



Autoethnographic Family Case Study: Combat Veteran PTSD and its Effects on Familial Dynamics, Parenting, and Marriage

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ABSTRACT

Posttraumatic stress disorder (PTSD) among combat veterans remains an urgent and, for some, unmanageable problem for those who have served in war, as well as their family members. This paper focuses on how familial dynamics are deeply affected by veterans returning with PTSD, especially after severe combat exposure. We examined the familial dynamics of PTSD in combat veterans by presenting an autoethnographic case study. One of the authors was a US combat veteran and wrote his personal account of social reintegration with his family after returning from multiple combat deployments. This autoethnographic case study is used to examine the family dynamics of a combat veteran and his family to present this argument. We argue that one of the reasons that combat-related PTSD remains so difficult to treat is due to the limited intervention strategies to treat individuals with PTSD within the family system. Ultimately, there are three contributing factors that currently hinder the ability to successfully treat and reintegrate combat veterans diagnosed with PTSD without alienating them from their family system. The first is a failure to look at family systems theory as a therapeutic intervention to treat the individual with PTSD, as well as those affected by the shift of the family dynamics. The second related issue is the effect of attachment prior, during, and after the deployment and development of PTSD. The third is to look at Moral Injury to understand another face of trauma that can be misdiagnosed as PTSD, affecting morals and values held by the family system.

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LAY SUMMARY

Over the last two decades, there has been a significant amount of research conducted on the effects of deployment, combat exposure, and posttraumatic-stress disorder on US military personnel and veterans. However, military veterans and servicemembers are not the only individuals who carry with them these difficulties related to the aftermath of war. Family members of veterans and servicemembers also bear the challenges associated with bringing their loved ones back into their family, neighborhood, workplace, and community. This experience of social return provides many challenges for the families of veterans. In this study, a veteran who had himself experienced PTSD after serious combat exposure tells his personal story of returning home. He describes how, in his return to civilian life and his community in America, the symptoms and behaviors he was experiencing from PTSD bore heavily on his wife and children. Ultimately, we discuss how different understandings of trauma can benefit veterans and their family members when they attempt to return home from combat.

INTRODUCTION

A portion of US veterans who serve in combat zones and return from their respective duties come home to face formidable challenges upon reentry to American civilian culture. Most veterans return home from active duty and/or deployment settings and, for various reasons, can resume their lives without severe functional impairment. However, many struggle with the burden of a myriad of symptoms related to posttraumatic stress. Others face the challenges that come with seeking treatment and proper support (Adams et al., 2017; Senecal et al., 2019). For example, transference and countertransference are unconscious psychosocial processes that involve projecting one's previous emotions and experiences onto a present situation. Some traumatic experiences that veterans carry with them may manifest as transference or countertransference to their family members affecting the dynamics of the family system when they return home (Lucero et al., 2018). A significant portion of research has been devoted to understanding the difficulties that family members might experience while their military partner is deployed (Balderrama-Durbin et al., 2017; Becker-Blease et al., 2005; Dekel et al., 2005; Erbes et al., 2011; Meadows et al., 2017; Sullivan et al., 2016). From a family system perspective, it is important to acknowledge that family members of veterans can also be impacted by deployment and that families may require special accommodations and resources to

provide the necessary support for both veterans and family members suffering the effects of trauma (Becker-Blease et al., 2005; Cederbaum et al., 2017a; Cederbaum et al., 2017b; Erbes et al., 2011; Meadows et al., 2017).

The American Psychological Association's (APA, 2013) *Diagnostic & Statistical Manual* (DSM-5) defines PTSD as a "disorder that some people develop after experiencing a shocking, scary, or dangerous event" and describes "identifying the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation" (Tull et al., 2016, p. 2). Though the effects of PTSD on veterans have received special attention, the stress experienced by spouses and other family members has been less studied despite its potential impact on the general health of the family system (Lucero et al., 2018; Meadows et al., 2017). An analysis of a deployed Division Mental Health unit supports the argument that families of servicemembers are affected while their loved ones are deployed. The analysis demonstrated that the major stressor connected to veterans deployed in a combat zone can be seen in the dynamics and living conditions of the veteran's family (Adams et al., 2017).

Many of the elements addressed in this case study (e.g., Moral Injury, family stressors, multiple deployments, etc.) are unique elements of the post-9/11 generation of US veterans. An abundance of literature has been compiled over the last 20 years devoted to the unique signature wounds of the post-9/11 veteran generation. Some of these signature wounds are less relevant to this case study—e.g., military sexual trauma (Kimerling et al., 2010), traumatic brain injury (TBI; Reger et al., 2022; Wall, 2012; Waszak & Holmes, 2017), polytrauma (Frayne et al., 2011; Lew et al., 2009), homelessness (Ganz & Sher, 2013; Lange, 2009), and health conditions tied to unique toxin exposure (Waszak & Holmes, 2017). However, as mentioned, other signature wounds of the post-9/11 generation such as Moral Injury (Brown et al., 2013; Litz et al., 2009, 2016; Maguen, 2009; Wood, 2016), suicidality (Bryan et al., 2015; Hoffmire, & Bossarte, 2015; Kang et al., 2015; McCarten, Shoenbaum et al., 2014), and the stressors associated with multiple extended deployments (Bryan et al., 2015; Schoenbaum et al., 2014) play a significant role in impacting the reintegration experience of veterans and servicemembers.

The present study is an autoethnographic case study of a military family in which the father is a US combat veteran diagnosed with PTSD. The case study will focus on the deterioration of the family system dynamics ending in divorce, which was attributed to the father's deployment and the stressor that comes from being a military family. The case includes discourse about trauma, psychological symptoms related to PTSD, Moral Injury, family dynamics, children, and divorce.

FAMILY SYSTEMS THEORY

Family systems theory posits that individuals cannot be understood in isolation and it is important to approach them as a part of the system that they belong to, in this case, their family (Bowen, 1978; Titelman, 2014, 2015). Families work as groups or systems, where each member simultaneously acts as an interconnected and interdependent individual. According to Bowen (1978), a family is considered a multigenerational emotional system that is founded and sustained by roles, rules, and values; each member is expected to fulfill their individual roles, follow the rules, and practice the values established in the family system. Consequently, the way each member will act is determined by relationship agreements established by the entire system. Agreement among the members of the family system will provide the space to remain in an emotionally neutral position whenever conflict arrives (Bowen, 1978). In family systems the establishment of boundaries among the roles and rules creates patterns that will be externalized in behaviors, causing direct and indirect behaviors as a response to their roles and rules. Maintaining the same pattern of behaviors within a system may lead to a balance in the family system, but any shift in this dynamic can lead to dysfunction.

Family systems theory has contributed to the understanding of how parentified children are more likely to become suicidal (Sandage, 2010). Hopper (2008), following Boszormenyi-Nagy's position (Boszormenyi-Nagy & Spark, 1973) defined parentification as, "the distortion or lack of boundaries between and among family subsystems, such that children take on roles and responsibilities usually reserved for adults" (p. 1). Furthermore, triangulation can be common in families when a child is brought to stabilize the system put under tension between parents (Bell et al., 2001). Both terms play an important role when dealing with any psychopathology related to the dynamic of the family system. For example, Jurkovic (1997) presented how children may become suicidal as a consequence of their failure to meet the tasks and responsibilities that their parents or other family members expect them to fulfill. This failure escalates when "ineffectual, and unappreciated, or even criticized" behaviors are directed to the children (p. 1).

Veterans' families often experience the effects of reintegration when a member of the family leaves active duty or returns from deployment. This reentry into civilian work and life involves challenges for both veterans and their family members. These challenges include but are not limited to the experience and symptoms of posttraumatic stress, Moral Injury, and a range of other psychosocial difficulties that might occur when reintegrating to civilian life (Creech & Misca, 2011; Creech et al., 2014; Herzog et al., 2011; Monson et al., 2009). Family systems theory informs

areas of parenting, marriage, and suicidality as they relate to veterans and their family members during reintegration. According to Jordan et al. (1992), a study conducted with veterans disclosed that combat veterans with PTSD and their partners report higher levels of marital and parenting problems such as higher rates of behavioral problems in children and violence by either partner. As a result of both increased personal and relationship problems, many veterans, as well as their family members, tend to cope with these challenges by resorting to alcohol, illegal drugs, disconnecting from loved ones, and an increase in suicidal ideation (Teeters et al., 2017).

ATTACHMENT THEORY

According to Bowlby, children that experience trauma directly or indirectly tend to develop deficiencies in their internal working models, especially in their interactions with the principal caregiver (as cited in Andersson, 2015). In the case of children, they tend to seek emotional regulation by feeling protection and security in the proximity of their caregivers (Benoit et al., 2010).

Research on veterans has identified the value of relational intimacy and the protective benefits experienced when veterans and their families are able to establish a sense of shared meaning in their work and relationships (Bowling & Sherman, 2008). Renshaw et al. (2008), further examined the correlation between how candidly veteran spouses speak of their symptoms after deployment and the level of marital satisfaction in their civilian spouses. Specifically, this study demonstrated how when civilian spouses perceive symptoms in their veteran partner, but the veteran partner does not personally acknowledge or communicate those symptoms, marital frustration is increased. The inability to communicate mental health symptoms is likely to increase marital distress and that the intersection of these two stressors is likely to exacerbate reintegration difficulties (Renshaw et al., 2008).

Furthermore, specific therapeutic interventions have focused on building social support through secure familial attachments and affect dysregulation techniques (Basham, 2008; Vormbrock, 1993). The research demonstrates that healthy familial attachment prior to deployment builds emotional synchrony and social bonds that endure when veteran families reunite post-deployment. Ultimately, it is these emotional and social connections that have a practical effect of further insulating reintegrating veterans from both marital discord and mental health symptoms (Keeling et al., 2016). Strong and healthy familial attachment allows veterans to continue to do this difficult work with resilience, consistency, and endurance (Basham, 2008; Bowling & Sherman, 2008; Keeling et al., 2016; Renshaw et al., 2008; Vormbrock, 1993).

MORAL INJURY

Beyond PTSD diagnoses for veterans, there is an increasing body of research suggesting that veterans may also struggle with a disruption to the moral dimension when they are exposed to combat. Shay (1994) coined the term “Moral Injury” to conceptualize the idea that some experiences can “transgress deeply held moral beliefs and expectations” (Litz et al., 2016, p. 2). Regarding the lived experience of combat, war, and military service, examples of Moral Injury might include the intentional or unintentional killing of civilians, failing to save the life of a fellow servicemember, or being involved in a friendly-fire incident (Courier et al., 2015). Wisco et al. (2017) conducted a large-scale study of combat veterans demonstrating that such possibly morally injurious events were relatively common for this population of veterans. In this study, 11% of participants indicated that they committed their own personal transgressions in war while approximately 25% expressed a perception of moral transgressions by one’s peers in combat.

Worthen & Ahern (2014) have identified some consistent emotions that present in experiences of Moral Injury; specifically, guilt, shame, and anger. The emotions linked to Moral Injury might possibly lead veterans who have experienced such trauma to engage in socially isolating tendencies, as well as refraining from disclosure with friends, family, loved ones, and other civilian peers out of fear that they will be judged for their experiences (Drescher & Foy, 2008; Nash et al., 2013). Most pertinent to this study, the ability to disclose committed or perceived transgressions is imperative to both the therapeutic and reintegration processes for servicemembers who have experienced such traumas (Gray et al., 2012; Steenkamp et al., 2013). Ultimately, if one struggles to or is unable to disclose experiences of Moral Injury to peers or loved ones the morally injured individual may only continue to perpetuate automatic negative thoughts of oneself and one’s behavior/experiences in war (Litz et al., 2009).

METHODS

AUTOETHNOGRAPHY

Autoethnographic research has a relatively short history (Ellis, 2004; Holman Jones, 2005) compared to more traditional methods of data analysis in social science. However, methodologically, autoethnographic research provides a medium for individuals to express their lived experience with a level of nuance that is difficult to replicate via traditional means of data analysis. Ultimately, autoethnographic research works to combine elements of autobiographical narrative and ethnographic cultural immersion to explore an individual’s subjective experience

through some unique event. As it pertains to this study utilizing autoethnography, Reynaldo is one of the coauthors of the manuscript. He conveyed the details of his personal narrative to the other coauthors through multiple open-ended interviews. Together, they collaborated to craft the narrative presented in the case study below.

It should be noted that limitations of autoethnographic research are present. Primarily, the methodology lacks generalizability due to the hyperfocus on a single participant’s life experience. This “deep dive” into a single case study calls into question the level of scientific rigor in this methodology. Acknowledging these limitations, the authors caution the reader to presume generalizability of these data. By offering the nuance of an autoethnographic case study, our hope is to lay a groundwork for further research on the themes presented in this analysis. It should also be acknowledged that many autoethnographic research efforts are intended to make social, political, and/or epistemological critiques about the nature of truth, power structures in science, social justice, and the sociopolitical effects of traditional science (Adams & Holman Jones, 2008; Spry, 2001). Though this autoethnography makes no explicit attempt to stand as a form of sociopolitical activism, the authors do suggest that there are nuances that more mainstream research on American veterans has overlooked in the attempt to understand PTSD for post-9/11 era servicemembers.

Finally, in this autoethnographic case study, the subject requested that he receive support in writing the narrative of his case study. Instead of traditional autoethnographic research that is written in the first-person and comes directly from the account of the subject, Raymond requested that the details of his narrative be written collaboratively and via a series of interviews. Therefore, in order to support the subject of this study, the case study was coauthored.

DESIGN

One of the authors of this study is a combat veteran who wanted to tell his family’s story of reintegration after multiple combat deployments, some of which involved significant traumatic events. This author now works as a faculty member in higher education; however, he began working on this project while in graduate school. He received Institutional Review Board approval from Boston University while he was a graduate student and worked with his family in disclosing their story. He received informed consent from his ex-wife and children to share their story and conceptualize the events with academic research. Two interviews were conducted with his ex-wife and son, respectively. The interviews were conducted privately, in the home of the participants. All data were recorded by the author on a private recorder and locked in his office at work. The transcribed data was kept stored on

a private laptop in a password protected Microsoft Word document. Upon writing the details of the case study, the author also corroborated the events with his ex-wife and son. Both participants agreed the events were accurate as described and were comfortable with the disclosures. Pseudonyms were given to the participants (family members and veteran) and all family members agreed to the pseudonyms before disseminating the data.

The author also reached out to the two coauthors of this study to collaborate in completing the literature review and conducting the analysis of the interview data. The data was shared with both coauthors via email on the same password protected document. All authors performed a theory-led thematic analysis of the data set. Once the initial coding phase was completed, theory in the field of veteran reintegration, family systems theory, and Moral Injury was used to conceptualize the major events, experiences, and circumstances for the family's case study.

Autoethnographic Case Study Description

Reynaldo is a Puerto Rican male and Afghanistan War combat veteran who was divorced after eight years of marriage. He has three children. He has a history of the following mental health conditions: PTSD, anxiety, depression, chronic adjustment disorder, Obsessive Compulsive Disorder, and insomnia. Reynaldo did not present any mental health symptoms prior to deployment and all symptoms began to present after his return from Afghanistan. There is no account of historical trauma in Reynaldo's life prior to deployment. Reynaldo's ex-wife, Juanita, also suffered from depression and anxiety and used prescribed medications prior to, during, and after his return from deployment. She participated in both marriage counseling (with Reynaldo), as well as cognitive-behavioral therapy with a personal therapist.

Prior to Reynaldo's military tour in Afghanistan, all participants agreed that the couple and family had a healthy, happy, and fulfilling relationship. However, there were preexisting issues that Reynaldo's military career exacerbated. The family was about to lose their house due to financial issues prior to Reynaldo's enlistment. Furthermore, there was a lack of support from extended family.

Their eldest son, James, is Reynaldo's stepson, but Reynaldo had been in his life since he was 4 years old. He was 11 years old during the deployment. His middle son, Edward, and his youngest child (daughter Kara), were 9 and 4 years old, respectively, during his deployment. The family lived in a relatively large working-class urban city in New England prior to Reynaldo joining the US Army. All participants agreed that this was a pleasant time, and the family unit was close, connected, and steady. Their immediate familial relationship was strengthened by the fact that the remainder of their immediate family lived abroad or far away. As a family they

regularly engaged in hiking, camping, fishing, and martial arts activities. Every Friday was family dinner outside the family home, and each family member took weekly turns to choose the place for dinner. Every Saturday was Jujitsu practice and, as a family, they all attended practice together. Sundays were dedicated to outdoor activities. The family normally traveled once a month to a Jujitsu competition to support each other at the competition level. It was their tradition to eat dinner at the table together every day, attend reading groups on Wednesdays and do movie nights on Thursdays. This was their family schedule prior to deployment and, consequently, it was significantly disrupted during the deployment. Reynaldo's wife mentioned that it was difficult for her to continue the schedule when she had more responsibilities, as these tasks had previously been shared with Reynaldo.

While Reynaldo was deployed, James (11 years old at the time) began experiencing suicidal ideation and expressed to Juanita a plan to take his life. After this, James shared with his therapist that he was thinking of cutting his wrist with a knife. He stated the reason that moved him towards suicide was the experience of constant nightmares and night terrors of his step-father dying in war. The tension and stress created by both Reynaldo's deployment and James' suicidal ideation were borne heavily by Juanita (27 years old during the deployment), resulting in exacerbated symptoms of anxiety and depression. For Reynaldo (age 28 at the time), the combination of being in a combat zone, as well as having to deal with the news of James attempting to take his life on three occasions, and Juanita developing anxiety and depression, destabilized him and led to further deterioration of his mental health while deployed. In addition to the amount of stress created by James' suicide attempts, Reynaldo's ex-wife struggled with the fact that the media was constantly reporting attacks and bombings in the place where Reynaldo was located.

While Reynaldo was deployed, his wife had to take charge of all the responsibilities of the house, as well as the socio-cultural context due to the family settling so far from Puerto Rico. As a Puerto Rican family, spending time with other family members and celebrating traditional festivities was central to them. However, the relocation prevented them from engaging in family activities and this became a new struggle.

During the deployment, there was an airstrike at a large, local hospital in the region Reynaldo was deployed in. His unit had received intelligence that terrorist activity was present at the hospital, and that enemy forces were hiding at the hospital. Although the intelligence information was given to Reynaldo's unit, there were also patients from different ages at the hospital during a consequent airstrike that destroyed the hospital and killed many of its inhabitants. Reynaldo's unit was directly involved in

completing the airstrike on this hospital. Since this is a classified event, Reynaldo was not able to speak about this event in full detail to his wife, therapist, or loved ones when he returned. This inability to disclose such a heavy experience of trauma while deployed perpetuated symptoms of PTSD and an experience of Moral Injury.

After Reynaldo returned from Afghanistan, he began to experience the following symptoms: phobias to crowded places, hyperarousal, hypervigilance, hyperactivity, hearing voices, flashbacks, numbness, difficulty feeling, compulsive behaviors, and difficulty expressing his emotions. For example, Reynaldo shared that when his family picked him up from the airport they ran towards him giving kisses, hugs, and telling him how much they missed him. While his family was greeting him, he expressed later to his therapist, “I knew that I was supposed to hug them, kiss them, and tell them how much I love them, but I was incapable of expressing my emotions.” Later in marriage therapy, Reynaldo, with the assistance of his therapist, became self-aware that his inability to express emotions was transferred to his sexual intimacy with his wife. It is possible that Reynaldo was unconsciously using sex as a form of triangulation and a coping mechanism (Worthington & Sandage, 2016). In this sense, the stressor during Reynaldo’s deployment to Afghanistan affected the entire family system, from their children’s behaviors to familial intimacy, to the marital relationship between he and his wife.

It should be noted that, in some cases, journalists have been described by family victims as individuals who intruded upon boundaries and misrepresent facts (Sandage, 2010). Consequently, the combination of the media reports, James’ suicide attempts, and having to deal with these distressing family dynamics by herself caused Juanita to develop a sense of repudiation, resentment, and blame toward the military for the situations that her family was experiencing. The couple did not have external resources or family that could assist them during their situation, and therefore, relied on each other to express their individual frustrations, struggles, and traumas. Juanita reports that discord related to these traumatic events directly contributed to loss of emotional intimacy with Reynaldo, leading to divorce.

RESULTS

FAMILY SYSTEMS THEORY

Three themes emerge to describe the effects of PTSD among the relational dynamic between Reynaldo, Juanita, and their three children: (a) suicide, (b) caretaking, and (c) emotional distance. These themes were central after Reynaldo returned from Afghanistan until the divorce was finalized.

SUICIDE: BURDEN ON CHILDREN

James was the child who was “parentified” by Juanita, which most likely triangulated her own stress and anxiety of having to handle all the responsibilities after Reynaldo left for Afghanistan (Worthington & Sandage, 2016). A child is parentified when he or she is directly or indirectly tasked with responsibilities and burdens within a family that are more appropriate for adult parents. Children who are parentified are often forced to take on roles, supports, and tasks that are not age appropriate and are well beyond their maturity level. The act of triangulating towards a family member in the absence of another individual within the family system is quite common in family dynamics. According to Worthington and Sandage (2016), “chronic triangulation typically perpetuates problems of unforgiveness by preventing growth in differentiation” (p. 4). Nevertheless, triangulation is not limited to another person within the family system; it can also be towards an object or behavior. Once Reynaldo and Juanita divorced, James’s behavior can be categorized as an expected outcome of a family system dynamic that was moving towards a marital separation, as well as James’ triangulating towards the attention or sensations of planning or even attempting to execute his suicide plan. James’ behavior was consistent with longitudinal studies that found marital discord negatively effects children (Amato, 2010).

For James, it can be argued that being a parentified child during the absence of his father was the main stressor that provoked suicidal ideation. Juanita ultimately attributed the suicidal ideations to the military sending Reynaldo to Afghanistan and, consequently, her eldest son’s anxiety, guilt, and nightmares. James’ suicidal ideation negatively affected the family dynamics and led Juanita to place blame for these stressors on the military through Reynaldo’s deployment.

CARETAKING: BURDEN ON SPOUSES

After Reynaldo returned from Afghanistan, he began isolating himself by spending hours reading books. Juanita observed this shift in behavior and began to express her concerns by acting as Reynaldo’s caretaker. This caregiver/caretaking attitude has been present in research conducted with Vietnam veterans where spouses were more likely to experience “caregiver burden and have poorer adjustment than partners of veterans without PTSD” (Calhoun et al., 2002, p. 2). In this case study, it is probable that the reason Juanita felt obligated to take care of Reynaldo is connected to her love commitment, as well as to the socio-economic context that pushed Reynaldo to join the military when they were about to lose their home due to financial issues. It is possible that these circumstances added to her sense of culpability that drove her to assume

this role as well. During the time that Reynaldo enlisted in the military, they had received an eviction notice. This may have contributed to Juanita's willingness to express her commitment and guilt towards the mental health condition that Reynaldo developed after his combat tour in Afghanistan. Juanita's caretaking behavior may have been a form of emotional parentification that she felt compelled to take since Reynaldo could not manage his responsibilities after his mental health deteriorated during his return home (Ellis, 2004). It is also possible that Reynaldo's regression made him less available to assume the adult spousal and parental responsibility and led Juanita to overcompensate.

ATTACHMENT: EMOTIONAL DISTANCE

According to Bowlby, children who experience trauma tend to develop deficiencies in their internal working models, especially in their interactions with the principal caregiver (as cited in Andersson, 2015). In the case of children, they tend to seek emotional regulation by feeling protection and security in the proximity of their caregivers (Benoit et al., 2010). The trauma experienced by Reynaldo while deployed likely shaped insecure attachment, as well. The insecure attachment was externalized towards Juanita in his lack of emotional intimacy and social isolation. Reynaldo's detachment and withdrawal only exacerbated Juanita's insecure attachment. Reynaldo acknowledged that his consequent deactivation strategies inhibited any potential expressions of distress, which could have increased his chances of receiving support from Juanita, or elsewhere. According to Benoit et al. (2010) "These insecure strategies, corresponding respectively to the insecure-avoidant and insecure-preoccupied internal working models (IWM), are initially adaptive, since they promote proximity to the caregiver" (p. 3). Hence, during the past years after the reintegration of Reynaldo, these insecure attachments manifested themselves in the marital relationship for Juanita. Prior to deployment Reynaldo was seen by his family as the main caregiver/supporter and, thus, these disruptions in attachment affected him in his transition from war to family life.

MORAL INJURY

Moral Injury (MI) is one of the most misunderstood experiences of military personnel. It is often conflated with PTSD, and while there are many overlapping connections between MI and PTSD, MI is deeply connected to the core of a person's moral belief system. MI occurs when the system is in turmoil. Reynaldo first experienced MI when James attempted suicide during his deployment. In light of his cultural and religious upbringing, suicidal ideation would be a violation of moral norms. Additionally, Reynaldo lost his social standing with his family when he returned. This caused him feelings of shame, guilt, anger, and loss (Meagher & Pryor, 2018). Reynaldo's decision to move

away from his extended family was a source of guilt that exacerbated the loss and pain he felt. Finally, he carried MI from the hospital bombing that his unit was involved in while deployed. The involvement in such an event, coupled with the fact that disclosing his experiences with loved ones or professionals was prohibited by the military, led to a serious compounding of guilt and disorientation.

Reynaldo's prevailing traumas preconditioned him for prolonged grief from loss (of his family structure, allegiance to his military duties, and sense of competence as a parent). Additionally, the experience of being deployed to a combat zone may also have contributed to moral injury, such as threatening his resilience, internal conflict from a morally injurious experience(s), and even life-threatening experiences (Litz et al., 2016).

Even though Reynaldo has stayed connected to his ex-wife and children, he is simply unable to engage in a way that he could prior to deployment. MI limits one's ability to construct a narrative for the future and it becomes difficult to express feelings, thoughts, and emotions with those to whom we are closest (Litz et al., 2016). Reynaldo's guilt causes him to struggle to see himself as a father, leaving him unable to assume new responsibilities for his family.

DISCUSSION

What this study uniquely offers is a window into how the processes inside one military family unfolded, and what the people in that family, especially the servicemember himself, is thinking and feeling as this all happens. Providing these insights from an autoethnographic perspective is a unique contribution to this field. More formal research that can promote veterans to speak about their deployment and reintegration experiences will undoubtedly add nuance and clarity to the lived experience of veterans and family members who experience deployments. Further research on veteran PTSD should properly account for the impact and the traumatic event that has affected each member of the family system in an individual way. Research would benefit by focusing on a way that family systems theory, when applied to military families or families with an individual with PTSD, highlights the impact on family dynamics, and fosters the development of coping mechanisms for the benefit and adaptation of the family systems.

The family system is the primary setting in which one can detect signs or symptoms of psychopathology in the servicemember, which may lead to problematic interpersonal dynamics. Family systems theory sees each member of a family as an important asset in the aftermath of trauma and provides solutions for assessing the behavioral changes that can potentially create friction with other members

of the family system. Ultimately, individual and family therapy, grounded in a family systems theory approach, can conceptualize the servicemember and their familial dynamics from a holistic standpoint. The present study plainly underscores the vulnerability present in the active deployment phase, thereby troubling the notion that the therapeutic focus should be on post-deployment reintegration back into the family. It is clear that family dynamics continue to play out while the servicemember is away, and that, for families with risk factors for familial friction during deployment (such as limited social support and excessive parenting burden on the deployed member's spouse), therapeutic interventions grounded in family systems theory may be beneficial at the earliest stage of pre-deployment.

COMPETING INTERESTS

The authors have no competing interests to declare.

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