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Veterans' Perceptions of the Impact of PTSD on Their Parenting and Children

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Although considerable research has examined the impact of posttraumatic stress disorder (PTSD) on couples and partners, relatively little is known about how it can affect parenting, children, and the parent–child relationship. Although adverse effects of parental PTSD on child functioning have been documented, the processes by which these outcomes occur are unknown. Further, parents' perspectives of how their PTSD affects parenting and children have yet to be studied. This 3-site, mixed methods exploratory study included 19 veteran parents who had a diagnosis of PTSD. Participants were recruited from Veterans Affairs (VA) medical centers. Veterans participated in focus groups or individual interviews and completed questionnaires, responding to questions about the impact of PTSD on their functioning as parents. Two sets of themes emerged from the qualitative inquiry. First, veterans reported parenting difficulties that were associated with three PTSD symptom clusters, including avoidance, alterations in arousal and reactivity, and negative alterations of cognitions and mood. Second, veterans described both emotional (e.g., hurt, confusion, frustration, fear) and behavioral (e.g., withdrawal, mimicking parents' behavior) reactions in their children. Veterans also shared numerous ways in which their children provided practical and emotional support. Implications of these findings for future research, program development, and clinical care are offered, including a free online parenting resource for veterans with PTSD based on this research.

Keywords: parenting, PTSD, veterans, trauma, parental mental illness

Posttraumatic stress disorder (PTSD) has been implicated in a wide spectrum of poor individual-level outcomes, including co-occurring disorders (e.g., depression and substance use) and physical health problems (Institute of Medicine, 2013; Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015). Research has broadened to examine the sequelae of PTSD on family relationships (Taft, Watkins, Stafford, Street, & Monson, 2011), including its effects on parenting, children, and the parent–child relationship.

Approximately 15 million Americans will have at least one biological child and have PTSD at some point in their lifetimes (Lauterbach et al., 2007; Leen-Feldner, Feldner, Bunaciu, & Blumenthal, 2011). Among adults, almost three quarters of women and more than two thirds of men living with PTSD are parents (Lauterbach et al., 2007; Nicholson, Biebel, Katz-Leavy, & Williams, 2004). In the military sector, it has been estimated that 43% of current servicemen and women are parents (Department of Defense, 2014), and elevated rates of PTSD have been documented among Iraq and Afghanistan veterans (Ramchand et al., 2015). Parenthood among veterans may be both a risk factor for poor outcomes (Jobe-Shields, Flanagan, Killeen, & Back, 2015), and a source of resilience and motivation to engage in treatment (Tsai, David, Edens, & Crutchfield, 2013); thus, it is important to further understand the complex, multifaceted processes underlying the expression of PTSD among veterans with children.

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Effects of Parental PTSD on Parenting

Parents with PTSD report more parenting and child behavior problems, lower parenting satisfaction, more family violence, and poorer parent–child relationships than parents without PTSD (Berz, Taft, Watkins, & Monson, 2008; E. Cohen, Zerach, & Solomon, 2011; Davidson & Mellor, 2001; Jordan et al., 1992; Lauterbach et al., 2007; Leen-Feldner et al., 2011; Samper, Taft, King, & King, 2004). The small literature on Iraq and Afghanistan veteran parents with PTSD reveals similar challenges, with PTSD related to parenting stress (Blow et al., 2013), parenting difficulties (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010), and reports of children being "afraid or not being warm" toward veteran parents (Sayers, Farrow, Ross, & Oslin, 2009). Further, research with military couples has found husbands' PTSD symptoms to be associated with poorer parenting alliance (i.e., couple's ability to cooperate and communicate respectfully in parenting), from the perspective of both husbands and wives (Allen, Rhoades, Stanley, & Markman, 2010).

Other lines of research have attempted to disentangle the effects of specific PTSD symptom clusters on parenting. For example, research has found that emotional numbing is predictive of low parenting satisfaction, increased parent–child aggression, disengaging from the parent–child relationship, difficulty displaying warmth and empathy toward children, and increased likelihood of identifying emotional and behavioral concerns in children (Davidson & Mellor, 2001; Duranceau, Fetzner, & Carleton, 2015; Lauterbach et al., 2007; Samper et al., 2004). PTSD avoidance symptoms have also been related to poorer, more disengaged parent–child relationships (Lauterbach et al., 2007). Recent observational research of semistructured family interactions have found PTSD service members' experiential avoidance behaviors (efforts to avoid negative memories or feelings from past experiences) to be associated with less positive engagement with their children, more withdrawal, and greater avoidance of distress (Brockman et al., 2016). Despite these findings, the processes involved in how specific PTSD symptoms affect parenting are less clear.

Alterations in arousal and reactivity may be particularly relevant to parenting, especially regarding irritability or aggression. Research in civilian samples has found parental anger to be related to increased parenting stress, unhappiness, and a negative attribution bias for ambiguous child behaviors (Pidgeon & Sanders, 2009; Rodriguez & Green, 1997). Parents who report high levels of anger have been shown to have inflexible expectations regarding their children's behavior; high parental anger has been correlated with an increased potential for physical discipline and abuse in high stressed samples such as low-income parents (Peterson, Ewigman, & Vandiver, 1994) and mothers with multiple traumas (L. R. Cohen, Hien, & Batchelder, 2008). The impact of anger on the parenting of veterans with PTSD has yet to be empirically examined.

Effects of Parental PTSD on Children

The impact of parental PTSD on offspring spans a broad range of behaviors and symptomology, including child internalizing symptoms (Boričević Maršanić, Aukst Margetić, Jukić, Matko, & Grgić, 2014; Danielson, Hankin, & Badanes, 2015; Hisle-Gorman et al., 2015; Lester et al., 2010), externalizing behaviors, hostility, elevated rates of conduct disorder (Boričević Maršanić et al., 2014), and attachment difficulties (Leen-Feldner et al., 2013). A recent meta-analysis found a medium effect size ($r = .35$) between parental PTSD and child emotional distress and behavioral problems (Lambert, Holzer, & Hasbun, 2014).

The clinical literature points to the mechanisms through which children are affected by parental PTSD. It has been theorized and reported clinically that children may mimic or carry on symptoms displayed by their parents, termed *secondary traumatization* or *intergenerational transmission of trauma* (Dekel & Goldblatt, 2008; Rosenheck & Nathan, 1985; Yehuda, Bell, Bierer, & Schmeidler, 2008). Traumatic stressors experienced by one member of a family (e.g., a parent) may impact all members of a closed system, resulting in a susceptibility for "systemic dysfunction" (Figley & Kiser, 2013). A newer area of research examines biologically driven transmission theories by studying physiological processes (for a review, see Leen-Feldner et al., 2013). In one study, offspring of mothers with PTSD showed an attenuated cortisol response to a lab stress task compared with controls, even after controlling for children's trauma histories, depression, anxiety, and maternal depression (Danielson et al., 2015). Research is needed to build on these theories and findings to enhance our understanding of the processes by which parental PTSD affects children.

The Current Study

Although research is beginning to reveal difficulties in parenting and child functioning in families managing parental PTSD, the literature base is small. Most of the studies use self-report, physiological, or observational approaches; we are unaware of any qualitative inquiry with veteran parents. Eliciting first-hand perspectives about veterans' parenting challenges and their perceptions about the impact of PTSD on their children is important. Improved awareness of these dynamics can inform quantitative research and guide assessment and treatment efforts. This study employed a mixed methods approach that emphasized the qualitative component to examine veterans' perspectives on (a) the impact of PTSD on parenting, and (b) their children's reactions to their behavior.

Method

Participants

Inclusion criteria included veterans being 18 to 80 years old, enrolled in Veterans Affairs (VA) care, having a chart diagnosis of PTSD, and at least one child (Age 4 to 18) living in the home at least half of the time. Veterans were recruited via a combination of staff referral, recruitment letters targeting veterans with chart diagnoses of PTSD, and presentations to PTSD groups of potentially eligible veterans. When interested veterans contacted the research team, project staff explained the study, confirmed eligibility, and offered the veteran a choice of a focus group or individual interview.

As shown in Table 1, a large majority of the 19 participating veterans were male, Caucasian, and not currently employed. Average age was 39.1 ± 6.9 years. Slightly over half of the participants were married or living as married, and 53% were college graduates. Most veterans had one (21%) or two (47%) children,

Table 1
Veteran Demographic and Clinical Characteristics (n = 19)

Characteristic	*n*	Percent
Demographic characteristics		
Gender		
Male	17	89.47
Female	2	10.53
Ethnicity (may be more than one)		
White	16	84.20
African American	4	21.10
Native American	3	15.80
Hispanic/Latino	1	5.30
Asian	1	5.30
Marital status		
Married/living as married/living with partner	10	52.63
Divorced	5	26.32
Separated	3	15.79
Never married	1	5.26
Employed outside the home		
Yes	5	17.60
No	14	82.40
Education		
Less than high school graduate	2	10.53
High school graduate/GED	3	15.79
Some college	4	21.05
College graduate	10	52.63
Number of children		
One	4	21.10
Two	9	47.40
Three	2	10.50
Four	2	10.50
Five or more	2	10.50
Deployed to a combat zone		
Yes	14	82.40
No	5	17.60
Number of combat deployments (of deployers)		
One	8	50.00
Two	4	28.57
Three or more	3	21.43
Age (in years)		
Mean (*SD*)	39.10 (6.90)	
Range	27–52	
Length of marriage/committed relationship (in years; *n* = 13)		
Mean (*SD*)	10.10 (8.10)	
Range	.5–22	

	M (*SD*)	Range
Clinical characteristics		
PCL-C	68.70 (9.70)	48–85
PHQ-9	17.80 (5.60)	8–27
AUDIT-C	4.70 (4.40)	0–12
DAR-5	18.50 (4.30)	8–25
Parenting Scale: Overreactivity	4.30 (1.50)	1.8–6.4

Note. PCL-C = Posttraumatic Stress Disorder Checklist, civilian version; PHQ-9 = Patient Health Questionnaire; AUDIT-C = Alcohol Use Disorder Identification Test; DAR-5 = Dimensions of Anger Scale.

ranging in age from 1 to 21. Considerable variability existed in child age, with the average being 11.1 ± 6.0 years. Most (82%) had deployed to a combat zone, including Iraq, Afghanistan, or Kosovo, and cumulative number of months deployed was 15.1 ± 8.3 (range = 6 to 36).

Design

This is a concurrent, mixed method study in which the emphasis of the data collection and analysis is on the qualitative component (Teddlie & Tashakkori, 2012). The qualitative portion of the study included semistructured interviews and focus groups. The quantitative section of the study included data derived from several self-report questionnaires.

Procedures

We conducted seven individual interviews and three focus groups across the three study sites (Oklahoma City, Oklahoma; Minneapolis, Minnesota; Phoenix, Arizona). The number of participants in each focus group ranged from two to six. Interviews and focus groups were conducted by two psychologists at the VA hospital; session length varied from 45 min to 2 hr. Approvals were secured from institutional review boards and VA research and development committees at each study site, and veterans provided informed consent prior to participation.

Interviews and focus groups followed a semistructured interview protocol of 15 questions addressing veterans' experiences of parenting when living with PTSD and how the VA can help veterans in this role. Questions focused on veterans' challenges in parenting and the perceived impact of their PTSD on their children. Sample questions include "What's the toughest part of being a parent with PTSD?" and "What are your kids' experiences of your symptoms?" A complete list of questions is available from the first author upon request. Interviews and focus groups were audiotaped and transcribed verbatim.

Upon completing the interview or focus group, veterans completed questionnaires including several standardized self-report measures. The 17-item Posttraumatic Stress Disorder Checklist (PCL), civilian version (Weathers, Litz, Herman, Huska, & Keane, 1993), assessed trauma-related *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV*; American Psychiatric Association, 1994) PTSD symptoms over the past month, and has strong reliability and validity (McDonald & Calhoun, 2010); the PCL-5 had not been released at the time of data collection. The AUDIT-C: Alcohol Use Disorder Identification Test (AUDIT-C; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) is a commonly used, reliable three-item alcohol screener to detect hazardous drinking, and the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a nine-item valid screener for depression. The five-item Dimensions of Anger Scale (DAR-5; Forbes et al., 2004) measures anger frequency, intensity, duration, aggression, and interference with social functioning, and has strong reliability and validity (Forbes et al., 2014), including with combat veterans (Novaco, Swanson, Gonzalez, Gahm, & Reger, 2012). Veterans also completed a researcher-developed measure that assesses demographic variables, experiences at the VA, and desired VA services to support them as parents living with PTSD.

Finally, we administered the five-item Overreactivity subscale of the Parenting Scale (Arnold, O'Leary, Wolff, & Acker, 1993), which assesses emotional, harsh discipline via five items on a 7-point Likert scale. Each item taps parenting behavior in the past 2 months, ranging from 1 (effective discipline such as "*I speak to my child calmly*") to 7 (ineffective discipline such as "*I raise my voice or yell*"); the scale has demonstrated adequate validity and internal consistency (Rhoades & O'Leary, 2007).

Analysis

Code development. Inductive analysis procedures were used in developing the Parenting with PTSD Codebook. We created a coding system to capture participants' reports about how PTSD affects their parenting. Coding for parenting interactions required examining text that related to parents' perceptions of how they interacted with their children when experiencing PTSD-related challenges, and how their children responded to these interactions. The analysis proceeded with strategies identified by consensual qualitative research (Hill, Thompson, & Williams, 1997) and included independent, inductive coding, cross-analysis, forming consensus on data interpretation, conducting internal audits, and charting the results.

The coding team consisted of three of the four authors, all of whom are psychologists. All of the coders have experience providing care for veterans with PTSD and their families within the VA system and have conducted mixed methods research in the past. The coding team read and coded initial transcripts as a group over several weeks. At this initial stage, the team sought to establish a coding scheme that adequately captured how veterans interacted in their families in relation to their PTSD. For this task, three transcripts across the three study sites were selected for initial coding. Each transcript was coded individually by team members and then coread during team meetings, allowing opportunities to discuss coding decisions. Codes were elaborated and refined as a result of these discussions.

Next, a member of the team used a cross-analysis method to develop the codebook (Hill et al., 2005). Using MAXQDA software, an exhaustive list of inductive codes was created. Codes were condensed and refined until the research team determined that the codebook had matured sufficiently to a point of thematic saturation (Corbin & Strauss, 2008). Saturation is the point at which all interpersonal interaction-relevant content in the transcripts was captured by a comprehensive set of codes; this was achieved after approximately three transcripts.

Coding procedure. The Parenting with PTSD Codebook was used to code the remaining transcripts. Coders worked independently and coded the remaining 15 transcripts, checking in with others periodically to ensure consistent application of codes. The first author then audited all the independently coded transcripts, verified the coding, and discussed discrepancies. A final database was then created that contained an exhaustive list of codes with corresponding textual passages. The credibility of the codes and the integrity of the analysis are supported by the development of a rigorous coding procedure and satisfactory dependability among raters. A second set of codes related to communications and desired supports was also found in the data and has been published elsewhere due to space limitations (Sherman, Larsen, Straits-Troster, Erbes, & Tassey, 2015).

PTSD symptoms codes. The PTSD Symptoms codes in our final coding scheme reflected a variety of interactions relating to fifth-edition *DSM* (*DSM-5*; American Psychiatric Association, 2013) symptom clusters of PTSD, including avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity associated with the trauma. These codes reflect the veterans' interpretations and perceptions of their parenting behaviors associated with their PTSD.

Child emotional and behavioral response codes. The child response codes fell into two major categories: emotional and behavioral responses. Emotional responses were all labeled as distressing and represented negative emotional responses. Behavioral responses were more diverse, including both internalizing and externalizing behaviors.

Results

The sample's clinical characteristics based on self-report data are summarized in Table 1. The mean PCL score was 68.7 ± 9.7, and 18 (95%) exceeded the diagnostic cutoff score of 50. Regarding depression, the mean PHQ-9 score was 17.8 ± 5.6; using standard clinical ranges (Kroenke et al., 2001), three (17%) of the veterans screened positive for moderate depression, nine (47%) for moderately severe depression, and seven (37%) for severe depression. Forty-two percent of the veterans had a positive screen on the AUDIT-C. Regarding anger, 95% of participants exceeded the cutoff on the DAR-5 for problematic levels of anger (Forbes et al., 2014). Finally, 58% (11/19) of the veterans exceeded the clinical cutoff on the Overreactivity subscale of the Parenting Scale (Arnold et al., 1993).

Impact of Specific PTSD Symptoms on Parenting

Veterans shared accounts of how their PTSD symptoms made parenting more difficult. Numerous themes emerged throughout the interviews, and were especially prominent in response to the question, "What's the toughest part of being a parent with PTSD?" As summarized in Table 2, the veteran interviews reflected challenges in three of the four *DSM–5* (American Psychiatric Association, 2013) PTSD symptom clusters, including avoidance, negative alternations in cognitions and mood, and alterations in arousal and reactivity. Notably, participants did not describe any parenting challenges related to intrusion symptoms, such as intrusive memories, flashbacks, or nightmares.

With respect to avoidance, many veterans painfully described difficulties in participating in their children's activities. Their avoidance of potentially distressing triggers and their social anxiety prevented them from attending their children's school, athletic, or other extracurricular activities. Most veterans shared inner conflicts regarding avoidance, as they balanced a desire to be present and support their children with an urge to avoid fear-inducing situations.

Numerous passages reflected parenting difficulties related to negative alternations in cognitions and mood. Many veterans described distorted negative beliefs and expectations about themselves and the world. Several passages reflected veterans' negative evaluations of their selves as parents and feeling unworthy of their children's love. For example, a 39-year-old married male said, "I believed that I was unlovable; I didn't deserve love or happiness." Negative trauma-related emotions were common and often centered on shame and guilt: "Look at me . . . [I] already use a cane and a walker . . . my gosh, now this [PTSD] too" (50-year-old divorced male). Further, many veterans described feeling alienated from others, including their children, often describing a sense of estrangement and detachment from their families. For example, a 37-year-old separated male said, "I'm kind of in my own little world. I'm either occupying my time reading, watching movies,

Table 2
Themes Identified by Veterans Regarding the Impact of PTSD Symptoms on Parenting by Symptom Cluster

Symptom	Quotes
	Avoidance
Avoidance of trauma-related reminders	"You tell [your children] to go on and enjoy themselves; have fun . . . Mom would go, but Dad's not there. But, Dad's at the door for you. He's there with open arms; he's supportive but he's not physically there." (34-year-old married male)
	"So I don't go out; I don't do anything; So even socializing with my kids, it's really hard for me because I can't say, 'Hey, let's go play ball or let's go do whatever.' Because I just can't." (36-year-old married male)
	Negative alterations in cognitions and mood
Negative beliefs and expectations about self and world	"I screwed everything up you know or I'm going to mess everything up." (37-year-old separated male)
	"I don't deserve their [kids'] love." (44-year-old married male)
Negative trauma-related emotions	"It's very difficult with PTSD . . . the feelings of failure are huge . . . you're broken in some way . . . if your kid looks up to you and then you're like, 'Oh I'm broken and I'm all messed up and I'm a piece of garbage.' Now what does your kid have?" (37-year-old separated male)
	"Frustration and inner turmoil with knowing the parent I want to be and am capable of but not actually being there for the kids." (31-year-old married male)
Feeling alienated from others (detachment, estrangement)	"I felt like I was watching my own life happen around me and I was just stuck . . . I wasn't actually participating in my own life . . . I was not there for him [my son] and I was just like a vacant shell of a person . . . as much as I wanted to, I couldn't get myself up off the couch to participate or play in life. I didn't know what was wrong or didn't know how to fix it." (39-year-old married male)
	"I'm not always in the present; I'm kind of locked in my head . . . it's not that I don't love them; it's just I'm not really there." (31-year-old married male)
Constricted affect (inability to experience positive emotions, numbing)	"When my son was born, people [had an] expectant look on their face like, 'You should be happy' . . . and I just don't feel happy." (39-year-old married male)
	There are times when I'll be with my son and I'll just be watching him. And—I don't feel anything. I look at him like he's 'a' child. I don't look at him like he's 'my' child . . . he's just there and where does that feeling go?" (31-year-old married male)
	Alterations in arousal and reactivity
Hypervigilance and exaggerated startle	"The toughest part [of being a parent] is not being able to control everything in front of your kids . . . like the panic attacks or the loud noises, being caught off guard." (33-year-old separated male)
	"I'm as patient as I can be to a point and then there is an immediate spike; there isn't really an in-between." (31-year-old married male)
Irritable or aggressive behavior	"Makes me so I get angry . . . to the point that sometimes I want to just punch him [my son] in the face." (34-year-old married male)
	"I do yell at them [my kids] when they do something wrong and I do the drill sergeant thing. I take that finger and poke them on the chest and take the paddle to them." (36-year-old divorced male)

playing video games . . . generally during the time they [my children] want to do something with me . . . these things are escapism for me." Constricted affect, including emotional numbing, was another commonly cited challenge in parenting; veterans described a sense of wanting to love and feel connected to their children, but great difficulties in feeling any emotional attachment. For instance, a 39-year-old divorced male said, "I stopped being a parent to him [my son] and I become more of . . . somebody who doesn't care . . . I completely shut my feelings off . . . I have no emotions at all—none."

Finally, veterans described difficulty in parenting related to the PTSD symptoms associated with alterations in arousal and reactivity. The hypervigilance and exaggerated startle experienced by many veterans created considerable difficulties in parenting. A 50-year-old single male poignantly described this conflict:

> I want to be here (at my child's activity) because I want to be the dad I want to be . . . but I've got to get out of here . . . I cannot be in this auditorium . . . the walls are starting to close in . . . the inner pull between one side wanting to be there and one side get the heck out of there—I'm paralyzed.

Furthermore, many veterans struggled with irritability and aggressive behavior, and shared how these symptoms affected their parenting. Several veterans described parenting incidents that involved aggressive urges, threats, or actual violence toward their children, and veterans often attributed these to military training and/or PTSD. For example, a 39-year-old divorced male said "I can't stand disrespect . . . I almost put him [my son] through a window . . . I (said) 'If you ever walk up on me again when I'm talking to you . . . I'll kill you' . . . I looked at him and he started crying." Another 40-year-old divorced male said he uses "reverse psychology [on his kids]—it completely torments them."

Children's Emotional Reactions to Parental PTSD

Veterans reflected on their perceptions of their children's emotional responses to their PTSD (see Table 3). Participants shared these ideas throughout the interviews and focus groups, but especially in response to the question, "What are your kids' experiences of your symptoms?"

Table 3
Themes Identified by Veterans Regarding Children's Emotional and Behavioral Reactions

Emotion	Quotes
	Children's emotional reactions
Sadness and hurt	"I would hear comments like, 'Dad, it seems like you don't care.'" (39-year-old divorced male)
	"When I finally told her what happened to me she was very sad . . . cried, just felt bad." (43-year-old married female)
Anxiety and confusion	"When I have anger . . . she may giggle, laugh or think it's funny . . . she may just kind of stop and look down and not know what to think." (27-year-old married male)
	"He [my son] kind of just stood still and had this confused look on his face like he didn't understand what was going on or why it was happening." (33-year-old separated male)
Frustration and resentment	"I see they get frustrated or sad that I'm not . . . spending the amount of time with them that they want or they need." (31-year-old married male)
	"The older ones were kind of getting bitter toward me . . . it was like, 'Here's comes this asshole.'" (43-year-old married male)
Fear of parent	"They're afraid to talk to me." (34-year-old married male)
	"When a father or a mother says, 'I killed a kid when I was overseas.' I think your kids go, 'He's killed a kid; he could kill me.'" (37-year-old separated male)
Self-blame for parent's behavior	"At times they [my kids] can feel like 'Oh man, what did I do?' because Dad's withdrawn." (37-year-old separated male)
	Children's behavioral reactions
Withdraw physically	"Some days they'll hide in their rooms and play their games and watch their Nooks and leave me alone because they know I'm in one of those moods." (39-year-old divorced male)
Ignore and exclude from family life	"[My children] have adjusted their lifestyles to even not including me . . . now they don't even ask me anymore . . . that's just the way dad is." (50-year-old single male)
	"Sometimes it's too late . . . because the child already disconnected themselves from the parent . . . my son—he's completely shut himself off from me." (39-year-old divorced male)
Mimic veteran's behaviors	"They're learning that behavior too . . . I can hear how they [my daughters] talk to each other; it's what or how I talk to them . . . it's a learned behavior they are learning." (44-year-old married male)
Provide support: Grounding	"I've given [my kids] certain things to say to help bring me back down . . . When they see that I'm going through something they'll come up and be like, 'Hey, it's okay; you're at home.'" (37-year-old separated male)
	"It shows them that if I get in la-la land, bring me back in versus just being mad at me." (36-year-old divorced male)
Provide support: Emotional and instrumental support	"They [kids] would come in and say, 'Hey mom how are you doing? Okay, we love you; we're going to go do this.' They would just check on me." (39-year-old married male)
	"I hope they're not taking me on as a charity case but they got my six; they've got my back so to speak . . . loading the appointments in my phone . . . I mean they're always, 'Dad do you need help with this?' As they get something's wrong and they're trying to help me . . . they are remarkable." (50-year-old single male)
Provide support: Minimize exposure to trauma-related triggers	"They know not to touch me if my eyes are closed." (46-year-old separated male)
	"When [my kids] began to understand it was, 'Dad . . . if you want to leave early' or 'I don't think you might like this' . . . they have been more considerate about my condition." (50-year-old single male)

Many veterans indicated that their children experience distress, such as sadness, hurt, anxiety, and confusion. Sometimes children exhibit these emotions in response to a specific parental behavior, such as crying or incongruent affect when the parent is angry or verbally attacking. A 34-year-old married male shared, "When I scream at her [my daughter] . . . she will just burst out and laugh." At other times, children struggle with painful emotions and moods more generally, and veterans often attributed this child distress to their PTSD symptoms. For instance, a 44-year-old married male veteran said, "I could feel genuine sadness in her (my daughter) . . . I've had a bigger impact on her than I thought I had."

Veterans also describe other emotional reactions in their children, including frustration and resentment toward the parent, fear of the parent, and self-blame for the parent's behavior. Key themes that emerged in the children's resentment included disappointment and anger that the parent was not spending enough time with the child, or a sense that the parent was malingering to get attention. For example, a 45-year-old divorced female said, "(My kids) still hold a lot of resentment . . . they think I'm faking it for attention." Many veterans indicated that their children are afraid of them, usually due to the veteran's displays of anger/aggression or high levels of need for control. A 44-year-old married male veteran said, "When I blow up at them, they get very scared . . . they don't know how bad I can get." Finally, some veterans observed that their children blame themselves for their parent's mental health symptoms; children wonder what they did wrong to upset their parent.

Children's Behavioral Reactions to Parental PTSD

Veterans shared that their children not only experience emotional reactions to their PTSD symptoms but also manifest a variety of behavioral reactions (see Table 3). Some children's behaviors likely reflected distress, such as when children withdraw physically from the parent or family and isolate themselves in their bedrooms. Other children seemed to ignore their PTSD-affected parent and exclude them from family life; these veterans described feeling hurt that their children no longer invited them to participate in school or social events. In addition, some veterans noticed that their children imitated some of their PTSD-related behaviors, such

as being hypervigilant and talking to others in a disrespectful manner.

Some veterans spontaneously described ways in which their children provided them with emotional support. Veterans appreciated their children's help in grounding them when having reexperiencing symptoms. Other veterans' children provided both emotional and instrumental support, such as loading doctor appointments in a calendar, reminding parents to take their medications, and expressing love during difficult times. Finally, some veterans noted that their children are cognizant of their trauma-related triggers and help their parents minimize exposure to them. For example, a 50-year-old divorced male said, "When [my kids] began to understand, it was, 'Dad, if you want to leave early' or 'I don't think you might like this' . . . they have been more considerate about my condition." Across these themes regarding children supporting their parents, veterans reported pride in their children's awareness of their needs and gratitude for the children's help. No veterans voiced concerns about potential overfunctioning among their children or worry about possible role reversal or parentification.

Discussion

The current study examined the impact of PTSD on veterans' parenting behaviors and the perceived impact of these symptoms on their children. Qualitative analysis of focus groups and interviews yielded two sets of themes: one corresponding with three of the four *DSM–5* (American Psychiatric Association, 2013) symptom clusters (see Table 2), and one representing children's reactions to parental behavior (see Table 3).

Consistent with past research with Operation Enduring Freedom/Operation Iraqi Freedom veterans and other veteran cohorts (Davidson & Mellor, 2001; Gewirtz et al., 2010), veterans in this study reported parenting difficulties that could be classified across multiple PTSD symptom clusters, including avoidance, alterations in arousal and reactivity, and negative alterations of cognitions and mood. First, veterans reported avoidance of situations that could exacerbate their symptoms and recognition that missing such events impacted their parenting effectiveness. Avoidance of possible emotional triggers created internal conflicts, where veterans wanted to be present and supportive, but feared high levels of distress or loss of control. Consistent with the small literature on PTSD and parenting in Iraq and Afghanistan veterans (Sayers et al., 2009), threat of embarrassment, fear of being viewed as crazy, and worry about experiencing symptoms in front of others factored into veterans' avoidance behaviors in our sample.

Second, veterans described hyperarousal symptoms (e.g., hypervigilance, elevated startle response, irritability) that sometimes resulted in anger and overreactions to children's normal behavior. Having children in the home can be stressful for veterans with PTSD (Jobe-Shields et al., 2015); children's misbehavior and parenting challenges may exacerbate PTSD symptoms (Duranceau et al., 2015). Reports of anger dyscontrol and fear of harming one's child in our sample were consistent with this PTSD cluster. Participants described reacting quickly and intensely at any sign of disrespect or disobedience, generating fear in some children ("they all walk on eggshells"), and alienation or resentment in other offspring. Clinically, concern about this exaggerated irritability and aggressive behaviors among veteran parents with PTSD is warranted. Several studies have documented associations between PTSD and intimate partner psychological abuse, physical aggression, and relationship discord (Taft et al., 2011); findings from our sample and previous research on aggression among military parents with PTSD (e.g., Jordan et al., 1992) attest to the importance of considering the broader family system and assessing child maltreatment as well.

Third, veterans shared parenting experiences that pertain to the *DSM–5* (American Psychiatric Association, 2013) PTSD category of negative alterations in cognitions and mood. Specifically, veterans described feelings of failure, being broken, isolation from their families, and being alienated from the world. Many of these symptoms are also consistent with depression, which is not surprising, as 84% of participants had moderate to severe comorbid depression. Many veteran parents also reported considerable emotional numbness, which was particularly poignant when they described feeling nothing when watching or holding their child. Veterans described guilt and shame for this lack of emotion and a sense of failure as a parent; it is possible that these negative self-perceptions exacerbated depressive symptoms and increased behavioral and emotional avoidance in a cyclical fashion.

Interestingly, intrusive thoughts, nightmares, and other reexperiencing symptoms did not explicitly emerge in our data, replicating the lack of association between this symptom cluster and parenting reported by others (Duranceau et al., 2015). Intrusion symptoms tend to be experienced internally and may not be evident to family members; other PTSD symptoms that are inherently relational and observable may have a greater impact on parenting.

The second category of themes that emerged in our analyses pertained to veterans' perceptions of their children's emotional and behavioral reactions to their PTSD symptoms (see Table 3). Children's emotional reactions included sadness, hurt, and frustration, often paired with a desire that the parent spend more time or interact differently with them. Confusion about what to say or do, anxiety, and fear of erratic or aggressive parental behaviors were sometimes described as contributing to mutual withdrawal and sadness. Further contributing to veterans' negative self-perceptions, some children blamed themselves for their parents' behavior.

Coupled with the emotional reactions of children observed by parents, many specific behavioral reactions were perceived as being related to parental PTSD. Veterans described how their children routinely withdrew to their rooms to play quietly when the parent was in a bad mood, which sometimes extended to purposefully ignoring and excluding the parent from family activities to minimize tension. In addition, some veterans described observing their children mimicking their behaviors, noting their own words and behaviors in their children's behavior. Theorists (Dekel & Goldblatt, 2008) have speculated that this modeling process may contribute to the impact PTSD has on family members, possibly including the intergenerational transmission of PTSD and the perpetuation of interpersonal violence.

Beyond the challenging behaviors veterans experienced in their children, participants also described appreciation for their children's support. Efforts included children adhering to rules (e.g., "Don't touch me while I'm sleeping"), offering to leave events early, helping with practical tasks (e.g., reminders to take medications), and even reassuring the parent when he or she is overwhelmed. These behaviors were universally experienced as com-

forting to our participants. Clinically, it may be important to monitor possible parentification in these families wherein children take on adult roles and responsibilities. Research with adolescent offspring of parents with mental illness has documented direct associations between parentification and increased internalizing problems (VanLoon, VandeVen, VanDoesum, Hosman, & Witteman, 2015). Interestingly, none of the veterans in our study described concerns about possible negative effects of such role reversal.

In light of these findings, interventions geared at supporting parents' distress tolerance and helping them talk with their children about PTSD symptoms may be useful in modulating the impact of PTSD on parenting and children. Some promising couple-based PTSD treatments have been developed and piloted in VA hospitals (e.g., Monson & Fredman, 2012; Sautter, Armelie, Glynn, & Wielt, 2011; Sherman, Fischer, Sorocco, & McFarlane, 2009), but explicit assessment of, and therapeutic attention to, the parenting role and parent–child relationship are rare. Notably, many veterans report a desire for parenting support (Sherman, Larsen, Straits-Troster, Erbes, & Tassey, 2015). In an effort to bridge this gap, findings from the current study guided the development of a free, online veteran and family education booklet, "A Veteran's Guide to Talking with Kids about PTSD" (Sherman, Straits-Troster, Larsen, & Gress-Smith, 2015). This interactive pamphlet may be provided directly to veteran parents for psychoeducation or used in combination with clinician-guided psychotherapy.

Although these findings provide a first in-depth look at the perspective of veteran parents living with PTSD, this study has several limitations, including a relatively small and demographically homogenous sample of veterans enrolled in VA care, geographic restrictions, PTSD diagnoses ascertained by chart review and a self-report measure, and the lack of standardized assessments for some constructs. Interpretation of the findings should also take into consideration the comorbid mental health problems experienced by many veterans in the sample, including alcohol abuse and depression, which may also explain some of the parenting difficulties. Due to the very small number of female veterans in this sample ($n = 2$), gender differences could not be explicated; future research could oversample women to specifically explore their perspectives. Research could also examine how these family dynamics differ across children's developmental levels. In addition, research could broaden our understanding of family functioning in the context of parental PTSD by studying not only veteran parents but also their partners and children. Veterans' perceptions of their parenting and of their children's functioning may be affected by their PTSD, so being able to compare reports across multiple informants would be useful. Future research could also examine how parenting challenges vary by the type(s) of trauma the parent experienced.

Despite these limitations, this is the first study to examine veterans' perceptions of how PTSD affects their parenting and interactions with their children. Our findings support the current interest in developing and disseminating accessible resources and services for parents and families affected by parental PTSD. In addition to efforts by the Department of Defense and Department of Veteran Affairs to meet these needs, civilian mental health providers, pediatricians, and primary care providers may be the first contact for distressed parents or children. These findings may facilitate a greater understanding of the parent and family issues that often occur in the context of PTSD, thereby empowering providers with information and resources to support healthy parenting among veterans and their families.

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