storm deployment ranked high on the scale of Catastrophic stress.

Why is the differentiation between Normative and Catastrophic stress relevant when considering family adjustment to Operation Desert Shield/Storm? McCubbin and Figley (1983) wrote, "Problems associated with transitional family stressors are rarely chronic. . .(however). . . A growing body of scientific literature. . .notes both the acute and chronic emotional fallout from catastrophes" (pp. 226-227). Thus, the peacetime deployment literature is accurate when it states that with a routine deployment, feelings of "Emotional Disorganization" are expected but *temporary*, expected to last two to six weeks, and that the bulk of the deployment is expected to pass in "a state of relative calm and confidence" (Emotional Stages of Deployment, 1990, p. 8). However, with a Catastrophic stressor, such as the Desert Shield/Storm deployment, the feelings of "Emotional Disorganization" may not have quickly resolved within two to six weeks, since it was not known when, or if the service person would return. The world situation heated up, and the sense of crisis worsened rather than lessened. Thus, "a state of relative calm and confidence" (characteristic of the bulk of peacetime deployment time) was difficult to achieve for the war-time families. Instead, as Hussein's threats of "the Mother of all wars" escalated, military personnel and their families lived for months with the possibility that if the service member came home at all, he or she might be seriously incapacitated physically, or scarred emotionally. Living with those fears, trying to metabolize them, and trying to help children in the family metabolize them, created the potential of short-term and long-term psychological symptoms (i.e., McCubbin and Figley's "acute and chronic emotional fallout").

Stresses Specific To Wartime

Death and the Media Roller-Coaster

In an article describing the traumatic effects of combat on military families during the service member's absence and subsequent homecoming, Solomon (1988) noted the following strain unique to wartime separation. Families of war-deployed personnel live with the fear of death. Simultaneously, there is minimal hard knowledge (sometimes no communication with the deployed family member for weeks or no knowledge of exact location), in combination with a relentless media bombardment of a detailed, anxiety-arousing, "soft" knowledge-rumor-speculation-fact mix (Rutter, 1991). There is an immediacy (both temporally and visually) to the documentation of destruction and fear (e.g., few people forgot the frightening images of Israeli reporters scrambling for their gas masks as Scud missiles with possible

chemical warheads were heading towards densely populated Israeli cities). As Solomon notes, the result of this combination of fear of death, lack of hard knowledge, and rapidly oscillating media news spills is that, "the mood of family members tends to oscillate rapidly and erratically between hope and despair" (p. 324).

Unchannelled Aggression

Second, coping with residual aggression is more problematic for wartime veterans and their families than it is in routine deployments. Actually engaging in combat and/or months of preparing for anticipated combat involves repeated exposure to violence or simulated conditions of violence. For example, medical unit casualty receiving drills utilize realistic moulage makeup to simulate severe burns, blown off limbs, and disfigured faces. Surgeons watch violent "blood and guts" movies to harden their reactions to man-made gore. Pilots "psych" themselves with pre-flight projections of bombing damage. Undertones of sadism infiltrate relationships, as military personnel in a war zone struggle to adapt to the potential for inflicting, or being exposed to, violence that runs counter to acquired ethics and morals. Horowitz and Solomon (1978) suggest that, as a result, some veterans learn to regard violence as a viable and sometimes pleasurable solution to problems. This familiarity with, hardening to, and occasional pleasure in, violence creates a reentry strain around aggression for wartime military personnel different from that of routine deployment. In this regard, it seems reasonable to speculate that some of the Naval aviators who perpetrated acts of sexually couched aggression on women at the 1991 Tailhook Convention were themselves Persian Gulf veterans whose unchannelled aggression and sadism may have culminated in socially unacceptable abusive behavior.

Simultaneously, a complementary strain around aggression develops in the spouse left behind. Typically, at some level, the separation has felt like abandonment, over which the spouse has had little control; in reaction, conscious or unconscious rage develops. In addition, the chronic strain of anticipated death/loss can manifest in rage when the service member returns, in much the same way a parent, frightened by a child who brushes with danger, can, once the danger is past, explode with anger at having felt so frightened and helpless. These feelings often have no readily acceptable outlets for expression, either during the separation or after. Anger at loss and abandonment runs counter to one's sense of national duty and personal moral obligation. Anger at a spouse returning from war seems poor gratitude for the sacrifice and personal danger the spouse endured, and inappropriate when the spouse is struggling with his/her own emotional scars. Speaking

of the anger to others can elicit uncomfortable silence or even censure for "complaining"; the listener may be unable to empathize due to puzzlement, anxiety, or guilt, and fall back instead on the construction that the spouse "should have known ahead of time what it means to be in a military family." The final result is heightened, poorly processed aggression for both the returning veteran and for his/her spouse and children. Solomon (1988) quoted a study by Williams (1980) that outlined a special pattern of episodic violent outbursts unique to returning war veterans' families. Terr (L.T., personal communication, October 14, 1991) labels this kind of post-trauma anger "unchannelled aggression," and feels its poor resolution can be a major impediment to achieving healthy resolution of a crisis.

"Masque of the Red Death": Manic Defenses and Marital Infidelities

A third stress unique to wartime is the "Masque of the Red Death" (Poe, 1940) syndrome. As Poe illustrated in his short story, fear of death can ignite manic defenses. In the face of foreshortened time, people sometimes seek escape through revelry or fantasy creation/gratification. "Parties," the overuse of alcohol, and sexual liaisons can stave off or dull the pain of fear. Long-term consequences dim when one is faced with possible short-term annihilation. However, when the crisis is past, and veterans do return home, the war-time romances leave an imprint on the participants, and subsequently can affect their partners and marital relationships. At best, trust has been breached and that breach leaves a scar. At worst, the families eventually are disrupted.

Rapid Reentry

Fourth, Solomon (1988) described how the returning veteran typically has little time between leaving the theatre of combat and re-entering family/work life to digest the experiences he/she has gone through. Nowhere was the suddenness of the "foxhole-to-front-porch transition" (Hobfoll *et al.*, 1991) more prominent than in some of the initial Gulf War homecomings in which veterans often received little more than a day or two's notice before they found themselves back home from the Middle East. Having little time to process their own emotions and culture shock, veterans can feel estranged from themselves. They can then develop a feeling of estrangement from others, who are perceived as being unable to understand what they went through (Solomon, 1988). This combination of emotional overwhelming and estrangement can make the returning spouse seem "different" to those who welcome him/her home.

Trauma Anticipation

The final factor limiting the applicability of peacetime deployment knowledge to the Desert Shield/Storm deployment was the prolonged exposure to trauma anticipation. Despite the fact that many returning veterans saw little, if any action, they sat for 6 months with little to do but think about the war, and the possibility of being wounded or killed. Skinner and Swartz (1989) noted that children of detainees in South Africa often showed the same stress-related symptoms following the anticipation or scare of a parent's detention as they did during the actual detention itself. Terr (1991) described psychological sequelae of *anticipation* of trauma. She wrote that "massive attempts to protect the psyche. . .are put into gear" (p. 15), and that such self-protective efforts can result in long-term personality changes. For example, one's attempts to numb oneself psychically can persist as chronic anhedonia; one's struggle with rage over being held psychologically captive can persist as problems regulating aggression; and one's loss of effectance in the fact of immoveable forces can result in chronic passivity.

Thus, the Desert Shield/Storm deployment was psychologically different for families than a routine peacetime deployment, in that it was a Catastrophic (instead of Normative) family stressor, a wartime (instead of peacetime) deployment, and carried with it the long-term anticipation of trauma. As such, it qualifies for Figley's (1989a) definition of trauma disorder for families: "Traumatized families are those who are attempting to cope with an extraordinary stressor that has disrupted their normal life in unwanted ways" (p. 5). Making this conceptual shift regarding wartime deployments, from family stress to family trauma, offers a tool for refining our educational, prevention, and treatment interventions for wartime families.

EDUCATION, PREVENTION, AND TREATMENT

Education: The Emotional Stages of Wartime Deployment

While the currently available reprints on the emotional cycles of peacetime deployment should be retained for families undergoing routine peacetime deployments, educational material specific to wartime deployment should be devised as well. Such a revision would incorporate a shift from the normative transition model of peacetime deployment, with its emphasis on phase-like resolution, to a trauma model underpinning for wartime deployments, with an emphasis on repetitive alternations of intensity and numbing without stable resolution ("intrusion" vs. "avoidance"

phases outlined by Horowitz, 1986). Families would be educated about catastrophic family stressors, the unique strains such stressors put on family functioning, and the expectable emotional phases of the *wartime* deployment as follows (the reader is encouraged to contrast the following wartime deployment phase descriptions with those outlined for peacetime deployments on pp. 177–178).

Phase One: Initial Shock

Instead of moving (as predicted for peacetime deployments) from the Anger/Protest to Detachment/Withdrawal phases and then to the Sadness/Despair phase over a few weeks time, those called to war unexpectedly, with brief notice, may more typically expect a crisis atmosphere. There might be an initial surge, upon hearing the news, of intense affect (notably including fear, despair, and protest), alternating with self-numbing. With inadequate time to process the intensity and rapidity of feelings, families may try to cope by blocking the potentially immobilizing feeling surges in order to concentrate on the rapid execution of the departure tasks necessary before separation (e.g., purchase of supplies, execution of wills, provision of child care, etc.). During this phase, family members can be educated that both strong feelings and self-numbing are normal; that certain family members may feel the emotions for the rest of the family while others are numb and focus methodically on details; that most family members will eventually show both strong feeling and numbing; and that emotional withdrawal is self-protective and should not be taken personally. Families should be forewarned that this will typically be a painful, frightening time, particularly as they try to say good-bye to children. However, they can be told that the work of good-bye can continue to unfold with a sense of better resolution during the deployment itself, and the more they can keep *communication* going, even while *feeling* numb or frightened, the less long-term strain there will be on family ties.

Phase Two: Departure

The peace-time deployment model describes the Emotional Disorganization or Sadness/Despair phase setting in at the time of departure. This may also be true of wartime deployment. However, equally possible at the time of wartime deployment departure is a disconcerting *numbing* of all feelings, even sad ones, as family members are separated. The absence of time to prepare emotionally for the separation, coupled with the intensity of fear and uncertainty, can trip a sort of emotional "circuit

breaker" in the mind, cutting off all feelings, so that the person does not get overwhelmed and subsequently paralyzed. Families should understand that an absence of feeling at the time of departure is not a signal of an absence of caring; quite the contrary, the stronger the numbing, the stronger the underlying emotion. Again, certain family members, particularly children, may carry the feelings for the family. Families should be cautioned not to isolate or add to the burden of those family members by defensively viewing them as too sensitive or an annoyance. Instead, family members need to realize, and verbalize with each other, that those members are feeling feelings that everyone shares, but perhaps can not let themselves feel yet. Sharing this perspective will help people feel together, less isolated, less guilty and confused, and will strengthen communication.

Phase Three: Emotional Disorganization

The peacetime deployment model notes that the period of Emotional Disorganization and Sadness/Despair starts at departure. In contrast, wartime families may find it takes several days or weeks following the departure, for the reality of the feelings to sink in. Families may have mobilized impressively in the few days before departure, and continue to stave off strong feelings with continued mobilization around practical coping issues (e.g., wills, car repairs, childcare arrangements) for weeks afterwards. It is when the practical things have been completed, and a few weeks have passed demonstrating that this is not simply a "bad dream" or an ordinary separation, that the intensity of feelings of Emotional Disorganization and Sadness/Despair can hit.

The peacetime deployment model goes on to describe a gradual resolution of the phase of Emotional Disorganization and Sadness/Despair over a period of about two to six weeks. In contrast, instead of being a predictable, brief phase, that resolves with time and acceptance, the period of Emotional Disorganization for wartime families may last the bulk of the deployment, intensifying and abating with news of the war, without ever achieving full stability of resolution. If the news of the war gets worse, feelings of emotional disorganization can get worse. Fear, guilt over things said or not said in the rush to say good-bye, and irrational anger stemming from the trauma can further intensify the Emotional Disorganization and hinder its easy resolution.

In the peacetime model, symptoms listed as expectable under the Emotional Disorganization phase are primarily depressive symptomatology, such as problems sleeping, periods of tearfulness, and difficulty eating. With wartime deployment, one would also need to add trauma symptomatology,

including the development of fears, bad dreams, unchannelled aggression experienced as heightened irritability and anger toward others, hyperalertness and hyper-reactivity, and "omens" or post-hoc efforts to create explanations for why the trauma took place (Terr, 1979). Families should be prepared for such symptoms and educated in ways of managing them adaptively. For example, the formation of omens should be uncovered, reality-checked, and dissipated before irrational and unproductively blaming ideas surreptitiously weave themselves in one's character style (Terr in Peebles-Kleiger *et al.,* 1992). Family members can be reminded that some things occur simply because of bad luck, with little or no input from what one says, does, or believes. As a second example, family members should be prepared for the irritability of unchannelled aggression, and cautioned against turning such anger against each other or themselves in potentially destructive, blaming ways. More productive is the sharing of such feelings with each other (realizing that each member feels this way and the feelings are normal), and the creative discovery of ways family members can channel these feelings into a project they work on together (e.g., helping other families in this situation, forming neighborhood support groups or outings, discussing and reorganizing one's life priorities, focusing on other areas of life in which one *can* effect change or achieve control, increasing family involvement in physical activity, etc.).

It might also be mentioned, relevant to the phase of Emotional Disorganization, that research shows children in wartime families respond with stress-related symptoms in negative proportion to the degree of emotional adjustment of the mothers to the stress (Bryce *et al.,* 1989). In different words, the more emotionally nurtured and stable the remaining caretaking parent or caretaker, the less stressed will be the children. In response to this knowledge, wartime deployment families can be counseled about the importance of keeping the remaining parent emotionally nurtured, of strengthening his or her support systems (e.g., visits from family, regular contact with friends), and of easing daily life task stress whenever possible, even if that means leaving housework undone, cutting back on overtime work, or developing a fund for a night of babysitting on some regular basis.

Phase Four: Recovery and Stabilization

The peacetime deployment model suggests that at about 6 weeks post deployment, the phase of Recovery and Stabilization sets in. In contrast, for wartime deployment, families could expect some adequate stabilization of home routines by that time; however, wartime families should not be

surprised to continually reexperience episodes of destabilizing feelings as the deployment continues. The reasons for this are several (and have been elaborated earlier). First, there is not certainty about the positive outcome of the deployment, and the news of such changes daily. Second, with no predictable endpoint in sight (i.e., it could be weeks, it could be years), the pacing of one's internal resources can not be regulated by a reliable timeclock. Finally, heightened media coverage creates a roller-coaster of highs and lows of rapidly alternating good and bad news that further impedes consistent emotional stabilization.

As a result of this continuous strain, particularly when it involves fear of death, manic defenses can be set in motion like those described earlier in the "Masque of the Red Death" syndrome. Families need to be educated about pressures that may spur them to spending sprees they can ill afford, impulsive decisions about geographical relocation, extramarital sexual liaisons or temptations to such, appearance changes, the overuse of alcohol, or even eating binges. Children or their parents may take on a flurry of activities to keep themselves preoccupied, which while potentially adaptive if done in moderation, can, when spurred by manic pressures to escape and avoid anxious feelings, be poorly regulated and exhaust child or parent, further weakening their resources. McCubbin (H.M., personal communication, February 21, 1992) described a paradoxical research finding that families in crisis frequently strain themselves further by creating new crises. It is possible that manic defenses play a role in this paradoxical phenomenon.

Phase Five: Anticipation of Homecoming

The peacetime deployment model describes an Anticipation of Homecoming phase beginning about 6 weeks before the service person's reentry. In certain wartime situations (such as the Gulf War), reentry can be as sudden as deployment was, with no known return date, and sometimes only a few days' notice of a family member's return. Such unpredictability precludes adequate anticipation of, and preparation for, homecoming. As a result the Anticipation of Homecoming phase, and its feelings of joy, relief, and excitement mixed with anger, hurt, and anxiety, are again condensed into a few days time, with inadequate time for family members to sort, label, and process reactions. The result can be unrealistic manic expectations for the immediate end to emotional pain, or the self-numbing response described earlier, both of which complicate the next Phase of Reunion.

Phase Six: Reunion

The Reunion phase is described in peacetime deployment as a 6 to 12-week period in which family members readjust to each other. In contrast, in wartime deployments, it can take from 3 to 9 months post-homecoming to resolve the acute phase, with lingering reactions as long as 12-18 months later.

The peacetime deployment educational literature (Logan, 1987; Emotional Stages of Deployment, 1990) offers many useful suggestions for reuniting couples to consider. We would like to highlight a few ideas especially relevant for wartime Reunion: First, the numbing response complicates readjustment. As described earlier, the returning veteran is typically experiencing culture shock, stimulus overload, and emotional overload. In addition, months of trauma anticipation, even in the absence of actual combat or diagnosable PTSD, have strained both families' and service members' emotional reserves. These factors can leave spouses disconcertedly dulled to each other emotionally, and consequently inexplicably lonely, at a time when they were expecting the loneliness to end. Anxiety can set in as family members wonder (usually mistakenly) whether feelings have permanently dimmed or relationships have significantly changed.

This anxiety, and the length of time it takes for the numbing to wear off, can strain resiliency in the already emotionally beleaguered family. Families need to be educated about the numbing response, not be further strained by unrealistic expectations about the length of time it takes to dissipate, understand it is not permanent, learn not to take it personally, and be counseled to continue taking sustenance from extra-familial support systems during this time as a way of counteracting the continued anxiety and strain.

Second, with marital couples, sexual difficulties are frequently reported post wartime deployment (S. Sheppes, personal communication, August 9, 1991). These difficulties have many sources, among them: unresolved feelings about the separation, unresolved unchannelled aggression, known or unknown marital infidelities, or the reentry numbing from too rapid and intense a Reunion. Wartime deployment families need to expect a lengthier period of sexual adjustment than that following peacetime deployments.

Third, the six months following wartime deployment is a time of heightened marital risk. The divorce rate among Vietnam veterans is higher than that of the rest of the U.S. population, with 38% of the marriages of Vietnam veterans breaking up within 6 months of their homecoming (Solomon, 1988). Within two months of the initial Persian Gulf

homecomings, CNN reported divorce rates rising among Gulf War veterans as well. As a result, wartime families should be counseled to carefully weigh and consider, perhaps even postpone, major decisions regarding separation or divorce during this phase. Many strong emotions are competing for resolution. Time is needed for adequate working through of the trauma response, and sometimes families can mistake trauma reactions for feelings about the relationship. In these cases, family dissolution can be mistakenly seen as a solution to what are really trauma responses. In other cases, dissolution can be unconsciously sought as an escape from the daily emotional pain of the work of reintegration. In either case, the decision to divorce might be premature or even unnecessary. Fourth, families should be educated to consider family symptoms that arise in the 6 to 12 months post-homecoming (even if not immediately following homecoming) as possibly being related to unresolved deployment reactions. These include children's problems in school or acting out at home, and parental sleep problems, irritability, or marital problems. Disentangling unresolved deployment reactions from non-trauma-related problems makes an important difference in treatment approach and prognosis.

Phase Seven: Reintegration and Stabilization

The Reintegration and Stabilization phase described in peacetime deployments is the phase in which the emotional life of the family finally reaches some stability, and the after-shocks of adjustment are, for the most part, over. In contrast, for wartime families, a recurrence of emotional after-shocks can be triggered at times of later family transition and crisis, much as they have been shown to occur for World War II veterans decades following the war (Van Dyke *et al.,* 1985). It is important for families to be educated to this phenomenon. The more they can disentangle "feeling memories" related to the war separation, from reactions to a here and now transition, the more efficiently and adaptively they will handle current transitions.

Further Prevention Efforts

Further educational efforts aimed at strengthening families' coping skills and thus preventing severe destabilization include: (1) education about family vulnerability factors; (2) education about self-help coping skills; and (3) suggestions for the timing and dissipation of educational materials.

1. Family Vulnerability

Families need to be aware of factors that increase their vulnerability to destabilization following a Catastrophic stressor. One factor is "pile-up" (McCubbin and McCubbin, 1989). Those families who have undergone an accumulation of life changes and demands, whether Normative or Catastrophic, in the 6 months prior to a traumatic event, are at four times greater risk for family system chaos following the traumatic event (McCubbin in Peebles-Kleiger *et al.,* 1992). Having this information could allow families (and/or support personnel) to target families with increased susceptibility due to pile-up, and plan early, proactive intervention that emphasized the importance of strengthening extra-familial support networks, strengthening positive family coping strategies, and referring for brief professional intervention if needed.

A second family vulnerability factor is style of communication (McCubbin in Peebles-Kleiger *et al.,* 1992). The more a "hot reactor" style of communication is used in a family (i.e., taking small events and blowing them into large crises; using language that is intense, vivid, blaming, and links people to the event in emotional ways: drawing old or tangential issues into current crisis; inflaming and intensifying instead of problem solving), the more susceptible the family is to erosive destabilization. Given this knowledge, families could be educated (perhaps trained as part of brief deployment workshops) about the characteristics of "cool reactor" communication (i.e., being calm and easy-going; using affirming communications; keeping focus on issue at hand; problem-solving).

2. Self-Help Coping Skills

Families can be educated that additional aspects of their style of relating to each other in a time of crisis can affect how successfully they are able to handle the crisis. McCubbin and Figley (1983) and Figley (1983, 1989a) describe eleven ways families can, on their own, increase their chances of coping successfully with a crisis, feel emotionally supported by each other, and emerge from the crisis with personal growth rather than family disruption. These strategies include, but are not limited to, family members acknowledging, without denial, that they are in a crisis; families working as a team without scapegoating individual members; families continuing overt demonstrations of commitment, affection, and communication during the crisis; and family members being flexible in shifting traditional roles. The interested reader is strongly encouraged to see McCubbin and

Figley (1983) and Figley (1983; 1989a) for a fuller description and listing of the self-help strategies families could be educated to adopt.

3. *Timing/Dissipation of Educational Materials*

Finally, we would encourage that dissemination of educational materials about wartime deployment (1) take place during peacetime before a crisis has occurred, (2) include *all* military personnel no matter how seemingly slight their chances of wartime duty, (3) include the *families* of personnel, and (4) include mental health workers and personnel likely to be involved in wartime contingency support operations. This education could take place as a half-day seminar, or weekend workshop for families, and/or handouts could be compiled and mailed to all families of military personnel and reservists.

The reasons for these suggestions are several. First, conducting the education during peacetime would provide time and a crisis-free atmosphere for adequate processing of difficult material. Second, conducting a broad-based canvas of all military active duty and reserve personnel and their families would insure that families, not familiar with routine peacetime deployments, would have some mental expectation of and preparation for the reality of a possible lengthy wartime separation. (In the Desert Shield/Storm Operation, tens of thousands of personnel and reservists were called for hazardous duty who had never undergone a previous deployment/family separation [nor were expected to] and, consequently, whose families were not psychologically prepared for the possibility of a lengthy deployment's occurring.)

Third, it would be important to include military mental health workers and personnel designated for contingency support operations, in the educational efforts about the wartime deployment trauma response model as well. Unfortunately, during Desert Shield/Storm, since the peacetime deployment experience pointed to the expectability of a brief and transitory period of crisis, military mental health and social work departments and families alike were unprepared for the prolongation and gradual intensification of emotional upset that families went through. Families felt guilty and isolated as their emotional stress did not dissipate as predicted, and Social work personnel ran the risk of feeling burdened and bewildered by families whom they perceived as becoming more "demanding" and "unrealistic." If a model of "Catastrophic" stressor could have been put in place of the peacetime deployment model, educational efforts might have anticipated and predicted the emotional upheaval of families, thus paving the way for less bewilderment and frustration and more recognition, tolerance and referral for intervention.

Treatment

Figley (Peebles-Kleiger *et al.*, 1992) differentiates between trauma crisis treatment and family treatment that works to restructure the family system. The former is brief (one to two sessions), focuses on the here and now, and emphasizes restoring to the family their natural strengths and pre-crisis level of functioning. The latter is lengthier, more typically delves into historical material, and focuses on restructuring dysfunctional family patterns. It is important when considering professional intervention with wartime deployment families (either during or following a deployment) to be aware of the trauma crisis treatment modality, its relative success with families disrupted by a traumatic stressor, and the fact that, in many such cases, lengthy restructuring treatment is often neither necessary nor appropriate.

The specific components of trauma crisis intervention with families, while beyond the scope of this paper, have been delineated, and interested readers are referred to Figley (1989a; 1989b) and Peebles-Kleiger *et al.* (1992).

In conclusion, we would like to end with a quote from an article rapidly prepared to appear in print within months after the Gulf War's end, and written by a team of clinicians, researchers, and theoreticians well known for their trauma work. They wrote:

> The overall message must be conveyed to all that adjustment of families and service personnel is not a short-term process. Nor can the commitment to these individuals be short term. . . Because the war was won with such relative ease, one should not assume that the peace will come as easily or quickly; unlike the war, it cannot be won from the air. (Hobfoll *et al.*, 1991, p. 854).

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