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EDITOR'S INTRODUCTION TO THE SPECIAL ISSUE
"A SOCIOLOGY OF SURVIVORS: POST-TRAUMATIC
SHOCK SYNDROME"

Dennis L. Peck

It is estimated that between 500,000 and 1.5 million Vietnam veterans suffer from Post-Traumatic Stress Disorder (PTSD), the nature of which includes sociological and psychological manifestations. However, despite past research efforts, an adequate understanding of the social consequences of PTSD and its effect upon veterans and their families remains largely unexplored.

I first became interested in Post-Traumatic Stress Disorder upon returning to The University of Alabama after serving as a Senior Analyst with the United States Department of Housing and Urban Development. During a subsequent visit to Washington D.C., I met with the Director of the Disabled American Veterans (D.A.V.) and soon learned that we shared a common concern about the magnitude of the PTSD problem. In my role as an academic, and as a former member of the United States military who served with a special forces unit in Laos, my approach to the issues surrounding the relationship between service in Southeast Asia and PTSD continues to be critical. That is to say, I am unwilling to accept without question the validity of the assertions made regarding the effect of PTSD on Vietnam veterans. This healthy cynicism is enhanced by the fact that, despite an array of research literature, a consensus does not exist among researchers regarding the pronounced effect of PTSD upon Vietnam veterans.

This view is not intended to suggest that PTSD is not real. Indeed, documentation of the syndrome in the American Psychological Association's DSM III (1980) and the more recent efforts to revise criteria during October, 1984 serve as testimony that the disorder is recognized as a problem experienced by victims of incest, rape and marital abuse. In this regard, then, the generic issue involving PTSD transcends the veterans of war and the civilian survivors of military conflict.
Post-traumatic stress disorder is a human problem as opposed to being a survivor problem. I also believe that important research questions and the social and legal issues emerging from current knowledge of PTSD cannot be adequately evaluated without input from social and behavioral scientists. The proposed thrust of this special issue of the Journal was intended to be a sociological analysis of PTSD and Vietnam War veterans. Another view expressed by members of the Editorial Board of the Journal was that PTSD should be evaluated within a broader context. Thus, in addition to the articles that focus on the relationship between PTSD and Vietnam veterans, this special issue of the Journal of Sociology and Social Welfare includes contributions on incest, suicide, and Holocaust survivors.

One of the great attractions of research lies in its capacity to explain important features of contemporary life. The articles in this special issue are consistent with this orientation and the contributors believe that a need exists to more fully explore the social and psychological dynamics of PTSD. Each contributor has a deep commitment to research and to the application of knowledge in the service to humanity. While selections in this issue are not intended as a definitive statement, each paper should sensitize the reader to the wide-ranging effects of stress which emerge in the aftermath of traumatic events.

The first article by Sangetta Singg provides an historical overview of the post-traumatic stress concept. In linking the historical perspectives of traumatic stress with contemporary research and clinically oriented efforts to evaluate and treat victims of stress, the author demonstrates that the concept has a long history in the annals of scientific inquiry. Dr. Singg concludes her review of the scientific perspectives on stress by suggesting a general method for dealing with the delayed symptoms known to be related to the post-traumatic stress syndrome.

The contributions that focus on Vietnam veterans are impressive. Each paper provides a different assessment of the effects of PTSD on Vietnam veterans,
although the findings do not appear to be consistent. First, the Flynn and Teguis paper offers an interesting albeit preliminary assessment of a California based treatment program. The Gusman program provides Vietnam veterans an opportunity to deal with their unresolved grief related to traumatic war experiences. Examples of the kind of unresolved grief dealt with by the Gusman program staff and a general overview of the treatment philosophy are presented. Rather than viewing victims as pathological misfits, mentally ill or "character-disordered," the Gusman approach, according to Drs. Flynn and Teguis, is oriented toward a specialized form of therapeutic assistance.

It is interesting that the Gusman orientation appears to be gaining in acceptance among both professionals and the lay community. Dr. Alexandra Teguis has recently agreed to work with employees of the MacDonalds fast-food establishment in California which, during the fall of 1984, was the scene of a massacre perpetrated by a lone gunman. Moreover, the American Psychological Association now appears ready to deal with PTSD as a normal response to abnormal life events.

John P. Wilson is well known among students of PTSD for the work he undertook several years ago. Wilson had the first PTSD research project funded by the D.A.V., and the results of this research have recently begun to appear in scholarly journals. Because of his expertise, Dr. Wilson currently serves as consultant to the Work Group to Revise DSM III.

The major thrust of the Wilson, Smith and Johnson contribution is that the loss of significant others and life-threatening events are sufficient predictors of post-traumatic stress. Comparing a group of Vietnam veterans living in Ohio with a national sample of Vietnam combat veterans and a group of non-veteran subjects, Wilson, et al., report that Vietnam veterans appear to be more depressed, experience more problems related to their primary social groups and are prone to experience serious physical problems.
The findings reported by Ritter generate some interesting questions about the relationship between combat exposure and PTSD. Few researchers would disagree with Ritter's suggestion that the relationship of interest cannot be adequately evaluated without the use of an acceptable theoretical framework. Moving beyond the challenge that such research should be developed, Dr. Ritter empirically demonstrates that combat exposure \textit{per se} may be an inadequate predictor of PTSD. The policy implications of the research reported in this paper for public service providers would seem to be substantial.

Inger J. Sagatun's discussion of attribution models of self-blame, coping strategies of incest victims and the effectiveness of self-help treatment programs predicated on reducing victim stress is another example of the incursion by sociologists into community-based treatment program evaluation. In her paper Dr. Sagatun reports on the effectiveness of a Parents United therapy program which assists family members to cope with a situation which only recently has been recognized as a significant social problem.

Reporting survey data gleaned from male offenders, female incest victims and spouses participating in a volunteer program, Sagatun observes that post-traumatic stress encumbers victims of incest to a greater extent than is found for either the offenders or their spouses. This difference can be explained in part by internal and external attribution models and in part by societal reaction to the participants of incest. Peer group support and rejection are also reported to be significant factors for explaining how program participants deal with the shame and guilt related to incest in an attempt to reduce the effect of post-traumatic stress.

In the paper on post-traumatic stress and life-destructive behavior, the author illustrates that not all individuals who experience stress choose to cope with this condition by seeking assistance. One of the most studied social problems, suicide continues to be a matter of vexation among concerned students.
Written by the editor, this study examines the relationship between traumatic stress and suicidal behavior, using case study material obtained from a Medical Examiner's office.

The general finding that suicide committing view themselves as insignificant and experience bereavement and stress sufficient to induce a life-and-death crisis would appear to be consequential for entire communities. Suicidal behavior, it is argued, can be attributed in part to stress-related reactions to negative perceptions of self-worth and in part to the actor's inability to act upon social conditions and events causing traumatic stress. This paper concludes with the suggestion that creation of public policies which overarch individual and community needs may be an important means to deal with the suicide problem.

The papers on Holocaust survivors offer an important review of extant research literature, an assessment of the Freudian and neo-Freudian clinical approach to post-traumatic stress disorder, and an interpretation of the needs of Holocaust survivors based on informal interviews. Written by sociologists and psychologists, each contribution has a common orientation; that is, the authors believe that historical and recent efforts to assist survivors of the Holocaust suffer from an excessive focus on the pathological effects emerging from the experience.

Each paper stands on its own merit, albeit the reader will undoubtedly recognize that the authors share similar concerns. Perhaps it is noteworthy that interested analysts have only recently recognized the heuristic value in attempting to establish an empirical relationship between post-traumatic stress disorder and the Holocaust. However, the extensive body of research and clinical literature on survivors strongly suggest that this relationship may have already been established.

Benjamin J. Hodgkins and Richard L. Douglass' evaluation of the PTSD research involving Holocaust survivors demonstrates that the need exists to fill an important empirical vacuum. The authors argue that,
irrespective of the large body of Holocaust literature, little data exists that is useful for evaluating the long-term consequences of post-traumatic stress evolving from the World War II concentration camp experience. Most surprising, perhaps, is the fact that the successful cross-cultural adjustment of the majority of Holocaust survivors has been ignored.

The authors raise several conceptual and methodological questions regarding the nature of extant Holocaust research and the lack of systematic design procedures employed in these projects. The literature review provided in this paper and the authors' critical assessment of the Freudian and neo-Freudian conceptual framework employed in previous research highlights yet another concern. Drs. Hodgkins and Douglass build a strong case for the development and implementation of a sociological approach to these issues, but they argue that a unique research opportunity will soon be lost because of the age of Holocaust survivors. Their recent experience with the LeVine Institute on Aging, Jewish Home for Aged, undoubtedly has sensitized the authors to the fact that if new insights are to be developed, the effort to do so must occur in the near future. Perhaps Drs. Hodgkins and Douglass will be able to use these insights and contribute to the research in this area, thereby adding a new dimension to post-traumatic stress studies.

The position posed in the contribution on the effects of the Holocaust by Drs. Harel, Kahana and Kahana compliments the Hodgkins and Douglass paper. In addition to the discussion of the theoretical and methodological limitations of the Holocaust and stress research literature, Harel, Kahana and Kahana formulate an eclectic perspective based on interviews conducted during 1983.

The authors' contention, based on an interpretation of unreported data, underscores an important human need. Survivors, according to the authors, continue to engage in post-war adaptation, primarily because of their pathological label and the lack of community support for their individual and collective
needs. One such need is symbolic in nature, but it is nevertheless real to survivors. This collective need would also seem to address a more generic human need regarding a symbolic memorial commemorating the Holocaust as an example of man's inhumanity to man.

Finally, the authors challenge scholars and interested analysts to explore the effect of environmental challenges and demands confronted by survivors in their efforts to adapt to new cultural and social environs. It logically follows, then, that a new theoretical orientation is necessary in order to develop a thorough and perhaps more appropriate assessment of the adaptation mechanisms employed to cope with post-traumatic stress.

At some point it seems insufficient to merely evaluate the analytical efforts of others without contributing to cumulative knowledge. In the brief paper subtitled "The Need for Conceptual Reassessment and Development," Dr. Jerome Rosenberg draws upon personal discussions with survivors and seven years of teaching and evaluation of the Holocaust literature to propose an alternative conceptual framework to existing clinical models. Although Rosenberg is concerned specifically with Holocaust survivors, the conceptualization presented in this paper skews toward more generic issues enshrouded in the post-traumatic stress syndrome.

The foundation for Rosenberg's current effort to develop a dehumanization scale can be identified in the work of Boder published 30-35 years ago, and more recent efforts of a select group of analysts who view survival from a non-pathological perspective. Reasons for why the pathological orientation has dominated the Holocaust literature for almost four decades are cited, and the author suggests that the continuous effort to focus upon the abnormal is detrimental to the creation of new knowledge and the application of alternative treatment modalities.

In the final paper Dr. Marlene Sway partially examines adaptive efforts of female survivors of the Holocaust. Based on interviews conducted with sixteen
middle-age and elderly women, Sway identifies three major factors that served to assist Jewish survivors in the adaptation process and to reestablish their sense of social worth, identity and self-esteem.

Grounded in the Weberian notion of the work ethic, this paper suggests that survivors who chose to resettle in the United States may have avoided another long-term traumatic event in part by embracing hard work as their means to survival. Similar to the other contributions on the Holocaust, the author concludes by suggesting that previous analysts and helping professionals may have prejudged the majority of survivors, thereby unwittingly contributed to their difficulty in coping with the stressors related to both the war experience and the post-war adaptation process.

The Journal was established on a principle of excellence and the recognition that the results of research should contribute to the community by assisting professionals and practitioners who strive to solve individual and organizational problems. This special issue, we hope, is consistent with this orientation in that the information will be useful to both researchers and practitioners.

A number of individuals have contributed through their time and effort to make this special issue possible. The entire issue is better because of their considerable assistance. Several individuals served as reviewers of the contributed papers at various stages of their development. The expertise of Gerald Globetti, Gary DeMack, Ron Jones, Sandra Lavender, Lucinda Roff, Jerome Rosenberg, Irene Rubin, Herbert J. Rubin, and Marlene Sway was invaluable to me as editor of this issue of the Journal. Special recognition for their effort to prepare the manuscripts in a form acceptable for publication is due Linda Crowson and Sandra Lavender. Finally, I wish to acknowledge the encouragement and advice received from Robert D. Leighninger, Jr., Edward J. Pawlak and Danny H. Thompson. I had contact with each of these individuals during some phase of the project; each was generous with his support on behalf of this initiative.
TOWARD AN UNDERSTANDING OF
POST-TRAUMATIC STRESS DISORDERS: AN
HISTORICAL AND CONTEMPORARY PERSPECTIVE

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ABSTRACT

This article traces the historical views that led to development of current scientific perspectives of the diagnostical concept post-traumatic stress disorder. Examples of the catastrophic precipitants of post-traumatic stress disorder, such as war, natural and man-made disasters, and rape are presented, and a description of the current clinical perspective is provided. Because post-traumatic stress disorder often involves all aspects of a person's life, the use of multimodal therapy soon after the trauma is experienced is recommended to prevent the symptoms from occurring.

INTRODUCTION

The purpose of this paper is to trace the historical views which led to the development and understanding of a diagnostical concept post-traumatic stress disorder (PTSD) and to highlight the current clinical picture along with the recent therapeutic approach called multimodal therapy. This account is intended to set the stage for more specialized issues related to PTSD which follow in this volume and to give the reader a broad understanding of the emergence of PTSD symptoms in a variety of situations.

There have been different views about the subject of PTSD which have changed with the passage of time. Until about two decades ago, the literature on the
subject lacked continuity and could only be characterized as anarchic (Kardiner, 1969). Every investigator had a point of view framed with circumstantial explanations. Various authors have also used different terms; for example, traumatic hysteria, traumatic neurosis, and situational crisis.

According to Trimble (1981), the debate over PTSD began in the 1860s with John Erichsen's lectures on certain obscure injuries of the nervous system: these injuries, according to Erichsen, were the result of shock to the body caused by railway accidents. Erichsen, a professor of surgery at University College Hospital in London, delivered lectures which were later incorporated into a book, *On concussion of the spine: nervous shock and other obscure injuries of the nervous system in their clinical and medico-legal aspects* (Erichsen, 1882) in which 53 case histories of patients who had received injuries of a wide variety were presented. Erichsen's work received wide attention in Europe as well as in the United States, and it later became an important reference in court cases dealing with compensation claims by victims of "shock." Thus, a legal point of view was established: that post-traumatic neurotic symptoms were based on somatic damage.

In 1889, Clevenger, an American physician, referred to the term "spinal concussion" as "Erichsen's disease" and considered it one form of the traumatic neuroses. The term "traumatic neurosis" was originally used by Oppenheim during the late nineteenth century in reference to the symptoms of concussion (Trimble, 1981). Oppenheim, a German physician, believed that the symptoms of traumatic neurosis were produced by molecular changes in the central nervous system (Trimble, 1981). Thus, PTSD came to be viewed as somatically based by most physicians between the 1860s and the early 1880s.

In 1885 Herbert Page, another British surgeon, published *Injuries of the spine and spinal cord without apparent mechanical lesion*, a refutation of the view held by Erichsen. Page dismissed the so-called "concussion of the spine" phenomenon and replaced it
with the explanation of "general nervous shock," thereby introducing the concept "functional disorders." This class of injuries was divided into two categories: organic, where injuries were clearly observable, and non-organic, where injuries were either slight or not observable. The non-organic causes were further divided into hysteria and malingering.

Hysteria achieved greater prominence with the work of Jean-Martin Charcot (1877), head of a neurological clinic for insane women in Paris and one of the most eminent neurologists of his time. Charcot investigated hysteria with the assumption that a common mechanism was responsible for the production of hysteria as well as other neurological disorders. During this same period hysteria continued to be ascribed to somatic bases; that is until Pierre Janet, Charcot's pupil and successor, challenged this knowledge. Janet rejected the assumption that hysteria was the result of physiological disorder, and, instead, considered it a symptom of mental disorder (Shultz, 1981). Thus, a dramatic conceptual shift occurred as the focus of the cause of hysteria changed from somatic in nature to psychic. Janet's work greatly influenced Sigmund Freud, the father of psycho-analysis, whose work later became the foundation for the grand theory of personality embraced during the early 1900s.

Freud broadened the meaning of hysteria and utilized the methods of treatment for hysteria which he had learned from Charcot. In 1886, Freud presented before the Viennese Medical Society a set of findings from which he equated post-traumatic neurosis with hysteria, a knowledge claim which became the point of dissent for Viennese physicians of that time (Ellenberger, 1970). In 1895, Freud published a book jointly with Josef Breuer entitled Studies on hysteria. The primary thesis of this work was that the symptoms of hysteria resulted from repressed memories of traumatic events. To support this notion Freud and Breuer documented the intrusion of "warded off" ideas, the compulsive repetition of behavior related to trauma, and recurrent attacks of trauma-related emotions (Horowitz and Solomon, 1975).
In time, Freud's original theory was modified; a changed emphasis began to be placed on ego function as opposed to a paradigm in which repressed impulses and the unconscious had been emphasized. Later theorists, such as Kamman (1951), viewed post-traumatic neurosis as a reaction to environmental factors involving personal failure in adaptation.

Kardiner's (1941) research focused on patients suffering with what was described as post-traumatic neurosis developed during war-time. Focusing on ego disturbances, Kardiner argued that symptoms related to the neurosis were not a result of conflict between two internal systems of the mind, but resulted from personal failure to adapt to a new or changed environment. Although many other studies have contributed to the clinical perspective of PTSD, its symptomology was first delineated by Kardiner (1969) as representing a mental disorder related to the traumatic neurosis of war.

In sum, PTSD has been the product of two historical schools of thought: the first perspective portrayed PTSD as resulting from somatic causes and the second view presented PTSD as a mental disorder. Then, around the turn of the century, a split between neurology and psychiatry occurred which led, in turn, to the recognition that functional disorders could develop without somatic causes. In more recent years PTSD has received considerable attention from social scientists and members of the helping professions. Numerous analysts have attempted to assess the nature, dynamics, and outcome of trauma-related disorders resulting from man-made catastrophes such as wars; natural disasters such as floods and accidents; and solitary catastrophes such as rape (e.g., Fairbank, et al., 1983; Kilpatrick, et al., 1979; and Wolfenstein, 1977). Examples of major precipitants of PTSD and a summary of the current clinical perspective are presented in the following sections.
MAJOR PRECIPITANTS OF PTSD

Man-made Catastrophes: Aftermath of War

According to Bootzin and Acocella (1984), most knowledge of PTSD has developed from studies involving survivors of war such as the two World Wars, the Korean and the Vietnam wars. Traumatic reactions to combat have been known by a succession of names such as "shell shock," "combat fatigue," "war neurosis," and "combat exhaustion." However, none of these terms represents a full and accurate description of PTSD because stress reactions to combat differ from one person to another (Bootzin and Acocella, 1984). Some soldiers suffer from fatigue and depression while others display intense anxiety escalating to panic attacks. The precipitating stimulus is usually the same, however,-a close escape from death and the trauma of seeing one's companions killed (Bootzin and Acocella, 1984).

In many instances soldiers do not manifest symptoms related to PTSD until they have returned to civilian life. Kardiner and Spiegel (1941) studied this problem in relation to both World Wars and concluded that war created a syndrome essentially no different from the traumatic neurosis of peace-time. Shell-shock, war neurosis, battle fatigue, and combat exhaustion, according to Kardiner and Spiegel, represent a manifestation of the same underlying cause—a common disorder resulting from war trauma.

Frederick Mutt, a British pathologist, coined the term "shell shock" during World War I (Coleman, et al., 1982). Mutt regarded such reactions as organic conditions produced by minute hemorrhages of the brain. It was found later, however, that only a very small percentage of combat cases showed physical injury. That is, most combatants suffered from physical fatigue and psychological shock. During World War II, the term "shell shock" was replaced by the term "war neurosis" and during the Korean and Vietnam wars, "combat fatigue" and "combat exhaustion" were introduced into the literature and the clinical vernacular.
Despite the varied terminology used to refer to PTSD, there was surprising uniformity in the general clinical picture which evolved during the war periods (Coleman, et al., 1982). The most common symptoms identified were dejection, weariness, hypersensitivity, sleep disturbances and tremors. In the majority of cases, soldiers who suffered from PTSD under combat conditions did not have history of prior maladjustment to military life, leading Kardiner (1969) to speculate that if it were not for the conditions prevailing during war, most soldiers would not develop PTSD. It has also been estimated that ten percent of American soldiers developed PTSD in World War II and, according to Bloch (1969), disabling combat exhaustion was the greatest single cause of manpower loss during that war. More recently Walker and Cavenar (1982) reported that of the 2.7 million Americans who served in the United States military during the Vietnam War, an estimated 20 to 25 percent continue to suffer from PTSD. In recognition of the enormity of the problem, the Veterans Administration began accepting PTSD in 1980, as defined by Diagnostic and statistical manual of mental disorder (DSM-III), as a compensable disability.

Man-made and Natural Disasters

Unfortunately as these are, disasters contribute a great deal to the understanding of PTSD. One of the earliest reports (Lindemann, 1944) evaluated the psychological symptoms experienced by survivors of the Boston Coconut Grove Night Club fire of November 29, 1942, in which a total of 493 people perished. Lindemann's work was later to become the cornerstone for the grief process theory and also served as the basis for the development of crisis theory.

Additional knowledge of PTSD developed in the aftermath of yet another tragedy. In 1972 the Buffalo Creek dam, constructed by the Buffalo Creek Mining Company, burst causing over one-hundred million gallons of mud to slide down the West Virginia hillside upon residents living in communities located below the dam. Within hours 125 people died and 4000 were left homeless (Erickson, 1976). Lifton and Olson (1976)
later categorized the PTSD symptoms manifested by the survivors into five categories. The first, death imprint and death anxiety, pertains to memories, visions, and recurrent nightmares of the death and massive destruction caused. The second category, death guilt, refers to survivor self-condemnation for having lived through the disaster while others perished. Psychic numbing, the third category, is characterized by a diminished feeling of self-worth among survivors involving apathy, depression, and a withdrawal from social intercourse. The fourth category, impaired human relationships, develops from the internal conflict between a need for love and succorance and the suspicion toward others who offer care or affection to disaster victims. The final category, the need to find significance, involves rationalizing the disaster to enable victims to resolve their inner conflicts.

Studies of other disasters, such as the Rapid City flood in 1972, the Three Mile Island Nuclear accident in 1979, the tornadoes in 1979 in two Texas communities--Vernon and Wichita Falls--, and the Kansas City Hyatt Regency disaster in 1981 further contributed to this knowledge base. According to Titchner, et al. (1976), such disasters tend to trigger an epidemic of PTSD, the frequency and intensity of which are determined by the nature of the impact, its duration, and the number of casualties.

The major feature of such disasters is that they affect a large number of people at the same time and create a state of emergency (Slaikeu, 1984). Such disasters are, of course, unexpected and cause the victims to experience severe psychological shock and to exhibit a response pattern consistent with "disaster syndrome." The disaster syndrome, according to Coleman et al. (1982), develops over three stages. During the initial shock stage, victims are stunned, dazed, and apathetic. They wander around aimlessly, cannot make sense of what is happening, and are unable to render aid to themselves or others. During the second stage, suggestability, victims become passive, suggestible, and appear willing to follow directives from almost anyone. In this stage victims also
express concern about others involved in the disaster. However, their behavior typically tends to be highly inefficient. In the final recovery stage, disaster victims begin to pull themselves together, think more clearly, and initiate constructive action. They are still tense, irritable, and hypersensitive to anything startling, however. Also, it is common that victims begin to discuss the disaster. Persons with acute episodes return to normal functioning after successfully passing through the three stages of disaster syndrome. However, individuals with chronic cases may continue experiencing symptoms of PTSD for several years after the disaster.

Solitary Catastrophes: Rape

The precipitant of PTSD need not be experienced en masse as, for example, in the case of flood, fire, or war. Rather, PTSD also evolves from solitary catastrophes such as rape (Rosenhan and Seligman, 1984). Recently there has developed an increased interest among mental health professionals and the general public over rape and related sexual abuse issues (King and Webb, 1981). Rape crisis was first described in detail by Burgess and Holmstrom (1974), who found that rape victims suffered significant physical and psychological trauma as a result of the rape. These analysts also noted that particular symptoms were exhibited by most victims regardless of their style of expression. Known as the "rape trauma syndrome," the reaction of most victims fall into three symptomatic categories: emotional responses, disturbances in functioning, and changes in life style (King and Webb, 1981).

Rape trauma syndrome strongly resembles the symptoms manifested in reaction to flood, combat, and concentration camps (Burgess and Holmstrom, 1979). Sleep disturbances, nightmares, genitourinary disturbances, and tension headaches are often evident. Similar to flood victims, rape trauma syndrome victims startle easily, and usually experience fear, depression, humiliation, anger, and self-blame. Sometimes phobias develop, and sexual fears are also common. In a recent study by Burgess and Holmstrom
(1979), it was found that four to six years after the rape, one-fourth of the victims still had not recovered from the trauma.

THE CLINICAL PERSPECTIVE

As abhorrent as war is, it has provided a "laboratory" in which the effects of severe environmental stressors on thousands of men can be evaluated. Similarly, disaster situations and personal catastrophes have not only added to the understanding of PTSDs for mental health professionals, but also provide insights for the general public as well. People are becoming increasingly aware of the potential impact of extreme stress and they have learned that anyone is vulnerable.

Post-traumatic stress disorder is characterized by anxiety. But PTSD differs from other anxiety disorders in that the source of stress is an external event of an overwhelmingly painful nature. A person's reaction, though it may resemble other anxiety disorders, seems to be justified (Bootzin and Acocella, 1984).

According to the DSM-III, PTSD is a psychological reaction to traumatic events that are generally beyond the range of common experiences such as bereavement, chronic illness, business loss, and/or marital conflict. The disorder may also evolve from physical damage such as head trauma, or body mutilation.

The symptoms characteristic of PTSD are reexperiencing the traumatic event, emotional anesthesia, and a variety of autonomic, dysphoric, or cognitive symptoms. The diagnostic criteria for PTSD, delineated in the DSM-III (1980:238) are as follows:

A. Existence of a recognizable stressor that evokes significant symptoms of distress in most everyone.
B. Re-experiencing of the trauma as evidenced by at least one of the following:
1. recurrent and intrusive recollections of the event
2. recurrent dreams of the event
3. sudden acting or feeling as if the traumatic event were recurring

C. Numbing of responsiveness or reduced involvement with the external world beginning some time after the trauma, as shown by at least one of the following:
   1. a markedly diminished interest in one or more significant activities
   2. a feeling of detachment or estrangement from others
   3. constricted affect

D. At least two of the following symptoms that were not present before the trauma:
   1. hyperalertness or exaggerated startle response,
   2. sleep disturbance,
   3. guilt about surviving when others have not, or about behavior required for survival,
   4. memory impairment or trouble concentrating,
   5. avoidance of activities that arouse recollection of the traumatic event, and
   6. intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

Other associated features include depression, anxiety, aggressive behavior, impulsive behavior, or organic mental disorders.

Impairment due to PTSD may be mild or it may affect nearly all aspects of life. The symptoms can either be experienced immediately or soon after the trauma, or they may emerge after a period of latency ranging from several months to several years after the traumatic event. When symptoms occur within six months of the trauma and/or the duration is less than six months, the disorder is considered acute. If the onset of symptoms develops more than six months after the event, it is delayed, and is considered to be chronic if the symptoms last longer than six months.
Furthermore, the disorder is usually longer lasting and more severe when a stressor is of human design.

Despite our increasing knowledge of the phenomenon, little is known about how to alleviate or prevent PTSD. Only minor improvements have been reported using drug therapy or psychotherapy in the treatment of trauma victims (Rosenhan and Seligman, 1984). Two confounding factors tend to cloud our understanding of improvement in PTSD cases. First, it is difficult to assess the health of the victim prior to the trauma since it is possible that individuals who suffer from the disorder may also have had poor adjustment prior to the trauma (Rosenhan and Seligman, 1984). Second, some victims remain ill for a long time because of the benefits or secondary gains involved (Trimble, 1981). According to Rosenhan and Seligman (1984), careful longitudinal investigations of PTSD are required to provide the necessary evidence for determining who is more vulnerable to PTSD, the duration of the disorder, and to identify the most effective therapeutic techniques.

At the present time, the best solution to the problem appears to be preventive in nature. Therapists can attempt to reduce the effect of PTSD symptoms in trauma victims before they take hold (Rosenhan and Seligman, 1984). Sank (1979) reports that such a therapeutic attempt was successfully made by therapists from the Health Maintenance Organization, Washington, D.C., with the 154 men and women held hostage by the Hanfi Muslim at the B'Nai B'Rith National Headquarters during 1977. Therapy sessions, based on the multimodal behavior therapy introduced by Lazarus (1976), took place at the hostage site twice weekly for four weeks, and then follow-up sessions were held three months and one year later. The unique feature of this method appears to be its immediacy and the use of a broad-spectrum of intervention treatment techniques (Slaiteu, 1984). Since a follow-up of the victims was not carried out, the efficacy of this treatment method cannot be assessed (Rosenhan and Seligman, 1984). However, as a therapeutic approach it warrants further evaluation.
In conclusion, PTSD has appeared in many guises. Further, explanations and understanding of the disorder have been in relation to the disciplinary approach of the time and the zeitgeist. With the recognition of the psychological component of PTSD, current etiological knowledge is advanced enough that the disorder is now officially recognized by mental health professionals. Whereas the complex and varied nature of PTSD makes it difficult to delineate a specific preventive and therapeutic program, recognition and greater understanding of the disorder offers considerable hope for future therapeutic success.

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GRIEF AND THE TREATMENT OF POST-TRAUMATIC STRESS DISORDER

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ABSTRACT

The effects of grief and grief-repression are described as being critical aspects of Post-Traumatic Stress Disorder. Qualitative interview and extant program material are utilized to assess the role of grief in the PTSD syndrome, and a program that incorporates grief-related therapy is described. Implications of grief-related therapy for the treatment of PTSD are also discussed.

INTRODUCTION

"Jeff"

Jeff, my friend, My closest
Friend I knew.
You're no longer here to
pal around
We went to school together,
You and me.
When we went to war together,
You and me.
We fought by each other's side
We talked about the girls
We left behind,
Shared the same food and
foxhole together--
You and me.
But on my orders one night
You took my place and died
For me.
I found your body and cradled
It in my arms.
And slowly let the tears run down.
I looked at your torn and mangled
Body. And all I could say was, "I am sorry."
But Jeff, you may be the lucky one.
Because I am still dying out here.

(A Vietnam veteran)

Vietnam veterans constitute a significant American minority group. At a relatively young age (the average Vietnam soldier was nineteen) they were sent to fight a war the controversial nature of which caused them to receive substantial blame for carrying out the directives of what now is viewed as misguided leadership.

Vietnam left emotional scars not only on the nation's soul, but on the over three million youths who served there. But the manner by which to deal with these scars also represents a problem. A number of studies in which the emotional effects of the war on the participants were examined (e.g., Starr, 1973; Lifton, 1975; Mantell, 1975; Wilson, 1979; Figley and Levantman, 1980; Moskos, 1980; Wikler, 1980; and Goodwin, 1981) specify how particular aspects of the war may contribute to emotional problems in veterans after their return to the United States. These include the age of Vietnam soldiers, the moral ambiguity of the war, the lack of positive feedback, and hostility from the public, the system of individual terms of service which undermined group solidarity, and the lack of a clear-cut enemy (Goodwin, 1981). In sociological terms, these factors combine to render the Vietnam experience anomic, in that normative guidelines were absent. The experience was also alienating, both in terms of the veteran's relation to fellow soldiers and, upon returning home, a sense of betrayal perceived of a society that failed to appreciate the sacrifices made.
Although it initially appeared that psychiatric casualties were much lower for Vietnam soldiers than the number of psychiatric breakdowns recorded during World War II and Korea, this was in fact an illusion. For many Vietnam veterans psychiatric problems began to emerge after they returned to "the world" (Figley and Levantman, 1980:xxiv). Gradually, a general pattern of symptoms became evident, and by the late seventies this phenomenon began to be referred to as Post-Traumatic Stress Disorder (PTSD). The syndrome is characterized by a number of interrelated symptoms the elements of which include depression, isolation from others, rage, avoidance of expression of feelings for others, survivor guilt, anxiety reactions, sleep disturbances and nightmares, and intrusive thoughts of combat-related experiences (Goodwin, 1981:13-19).

Perhaps the most extensive effort to study PTSD to date is Wilson's *The Forgotten Warrior* (1979). In addition to interviewing over 400 Vietnam veterans, Wilson subjected them to a battery of social-psychological tests from which a number of patterns associated with the syndrome were uncovered. Among the most significant of these was that the youthful average age of Vietnam G.I.s meant that they had been denied a period of late adolescence for development; an opportunity for a "moratorium" or a time to develop a consistent set of values and a sense of self-identity. Instead, they were forced to cope with experiences and pressures that would strain the resources of much older men.

**Grief Repression**

Though scholars such as Lifton (1975) discuss the role of survivor guilt in the development of PTSD, few focus on the fact that suppression of the normal grief response is a ubiquitous combat phenomenon. The mass media creates images of war which give the impression that expressions of grief and bereavement are either infrequent or are not central to the combat experience. In the film "Patton," for example, General Patton is portrayed as telling his soldiers that they need not worry about being motivated to fight, since they will "know what to do when they see their friends..."
faces turned to goo." The implication, of course, is that the only legitimate response is to seek revenge against the enemy. More realistically, there exists a number of reasons to hypothesize that the kinds of horror experienced by Vietnam combat soldiers would have more traumatic effects than would those experienced in other facets of life. Relatively few people witness violent death, and in a peacetime environment the image of death is usually relegated to morgues or to the funeral industry.

The literature on the psychological effects and reactions to protracted grief indicate that depression, rage, and other reactions are common response patterns in peacetime situations. These problems tend to increase when grief is found to emerge from the disaster-related deaths of loved ones. The difference between grief experienced in peacetime and in war is that in war a soldier would mourn a dead or dying buddy at the risk of his own life. The exigencies of survival and maintaining group functions mandate that grief reactions be repressed. As one veteran quoted by Robert Lifton (1975: 189) in _Home from the War_ stated, "Every time you'd start to feel human, you'd get screwed."

PTSD also has secondary side effects as well, such as geographic, employment, and marital instability. Occasional PTSD-related criminal acts, and the retreatist behavior expressed through alcoholism and drug abuse have also been documented. The effects on spouses, children, family and friends require more effective means for dealing with PTSD (Marafiote, 1980). Marafiote contends that once the relationship between unresolved grief and PTSD is acknowledged, greater treatment success will follow.

**Grief-Related Treatment Modalities**

Stories told by veterans about their experiences in Vietnam point to the need to develop a treatment modality for dealing specifically with PTSD—-one which is able not only to address the overt symptoms of PTSD, but to ferret out the deep, grief-related etiology of the syndrome.
In the past the failure of many Vietnam veterans to cope with the pressures related to jobs, family life, and other aspects of "normal" existence led to mental breakdown, violence, and other pathologies that have been treated on the basis of generally accepted psychiatric diagnoses (Gusman, 1983). Following an incident sufficiently disruptive to render suffering to friends, family, or employers, a veteran or a member of his family will typically approach a social worker, who, in turn, will arrange either for individual out-patient counseling or admission to a Veteran's Administration hospital. These efforts may temporarily alleviate the symptoms, but do little to deal with underlying causes of the problem. After making this overture, veterans attempt to resume a "normal" life and may even appear to succeed temporarily. Almost inevitably, however, the veteran is again unable to function, and the revolving-door process begins leading to serious strain within marriages and to negative effects for children and friends (Williams, 1980).

Although efforts to deal with PTSD are moderately successful, only a few veterans have been adequately treated to alleviate the syndrome. Kuramoto (1980), for example, points out that over one-half of the Veterans Administration medical facilities are devoted to psychologically related problems and that there has been a substantial shift towards out-patient treatment. Passed in July, 1979, Public Law 96-22 created the Veterans' Outreach Counseling Program, which led to the establishment of Veteran Centers in most large cities. A place where Vietnam veterans can receive "help without hassles," outreach centers are staffed primarily by counselors who are also Vietnam veterans. Offering individual counseling, family counseling, rap groups, employment and veterans' benefits counseling, discharge upgrading, and educational, medical, and vocational assistance, these centers fill an important void in meeting the needs of veterans. Because of a Griefwork program conceived and implemented by one of the co-authors in 1981, counselors are exposed to therapeutic techniques similar to those developed by Kubler-Ross (1982). Since many of the Outreach staff are themselves former Vietnam veterans, they, too,
take part in workshops designed to provide them with the knowledge to deal with their own unresolved grief.

The Gusman Program

The need for a program to effectively deal with PTSD has long been recognized. In 1978, Fred Gusman, a Vietnam-era veteran and a trained social worker and psychologist, responded to that need by establishing a residential treatment program at the Veterans Administration Mental Rehabilitation Center located in Menlo Park, California. The program is designed to care for a maximum of 90 patients and a long waiting list for admission exists.

Most patients display serious symptoms ostensively related to their Vietnam experience, and manifest a variety of psychopathological behavior including life-threatening behavior. The Gusman program is specifically designed to help these veterans experience the identity-forming "moratorium" previously denied them. Much of the program involves assisting veterans to sort out their feelings about themselves and to evaluate the meaning of life within a therapeutic environment free from worry of such things as employment and family life. Development of interpersonal ties and a strong sense of community are stressed; sociological characteristics not previously experienced during the time in Vietnam. A personal orientation dominated the Vietnam experience which, in turn, caused each to think primarily in terms of individual rather than group survival. Gusman assists veterans to relate to one another within formal therapy groups, one-to-one encounters and informal group "rap" sessions. Development of close personal ties substitutes for the fact that, unlike veterans of the World Wars and the Korean War, Vietnam veterans returned home individually after their tour of duty and often found themselves in "the world" without having an opportunity to adjust to normal life. The Gusman program retroactively provides a kind of "deprogramming."

Finally, one of the most striking aspects of the program involves the various ways in which the
patients are not only encouraged, but actively "pushed" to uncover deeply-buried and previously unexpressed thoughts and feelings related to their grief. The most moving and dramatic role-playing sessions we witnessed were those in which patients spoke to dead "buddies." Externalizing their deep-rooted grief and guilt, patients were able to resolve some of these feelings.

In the discussion to follow, the authors will focus on one particular aspect of PTSD which has not been given full attention in the literature; specifically, the role of grief and bereavement and the repression of grief which we believe represent significant elements of PTSD.

METHOD AND DISCUSSION

During 1983 the authors conducted a series of interviews with staff counselors and Vietnam veterans (N = 48) who participated in a unique program at California Mental Rehabilitation Center of the Veterans' Administration located in Menlo Park, California. We tape recorded and then transcribed the unstructured interview data, but the wishes of respondents who did not wish to be taped were respected. Whereas the use of questionnaires would yield quantitative data, the distrust Vietnam veterans express toward non-veterans led the authors to adopt an unstructured format. Poems and other statements in which grief-related feelings were expressed by these veterans also comprise part of the data.

The authors also took part in staff and therapy group meetings as participant observers. Because of the sensitive nature of the subject matter, and a general distrustful reaction among Vietnam veterans toward non-veterans, the authors spent considerable time developing trust and rapport with the subjects. The questions posed attempted to elicit the feelings veterans had about war-related experiences especially as they pertain to the deaths of "buddies," and retrospectively, how they felt when the deaths occurred. Various techniques also were utilized as part of our
own effort to deal with the feelings and perceptions of the interviewees without causing them undue stress or depression.

The Gusman program represents one special effort to deal with the many facets of PTSD and requires that the staff be trained in a wide variety of counseling and treatment approaches. The program emphasizes the common bond existing between patients because of shared Vietnam experiences, and employs a wide range of individual and group therapeutic approaches in a communal context. These approaches include encounter groups, psychodrama, Gestalt and behavioral techniques, physical conditioning, remedial and supplementary education, vocational counseling, and participation in a variety of recreational activities. Psychological testing, administered before veterans enter the program, assists in identifying the most effective approach.

Treatment involves three phases. First, acute psychological problems are dealt with by developing a sense of trust and rapport between staff members and veteran patients. During this stage, veterans are encouraged to review painful combat experiences that cause them to experience nightmares, flash-backs, and intrusive, compulsive thoughts. Clients take part in intensive group therapy sessions known as "Nam I" in which they are encouraged to verbally recall and to act out through role-playing the events that led to the deaths of buddies. The following example highlights the method used: One veteran, a former sergeant, was blindfolded and asked to mentally place himself back into a situation in which a young lieutenant died—a death he felt responsible for. Then the veteran was requested to describe in detail how he felt toward the lieutenant. During this process, the patient related that the lieutenant had asked for assistance at a time when he (the sergeant) had just completed several weeks in the field and was looking forward to a much needed period of rest and relaxation. Reluctantly the sergeant went out in the field with the lieutenant and in a perfunctory manner "showed (him) the ropes." On his very first mission the lieutenant was killed. Believing that he was
responsible, the sergeant carried feelings of guilt for fifteen years. This guilt was dealt with through a dramatic process of role-playing in which the sergeant asked the lieutenant's forgiveness. Such emotionally charged scenes represent a common, moving, and impressive aspect of the program.

In the second phase, assisted by "Nam II" groups, such as relaxation therapy, values clarification, anger group, conflicts and resolution, minority group rap sessions, and art therapy, patients review their pre- and post-Vietnam experiences and then attempt to integrate memories of Vietnam with other experiences. The emphasis placed in this phase is on assisting patients to recognize that their war-related experiences constitute a small, albeit important aspect of their lives. Assisted by staff members, the patients also begin to plan reentry into their community.

In the third and final phase veterans begin to actualize their plans to return to jobs, family, and community. "Nam III" groups are formed to discuss ways in which war experiences can be dealt with on a long-term basis. Patients become involved in attempting to re-establish contacts relating to employment, education, and family ties. Phase three of the program also entails a "testing-out" period in which patients leave the program for short periods and then return to discuss their experiences in group settings and with the staff, and to receive social and psychological support. Patients are also encouraged to serve as volunteers in community-based projects through assisting the elderly, the handicapped, and juvenile delinquents.

Another aspect of the overall thrust of the program is worthy of comment. After discharge, patients are encouraged to retain their ties with the program through various types of individual and family counseling activities. They participate in these activities aimed at consolidating and reinforcing the gains obtained, from the program while on in-patient status. Eventually veterans are able to establish their own support network and then withdraw completely from the Gusman program.
The extent to which unresolved grief is a central tenet of PTSD is evidenced in the continued anguish that veterans felt over the loss of buddies. Things that happen to combat soldiers are difficult to imagine for those unfamiliar with war, and for this reason each interviewee emphasized that it is simply impossible for anyone to fully relate to the meaning of the environment. As one veteran put it: "I could tell you the sights and the sounds and how we felt but it doesn't convey half of what it was like."

Another veteran stated that when a buddy went on patrol one afternoon:

I stayed behind. Before he went, he said 'Well, I'll see you on the other side.' I said, 'What do you mean?' He was gone outside of the parameter about five minutes and one round was fired at him. They brought him back and his head was blown to bits. I was down there for about an hour scraping my buddy's brains off the sandbags, trying to put him back together.

The emotional reaction to the horror of war has to be repressed if one's own survival is to be ensured. This is particularly true of medics who assist the wounded and try to comfort the dying. One former medic told us of three different situations experienced during his first month in Vietnam. The first event involved a dying solder who had both arms and legs blown off when a land mine was detonated. The soldier, a Catholic, begged to be given the last rites, but the medic, a Protestant, was only able to recite the Lord's Prayer.

Soon thereafter, the second event occurred. The medic's helicopter was shot down and the entire group was overrun during an enemy attack. Having run out of ammunition, the medic started swinging blindly in the dark with an entrenching tool and, despite sustaining several wounds, survived. When he awoke the next morning, he discovered that along with several enemy
he had also killed two of his wounded comrades with the tool.

The third traumatic event took place when a gravely wounded soldier begged the medic to "put him out of his misery." The medic, believing that it is wrong to take the life of another, finally yielded to the dying man's wish and shot him in the head. At the time, the medic was eighteen years old. Although managing to function well enough to hold a responsible middle-level management job, the former medic was admitted to the Menlo Park program because of fits of uncontrolled rage, one of which nearly resulted in the death of his girlfriend.

Temporary repression, required by the exigencies of psychological and physical survival, is not appropriate for dealing with the horror and grief experienced. As another interviewee put it: "It never leaves. I keep seeing my buddy's blood all over my jacket." The medic described above felt guilty about not being able to offer the last rites to his dying comrade. This sense of guilt was exacerbated by the event in which he accidently killed his own comrades.

In relating similar events, another veteran described why it was necessary to repress grief:

You couldn't be effective and not squelch it. You had to learn to shut down all your emotions. You just shut down. You become numb. And the situation either resolves itself or it doesn't. But either way you can't be hurt. That's what you tell yourself anyway. You know instinctively that you'll flip if you don't do something like that.

CONCLUSION AND IMPLICATIONS

It seems axiomatic that war, in the final analysis, is "about" death. Yet until recently few analysts have accepted the possibility that unresolved
psychological grief may be responsible for the PTSD symptoms manifested by many Vietnam veterans. It seems imperative that these insights as well as information pertaining to the techniques used in the Gusman Program be shared with members of the helping and mental health professions who deal with individual and family crises related to the effects of PTSD.

Provided that members of the helping professions recognize the potential effect of the relationship between grief and the PTSD syndrome, some assistance should be forthcoming. At the very least, veterans and their family members could be encouraged to recognize that a normal human response to death and tragedy did not occur at the appropriate time and that this can still be properly dealt with. In addition to disseminating this information to professionals, such as social workers, clergy, psychiatrists, and law enforcement officials, training should include a basic understanding of the dynamic effects of PTSD enabling them to respond to its victims more effectively.

Although the data required to scientifically confirm the success of the Gusman Program are not yet available, a preliminary in-house evaluation by Berman et al. (1982:922) stated:

In a recent outcome study of a random sample of 40 graduates of the program, the staff were asked to rate whether the program was successful in helping the patients reach three objectives considered the most essential goals of the program: achieving relief from acute psychological distress, resolving a crisis with a spouse or significant other, and securing employment or beginning or continuing school. Based on patient interviews at the time, discharge staff judged that 24 of the graduates, or 60 percent, reached the goals.

The lack of information to fully assess the efficacy of this program stems in part from the overwhelming amount of work for the staff involved at the
nine centers operated by Gusman. Realistically, a thorough program impact assessment would require the assistance of outside evaluators. The subjective information provided by Berman et al. (1982), however, offer some support for the authors' contention that the role of grief in the etiology of PTSD is real, it is substantial, and it requires programs and therapeutic techniques to resolve the problem.

Although the program's effectiveness has not been thoroughly evaluated, Gusman's approach does demonstrate that efforts to treat veterans with PTSD require that staff members either be veterans themselves or have specialized training. It is also noteworthy that victims of PTSD are not merely being treated as being mentally ill or "character-disordered", but receive specialized assistance available from persons able to empathize with these experiences.

Finally, it should not be forgotten that soldiers are, above all, human beings. This humanity should not be denied regardless of how much it has been repressed in the past. Policy-makers who favor military solutions to political problems should recognize that the human consequences of their decisions are inevitably deep-seated and long-lasting, influencing the lives of all participants whose "war within" continues to affect them, their families, and their communities.

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A COMPARATIVE ANALYSIS OF POST-TRAUMATIC STRESS SYNDROME AMONG INDIVIDUALS EXPOSED TO DIFFERENT STRESSOR EVENTS

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ABSTRACT

The purpose of the present study was to compare post-traumatic stress syndrome among persons involved in nine different stressor events: combat in the Vietnam War; rape; serious life-threatening events; divorce; the death of a significant other; critical, near fatal illness of a significant other; family trauma; multiple traumatic events; and no stressful event. To assess the severity of the symptoms which define post-traumatic stress disorder (PTSD), the Impact of Event Scale, the Beck Depression Inventory, the Stress Assessment Scale for PTSD from the Vietnam Era Stress Inventory (Wilson & Krauss, 1980) and the Sensation Seeking Scale were administered to the participants (N=409). A person by situation conceptual model of PTSD was presented from which two major hypotheses were tested. As predicted from the model, the degree of loss of a significant other and life-threat were predictive of syndrome-specific symptoms of PTSD. The results of the study strongly support the heuristic value of an interactionist model of PTSD.
Introduction

The purpose of the present paper is to develop a conceptual framework for analyzing post-traumatic stress disorder (PTSD) in survivor groups and to examine empirically the nature and severity of this stress response syndrome among persons exposed to nine different stressful life events. The need for a comparative analysis of PTSD among different populations of survivors of unusually stressful life-events stems from a number of theoretical and clinical sources. First, PTSD is now recognized as a distinct mental disorder with explicit diagnostic criteria presented in DSM-III of the American Psychiatric Association (1980). Second, despite the new diagnostic category for the stress syndrome, the phenomena of prolonged stress reactions to catastrophically stressful events has been documented for many decades in medical reports and the psychiatric literature (e.g., Lifton, 1983). Third, there is a growing body of empirical research which has begun to identify the antecedent stressor variables that best predict PTSD and its severity in different survivor populations (c.f. Gleser, Green, Winget, 1981; Wilson & Krauss, in press; Figley and Leventman, 1980, Wilson and Zigelbaum, 1983). These studies suggest that it is important to construct valid measures of the syndrome in order to obtain precise predictions of the onset, duration, and severity of stress disorders and levels of impairment. Fourth, although there is a core set of features which characterize PTSD, it is likely that the syndrome may vary among survivors depending on predispositional variables, the nature of the trauma, and the recovery environment to which the survivor returns (Green, Wilson, and Lindy, 1984). Thus, a comparative analysis of PTSD among survivors of different stressor events is heuristically important since it facilitates an understanding of the dynamic mechanisms which underlie PTSD and its idiosyncratic expression in groups or individuals exposed to qualitatively different life-events.

In recent years attempts have been made to develop theoretical models of stress response syndromes and the patterns of adaptation that individuals make to extraordinarily stressful life-events (e.g., Horowitz, 1976, 1979). In this vein, Green, et al. (1984) recently have constructed a conceptual model by which to understand PTSD.
in different survivor groups. Building upon the seminal work of Horowitz (1976, 1979) they propose that it is necessary to consider how dispositional variables (e.g., personality traits, pre-morbid psychopathology, learned ego-defenses, etc.) and situational variables co-determine the specific way in which the trauma is processed cognitively by the survivor. Thus, in order to predict the nature of psychological adaptation to a traumatic event (healthy or pathological) it is necessary to attempt to specify how personological variables interact with situational-stressor variables to produce syndrome-specific symptom clusters. Obviously a full discussion of a person by situation interactional analysis of stress syndromes is well beyond the scope of this paper. However, for the purpose of this study a theoretical perspective of the relationship between personality and stressor variables and the development of post-traumatic stress syndromes is relevant to the hypotheses being tested.

Theoretical Overview and Review of the Literature
The Effects of Stressor Variables on Core Personality Processes

In order to understand the different forms of human adaptation to stressful life-events it is necessary to consider how personality processes moderate the perception, evaluation, and cognitive-processing of the stressor experience. Clearly, not all persons respond to stressor events in a similar manner, a fact which underscores the need to assess how individual difference variables influence post-trauma adaptation. Thus, it is relevant to this inquiry to present an abbreviated conceptual analysis of the possible role that personality variables play in the development of post-traumatic stress syndromes.

Table 1 presents a broad theoretical overview of the effects of stressor variables on core personality processes and the formation of the symptoms that define PTSD. This table is not intended to be a comprehensive analysis of the personological determinants of PTSD. Rather, the goal is to develop a useful way of thinking about the effects of stressor events on some of the core processes of personality functioning. In constructing the table we have selected for discussion those theorists whose work seems most directly applicable to the analysis of PTSD as well as other psychosocial effects of unusually stressful life-events. Thus,
these theories include: (1) epigenetic psychosocial development (Erikson, 1982), (2) psychoformative processes (Lifton, 1983), (3) learned helplessness (Seligman and Garber, 1981), and (4) cognitive processing of trauma (Horowitz, 1979).

**Psychosocial Development: The Application of Eriksonian Theory to PTSD**

In an attempt to construct a broad theoretical basis of psychic trauma in Vietnam veterans, Wilson (1978, 1980) presented a detailed analysis of stress-producing experiences and their effects on psychosocial development from Erikson's (1968) perspective of ego-development. Wilson (1980) suggested that a stressor event could impact on psychosocial development in a variety of ways that could lead to PTSD. First, the stress producing event could intensify or aggravate the predominant stage of ego development. Thus, the effect produced in terms of PTSD might vary greatly as a function of the stage-specific qualities of personality development. For example, a person in the process of identity formation who experiences a life-threatening event might develop acute or chronic identity diffusion (see Koenig, 1964, for an example in Nazi persecution victims). As an outcome, then, such a person may manifest ideological confusion, an inability to make commitments to self and others, bisexual confusion, low self-esteem and a loss of a sense of continuity and self-sameness. In extreme cases, identity diffusion might lead to the formation of PTSD and a borderline or Schizotypal personality disorder if the disturbance in identity is the predominant clinical symptom.

Second, the stress producing event might cause retrogression in ego development by taxing ego-defenses beyond their limits. As a consequence, the survivor may show strong regressive tendencies that are stage specific in nature. For example, a trauma could produce profound mistrust, a loss of hope and will, feelings of abandonment, a heightened sense of vulnerability and the need to be nurtured by a protective person. While it is probable that retrogression occurs to some degree in all cases of PTSD, it is likely to be most pronounced and debilitating when there exists either pre-morbid pathology or a set of specific personal vulnerabilities that resulted from childhood development.
Third, the stress-producing event may cause acceleration in ego development. Wilson (1980) has indicated that although this is an unusual response to a traumatic event, it is nevertheless one which seems to strengthen the survivor by creating more ego-strength through the premature emergence of qualities of awareness centered around the issues of generativity and integrity (Wilson, 1980). In this case the survivor is likely to face the paradoxical task of coping with PTSD while experiencing positive changes in ego-identity, values and beliefs. Based on interview data, Wilson (1980) found that the psychosocially accelerated person becomes more ethical, altruistic, humanitarian and self-actualizing in behavior.

In summary, a traumatic life-event can affect psychosocial development in different ways depending on the predominant stage of ego-development, the level of personality integration and identity formation and the severity of the trauma itself. Thus, in terms of PTSD, Table 1 indicates that the effects of the stressor on psychosocial development can produce mistrust, a sense of isolation, time confusion, guilt, loss of intimacy, identity diffusion, despair, hopelessness, ideological changes, decreased autonomy and a lack of goal-directedness. These symptoms would comprise part of the stress syndrome as an overlay to the process of re-experiencing the original event. Table 1 also indicates which of the diagnostic criteria in DSM-III are met by this theoretical derivation.

**Psychoformative Processes**

In a modification of Erikson (1968), Lifton (1983) has attempted to construct a general psychological theory that moves beyond the limitations of instinct and epigenetic models of personality to one that places emphasis on the self as an active constructor of reality. Briefly, psychoformative theory concerns the ways in which persons conceptualize and symbolize their experiences in life. As an active process, individuals evolve images and forms of their experiences which contribute to a sense of continuity or discontinuity in the self structure. Specifically, Lifton (1976) proposes that the major focus of experience can be conceptualized as the paradigms of connection versus separation; movement versus stasis and integrity versus disintegration. Thus, when
individuals feel centered in their life experiences, they have a symbolic or actual sense of connection (to people, ideas, space, time), movement (growth, aliveness, creativity, etc.) and integrity (psychic wholeness, physical well-being, ego-vitality). However, immersion in the death experience can radically alter an individual's sense of continuity and self-sameness and lead to traumatic survivor syndromes. Thus, exposure to death, dying, destruction and the loss of social order may cause the survivor to experience a loss of continuity in psychoformative processes. In many different ways the individual may struggle with a sense of separation, stasis, isolation, and a "broken connection" (Lifton, 1983) with life as previously experienced. Immersion in the death experience may also lead to a feeling of physical and psychological disintegration—that the self has fragmented into emotional shards that no longer cohere in a meaningful or ordered structure. Thus, in response to these massive changes in psychoformative processes the survivor may become psychically numb during the initial stage of adaptation following the trauma. This blunted emotional responsiveness is often coupled with survivor guilt, the re-occurrence of the death imprint in consciousness, anger, rage, depression (the loss of self, others, and self-control), and the task of reformulating the experience so as to develop a new sense of the self as alive and growing again. As Table I illustrates, psychoformative theory provides a conceptual basis for understanding all aspects of PTSD.

**Learned Helplessness**

Learned helplessness (Seligman and Garber, 1981) occurs when a person is subject to an environment in which there are aversive consequences of an uncontrollable and unpredictable nature. Clearly, learned helplessness is often a core element of PTSD since the survivor of a traumatic event develops cognitions that he/she is a pawn whose destiny is shaped by external forces over which there is little or no control. This external locus of attribution in causality may then produce motivational deficits in the form of a loss of ability to initiate adaptive responses. When this occurs, the survivor typically begins to see the world as a hostile and threatening place which can inflict more pain and suffering in their life. Ultimately, the eventual outcome of learned helplessness is depression, withdrawal from the field,
isolation, and chronic anxiety associated with the fear that the trauma will reoccur (Seligman, 1974). If prolonged, this psychological state of being is very likely to lead to illness of a somatoform nature. Table 1 indicates that these symptoms are associated with numbing and changes in adaptive behavior.

Cognitive Processing of Trauma: Horowitz Information Processing Model

In recent years the seminal research of Horowitz (1976, 1979) has attempted to explain post-traumatic stress syndromes from a cognitive model of information processing. This approach assumes a completion tendency in which "the mind continues to process important new information until the situation or the models change, and reality and models reach accord (1979, p. 249)." Thus, until a traumatic life-event can be successfully integrated into the existing self structure, the psychological elements of the event remain in memory and therefore as determinants of intrusive imagery or other stress response symptoms. Further, Horowitz (1979) has found that survivors typically progress through a well-defined sequence of stages when assimilating the trauma: outcry, avoidance, intrusive imagery and re-experience of the event, transition, and integration. However, depending upon the severity of the trauma and the personality of the victim, the survivor may experience a cyclical alternation between the avoidance and intrusion stages. In the process, survivors report feelings of depression, anger, episodic rage, and unconscious re-enactment of the event. Thus, Horowitz (1979) has developed a general model of post-traumatic stress disorder as it affects survivors of different stressor events.

For purposes of a summary, Table 1 illustrates the proposed relationship between stressful life-events and the dimensions of personality most likely to be affected by the trauma as derived from the four theoretical positions discussed above. The table also indicates the hypothesized dimensions of PTSD related to core personality processes and to which of the diagnostic criteria in DSM-III they conform.
The Relation of Stressor Variables to PTSD

A person by situation model of PTSD assumes that there is a predictable relation between personality and situational variables in determining the syndrome-specific dynamics of post-trauma adaptation. Conceptually, then, three major effects may be discerned regarding post-traumatic adaptation. First, dispositional or pre-morbid variables may account for significant degrees of variance in the determination of post-trauma adaptation. For example, individuals with a pre-morbid personality disorder might manifest more psychopathology after a stressful life-event than matched control subjects with no pre-morbidity. Second, the observed pattern of post-trauma adaptation may be explained by the interaction effect of personological and situational variables. (Aronoff and Wilson, 1984). For example, persons with a strong sense of morality and ethics might develop strong survivor guilt as a result of involvement in a situation where they fail to act prosocially to help save the life of a victim in a flood. Third, the nature of the stressor event itself may constitute the major determinant of the observed pattern of adaptation to the trauma. For example, Lifton (1967) reports that obsessional fears of "atomic-disease poisoning" were universal symptoms among the survivors of the atomic bomb at Hiroshima.

Dimensions of Stressor Variables

All traumas are not alike nor are they assimilated identically by individual victims or survivors. However, a person-by-situation model of post-traumatic stress syndrome necessitates that the stressor dimensions which impact on the person be specified as precisely as possible. Thus, if relatively well-defined stressor variables can be identified, then it becomes possible to examine their effects across different traumatic events. In recent years, Gleser, Green and Winget (1981) and Wilson, Smith and Johnson (1984) have made extensive discussions of different stressor variables which include: (1) degree of life-threat; (2) degree of bereavement; (3) speed of onset; (4) duration
of trauma; (5) degree of displacement in home community; (6) potential for reoccurrence; (7) degree of exposure to death, dying and destruction; (8) degree of moral conflict inherent in situation; (9) role of person in trauma; and (10) proportion of community affected by trauma. Clearly, of course, many stressful life-events contain one or more of these stressor dimensions. Thus, the task of assimilating the trauma and the onset of post-traumatic symptoms clusters probably varies as a function of the interaction of dispositional and situational-stressor variables.

A Study of Survivor Groups

We have presented a conceptual framework of PTSD which explicates some of the ways that stressor events affect personality and the development of stress response syndromes. The purpose of this paper is to undertake a pilot study which presents a comparative, empirical analysis of the nature and severity of PTSD among individuals who have been involved in different stressful life-events. As such, this research specifically compares stress response symptoms among the survivor groups which include: (1) Vietnam combat veterans, (2) victims of rape, battering, and child abuse, (3) victims of serious life-threats which include auto accidents, armed robbery, natural disasters, (4) persons divorced, (5) serious, near-fatal illness of a loved one, (6) family trauma, including the effects of alcoholism, mental illness, family break-up, (7) the death of a significant other, (8) victims of multiple traumas, and (9) a control group made up of persons who did not report experiencing stressful life-events (see Method section). An additional purpose of this study was to explore the effects of threat and loss of significant others, different stressor variables, or the specific manifestation of the symptoms clusters which define PTSD.

METHOD

Subjects

The combat veterans (N=74) were volunteers who belonged to the Northern Ohio Veterans Association. All subjects had verified combat experience and ranged in age from 31 to 41 with a mean of 35 years. For purposes of statistical comparison, their scores on the assessment
instruments were compared with those of a national sample obtained by Wilson and Krauss (in press) of combat veterans participating in the VA's readjustment counseling program. Statistical analyses indicated that the scores for combat subjects in this study did not differ significantly from those obtained in the national sample and thus appear representative of the larger population of Vietnam combat veterans.

The non-veteran subjects (N=335) who completed the assessment instruments were drawn from several sources. Approximately 85% were undergraduate students who were attending an urban, state-supported university. These subjects ranged in age from 18 to 50 years with a mean of 21 years. The other subjects were volunteers who worked at centers of abortion, wife-battering, or in other health care agencies located in Cleveland, Ohio. They range in age from 21 to 33 years with a mean of 22. In all, 409 subjects (185 females, 214 males) successfully completed the questionnaire. Data on gender was missing for 10 non-veteran subjects.

**Assessment Questionnaires**

To assess the symptoms of PTSD and other dimensions of personality, the following questionnaires were given to the subjects: The Impact of Events Scale (IES) by Horowitz, Wilner, and Alvarez (1979), the Beck Depression Inventory by Beck (1961), the Stress Assessment Questionnaire for PTSD from the Vietnam Era Stress Inventory (VESI) by Wilson and Krauss (1980), and the Sensation Seeking Scale (SSS) by Zuckerman (1979).

**Identification of Stressor Groups**

In an adaptation of the IES (Horowitz et al., 1979), each of the subjects was asked to write down the date and nature of any unusually stressful events that had occurred in their lives.

All events were independently coded by two judges who subsequently agreed on a nine-category system of classification with the following operational definitions: (1) **Vietnam Combat Veteran** (N=74). All veterans had validated
combat experience. (2) **No Event** (N=93). Included here were control group subjects who indicated that they had not experienced any unusually stressful life events. (3) **Death of Significant Other** (N=96). This category included subjects who had experienced the death of family members or friends, abortion or miscarriage, or the suicide of a friend or significant other. (4) **Rape/Battering** (N=9). The subjects were all women who had experienced rape, battering, or severe physical or sexual abuse as children. (5) **Divorce** (N=13). This category was defined as the termination of a marriage or a long-term, primary love relationship. (6) **Critical Illness** (N=19). The events defining this category include the threatened loss of family members or friends due to serious or critical illness, accidents, or attempted suicide. (7) **Life-threat** (N=62). Events include serious auto accidents, robbery at gunpoint, naturalistic disasters, fires, explosions, near drowning, and serious medical problems. (8) **Family Trauma** (N=16). This category includes family alcoholism, divorce, mental illness, and serious legal problems. (9) **Multiple Stressor Events** (N=27). This category includes persons who had experienced more than one of the stressor events listed above. A total of 58 different stressor events were listed by these subjects and include: 20 deaths, 10 rapes, 10 batterings, 6 divorces, 7 serious illnesses of significant others, 10 serious life-threats, and 5 family traumas.

**Results**

Two major analyses were performed on the data. First, the mean scores on each of the scales assessing PTSD were compared for each of the stressor categories. Although this analysis does not control for the time-from-event effect, it does provide a general indication of the overall severity of PTSD-related symptoms that are heuristically valuable in terms of the person-by-situation theoretical model presented in this paper. Second, two stressor variables thought to be importantly associated with the onset of PTSD, i.e., degree of life-threat or loss of significant other, will be examined.

**Threat.** An a priori basis was used to group together into a conceptual variable subjects who had experienced a life-threatening, stressful event. Members of
stressor categories which, by definition, involved a life-threatening event comprised the conceptual variable Threat. Members of the rape, life-threat and combat categories define this variable. In contrast, the No Threat group contained the other stressor categories except for the No Event category. This procedure resulted in three new stress categories whose scores on the dimension of PTSD could be compared.

Loss. Similarly, the effects of loss of a significant other comprised the second conceptual variable and included members of the combat veteran, divorce and death categories. The No Loss stressor cohort included the other stressor categories except for the No Event category.

In order to avoid violating the assumptions of parametric statistics, individuals who had experienced multiple stressful life-events were excluded from the Loss and Threat statistical analyses.

Comparison of PTSD Dimensions Across the Stressor Categories

Table 2 shows the mean scores on the VESI, SSS, BDI, and the IES for the different stressor categories. Inspection of the table indicates that the scores for Vietnam Combat Veterans are two to three times higher than the other stressor groups for nearly all of the dimensions of PTSD.

Multi-variate analyses of variance (MANOVAs) were performed to control for alpha levels resulting from a large number of statistical tests. As suggested by Spector (1977), significant MANOVAs were followed up by separate univariate ANOVAs for each variable in the set. As Table 3 indicates, tests of simple effects (Winer, 1971) showed that the stressor categories were significantly different from each other on all of the scales with the exception of the SSS Disinhibition scale ($F > 20.60, p < .05$). To test for differences in the mean scores on the PTSD dimension across
stressor categories, the Newman-Keuls procedure of ranked means comparison was used for unequal sample sizes (Winer, 1971). Table 3 indicates a summary of the significant differences found in the mean scores of the different stressor categories. By examining the mean scores shown in Table 2, it can be seen that Vietnam combat veterans have significantly higher scores on nearly all of the dimensions of PTSD being assessed with the different scales. The Newman-Keuls analysis indicated that the combat veteran scores on the VESI scales and the BDI are significantly higher than those of all other stressor categories.

The combat veterans and individuals who had experienced multiple trauma yielded significantly higher scores on the SSS experience-seeking subscale than those in the No Event category. In addition, the Combat Veterans, Rape, Divorce, Death, and Multiple Trauma categories showed significantly higher mean scores than the Life-Threat cohort. Scores for the combat veterans also were significantly higher than those of the Death, Serious Illness, Family Trauma, and Multiple Trauma on the Intrusion subscale. On the Avoidance subscale, Family Trauma scores were also significantly higher than Life-Threat scores and on the IES total subscale, both Family Trauma and Serious Illness scores were higher than those of Life-Threat.

Comparison of Stressor Categories Involving a Loss of a Significant Other versus No Loss or No Event.

Table 4 shows the mean scores on the dimensions of PTSD for the stressor categories involving a loss of significant others versus those with no loss or no stressor event. Inspection of the table indicates a clear linear trend in the mean scores: those stressor categories involving the loss of a significant other person have higher scores on the PTSD scales than the No Loss stressor category which, in turn, have higher scores than the No Event group.
Table 5 indicates the results of the one-way ANOVA for the stressor groups experiencing different levels of loss. Tests of simple effects revealed that the three stressor categories were significantly different on all of the assessment scales except for the disinhibition and boredom susceptibility subscales of the SSS, $F_s > 3.74, p < .05$). The results of the Newman-Keuls mean comparison test produced a large number of significant differences ($p < .05$) between the Loss groups which are summarized in Table 6. First, the stressor category experiencing a Loss of a loved one is significantly different from the No Event group on every scale except the SSS subscales disinhibition and boredom susceptibility. Second, the Loss group is significantly different from the No Loss category on all the variable except the VESI rage scale and the SSS subscale adventure seeking and experience seeking. Additionally, the No Loss stressor category manifests more PTSD than the No Event group as assessed by the IES scales and the SSS adventure seeking scale. Thus, in comparing the three stressor categories, the results indicate, as expected, that the greater the degree of loss of a significant other, the more severe are the syndrome-specific symptoms of PTSD.

Insert Table 5 about here

Table 6 shows that the results of the ANOVA for the stressor categories exposed to different degrees of Threat. As expected, the high Threat stressor category shows higher mean PTSD scores than the No Threat category which has, in turn, higher scores than the No Event category.

Insert Table 6 about here

Table 7 indicates the results of the ANOVA simple effects and Newman-Keuls tests. As predicted, the ANOVA reveals significant differences between the stressor categories $F_s > 4.06, p < .05$. Further, the Newman-Keuls comparison shows that the Threat category is significantly different from the No Threat and No Event categories on all
of the VESI dimensions of PTSD. In addition, the Threat category differs significantly from the No Event category on the SSS experience seeking subscale, the BDI, and the IES. It is also significantly different from No Threat on the SSS experience seeking and boredom susceptibility subscales as well as the BDI. Finally, on the SSS adventure seeking and experience seeking subscales, the BDI, and the IES scales, the No Threat category showed significant differences from the No Event category.

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Insert Table 7 about here

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Discussion

The results of this preliminary study comparing stress response syndromes in different survivor groups contains within it a number of strengths and limitations. As an exploratory study, the present research is limited in its external validity due to the lack of a random sample, time-since-event effect, and the disparate ages of the subjects in the comparison groups. Despite these methodological problems the overall configuration of the research findings lends support to the person-by-situation conceptual framework presented in this paper as summarized in Table 1. In particular, the effects of two stressor variables, Threat and Loss, on the severity of the symptoms which define PTSD were examined. Overall, the results of the analyses provided strong support for the hypothesis that these variables are linked to the mechanisms which influence post-traumatic adaptive behavior. Individuals who had experienced more life-threat or loss in stressful situations consistently scored higher on the symptom clusters which define PTSD.

First, it is reasonable to expect that the greater the degree of loss or life-threat, the more difficult will be the survivor's task of assimilating elements of the stressful life-event into the self-structure. In this study, Vietnam combat veterans constitute a group of survivors who were exposed to high levels of life-threat and the loss of significant others (e.g., Figley, 1978; Wilson, 1980). Thus, in comparison to the other stressor categories, Vietnam veterans did manifest more severe PTSD as indicated by the
scores on the assessment scales. Taken as a set, the men in this sample appear depressed, troubled by intrusive imagery, stigmatized, lack stable intimate relationships, and are prone to physical symptoms. Furthermore, their scores on the VESI, BDI and IES depression and intrusion scales are remarkably higher than those for the other stressor categories. Since combat in Vietnam nearly always involved the combatant in guerrilla warfare which exposed the soldier to death, dying, destruction, and frequent life-threat, these results may indicate that today these men suffer from impacted grief (Shatan, 1974), feelings of loss of self and former comrades, despair, and a sense of being trapped in the trauma without a tangible sense of a productive future filled with hope and meaning. By way of comparison none of the other stressor categories manifest the severity of depression or total PTSD as did the Vietnam combat veterans. Interestingly, however, the small sample of rape victims exhibit the next highest level of PTSD symptoms across the different scales despite the lack of statistical significance. Indeed, their level of PTSD, as assessed by the IES, is equal to that of the combat veterans despite lower scores on the other scales. Thus, looking at the mean scores across the stressor categories there is enough evidence to suggest that the severity of PTSD, is, in part, a function of the severity of threat and loss.

The results summarized in Table 3 bolster the hypothesis that loss of a loved one and threat are among the central stressor variables associated with post-trauma problems of adaptation. Indeed, victims of rape, multiple trauma, the death of a loved one, family trauma, and divorce show significantly more total PTSD as assessed by the IES scale than do persons who report no event or a life-threatening event. Clearly, the interpretation of these data illustrates the need to specify how the nature and complexity of the stressor event impacts on the unique personality of the survivor. In general, however, these results might be construed as suggesting that the more severe and complex the stressful life-event, the greater the number of stressor variables, the more likely it is that the victim-survivor will develop symptoms of PTSD.

The results of the analysis for the effects of a loss of a significant other through death or the termination of
a love relationship provide further support to the argument made above. As Tables 4 and 5 summarize, those individuals experiencing the loss of a loved one show more severe symptoms of PTSD, as indicated by the mean scale scores on all variables except the SSS subscales disinhibition and boredom susceptibility than do the No Loss or No Event stressor categories. Even more impressive is the finding that the No Loss Category, which contains persons exposed to trauma, does show more PTSD on the IES scales than the No Event stressor category. Clearly, if the relationship between stressful life-experiences to PTSD were essentially random, one would not expect to find the obtained pattern of results. Further, since depression following trauma is thought to be associated with the loss of an object of love, affection and value (Freud, 1957; Jacobson, 1974) the hypothesis that the stressor categories with greater degrees of loss would have significantly higher PTSD as indicated by the mean scores on the VESI, BDI and IES depression scales gains support. As Table 4 shows, this is indeed the case in as much as the Loss category is significantly different from the No Event and No Loss categories on all three measures of depression or tendencies towards denial and avoidance of thoughts connected to the trauma. This same pattern of results tends to hold across the comparisons of the other stressor categories. Moreover, as Table 4 indicates, the VESI and IES scales indicate that there is a linear relationship between the degree of loss and total PTSD.

The results of the analysis for the effects of threat on adaptive functioning support the significance of this conceptual variable in the development of PTSD. Once again the data summarized in Tables 6 and 7 suggest that the greater the degree of threat, the more severe is the PTSD. In particular, the tables show that the Threat category has particularly high mean scores on depression, stigmatization, and intrusive imagery ($r^2 = .19$ to $.32$). Thus, the impact of a life-threatening event seems likely to be associated with re-occurring images and thoughts of the trauma, feelings of helplessness and depression, and a tendency to be self-conscious as a stigmatized victim. Thus, whether one is a victim of rape, a combat veteran, or involved in a naturalistic disaster, the survivor may feel acutely aware of a change in personal identity, social status, or sense of continuity and centeredness (Lifton, 1976). This severe stigmatization may
also be an expression of the survivor's feeling that they did not "ask for what happened" yet realize implicitly the "just world" phenomena (Lerner, 1974) that those who suffer "bad fate" somehow deserve it. If this is so, then the victim of a life-threatening event may be caught in a no-win cycle of events. To talk about the powerful and overwhelming trauma means the risk of further stigmatization; the failure to discuss the traumatic episode increases the need for defensive avoidance and thus the increased probability of depression alternating with cycles of intrusive imagery and other symptoms of PTSD (Horowitz, 1979).

In conclusion, the present study has suggested that a comparative analysis of PTSD among different stressor categories yields important information on the types of events that produce syndrome-specific symptom clusters. Further, the results of this study strongly suggest that the attempt to understand and predict PTSD from a person by situation interactionist model of behavior has heuristic value. Consistent with others (e.g., Green et al., 1984), we believe that such an approach offers promise: to move beyond the traditional assumptions that suggest that PTSD is either caused by pre-morbid character pathology or simply a reactive process to catastrophic stress. It is undoubtedly the case that some persons are more vulnerable to stress than others and that some stressors will produce stress syndromes in everyone (e.g., Hiroshima). The scientific explanation of PTSD, however, will ultimately necessitate complex theoretical predictions of how persons, situations, and stressor events jointly produce the adaptive syndromes which define post-traumatic personality processes.
Reference Note

More specifically, the question said: Many people experience unusually stressful events from time to time in their lives. This includes such things as car accidents, rape, death of a close family member, assault, floods, tornadoes, fires, airplane accidents, near drowning, witnessing a life-threatening event, military combat, incarceration, child abuse (sexual or physical), wife-beating, sexual assault, robbery, or being with someone who is critically ill, etc.) If you have had an experience similar to the ones described above, please indicate the approximate date/year _____ that you experienced _________ (stressful life-event).

Below is a list of comments made by people after stressful life events. Please read each item and indicate how frequently these comments were true for your DURING THE PAST SEVEN (7) DAYS by marking the appropriate letter on the computer answer sheet. If they did not occur during that time, please mark the "Not at all" answer.
REFERENCES


### Table 1

The Effect of Stressor Events on Core Personality Processes: Personological Variables in PTSD

<table>
<thead>
<tr>
<th>Core Personality Processes: Dimension and Theorist</th>
<th>Dimension of Personality Affected by Stressor Event</th>
</tr>
</thead>
</table>
| Stages of Psychosocial Development (Erik Erikson, 1982) | 1. Stage-specific impact on psychosocial development  
2. Age-related influences on emergent ego-strengths and integrative capacities |
2. Motivational: Loss of response initiative; loss of goal-directed behavior |
| Cognitive Processing of Trauma (M. Horowitz, 1979) | 1. Entire self-structure: cognitive process of assimilating trauma into self |

Source: John Wilson
<table>
<thead>
<tr>
<th>PTSD Symptom Related to Personality Process</th>
<th>DSM-III Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mistrust, isolation, time confusion, identity diffusion, loss of intimacy, decreased autonomy, loss of industry, death anxiety, despair, loss of meaning, ideological changes.</td>
<td>Numbing and changes in adaptive behavior</td>
</tr>
<tr>
<td>Psychic numbing, survivor guilt, rage, depression, loss of continuity in self-structure, symbolic death, search for meaning, denial, loss of intimacy, death guilt, survivor guilt.</td>
<td>Re-experience, numbing, changes in adaptive behavior</td>
</tr>
<tr>
<td>Depression, helplessness, intense anxiety somatic processes, withdrawal, isolation, despair, negative view of world, fear of repetition.</td>
<td>Re-experience, numbing, changes in adaptive behavior</td>
</tr>
<tr>
<td>Avoidance, denial, dissociation, anxiety, nightmares, intrusive imagery, cognitive constriction, somatic complaints, fear of repetition, rage at source, etc.</td>
<td>Re-experience, numbing, changes in adaptive behavior</td>
</tr>
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</table>
Table 2
Mean scores on PTSD dimensions classified by Stressful Life Event

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<thead>
<tr>
<th>STRESSOR CATEGORY</th>
<th>VIETNAM COMBAT VETERANS</th>
<th>National Sample</th>
<th>Northeast Ohio</th>
<th>No Event</th>
<th>Death</th>
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<td></td>
<td>N-114</td>
<td>N-74</td>
<td>N-93</td>
<td>N-96</td>
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<td>PTSD DIMENSION</td>
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<td>VESI</td>
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<td>Depression</td>
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<td>Physical Symptoms</td>
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<td>Rage/Anger</td>
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<td>Intrusive Imagery</td>
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<td>Intimacy Conflict</td>
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<td>Total</td>
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<td>35.38</td>
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NOTE: Mutually exclusive group membership. No subject who experienced multiple events has been included in any primary stressor category.
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<th>$\eta^2$</th>
<th>Newman-Keuls Mean Comparisons</th>
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<tr>
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<td>49.09****</td>
<td>.44</td>
<td>Combat veterans</td>
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<td>Physical symptoms</td>
<td>24.75****</td>
<td>.28</td>
<td>Combat veterans</td>
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<td>287.76****</td>
<td>.82</td>
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<tr>
<td>Rage/Anger</td>
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<td>.23</td>
<td>Combat veterans</td>
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<td>Intrusive Imagery</td>
<td>145.94****</td>
<td>.70</td>
<td>Combat veterans</td>
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<td>Intimacy Conflict</td>
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<tr>
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<td>.03</td>
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<td>.06</td>
<td>Combat veterans/multiple trauma No Event*</td>
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<tr>
<td>Disinhibition</td>
<td>.74</td>
<td>.01</td>
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<tr>
<td>Boredom Susceptibility</td>
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<td>.03</td>
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<tr>
<td>Beck Depression Inventory</td>
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<tr>
<td>Depression</td>
<td>31.88****</td>
<td>.33</td>
<td>Combat veterans/multiple trauma All stressor categories**</td>
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</table>

* Significant at the .05 level.
** Significant at the .01 level.
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<thead>
<tr>
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<th>Intrusion</th>
<th>27.40****</th>
<th>.30</th>
<th>Combat veterans</th>
<th>No Event**, Death**, Life-Threat**, Serious Illness**, Family Trauma**, Multiple Trauma**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rape, Divorce, Multiple Trauma, Death</td>
<td>No Event**, Life-Threat**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Family Trauma, serious Illness, Life-Threat</td>
<td>No Event**</td>
</tr>
<tr>
<td>Avoidance</td>
<td>20.60****</td>
<td>.24</td>
<td></td>
<td>Rape, Combat Veterans, Divorce, Multiple Trauma</td>
<td>No Event**, Life-Threat**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Family Trauma, Death</td>
<td>No Event**, Life-Threat**</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Serious Illness, Life-Threat</td>
<td>No Event**</td>
</tr>
<tr>
<td>Total</td>
<td>36.51****</td>
<td>42</td>
<td></td>
<td>Rape, Combat veterans, Divorce, Multiple Trauma, Death</td>
<td>Life-Threat**, No Event**</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Family Trauma, Serious Illness</td>
<td>No Event**, Life-Threat**</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Life-Threat</td>
<td>No Event**</td>
</tr>
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</table>

Note: N = 409; df = 8.400

+ p < .10; * p < .05; ** p < .01; *** p < .0005; **** p < .0001
Table 4
Mean scores on PTSD dimensions for stressor categories involving a loss of significant other versus those with no loss or no event

<table>
<thead>
<tr>
<th>Loss (Combat, Divorce, Death)</th>
<th>n = 183</th>
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</thead>
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<td><strong>PTSD</strong></td>
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</tr>
<tr>
<td><strong>DIMENSION</strong></td>
<td></td>
</tr>
<tr>
<td>VESI</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>78.83</td>
</tr>
<tr>
<td>Physical Symptoms</td>
<td>47.73</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>20.17</td>
</tr>
<tr>
<td>Rage/Anger</td>
<td>14.12</td>
</tr>
<tr>
<td>Intrusive Imagery</td>
<td>15.88</td>
</tr>
<tr>
<td>Intimacy Conflict</td>
<td>11.43</td>
</tr>
<tr>
<td>Total PTSD</td>
<td>203.38</td>
</tr>
<tr>
<td><strong>SENSATION SEEKING</strong></td>
<td></td>
</tr>
<tr>
<td>Adventure Seeking</td>
<td>7.01</td>
</tr>
<tr>
<td>Experience Seeking</td>
<td>4.94</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>4.79</td>
</tr>
<tr>
<td>Boredom Susceptibility</td>
<td>3.01</td>
</tr>
<tr>
<td><strong>BECK DEPRESSION INVENTORY</strong></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>14.24</td>
</tr>
<tr>
<td><strong>IMPACT OF EVENTS SCALE IES</strong></td>
<td></td>
</tr>
<tr>
<td>Intrusion</td>
<td>17.62</td>
</tr>
<tr>
<td>Avoidance</td>
<td>18.55</td>
</tr>
<tr>
<td>Total</td>
<td>36.17</td>
</tr>
<tr>
<td>No Loss</td>
<td>No Event</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>(Rape, Threat,</td>
<td></td>
</tr>
<tr>
<td>Illness, Family</td>
<td></td>
</tr>
<tr>
<td>Trauma)</td>
<td></td>
</tr>
<tr>
<td>n = 106</td>
<td>n = 93</td>
</tr>
<tr>
<td>57.09</td>
<td>51.54</td>
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<td>13.37</td>
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<tr>
<td>14.69</td>
<td>9.12</td>
</tr>
<tr>
<td>28.06</td>
<td>17.11</td>
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</table>

Note: Subjects who experienced multiple trauma have been excluded.
Table 5
Summary of significant differences between stressor categories involving a loss of significant other versus those involving No Loss or No Event
Analysis of Variance of Simple Effects and Newman-Keuls Multiple Mean Comparison Test

<table>
<thead>
<tr>
<th>PTSD Dimension</th>
<th>F-value</th>
<th>( \eta^2 )</th>
<th>Loss vs. No Event</th>
<th>Loss vs. No Loss</th>
<th>No Loss vs. No Event</th>
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<tr>
<td>VESI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>39.52***</td>
<td>.17 **</td>
<td>**</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Physical Symptoms</td>
<td>24.32***</td>
<td>.11 **</td>
<td>**</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Stigmatization</td>
<td>55.99***</td>
<td>.23 **</td>
<td>**</td>
<td>**</td>
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<td>.12 **</td>
<td>**</td>
<td>**</td>
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<tr>
<td>Rage/Anger</td>
<td>18.76***</td>
<td>.09 **</td>
<td>**</td>
<td>**</td>
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</tr>
<tr>
<td>Intrusive Imagery</td>
<td>48.69***</td>
<td>.20 **</td>
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</tr>
<tr>
<td>Intimacy Conflict</td>
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<td>.18 **</td>
<td>**</td>
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<td>.02 *</td>
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<td>Experience Seeking</td>
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<td>.02 **</td>
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<td>Disinhibition</td>
<td>NS</td>
<td></td>
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<td>NS</td>
<td></td>
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<tr>
<td>Boredom Susceptibility</td>
<td>NS</td>
<td></td>
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<td>NS</td>
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<td>14 **</td>
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<td>Total</td>
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Note: df = 2,379

* = p < .05; ** = p < .01; *** = p < .005; **** = p < .0001
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<td>n = 144</td>
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<td>82.03</td>
<td>59.60</td>
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<td>Physical Symptoms</td>
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<td>23.75</td>
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<td>15.56</td>
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<td>32.51</td>
<td>17.11</td>
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Note: Individuals who have experienced multiple stressful life events have been excluded.
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<td>0.99</td>
<td>0.99</td>
<td>0.99</td>
</tr>
</tbody>
</table>

Note: df = 2, 22
OCCUPATIONAL STRESS AND DEPRESSION AMONG VIETNAM VETERANS*

Christian Ritter, Ph.D.
Department of Mental Hygiene
The Johns Hopkins University
Baltimore, Maryland 21210

ABSTRACT

An exploratory analysis was conducted to assess the effect of exposure to a distal source of extreme trauma on current levels of depression. The purpose of this study was to assess the nature of the relationships among: (1) exposure to the extreme stressor of combat in Vietnam; (2) persistently difficult life conditions; and (3) psychological distress. The impact of various stressors on current psychological distress is evaluated in light of the mediating influence of personal coping resources. Findings suggest that exposure to combat has neither a direct nor an indirect effect on current levels of depression. Exposure to combat was found to affect depression only as it interacts with work-related sources of chronic strain.

INTRODUCTION AND PURPOSE

Almost a decade has passed since United States armed forces withdrew from Vietnam, yet debate continues about the long-term impact of the war on the lives of the survivors. Relatively few battlefield psychiatric casualties were produced by the Vietnam War. However, once the war had ended, mental health

* An earlier version of this paper was presented at the annual meeting of the Midwest Sociological Society in Chicago, April 20, 1984. The research was supported in part by the National Institutes on Drug Abuse, Grant DA-2046, Richard R. Clayton and Harwin L. Voss, Co-principle investigators.
professionals began to report high rates of psychiatric symptoms among Vietnam veterans. This problem was also acknowledged by the government, as noted in a 1975 Veterans Administration internal memorandum indicating that: "... serious and prolonged readjustment difficulties seem to exist in one out of five Vietnam Veterans and to a lesser degree are experienced by all." (Boulanger et al., 1981)

Labeled Post-Traumatic Stress Disorder (PTSD) in 1980 by the American Psychiatric Association, service in Vietnam became legitimized as a distal but powerful causal factor in producing a set of symptoms that includes: feeling jumpy and irritable; having nightmares and flashbacks; apathy; anxiety; depression; insomnia; fear of losing control; and experiencing general dysphoria. A variety of related behavioral problems found to be associated with exposure to combat in Vietnam include confusion, anxiety, frustration, helplessness and social isolation (Worthington, 1978); drug dependence (Robins et al., 1974); substance abuse and (Nace et al., 1978); and manifest anxiety (Enzie et al., 1973).

Since the war, there have been a number of research reports that address the psychological and social adjustment process of Vietnam veterans to reintegrate back into society (Boulanger, 1981). In a review of the literature on the long-term psychological consequences of combat exposure, Boulanger et al., (1981) indicate that many of these studies identify the amount and intensity of exposure to combat as potential causes of psychological distress (i.e., Helzer et al., 1978; Glass and Appel, 1969; De Fazio and Rustin, 1975; Strayer and Ellenhorn, 1975; Figley and Southerley, 1980). Boulanger further notes that the more precisely combat experience is measured, the more the long-term psychological consequences become apparent.

In a number of other studies, no "significant" effects of combat exposure were found. However, Boulanger et al. (1981) argue that these results can be discounted for two reasons: (1) because they failed to precisely measure combat exposure or (2)
biased samples were used (i.e., Borus, 1974; Buchbinder et al., 1979; Panzarella et al., 1978). Neither Buchbinder et al. nor Panzarella et al., distinguishes between combat and non-combat Vietnam veterans, however, although both reports suggest that military service in Vietnam was itself sufficient to produce stress reactions.

These findings are subject to further criticism because in failing to control for combat exposure the analysts fail to provide support for the existence of a post-Vietnam stress syndrome associated with combat experience. Boulanger et al. (1981) also criticize the research of Nace et al., (1978) for only using an "approximate" measure of combat exposure thereby raising a question about the validity of the major finding: that the only psychological adjustment difference found to exist between combat and non-combat veterans of the Vietnam War was an increased incidence of depression.

In addition to "psychosocial" responses to combat exposure, there is some evidence to suggest that military service in Vietnam had an effect on the educational and work careers of the veterans. These "social" consequences were the primary focus of a work entitled Legacies of Vietnam (U.S. Congress, 1981). The data show that veterans of the Vietnam era have attained less education and hold lower level jobs than do non-veterans. These differences appear to be even more marked among veterans who served in Vietnam since a large number of them have experienced serious work-related problems and have higher levels of unemployment. It is further reported that many of the occupational differentials observed between veterans and non-veterans are due to the greater likelihood of non-veterans having graduated from college.

It is also reported in Legacies of Vietnam that occupational and educational disadvantages of veterans as compared to non-veterans are largely due to background characteristics. The most important of these pre-military characteristics is the level of education attained prior to entry into the military. Moreover, the most disadvantaged group appears to be veterans
who were exposed to combat. In sum, these findings suggest that the effects of military service in Vietnam and exposure to combat on occupational attainment result primarily through its negative impact on post-service educational attainment.

Kadushin et al. (1981) do not specifically consider the potential moderating effect of occupational and educational attainment on the relationship between long-term stress reactions and combat exposure. While some evidence is provided that status as a Vietnam veteran has a deleterious effect on such attainment and that exposure to combat increases the likelihood of post-traumatic stress symptoms, they fail to present their findings in a convincing integrative fashion. This is typical of research that attempts to assess the effect of exposure to traumatic situations. No attempt is made to sort out the potential statistical interactions, and no attempt is made to theoretically integrate the process by which stressful events impact on the subsequent life-course of the survivors. For example, Kadushin et al. (1981) indicate that psychological stress reactions were more intense and more likely to persist among men whose social position makes them least able to cope (i.e., minority members, the unemployed, the poor, and members of unstable families). In reporting these findings, however, the analysts fail to conceptually account for or empirically disentangle the effects of exposure to combat.

In order to understand the relationship between the extreme stress of combat and subsequent levels of psychological distress, it is necessary to extend conceptually and analytically previous lines of inquiry. To understand the manner in which exposure to combat affects the psychological well-being of survivors, it is essential to consider the relationship in terms of predispositional characteristics as well as taking into consideration the potential consequences of exposure to combat. It is also essential that the relationship between combat exposure and subsequent psychological and social adjustment be examined within the more general context of the effects of stressors on distress.
The purpose of this paper is to examine the consequences of Vietnam military service within the integrative framework suggested by Pearlin. This framework allows for consideration of the nature of the relationships among: (1) exposure to the extreme stressor of combat in Vietnam; (2) persistently difficult life conditions; and (3) psychological distress. The impact of various stressors will be assessed in light of the mediating influence of individual coping resources.

CONCEPTUAL FRAMEWORK

Pearlin et al. (1981) indicate that stress can result from either discrete events or the presence of continuous problems. The analysts also note that adverse consequences are primarily dependent on the "quality" of stressful life events as determined by their desirability (Gersten et al., 1977; Mueller 1979; Vinakur and Seltzer, 1975), the degree of control people have over their occurrence, and whether or not these life events are "scheduled" life-cycle transitions.

Another important factor is the recognition that stressful events do not always have a direct effect on individuals, but may also operate through a wider context of "chronic" stressors. Arguing that stressful experiences and chronic stressors converge in the production of psychological distress, Pearlin and Liberman (1979) empirically demonstrated that life events may create new stressors or intensify pre-existing stressors thereby producing a stress-related response. Occupational strain and job dissatisfaction, for example, have been shown to have a deleterious impact on mental health (House et al., 1979; House, 1981; Kasl, 1974, 1978; Kornhauser, 1965; LaRocco et al., 1980), and are included among the category of stressors identified by Pearlin and Schooler (1978) as having the potential for arousing threat.

These research findings suggest that role strains are important mechanisms linking stressful events to adverse reactions such as depression. Moreover, these
adverse changes can serve to intensify the level of psychological distress. Stressors often have both direct and indirect effects on the exacerbation of role strains (Pearlin and Lieberman, 1979). This further suggests that exposure to stressful events not only increases role strain, it increases the vulnerability to depression when the strains become intensified.

The conceptual framework explicit in Pearlin's work in particular provides insight into how exposure to combat in Vietnam can have long-term effects on the survivor's psychological well-being. Nevertheless, there is evidence to suggest that the impact of exposure to combat on psychological distress may also be contingent upon predisposing and mediating factors.

Kohn (1972, 1977) defines coping resources as learned individual predispositions relevant to coping that are generally interpreted as dispositional characteristics affecting psychological well-being (Wheaton, 1983). Pearlin and Schooler (1978) define psychological resources as the personal characteristics that people draw upon to help them withstand threats to their environments. These resources usually act as barriers to the psychological consequences of stress. Prominent among these psychological resources are self-esteem and mastery. Self-esteem refers to the positiveness of one's attitude toward oneself (Rosenberg, 1965), while mastery concerns the extent to which one's life is personally controlled (Pearlin and Schooler, 1978). Both serve to buffer the negative consequences of stress.

A number of researchers have looked at personal control as an important mediator in the stress process. Smith (1969) and Turner and Noh (1983) view personal control as a powerful mediating force which is largely derived from one's history of efficacies and inefficacies in coping. However, Turner and Noh found that stress factors alone cannot account for variations in mental health between social status groups; that is, controlling for personal control rendered the relationship between social class and psychological distress nonsignificant. In general, then, the differences observed in personal vulnerability
may be no less important than are the differences in the incidence and level of stress in accounting for the social class/psychological distress relationship (Brown and Harris, 1978; Dohrenwend, 1973, Kessler, 1979; Kessler and Cleary, 1980).

Wheaton's (1980) suggestion that fatalism may be an important factor in mediating the effects of stress and psychological disorder implies that low social status leads to a behavioral pattern of deference. In this context, fatalism is a defense or coping mechanism which fails. High levels of stress may undermine the individual's sense of personal power and control leading, in turn, to a general loss of successful coping strategies.

The above discussion clearly indicates that social stress is a complex phenomenon which should be evaluated in a manner that considers stress as emerging within an intricate set of inter-relationships. The relationship between problematic life circumstances and coping mechanisms is also potentially useful for developing a more complete understanding of the conditions under which exposure to an extreme stressor (such as combat in Vietnam) can have long-term effects on social and psychological well-being.

DATA AND MEASURES

The data used in this research are from a national sample of young men ages twenty to thirty (N=2,510) who were first interviewed in late 1974 and early 1975. In 1982, a purposive sample of 445 of the original sample were reinterviewed as part of a study concerned with the effects of chronic marijuana use (Clayton and Voss, forthcoming). This research is based on data obtained at these two points in time for the 445 men. While the sample is not assumed to be representative of all men born between 1944 and 1954, it does consist of 298 non-veterans, 57 veterans who served in the United States, 38 men who served overseas but not in Vietnam, and 52 Vietnam veterans.
Depression

Depression was measured using the Center for Epidemiological Studies Depression Scale (CES-D). Developed to measure depressive symptoms in community populations, the CES-D does not provide diagnostic criteria for assessing depression. However, the scale does discriminate between clinically depressed patients and others and has been found to have a high correlation with other depression rating scales (Weissman et al., 1977). The entire scale has a high level in internal consistency (Cronbach's Alpha reliability .87). The items and scoring procedures for the CES-D as well as the other measures used are discussed at length elsewhere.1

The CES-D contains 20 Likert Scale items representing several components of depression including: depressed affect, feelings of worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, sleep disturbance and the absence of positive affect (Radloff, 1977). Respondents indicated how much time within the previous week they had experienced each symptom ranging from "rarely or never" to "most of the time." The CES-D score was computed by summing the responses on each of the 20 items with a potential range from 0 to 60, with the larger score indicating a high level of depression.

Combat Exposure

Level of combat exposure was measured using a series of questions pertaining to combat-related events. The fifty-two Vietnam veterans in the sample were asked if they had ever experienced combat, and eleven stated that they had not been exposed to combat. However, when questioned further about their Vietnam experiences, only four of the eleven "non-combat" respondents indicated that they had "never" experienced combat.

Because of this discrepancy, the following indicators of combat were used: (1) whether he was part of a land or naval artillery unit which fired on the enemy; (2) whether he received incoming fire from
enemy artillery, rockets or mortars; (3) whether his unit received sniper or sapper fire; and (4) whether his unit patrol engaged the Vietcong or North Vietnamese Army in a fire-fight. The 48 respondents who had part in these activities were then asked how much they were involved ranging from "very little" to "most of the time." The alpha reliability of this scale computed (N = 52) for the index before multiplication by the frequency rating resulted in an alpha of .65.

Chronic Stressors

Chronic stressors were measured directly and indirectly. The indirect measures, low occupational status and low income, are interpreted as proxies standing for potentially stressful environmental conditions (Wheaton, 1983). More specific items were used to construct indicators of persistent occupational strains.

The questionnaire contains ten items about work-related sources of stress. These questions were asked of the 393 employed respondents. In the interest of data reduction and the formation of reliable scales, a principle component factor analysis with oblique rotation was used to extract four factors. The first factor, bored with job, included three variables. In two of these variables the respondent was asked to rate (a) how routine and boring the work is, and (b) how intellectually stimulating and challenging the work is--resulted in a standardized item alpha of .69. The third variable concerns the degree to which the respondent agreed or disagreed that his job gave him satisfaction.

The work stress scale factor included two variables. The first item measured the degree to which the respondent agreed that he had few problems or hassles on his job. The second item measured the respondent's perception of the general level of job-related stress. The third factor included two items for measuring the respondents' perception of job advancement opportunities and the adequacy of financial rewards provided by his work. Two items also loaded on the fourth factor. These items measure the
degree to which the respondent felt that his work had good fringe benefits such as sick pay and retirement, and the degree to which his job paid well.

Self Concepts/Personal Coping Resources

Measures of personal coping resources were derived from a set of items designed to measure a variety of dimensions of self-concept. Respondents were asked to respond to sixteen statements dealing with how they felt about themselves. These Likert Scale items were then factored using a principal component analysis with oblique rotation. Three distinct factors were extracted: (1) self-derogation, (2) positive self-esteem and, (3) mastery. Since this study is concerned with the mediating effect of coping resources, only those items which loaded on the factors relating to positive self-esteem and mastery were used. 2

RESULTS AND DISCUSSION

To assess the relative impact of combat exposure on depression the analysis was conducted in three stages. The first stage of the analysis deals with the additive effects of combat exposure and occupational chronic stressors on depression as mediated by the personal coping resources, mastery and positive self-esteem. In the second stage the indirect effect of combat exposure on depression based on occupational strain, mastery and positive self-esteem is evaluated. In the third and final stage, the focus is on determining whether post-combat exposure operates in conjunction with current chronic stressors in predicting current levels of depression and whether this hypothesized effect is mediated by a sense of mastery and/or self-esteem.

Table 1 About Here

-835-
Based on a hierarchical regression analysis model, the additive effects of combat exposure, work-related sources of stress, and a set of control variables, namely race, level of education, father's occupational status, and age, are shown in Table 1. The first equation also includes the combat exposure variable, four direct measures of occupational stress, occupational status, and income. Both standardized and unstandardized regression coefficients are reported for all variables in each step of the equation. In the second step, mastery is added to the model, and positive self-esteem is added in the third step (equation three).

The findings in Table 1 address two issues: (1) the degree to which the distal stressor of combat exposure, current levels of work-related stress and coping resources affect depression and, (2) the effect of personal coping resources in buffering the impact of various stressors on depression. In the first equation the findings indicate that bored with job, work stress, lack of prospect for advancement, occupational status, and income all have a statistically significant effect (P < .05) on depression in the predicted direction.

In the second equation mastery was added to the model and was also found to have a statistically significant effect on depression (beta = -.526, P < .01). As expected, the higher the score on the mastery variable, the less likely it was that depression existed. Moreover, mastery buffers the impact of chronic stressors on depression. Comparison of the unstandardized beta coefficients in equations one and two indicate that the coping resource of mastery reduces the relationship between four of the five significant stressors and depression. The reduction in strength is greatest for bored with job, which is rendered non-significant. However, no prospect for advancement is significant at the .01 level with the addition of mastery to the model.

Positive self-esteem was added to the model in equation three. This variable has a statistically significant impact on depression (beta = -.090,
The direct effect of self-esteem on depression is weaker than that of mastery when both variables are included in the same model (beta = -.090 for self-esteem; beta = -.496 for mastery). As shown in Table 1, the personal resource of self-esteem also serves to reduce the relationship between the stressors and depression. In addition, it can be seen that while self-esteem also buffers the impact of stressors, it is secondary to that of mastery. This finding provides some support for the results reported by Pearlin and Schooler (1978), in that a sense of personal control tends to be a more important factor in buffering the effect of stress than is a favorable attitude toward self.

A summary measure of work-related chronic strain was constructed as a means of data reduction. Following the strategy employed by Wheaton (1983), the various measures of work-related chronic stressors were used as a general measure of chronic stress: bored with the job; job stress; lack of chance for advancement; inadequacy of rewards; occupational status and income. A summary index was then calculated by dividing the distribution of each variable into quartiles and assigning a "1" for scores within the most disadvantaged quartile and a "0" for others. A total score for the chronic stressors measure was determined by adding across the variables. The resultant index score of work-related chronic stress has a range of 0 to 6 with high scores indicating the most disadvantaged, i.e., the greatest exposure to chronic stress.

At this point, our interest is in determining whether this stress measure can be used without distorting the effects of the other variables on depression. The data for equation one in Table 2 suggest that the chronic stress measure has a statistically significant impact on depression (beta = .252, P < .01). A comparison of all other regression
coefficients reported in equation one of Table 2 with those in the first equation in Table 1 suggests that among nonwork-related variables, only race has a significant effect on level of depression. This result also held when mastery and self-esteem are added to the model which again are both statistically significant at the .01 level with unstandardized coefficients similar to those in equation three of Table 1.

Some additional comparisons can be made between equations one and two in Table 2. Mastery and positive self-esteem substantially reduce the effect of total chronic stressors on depression as shown by a reduction in the value of the unstandardized regression coefficients 1.581 and .890. Although the effect of the summary measure of total chronic stressors on depression is still statistically significant (P .01), these personal resources clearly serve to buffer their psychological impact. It can also be noted at this point that exposure to combat has no direct effect on level of depression.

In the next stage of the analysis we are interested in determining whether combat exposure in Vietnam has an indirect effect on depression through level of work-related stressors, mastery and on self-esteem. As noted, the results of previous research suggests that general level of occupational strain is one type of negative outcome of exposure to combat in Vietnam. Since it has been established that these stressors are significantly related to depression, they may serve as a mediating factor between combat and depression. Mastery and self-esteem may also serve as indirect links to depression.

The data shown in Table 3, however, indicate that combat exposure does not appear to be related to any of these variables. Individuals exposed to combat are
no more likely to experience high levels of work-related chronic stressors (beta = .057, n.s.), low mastery (beta = -.025, n.s.) or low self-esteem (beta = .041, n.s.) than are those who have not experienced combat. Level of education, father's occupational status and age are all significant predictors of total chronic stressors, as are mastery and self-esteem. Total chronic stressors are both predictive of level of mastery (controlling for self-esteem) and self-esteem (controlling for mastery) with individuals scoring higher on the index of chronic stressors being more likely to experience lower levels of mastery (beta = -.131, P < .01) and self-esteem (beta = -.071, P < .01). In addition, level of educational attainment is significantly related to one's self-esteem. In sum, these data suggest that there is no indirect effect of combat exposure on depression.

The final question concerns the effect of combat exposure and high levels of chronic stress on depression. As previously discussed, acute stressors, in conjunction with chronic stressors, affect psychological well-being. To determine whether the effect of combat exposure on depression is moderated by general level of occupational stressors, two models for testing two-way interactions are considered. As suggested by Pearlin, the effect of combat exposure on depression is expected to be contingent upon the number of work-related chronic stressors experienced by the veteran. Two models were used to test this hypothesized interaction and the results are presented in Table 4.

| Table 4 About Here |

In the first interactive model (equation one) the interaction of combat exposure with total chronic stressors is found to be significantly related to depression (P < .01, unstandardized coefficient=.095). This finding suggests that combat exposure, when experienced in conjunction with work-related stressors, does affect depression.
In equation two the personal coping resources measures (mastery and self-esteem) were added to the equation. As shown in Table 4, coping resources serve to buffer the impact of this interaction on depression. Although still significant, the unstandardized coefficient decreases from .095 to .052 and drops in statistical significance to the .05 level.

In sum, the findings suggest that: (1) combat exposure has no direct, additive effect on current levels of depression, (2) combat exposure does not indirectly affect depression via mastery, self-esteem or work-related chronic stressors, and (3) that combat exposure does seem to operate in conjunction with chronic stressors in predicting depression.

CONCLUSION

The finding that combat exposure is not directly related to depression is perhaps surprising since prior studies suggest that exposure to combat is significantly related to Post-traumatic Stress Disorder (PTSD) (e.g., Boulanger, 1981; Kadushin, 1983; Laufer et al., 1984). These studies begin by demonstrating this relationship and then specify the conditions under which it is diminished. In contrast, this report began with the premise that in order to assess adequately the impact of distal stressors on psychological well-being, it is necessary to assess that relationship within a theoretical framework.

As typically posed in the literature, the question of why we should expect individuals who experience the trauma of war to be more psychologically distressed than individuals who did not experience such trauma reflects the orientation of researchers who view stress in terms of the "life events model." Proponents of the "life events model" argue that changes in that which is normative require adjustment and this adjustment is often followed by increased psychological distress.
More recently, the literature on stress has been influenced by Pearlin's empirically-derived models. Pearlin argues that it is not sufficient to conceptualize stress in terms of negative life events, and he further suggests that a comprehensive assessment must include continuing life stressors. The expanded model calls for coping mechanisms, and the availability of social resources that support the coping process and affect the level of depression by mediating the impact of stressors (Pearlin et al., 1981). To assess adequately the long-term effects of exposure to a distal yet potent stressor, such as combat on psychological well-being, it is necessary to recast the findings of previous research within a complete theoretical framework.

Application of the conceptualization provided by Pearlin allows for the assessment of both indirect and interactive effects. While exposure to combat was not found to operate on depression via the mediating variables considered in this research, combat exposure was found to operate in conjunction with chronic stressors in the prediction of distress. These findings further suggest that depression among Vietnam veterans is best understood in terms of chronic occupational related stressors. That is to say, combat exposure alone does not appear to serve as an adequate predictor of depression.

These findings have a number of implications. In particular, the results suggest that researchers should seek to understand the effect of past trauma on depression in conjunction with current strains. Some evidence is provided in support of the argument for further investigation of this interaction. The findings also indicate that our knowledge of the Post-traumatic Stress Disorder should be conceptually extended to include factors suggested by Pearlin and others, and should be studied using samples which include Vietnam veterans, non-Vietnam veterans and non-veterans. Such expansion may provide a more accurate assessment of the nature of psychopathology among Vietnam veterans.
ENDNOTES

1. A complete list of items and procedures used can be obtained by writing to the author.

2. The seven-item scale construct measuring positive self-esteem consisted of the following: (1) What happens to me in the future mostly depends on me, (2) I can do just about anything I really set my mind to do, (3) I feel that I have a number of good qualities, (4) I feel that I am a person of worth, at least on an equal plane with others, (5) I am able to do things as well as most other people, (6) I take a positive attitude towards myself, and (7) On the whole, I am satisfied with myself. The self-esteem scale had an alpha reliability of .91.

The Mastery Scale consisted of five items which measure the degree to which respondents felt they were in control when dealing with the world around them: (1) I often feel I'm being pushed around in life, (2) I often feel helpless in dealing with the problems of life, (3) There is little I can do to change many of the important things in my life, (4) There is really no way I can solve some of the problems I have, and (5) I have little control over the things that happen to me. These Likert Scale items had a high level of reliability (alpha = .86).

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Kasl, Stanislof


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Weissman Myra M., Diane Sholomskas, Margaret Pottenger, Brigitte A. Prusoff, and Benz Locke 

Wheaton, Blair 


Worthington, Earl Robert 
** Variable not in equation  
+ Coefficients less than .001  

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Equations

3

R²

Adjust R²

Multiple R

Coping Resources on Depression (Standardized coefficients are reported in parentheses).
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<td>-</td>
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* Variable not in equation
** Significant at .01 level
* Significant at .05 level

Equations

Table 2. Hierarchical Regression of Combat Exposure, Total Chronic Stressors, and Coping Resources on Depression (standardized coefficients are reported in parentheses).
**Table 3**. Additive effects of combat exposure and other predictors on Total Chronic Stressors, Mastery and Self-Esteem (standardized coefficients), are reported in parentheses.

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- **Variable not in equation**
- **Significant at .01 level**
- **Significant at .05 level**

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*Denotes are reported in parentheses.

Stressors and Coping Resources on Depression (standardized coefficients are regression coefficients of Combat Exposure, Total Chronic Stressors, and other variables).

Table 4. Interactive Models: Regression of Combat Exposure, Total Chronic Stressors, and Other Variables.
POST-TRAUMATIC STRESS AND ATTRIBUTIONS AMONG INCEST FAMILY MEMBERS*

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ABSTRACT

This paper presents a discussion of the relationship between attribution models of self-blame and coping strategies among members of incest families. The findings suggest that incest victims are more likely to experience prolonged post-traumatic stress than are offenders and their spouses. The argument is made that by focusing on individual adjustment, therapy programs may be neglecting the interactive effect of attributions made by other family members, the legal system and outside observers. The author concludes by suggesting that a sociological model in which the relationship between social reactions to incest and attributions is addressed would enhance the effectiveness of self-help treatment programs intended to reduce victim stress.

INTRODUCTION

Researchers and clinicians increasingly recognize that stressful events can have prolonged emotional and behavioral effects upon its victims. Whereas the most recent post-traumatic stress literature has focused on Vietnam veterans (e.g., Atkinson et al., 1982; Frye and Stockton, 1982; Hendin, et al., 1981; Levenberg, * The author thanks members of Parents United for participating in the study. This research was supported by a grant from the University of California, Riverside.
In 1983; Silver and Iacono, 1984; Williams, 1983), survivors of concentration camps (Kinzie et al., 1984), automobile accidents (Singer, 1983), kidnapping (Terr, 1983), bereavement (Krupnick and Horowitz, 1981) and rape (Burgess, 1983), this paper focuses upon members of incest families. Specifically, this article examines families in therapy and the extent to which stress symptoms relate to the manner in which responsibility for incest is assigned.

Incest families include the victims of incest, offenders, and the offender's spouse. In the most general example, incest involves the father and daughter. It is well-documented that family members often react to the incest and to public knowledge of their incest with great emotional stress and varied difficulties in coping (Browning and Boatman, 1977; Herman, 1981; Herman and Hirschman, 1977, 1981). Additionally it has also been found that many incest victims continue to suffer for several years after the experience (Meiselman, 1979; Sagatun, 1982; Silver, et al., 1983).

Although much of the recent literature has dealt with stress resulting from the Vietnam war experience, war is an extraordinary event outside the realm of everyday life. The trauma associated with incest, on the other hand, may be effected by more ordinary events such as marital discord, child rearing practices, and the lack of economic stability. A study of kidnap victims by Krupnick and Horowitz (1981), for example, showed that the severity of post-traumatic stress was related in part to family pathology and the lack of community support, and that symptoms manifested included shame and fear of reexperiencing the event. Among rape victims anxiety, depression, withdrawal, and interpersonal problems are, according to Koss (1983), the most frequent symptoms identified.

A few researchers have focused on the relationship between attributions and stress. Singer (1983), for example, noted that victims of vehicular accidents frequently externalized responsibility for the accident onto others, and also blamed subsequent personal problems on the accident. Similarly, Frye
and Stockton (1982) found that Vietnam veterans diagnosed as suffering from post-traumatic stress were more likely to have an external locus of control orientation than were veterans who did not have the disorder. And among patients treated for post-traumatic stress related to bereavement, feelings of personal (internal) responsibility for the event were common (e.g., Krupnick and Horowitz, 1981). Victims of violent crimes were also found to have fears of repetition of the event, feelings of responsibility, and concern about their vulnerability.

**Attribution Theory and Traumatic Events**

Attribution theorists suggest that the ability to cope with a traumatic event is related to the manner in which responsibility for that event is assigned (Antaki and Brewin, 1982; Bulman and Wortman, 1977; Miller and Porter, 1983; Wortman and Dunkel-Schetter, 1979). The ability to cope is also found to be related to how significant others support external attributions of responsibility (Coates, et al., 1979, Coates and Winston, 1983).

Two distinct models account for the hypothesized relationship between attributions of responsibility and the ability to cope with stress following traumatic life events. The first, the external model, suggests that self-blame for negative events causes depression (Abrahamson, et al., 1978) and that the tendency to project responsibility or blame elsewhere is a good coping mechanism. It is theorized that external attributions lessen the negative effect of traumatic events (Layden, 1982; Storms and McCaul, 1976; Valins and Nisbett, 1972) all of which leads to the assumption that most people are defensive about their own role even to the point of denying responsibility for a traumatic event (Weiner et al., 1972).

The internal model provides a very different view—one which suggests that assuming personal responsibility for the traumatic event may actually promote feelings of personal control thereby enhancing the ability to cope with stress (Bulman and Wortman, 1977; Wortman, et al., 1980). Moreover, a sense of
personal control enables individuals to believe that a recurrence of the event can be avoided. Bulman and Wortman (1977) found that victims who assumed self-blame for accidents felt more in control of their lives, less fearful of repeated trauma, and were better able to cope than were the victims who blamed external factors such as chance, circumstances, or other persons.

In cases involving incest, victims tend to blame themselves (internal attribution), and offenders often enact external attribution by blaming the victim or the mother (Herman, 1981). The standard method employed to treat members of incest families is to reverse the focus of these attributions; that is, victims are encouraged to make external attributions, while offenders are encouraged to develop internal attributions. Spouses are encouraged to recognize and to accept that they also contributed to the incestuous relationship (Giarretto, 1982; Herman, 1981). By reversing the attributional patterns it is assumed that better coping mechanisms will develop and that long-term depression for the victim in particular can be prevented.

Although this treatment model appears to be beneficial for incest offenders and their spouses, it may not prevent post-traumatic stress among the victims of incest (Herman, 1981). According to Lerner (1980), the tendency to attribute blame to others is an effort to preserve illusions of a "just world." But for victims, externalizing blame for incest means placing the blame on the parents. Blaming the father and/or the mother may assist incest victims to cope with their stress but, then, victims often lose parental support and subsequently become alienated from the family. Moreover, when friends and acquaintances "blame the victim", victims are deprived of much needed support (Lerner, 1980). Schachter's (1959) experiments demonstrated that people under severe stress have a special need for supportive relationships. Although external attributions assist victims to cope, a bias toward internal attribution (personal culpability) make external attributions the most likely to generate negative reactions from outside observers.
Thus, a lack of support for the victims' external attributions often results in severe post-traumatic stress.

In contrast, offenders and their spouses are more likely to receive support if they adopt the desired internal, self-blame model. Both the legal and the social environs promote internal responsibility, and representatives of the criminal justice system clearly encourage offenders to admit their guilt and to accept their legal responsibility. (Sagatun, 1981).

Finally, victims suffer more severe trauma than do other family members. While the concerns of parents are to a large extent related to legal, economic, and social consequences, the victims, because of their age, are more likely to experience adverse emotional problems following incest. Silver, et al., (1983) argue that the betrayal of trust and the abuse of the parental role in incest relationships produce devastating effects on the social-psychological development of incest children.

In summary, while offenders and spouses receive social approval for adopting a self-blame model, the lack of support for victims' external attributions enhances their difficulty to cope emotionally with stress related to the event. In this regard they become double victims.

In the section that follows, the author examines the relationship between self-blame and the ability to cope with stress among incest family members both before and after therapy. It is assumed that all incest family members experience stress. But victims may exhibit longer-lasting stress. When offenders assume personal responsibility, they are less likely to experience long-term negative effects related to incest. Incest victims, on the other hand, manifest negative consequences even after they shift their self-blame for incest to an external cause.
METHOD AND PROCEDURE

In an effort to examine the hypothesized relationship between attributions and coping strategies, a questionnaire was distributed among incest family members participating in a Parents United therapy program. Parents United is a group which assists incest families by introducing the self-help component into therapy.

Permission to conduct the study was obtained from officials of the Parents United Leadership group. Participation in the study was voluntary, participants were assured of anonymity, and were advised that participation in the study was not related to the therapy itself. A questionnaire was distributed during group meetings among three therapeutic groups consisting of 1) the victims, 2) the adult offenders, and 3) the spouses. The sample included 54 offenders of whom 40 were white, 31 spouses, and 36 victims. All offenders were male; 53 were fathers or stepfathers and one was a grandfather. All victims were females.

Self-blame was measured by asking the subjects to describe how blame for the incident was assigned (internal versus external) both before and after therapy. To assess the stress factor the subjects were requested to respond to a series of questions designed to evaluate feelings of being in control, perceptions of family relationships, perceived consequences of the incest, and attitude changes. Respondents were also requested to describe the general impact of incest and to comment on their relationships with significant others and their ability to maintain personal relationships.

RESULTS

Attributions of Responsibility Before Therapy

Forty-two percent of the victims (N = 15) reported that they blamed themselves for the incest before
therapy, 41 percent of the offenders \((N = 22)\) assumed self-blame, and 31 percent of the mothers \((N = 11)\) reported that they had blamed themselves before undergoing therapy. The data shows that even though the offenders claimed they blamed themselves for their incestuous behavior, they, in fact, assigned blame to both external and internal causes. For example, problems with alcohol and drugs were mentioned in the self-reports as one external cause.

The Offenders

Typically, unsympathetic or physically unattractive wives were a second object of external blame. The following statement of an offender reveals his external assignment of blame:

Mother set the stage for the acts I and daughter were involved in. She may have been going through menopause at the time. Daughter was making herself ready and available to me and verbally telling me she wanted me in a sexual way. She loved me very much and she would stop at nothing to keep me from leaving her. I had a bitch of a wife with a very run down mental condition and a daughter who loved me.

The internal reasons offenders offered for their behavior focused on feelings of low self-esteem. Some offenders mentioned bad childhood experiences with sex. One man stated that he had a "need to show and receive love and affection, but (was) unable to do it in an acceptable way.

The Spouses

The mothers blamed themselves and external factors for the problem. Frequently these women mentioned being victims of sexual abuse themselves as children which resulted in feelings of low self-esteem and powerlessness in adult life. The essence of these feelings is captured in the statement of one spouse:
He said he did it to hurt me for something I did before we were married. I should have turned it in sooner, but I was afraid he would kill my daughter.

As external causes, these mothers tended to blame their husband's childhood upbringing and resultant feelings of poor self-esteem. One mother stated:

He totally shut me out of reality and turned to a child for his love because he could not accept it from a woman. My husband is weak and his family destroyed his feelings of any self-worth as a child.

Alcohol and drugs were also cited by the victims' mothers as a source of external blame. One woman said, "I was on PCP at the time and was pretty messed up." Another mother attributed the abuse to both external and internal causes exemplified in the following statement:

I was abusing drugs (heavily). My relationship with my husband was not very feeling or loving--thus he turned to my children to give him the love he didn't receive from me.

The Victims

For the victims, blame was often assigned to some internal weakness in themselves as is indicated in the statement: "I felt that I seduced him, even though I was very young at the time. He told me I did." However, these feelings were often mixed with strong memories of fear. The following quote from a victim sheds some light on this issue:

I became anxious around 6 about my father molesting me. When I turned to my mother, she fought with my father, but he continued to molest me when he had a chance. She told me when I was 7 years old she couldn't do anything about it; that all they did is
fight and he'd still bother me, so what I must do is stand up to him and say no. I was only 7 years old, and he would make my life miserable for saying no. He would tell my brothers that I was a tattletale. He said that God would punish me for not loving and respecting my father--I was breaking a commandment.

Many victims mentioned the belief that a lack of cooperation in the incestuous act would have led to violence and even murder. One victim expressed this fear stating: "I should have tried to stop it earlier, but I was afraid that he would kill me."

Attributions of Responsibility After Therapy

When asked to explain the incest event after spending a period of time in therapy, offenders and victims used the models advocated by the therapy program. Mothers were divided almost equally between the two models. Eighty-seven percent (N = 47) of the fathers said that they now blamed themselves, whereas thirteen mothers and seven victims blamed themselves.

The Offenders

Typically, after undergoing therapy, offenders assumed blame for their behavior, admitting that they were responsible--regardless of the factors which led to their behavior. However, some offenders could not blame themselves completely and attributed some degree of responsibility to their wives: "To a certain extent I mostly blame myself, but I blame my wife a little too." The next statement also demonstrates this mixed assignment of blame:

My quest for power and my awareness that my daughter was turning into a woman (caused the incest to happen). My daughters were victims, I forced them to do what they did by fear. I blame myself a lot because I am responsible for my action, but I feel that a share of the blame goes to my wife.
Offenders who internalized blame for the incestuous relationship framed their views within the context of their adult role: "I should have known that what I was doing was wrong and I should have restrained myself." Internal attribution was complete for most offenders of whom one stated: "I accept full responsibility regardless of what factors led to this mess."

The Spouses

Many mothers recognized their responsibility, mentioning how they should have done something to prevent or stop the problem. In response to the question, "Do you think that anyone or anything is responsible for what happened?", one mother responded:

Yes, I blame myself... I feel that I could have relayed protective information to daughter. I should have warned her—I should have considered he could... I never did.

Escape from reality and the lack of adult responsibility were also recognized as factors contributing to the event. Another spouse indicated these beliefs in the following: "All persons involved on an adult level were responsible if we allowed things to be so terrible that we would turn to drugs or children to hide our feelings or to not deal with things."

Yet some mothers denied that they were responsible in any way. A typical response from this group was: "Blame means nothing, would not help anybody, least of all myself."

The Victims

Therapy seemed to help the victims assign the blame to the offender. One victim stated that: "I was too young to understand--I consider it all my dad's fault." Another victim cast her post-therapy attribution in the form of a sick-role as indicated by the following statement:
There was no justification for what he did to me. I believe he was schizoid. He said he wished things were different so he could marry me. He liked to pretend we were two lovers parted by a quarrel.

The effect of incest upon victims' self-esteem also was apparent among the program participants as suggested by a victim who responded:

I used to feel like a nothing and would run and didn't care if I lived or died. I hated men and was uncertain if I'd ever be like any normal family child. I always felt like something deformed and I drew all the attention in public places.

An older victim, who later married, described herself in the following way:

I have felt different from other people, second class, not as good as, not as deserving the same rights. I have no close friends. I haven't been able to have sex with my husband the last 3 years. I can't stand to be touched--not even by my own children.

**Learning to Cope with a Traumatic Event**

Although most parents felt that their participation in therapy had a positive overall effect, victims were less likely to experience the positive effects. These contrasting results are demonstrated by the optimistic tone of statements made by offenders and spouses as opposed to the more negative tone of victims.

A number of offenders indicated that therapy enhanced their ability to understand other problems and the underlying causes that led them to engage in abusive acts. Some offenders viewed themselves as entirely different persons:
I now understand that I made a big mistake and that I will never lose control of my life again thanks to the therapy from Parents United. It saved my life I feel. My life was a lot of broken pieces and the program has put them back together.

Spouses seemed to believe that the therapy was beneficial in that it allowed them to cope with themselves, to accept the fact that incest did occur, and to justify their role in working to establish a solution for the problem:

We're not alone and it didn't happen out of maliciousness. It was merely a mistake that we can't change, but can understand why it happened and how to keep from getting such a bad space again as to allow it to happen again. Basically I have learned a lot about me. Self-awareness, communication skills, parenting skills, etc. etc. I feel heard, understood, accepted, loved, and I am worthy. --Prior to incest incident I felt I was dirty, nasty, no good. No self-worth at all. We (mothers) don't have to feel guilty because husband and father is being punished because we told about (the) problem.

Some victims, on the other hand, continued to experience negative effects related to the incestuous relationship. Symptoms related to post-traumatic stress syndrome are clearly demonstrated by one victim who wrote: "It was a living hell, I dropped out of school. I can't concentrate on anything or sleep."

DISCUSSION AND CONCLUSION

These data suggest that incest family members do experience stress resulting from the incest relationship and the subsequent effort to deal with it.
Several respondents experienced symptoms related to the post-traumatic syndrome such as a loss of interest, distance from others, and difficulties in sleeping and concentrating. Feelings of being out of control, poor family relations and the experience of negative consequences were also demonstrated. Many mentioned the shame and stigma associated with incest, and parents also indicated that economic and social hardship resulted from disclosure of the incest experience.

The data also suggest that victims are more likely to experience post-traumatic stress than either offenders or their spouses. Whereas therapy seemed to have a positive effect on offenders' stress, this does not appear to be as true for victims. Although some victims reported that therapy had helped them, strong negative reactions to the experience continued after therapy. Offenders seem to benefit most from therapy and victims the least; mothers appear to be more ambivalent.

Stress reduction among offenders may be due to the change in attribution. Prior to therapy offenders were more likely to blame external factors; after therapy they were more likely to assume a greater responsibility for their actions. Mothers were almost equally divided between internal and external attributions both before and after therapy. Victims changed from blaming themselves before therapy to external attributions casting blame toward the father or the mother. However, they did not experience a corresponding reduction in stress.

These findings offer some support for the internal model as a more effective coping strategy. Offenders who switched from an external to an internal orientation experienced fewer stress-related symptoms than did victims who changed from an external to an internal focus. Again, mothers were less easily understood since they divided almost equally on internal versus external attributions.

According to the internal model, self-blame and acceptance of responsibility for an action increases
self-control. Such control enables the individual to believe that the serious life event can be prevented from recurring, thereby enhancing the ability to cope. Indeed, earlier studies on post-traumatic stress indicate that stress symptoms are associated with a tendency to externalize responsibility, (Frye and Stockton, 1982; Singer, 1983). However, other students of the problem have noted that feelings of responsibility for the traumatic event was a common factor among victims experiencing stress after rape (Krupnick, 1980; Krupnick and Horowitz, 1981).

Janoff-Bulman (1979) and Janoff-Bulman and Frieze (1983) argue that while characterological self-blame is associated with continued depression, behavioral self-blame is not. Perhaps incest victims experience stress both when they use characterological self-blame (i.e., blaming the incest on their own "bad" character), and external blame, but are able to reduce the level of stress using behavioral self-blame (i.e., blame directed at transitory behaviors).

For incest victims it is difficult to make the distinction between stable and unstable self-blame. Incest is typically a form of abuse that occurs repeatedly over a period of time and, therefore, may be much more difficult to blame on particular behaviors than is the case when single events such as rape occur (Miller and Porter, 1983). Incest victims tend to move from the damaging characterological internal model to an external model thereby reducing their ability to feel in control. It is important, therefore, that therapists encourage incest victims to develop behavioral self-blame. Victims of incest should be directed to think that future outcomes can be controlled by change in behavior; that she is not "bad," and that she is not totally at the mercy of external circumstances. The distinction between assigning blame for a problem and assuming control for the solution is helpful in this regard (Brickman et al., 1982). According to Brickman et al., the question of responsibility involves two separate processes; assigning blame and assuming control, each with different implications for helping and control. In general, longer lasting change is produced when people assume internal
Offenders and their spouses receive more social support for adopting an internal model of blame than do victims for adopting an external model or internal model. Although many therapists encourage victims of incest to externalize the blame in order to diminish the effects of guilt and shame (Fox and Scherl, 1972) this shift increases the difficulty to forgive and to restore the family unit. Blaming the parents also contributes to the continuation of stressful relations within the family.

The offender may learn to assume personal responsibility, but he may also feel resentment and anger toward the daughter for reporting the abuse, and for blaming him. The relationship between mother and daughter is crucial for recovery, however. Daughters blaming mothers for not protecting them from abuse generated a negative reaction to such blame. If victims try to blame themselves, counselors may fail to see this as a healthy need for control (Brickman et al., 1982).

To recover from the incest trauma it is essential that victims gain the support of significant others. Understanding how the individual, the family, and therapy and societal reactions interact is important in overcoming the emotional stress involved. Representatives of the legal system should realize that conflicting cognitive influences affect the victim. It is much easier to unilaterally blame an unknown rapist than an incest offender who is also one's father. It is also important that victims not assume the burden of guilt for the parental abuse; it is equally essential that therapists recognize the complex personal relationships involved in assigning responsibility for the act.

Victimization studies have focused either on the victim's reactions or others' reactions, but not on the interactions of these reactions (Coates et al., 1979). To develop an attribution orientation in the
mind of the victim does not provide assistance if no one else supports this view. Understanding the importance of social support for the coping efforts of victims is essential. It is easier to recover from trauma if others share and support the victim's perceptions of the event. However, if observers "blame the victim" as proposed by Lerner in the "just world hypothesis" (1980), victims receive little support from others; whereas offenders and spouses, who are encouraged to make internal attributions, are more likely to receive approval.

The relationship between attributions and coping strategies requires a sociological focus and should include variables that refer to the effect of significant others. Structural and environmental components in models of attributions and coping would transcend the current emphasis on individual cognitive balance. The proposed interactive model has important social policy implications as well. First, not only offenders but spouses and victims need family therapy. Without the authority of the court, however, incest offenders (and spouses) are not committed to attend. Imprisonment and probation are not enough to change the attitudes of offenders toward incest (Giarretto, et al., 1978, Giarretto, 1982; Peters and Sadoff, 1977). Court order is the only means by which the legal system can insure that all family members receive the appropriate treatment needed to reduce post-traumatic stress. Court ordered family therapy programs are already in effect in some jurisdictions, and preliminary results indicate that court ordered clients are more likely to develop the desired attitudinal change than are voluntary clients (Sagatun, 1981).

Second, treating the entire family unit is more likely to encourage the development of attributional models that are compatible for all family members. It is also more likely that individual family members will develop an understanding of the reasoning behind each other's perceptions. To this end it seems crucial that incest therapy groups incorporate a self-help component. Several respondents referred to the sense of community that such groups provided. Having
the opportunity to meet and talk with other incest family members reduces the feeling of being "all alone," deviant and stigmatized, all of which should have the desired therapeutic effect (Coates and Winston, 1983).

Self-help groups provide peer-group confrontation and pressure and, ultimately, support. This kind of family therapy offers an important technique for assisting incest victims as well. Victims have already learned that adults dominate and exploit them (father) or neglect and abandon them (mother). Group therapy should afford victims an opportunity to reduce their levels of shame and guilt through acceptance by other group members.

Most incest victims do not confide the incest problem and often continue to suffer the effects of their victimization even during their adult lives (Herman, 1981). A recent study suggests that incest may be more prevalent than is generally acknowledged (Gordon and O'Keefe, 1984). It is imperative, therefore, that victims be encouraged to report incest, and that programs be developed to reduce the effects of post-traumatic stress among victims of incest. Families should learn to confront their problems, but also to approach the future in a positive light. In this sense, incest victims can learn to be survivors.

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POST-TRAUMATIC STRESS AND LIFE-DESTRUCTIVE BEHAVIOR

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ABSTRACT

Results of content analysis of investigative reports and suicide notes illustrating the association between traumatic stress and life-destructive behavior are reported. A breakdown of interpersonal relationships and the inability to adapt to situational arrangements over which they lack control are shown to be factors critical to understanding committers' motivations to suicide.

INTRODUCTION

Emerging from a disturbance in the flow of person-person relationships, stress is a mental state based on one's awareness of the meaning of an environmental situation (Lazarus, 1966). A desire to minimize the effect of such disturbances prompts individuals to cope by attempting to reshape the environment thereby reducing the threat of the disturbance. Provided that failure can be rationalized and energies redirected toward alternative goals, the process leading to what Breed (1968) called a terminal failure situation is aborted. The alternative--an inability to accept failure and to cope with stress--often results in life-threatening behavior.

Employed by actors to cope with traumatic stress, suicide is increasingly recognized as a viable coping strategy (e.g., Breed, 1972; Peck and Bharadwaj, 1980; Wilson, 1981; Battin, 1982; Maris, 1982; Peck, 1983). Merton's (1938) seminal statement regarding structural

* The author acknowledges with appreciation the special assistance of Sandra Lavender.
strain and stress illustrates that behavior considered to be ill-conceived may in fact represent a normal re-
response; that is, deviant behavior is purposeful and meaningful for the participants. From this perspec-
tive the decision to engage in self-destructive acts represents a rationally determined act (Maris, 1981; 1982; Battin, 1982).

Clearly, failure affects one's perception of self-worth; failure also causes sufficient stress for a crisis situation to emerge. Whereas the intensity of crisis-related stress usually subsides for most persons (Seiden, 1977), for others self-destructive behavior offers a rational solution to the crisis. Suicide risk also appears to be related to the intensity and duration of stress-related events and conditions.

Low self-esteem and high expectations inhibit personal growth, well-being and social adaptation. In particular, diminished perceptions of self-worth are found to be prevalent among the least powerful members of society (e.g., Maris, 1969; Peck and Klemmack, 1980; Peck, 1980-1981; 1983)--these include the very young, young adults, and the elderly. One obstacle to personal well-being is that persons encumbered by stress perceive themselves as powerless to act as an effective force on their own behalf (Throits, et al., 1982; Ritter, 1984). Control over personal situations and the environment is, as noted by Reynolds and Faberow (1976), instrumental in the development of a healthy self-image and general view of life.

METHOD

The data reported in this study were obtained from a sample of over 500 suicide records in a County Medical Examiner's Office. Recorded as part of an official investigation of equivocal death, the data pertain to contextual factors that constitute the social milieu of the deceased. In all instances, the case material is based on the recorded observations of acquaintances, relatives, friends, employers, or medical staff who had knowledge of the committer's
background. Suicide notes were also available, and these serve as another source of information.

Although secondary analysis of official data is limited, the use of investigative case reports, augmented by suicide notes, provides an opportunity to assess the effect of intrapersonal and interpersonal motivational factors associated with suicide. Reconstruction of situational meanings is important, and suicide notes often provide insight into the events and circumstances affecting the attitudes and beliefs of the writer. Suicide notes also provide a reasonable means for evaluating the reasons for life-threatening behavior. In the following section data are brought to bear on the hypothesized relationship between traumatic stress and suicidal behavior among a selective group of youthful committers.

DATA AND DISCUSSION

Farberow (1968:393) suggests that interpersonal motivations predominate among members of youthful and middle-age groups, and may encourage life-threatening behavior "... as a means to influence, persuade, force, manipulate, stimulate, change, dominate, restate, etc., feelings or behavior in someone else." Such interpersonal motivation can be illustrated in the following descriptive cases of committers, all of whom experienced strain, stress and low-esteem.

Case One

By leaping out of a dormitory window, a recently terminated, assistant junior varsity basketball coach ended his life soon after he was informed of the loss of that position. Prior to assuming the junior varsity position, the deceased played basketball for a major university located in the southeastern portion of the United States. An All-American high school player, he also earned All Conference honors for three years while playing basketball at the university level. According to a brother, the pressure of being one of the first minority players to participate in the conference had been very great. The brother also
stated that the deceased had made a decision to "join white society to get ahead, and he felt that who you know, especially if you were black, would make a difference." The emphasis placed on education by the mother was inconsistent with the deceased's academic performance, however. He failed to graduate from the university as a result of his low grades.

The deceased had a great desire to play professional basketball, but a knee injury suffered during his collegiate career resulted in his being a low draft choice. A subsequent tryout with a professional team was not successful because the injured knee required surgery. Thus, when he was offered the junior varsity basketball position, he accepted.

Hired for the junior varsity job by the same coach who recruited him to play at the university level, the deceased was again left behind when the head coach accepted a position as a professional coach. In addition to the recent departure of his benefactor and friend and the prospect of being without financial support, the deceased was upset because his white girlfriend had gone out-of-state on vacation. Having spent almost every night with the female friend during the previous five months, her departure bothered the deceased a great deal. A student, who had spoken with him a few hours before his death, quoted the deceased as stating "I feel empty, empty like a shell, and I want to die."

Case Two

The 30-year-old son of a physician died by hanging. Holder of a Ph.D., the deceased experienced difficulty obtaining employment after having been committed to a county hospital for treatment of a nervous breakdown. Shortly after being released from the County Hospital, the deceased committed himself to a private hospital for further treatment.

Information upon which this case is built was obtained from male friends. Although the deceased did not drink or use other kinds of drugs, he was described as a very nervous person. According to a
notation in his medical records at County Hospital, "The deceased thought he was God." The text of one of several notes found at the scene stated.

There must be a way for me to return—to return to my former self. I was happy, employed and satisfied with my daily life. I had no fear, now I'm plagued with fear—the fear that I can't go on. The boredom of daily life plagues me. Is there an answer if there is is it work, a lover, life or death?

If I live, will I return to my former self? Will I again be happy and free—free to enjoy the little things, my daily life? Or will I forever be locked into my living death. A dead spirit without hope or care. Will my life continue in this way or will my spirit awaken, a new soul develop.

Questions, Questions—all without answer. Except for time—time the great healer.

Dear God please help me. Give me meaning for this existence, give me life, give me sex. All this I ask of you. With only the promise that I'll continue with my life as it was—an attempt to help all people with no request for help for me. Help Me! Help me! Help me!

I guess there is no help for me. No one answers my prayers. I need a job and sit here by the phone hour after lonely hour waiting for that call, but it never comes. Rejection after rejection nothingness, years of hard work washed away by callous employers who don't answer your call—why, oh why don't they call even to say "no" so the waiting will end? Oh, God, help me.

Day after empty day with nothing to do. Why oh why do I have to suffer so? The emptiness of winter surrounding me. The loneliness of life swelling in my breast. Is there hope?
Or is the only hope death? I wish there was some other way but I doubt it it.

Case Three

Described as a very intelligent person, a 26-year-old divorcee reacted to her failure to establish a meaningful, long-term relationship by taking her life. The deceased thought of herself as being socially ineffective, and that future encounters with men would be problematic.

Resigned to the fact that she was powerless to control these relationships, suicide represented an alternative to coping with the problems of living. The following suicide note was written to her physician.

Dear Dr. C. . . .

I have been afraid, off and on for several months, that I might try to commit suicide again after 5 long years of getting cured of it . . . . I've been thinking I might try it partly because I have questioned why I was alive, anyhow, most of my life; partly because I can't seem to get along without making up turmoil for myself and any passers-by I can get in on it. Partly because I came to regard suicide as a good way out of it years ago; partly for a great bunch of reasons I don't know anything about; and now mainly because I got myself into another disastrous love affair. I haven't been able to understand much about . . . especially his feelings about his family and his feelings toward me, I've just insisted that he love me exclusively and forever, and make everything all right. Desperate of me, yes? When he made it more and more clear that he would rather patch up his domestic life than stay with me, I tried hard as I could to keep in mind that it was only reasonable, and he loved his children, and there were four of his family and only one of me but it didn't work and I got
desperate in the other direction—with within a week I doggedly made love to two men I knew slightly and like mildly. It was (or they were) partly a defiance gesture but mainly a try at breaking off my dependence on . . . Since . . . and I had decided to become "friends," I told him the first time I spent the night with someone else, and he got ferociously angry. I told him because I thought it would be easier for both of us to abolish our romantic attachment, and it certainly was. Then I figured out that not only could I not bear his contempt, I also couldn't bear much of anything at all. So I'm going to try my best to kill myself. It isn't easy to do; I've had to get somewhat drunk to really put my heart in it. I suppose I'm doing it to make . . . sorry, for something or other, I forget what, more as a way to tell him that I'm sorry and that I know how irreversible it all is, his behavior and mine. It's a kind of penance.

I don't like writing this to you. I don't like the whole idea of suicide notes. I would guess they're usually pretty wild and that the truths they ever tell have got to be pitifully partial. But, I don't like mysteries so I felt I ought to tell you what I was thinking at least some of the time, distorted as it may be, before I stop thinking altogether. . . .

Last, I want to tell you that, rigid, naive, and devious as I am, I'm sure I would have found reasons to kill myself sooner or later, with or without . . . I have been unhappy and frightened about dying for the past several days, but also determined and sometimes euphoric. The mood in Shakespeare's "Fear No More" speech fits mine exactly, except that as subject right now, I am also excited and terrified by what seems to me to be the miracle as well as the horror of death.
Thanks for being my confident and friends, and for being a fine man. I'm glad to be leaving you.

Case Four

Reared in an upper-middle-class environment, a 19-year-old university dropout died from an overdose of barbiturates. Three short notes were found near the corpse. In the first the deceased wrote "Last chance. If it isn't past one, tell me how your weekend was." The second note contained an equally oblique message. "Play it all the way through, that (sic) all there is to say." Another note written to a friend stated: "Matt, I've gone to . . . . If no response on phone, I'm in Hell, meet me." Finally, a tape recorded message found at the scene indicated that the deceased had planned to asphyxiate himself because he was emotionally upset for a variety of reasons, most of which were attributed to the recent death of his father.

The young man took his life approximately two months after his father's death. Described as chronically discontented, the deceased, according to a brother, had not gotten along well with his father. Then, after the father's death, the deceased experienced guilt feelings related to this unhappy relationship. According to the mother, the father had pressured the children to excel in everything, including academic study, and the deceased was subjected to ridicule from family members because he flunked out of college. Each child was taught to be a perfectionist. Less than acceptable performances prompted constant reminders that the deceased did not measure up to the level of performance demonstrated by other family members and expected by the father. When the father became ill, pressure on the son subsided. This prompted some resentment among the deceased's siblings who, in turn, directed their anger toward the deceased.
Case Five

After serving three months in the U.S. Army, an 18-year-old male was medically discharged because of his malformed feet. Two months later his mother found him hanging in the attic of the residence they shared. Stating that she had argued with her son several hours before his death about his lack of employment, the mother did not believe, however, that this argument caused the son to become despondent.

The deceased apparently perceived himself to be a social misfit because of his deformity. He also believed that difficulty experienced in walking was responsible for his lack of success in securing a job. The family physician supported this view.

Along with a bag of marijuana, the following suicide note was found.

Mom,

Sorry I caused you so much trouble in my life time. Didn't mean to hurt you at all. As for drugs, I might as well tell you what I did. I've done grass, of which you already know about. You once asked me if I did anything else. I saw how heartbroken you were so I was afraid to tell you that I've also done Hash, acid, speed, THC and Mescaline. I sold my coin collection about a year ago, but you still have my bank account, my check for $110.00 and my life insurance policy to get you by easily. The only thing I want you to do for me is to never tell... or... baby about me. I'm the black sheep of the family. As for the savings bonds of... just tell him when he's old enough that I was a friend of the family with the same last name. I don't want him to look down on me when he is older. Maybe he'll turn out to be a better person than I was. Don't feel too bad, it's all for the best.
I was just telling someone last night that
I've experienced life and didn't like it, so
I'd like to experience death. Just turn to
. . . for help and understanding. He's a
great person, I hope you two get married
someday.

Just one last thing, I'd appreciate it if
you would find some connection for me. I
want my body to be willed to science. Maybe
it can help somebody live. Since I'm a legal
adult I have this right. Whatever the
doctors need is theirs for the taking. Now
I can be with gramma . . . again. She's a
great person I've always loved her. Give my
albums to . . . also give my television and
table to . . . Give my army shirts and
jacket to . . . You can give the rest of
the stuff to Goodwill. Sorry about all this
trouble.

You had nothing to do with the reasons for
this. I'll see you all again someday.

Love,

Paul

P.S. Please do all I asked. My body is in
the attic. I've come to the end of my rope.
I enjoy hanging around.

"Paul"

Case Six

Hanging by a rope ended the life of a male two
weeks before his twentieth birthday. Aspiring to be a
magician, the deceased tried to support himself as a
housepainter. Unfortunately, some clients paid for
this service with checks written on accounts with
insufficient funds and as a result, the deceased ex-
perienced financial problems which caused him to be
despondent. The following note was found in a wallet.
I am very sorry--but the future holds for me only more trouble--I've tried my damnest to make good--but, even working legally--people try and try to rip me off. I do not wish to hurt anyone... I love you all. I think it's better this way. Don't weep for me--the tears will be wasted....

Case Seven

After six unsuccessful attempts to end her life, a 34-year-old woman committed suicide after checking into a luxury motel one day before she was scheduled to appear at a divorce hearing. Even though the deceased had initiated the divorce action, she was distraught over the possibility that custody of two children would go to the husband. At the time of death the deceased was employed by a nursing home, but prior occupational activities included work as an advertising salesperson and the presidency of a corporation she had created.

Similar to the previous suicide attempts, the deceased slashed her wrists and took an overdose of aspirin and sleeping tablets. A suicide note addressed to one of her children stated:

Dear Stacy,

Try to understand Mommy did her best to have you with me again. But I wasted too many years before I began doing all the right things.

Love, please believe I did love and want you, but I've used up all my strength fighting. I wouldn't have had to go through so much and fight so hard if I hadn't been so foolish in the beginning.

Oh, Stacey, I love you!

Mommy
Case Eight

Unable to cope with the fact that he and his male lover were drifting apart after an intense six-month relationship, a 19-year-old took an overdose of barbiturates. On the previous night the deceased and his former boyfriend had gone out to drink. During that evening it was decided that they terminate the relationship. This caused the deceased to become upset and he began drinking. The autopsy report indicated that any of the several drugs identified in the blood was at a level sufficient to be fatal when combined with the amount of alcohol consumed. This particular death might have been considered an accident except that the following note was found at the scene of death.

Dearest Love,

I just thought I'd write you a farewell letter. I feel it would be nice to tell you things that you might not want to hear and also so I wouldn't waste your time and (sic) lengthen this hard task.

I love you deeply and hate to lose you, but I won't persist you anymore, seeing how you don't think I can offer you what you want—Sorry—but a little longer time might have helped for us it could have been a balanced relationship.

I love you from the bottom of my heart that hit the deepest part of me—don't forget it please—but that's life. I'm taking a quick way out it was one of the two I'm taking the quickest way out. I don't care if you say I'm coping out either way it would be and I don't expect for this letter to change your mind it can't if you wanted to do anything about it, it would just screw you more so—So don't let it happen—Just forget we ever had anything—I was too skitsofrenic (sic) for you—
Well that's enough don't worry there won't be anyone I'm imposing on a soul. I'm leaving too quick and it's almost a free ticket and nobody but myself will be paying for that ride the final one, one way only.

Take care my last love for there will never be another one in my life believe me I mean what I say.

Hope you (sic) be happy in the future I know I will not be here for long it's a matter of a couple of hours before I depart.

Bye Bye my love,

Greg and Mike could have been.

Live well.

Cases Nine and Ten

Married only six months a 23-year-old female shot herself in the head. The young widower told investigators that although the deceased was a nervous person who easily became depressed, she never complained, nor did she give any indication that she was contemplating suicide. However, she was concerned about their inability to pay for needed automobile repairs and the fact that money was not available for a down-payment on a house of their own. Another contributing factor to their financial plight was the psychiatric care required for the deceased’s chronic anxiety depression and the chiropractic treatment for numbness in her left side.

The deceased was invited to accompany her husband on a hunting trip. While thought to be in good spirits, she refused to go along. Seven hours later the husband returned to find his wife dead and two short notes in their bedroom.

Mom & Dad,

Please forgive me. I'm sorry.
I am sorry for everything, Every time I try to talk things out I make matters worse. I have to end it. Please forgive me. God knows I love you but somehow it comes out all wrong. Maybe after I'm gone your bad luck will go away. I'm sorry.

Five days later after his wife's death, the 24-year-old widower was found lying over the grave of his wife, a bullet wound in the head. A picture of his wife along with the following note were found at the scene.

Dad,

I'm sorry for this but I have to. Karen was and will be my life. There is nothing without her. I know this will cause pain again, but she is calling me. Dad I love her so much and I love you but I can't go on. I pray there is life after death and we will be together, we have to be. I know I'm weak but if you could have loved her as I did and do you would know. If I hadn't worked those nights or we had gone more places I don't think this would have happened. She did it for me and now I do it for her. Just turn on the tape player and the tape will say what I'm trying to. I'm sorry Dad, really I am, but I must. I love you and under the rug of the front door are the keys.

SUMMARY AND CONCLUSION

This study examined the relationship between traumatic stress and life-destructive behavior. Based on the information reported, some evidence to support the hypothesized relationship is found: stress, emerging from failure is related to suicidal behavior. Ineffectual in controlling the actions of others or the outcome of events, these committers recognized
their inability to influence future outcomes as well. The manner in which individuals assess their well-being, then, seems crucial to understanding motivations to engage in life-destructive behavior.

Suicidal behavior can be attributed in part to the actor's stress-related reaction to negative perceptions of self-worth, and in part to an inability to act upon situations causing traumatic stress. Moreover, the data suggest that life-destructive behavior is related to strain and stress emerging from what the general population experience in their everyday living patterns. Circumstances affecting the mental state of committers include the breakdown of intimate relationships and economic problems. Committers opt for what seems to them a reasonable alternative route to a painful situation.

Motivations to suicide include a breakdown of intimate relationships and the inability to accept situational arrangements dictated by others. One obstacle to social and psychological well-being among this sample of committers was the recognition that they were powerless to act as an effective force on behalf of their own best interests. Obstacles to personal well-being appear to contribute to the decision to suicide; the taking of one's own life may be the final effort to control an outcome.

The finding that people view themselves as insignificant seems worthy of attention. A public policy directed towards meeting the needs of individuals who are bereaved and experience stress sufficient to induce a life-and-death crisis would seem consequential for whole communities. Whereas individual initiative is involved, life-destructive behavior is the result of an interface between the individual and society. Both have needs which can be fulfilled by assisting individuals to develop positive self-concepts that are both consistent with acceptable lifestyles and also correspond to realistic levels of expectation. Perhaps responsible persons can demonstrate their concern by creating realistic public policies oriented toward assisting people to deal with bereavement and in responding to traumatic stress.
related crises in ways other than by acts of self-destruction.

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ABSTRACT

The thesis of this article is that, in spite of a large body of literature on the subject, a significant need exists for sociological research on the long-term consequences of the trauma experienced by survivors of Nazi concentration camps. Most of what is known about the adjustment of Holocaust survivors is based upon limited case histories of survivors who sought psychiatric aid, or requested assistance in qualifying for indemnification payments from the German government. The social and psychological dynamics of successful adjustment to life after the traumatic Holocaust experience by the majority of survivors has largely been ignored. Reasons for this oversight are discussed, and several areas of further research are suggested.

INTRODUCTION

From a socio-historical perspective there are few, if any, man-made catastrophies in western civilization which match the Holocaust in either the numbers slain (over 6 million Jews and 5 million non-Jews), or in the maximum and deliberate use of organizational and technological resources to destroy civilian populations. Failure to achieve total success was a product of military defeat, not world moral revulsion or
inadequate effort given to the process. Survivors of the Holocaust experience are unique in that this group provides the human sciences with a rare opportunity to study the long-term effects of massive trauma upon a large number of people. Yet, almost forty years have passed since the survivors' liberation with little gain in our knowledge of such experiences beyond that derived from case histories of survivors who sought psychiatric treatment or needed assistance in documenting their claims for remuneration from the West German government. This hiatus in the research literature has been ascribed to many factors, ranging from the desire to forget the horrors of the World War to the reluctance or inability of scientists to remain detached from the suffering experienced by the survivors.

But the fact remains that with the passage of time and as survivors die, the opportunity to learn from the horror of the Holocaust slips away. It is the thesis of the discussion to follow that the loss of this research opportunity can be avoided only by an immediate, systematic research effort, an effort that explores beyond the trauma induced by concentration camps and emphasizes the long-term consequences of that trauma for social adjustment. Because Holocaust survivors constitute a rapidly aging population, it will be necessary to focus upon the nature of social adjustment within the context of growing old in contemporary American society.

OVERVIEW OF RELATED LITERATURE

To understand the nature of the post-traumatic stress disorder (PTSD) produced by an experience, knowledge of that experience is required. A great

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1 At a time when the demands of warfare dictated the total mobilization of available resources, perhaps it is ironic that the Nazi regime gave top priority to its massive genocide program contributing to its own military defeat.
deal of information exists about life in Nazi concentration camps (see, for example, Davidowitz, 1975; De Pres, 1976) which can be summarized as follows: inmates were exposed to abysmally inadequate nourishment, clothing and shelter; forced labor; medical experimentation; and physical torture. Social and psychological consequences attendant to these physical conditions included (1) the separation from family and friends, (2) efforts by camp officials to stifle the development of social support systems, (3) the abandonment of conventional norms of civility, (4) the total subjugation of inmates to rigid authoritarian hierarchy of control, (5) systematic and prolonged efforts to destroy the inmates' sense of individuality, integrity and self-worth through insult, forced self-degradation, and cruelty, (6) and the constant threat of death.

Individual survival in camps such as Auschwitz and Buchenwald was a fortuitous matter since many were killed shortly after their arrival. Those in good physical condition were given forced labor. Religious and/or cultural origins also played a significant role in survival. Jews and Gypsies in particular received the worst treatment and were exterminated in large numbers. It is estimated that 72 percent of all Eastern and middle European Jews died while held in concentration camps (Bergman and Jucovy, 1982). Other nationalities received varying treatment depending in large measure on the Nazi's view of their "worth" to the Third Reich. Still, with all of these factors operating, some individuals managed to survive.

After liberation, the trauma of the concentration camp experience was followed by additional stress for the survivors; they had to pick up the pieces of the pre-war life. For most non-Jews this meant returning home to attempt the difficult task of reestablishing interrupted careers and social relations (Eitinger and Strom, 1973; Matussek, 1975). For most Jews, however, no pre-war life existed to piece back together. Family members and friends were dead, or otherwise unaccounted for, material wealth and possessions were lost, and physical health was badly damaged. For these survivors in particular, liberation meant
establishing a completely new life in a strange land. In itself sufficiently disruptive to induce trauma (Shuval, 1982), this experience may have reinforced pathogenic symptoms developed earlier in the camps (Shuval, 1982).

The literature developed following the survivors' liberation has been well summarized by Bergman and Jucovy (1982). Little information was published on their physical and mental state or of the treatment received, however. This hiatus in the literature has been attributed by Bergman and Jucovy (1982:5-6), to a nation's desire to forget the horror of WW II, and the need of Holocaust victims to avoid preoccupation with their past.

Significant attention to the physical and psychological needs of survivors began during the 1950's with the passage of the German Indemnification Laws, which provided financial restitution for victims. However, payment required the verification of the correlation between poor mental and/or physical health and the concentration camp experience. Further, psychiatric examinations were required which ultimately led to the publication of numerous case studies in which various pathogenic symptoms associated with survival were identified.

Focused upon the physical and psychological symptoms of the survivors, these case studies ultimately led Niederland (1981) to identify what is commonly referred to as the "survivor syndrome"--a series of pathogenic symptoms found among survivors regardless of their sex, age, or socio-economic background. These symptoms include: 1) chronic or recurrent state of depression, frequently reflected in complaints of physical pain and tendencies toward withdrawal, brooding and seclusion; 2) anhedonia, the inability to experience most types of pleasure; 3) anxiety (the predominant symptom) associated with fears of renewed persecution accompanied by various phobias and recurrent nightmares; 4) hyperamnesia, the inability to repress memories of persecution; 5) alterations in one's sense of identity, (e.g., a sense of being a "different" person from the one who had entered the
concentration camp); 6) psychosomatic pathologies including peptic ulcers, hypertension, vascular diseases, tension headaches, gastrointestinal disturbances, insomnia, and asthma; 7) survivor guilt and unresolved grief associated with the loss of family and friends.

More intensive research efforts, which go beyond the case study method, are the "Norwegian Studies" conducted during the 1960's by Eitinger (1980) and the study by Matussek (1975). A sample 227 survivors from more than 2,500 psychiatric patients treated at Oslo University Hospital were selected for examination because of the complexity of their cases. Most were from working and middle class backgrounds and none were found to have experienced unusual health, childhood, education, or social adjustment problems prior to the war (Eitinger, 1980:134). It was found that the majority of survivors returned to work within one year of liberation, albeit many chose different occupations and frequently changed jobs. Initially the ability to perform specific work appeared to be normal, but a gradual reduction in this capacity developed over time. Two-thirds of survivor marriages were reported as "satisfactory." Later, however, interviews with spouses of survivors revealed the existence of a great deal of stress and dissention in the marriage arising from concentration camp-related symptoms.

Eitinger (1980:149) concluded that disturbances arising from the "concentration camp syndrome" were of a dual nature; namely, somatic and psychic. The most prominent symptoms manifested by a majority of the Norwegian patients were: poor memory and the inability to concentrate, nervousness; irritability; anxiety; emotional lability; moodiness; vertigo; and nightmares. None of these symptoms appeared to be related to age or background factors, although they were found to be related to severity of treatment received while in the concentration camp. Encephalopathy was diagnosed in 81 percent of the subjects. Somatic disorders including back problems, digestive problems, cardiovascular diseases, and respiratory diseases were also common (Eitinger, 1980:137-143).
In a previous study, Eitinger and Strom (1973) investigated the post-concentration camp mortality and morbidity rates of Norwegians incarcerated in Germany between 1940 and 1945. Using mortality and morbidity rates of the general Norwegian population for comparative purposes, the authors found higher mortality rates existed among survivors for the post-war period. Additionally, the sample of 498 survivors had a higher incidence of sick periods, longer sick leaves, and more frequent periods of hospitalization. The authors concluded that the stress related to imprisonment had lowered their resistance to infection and thus impaired the survivors' ability to adjust to environmental changes (1973:113-117).

While Eitenger and Strom concentrated on Norwegian survivors, Matussek (1975) used indemnification files available in Germany, and studied 245 survivors who resided in Germany, Israel and the United States. Using Rorschack tests, questionnaires and psychoanalytic interview schedules to recreate life histories, Matussek focused upon the social and psychological factors influencing stress experienced by the survivors and their subsequent efforts to adjust to this stress. Matussek found that the large number of somatic and psychological complaints could be classified into three general areas: 1) internal and gynecological disorders, 2) a "psychophysical syndrome" (similar to the "survivor syndrome") and 3) an "anomic" factor associated with the breakdown of interpersonal relations. Additionally, three psychological disturbance factors were found to predominate: 1) resignation and despair, 2) apathy and inhibition, and 3) aggressive-irritable moodiness. Survivors who manifested withdrawal and isolation appeared to experience the greatest difficulty in adjusting to the post-war environment. Personality traits formed prior to the war also were found to correlate highly with both the nature of stress endured, and social adjustment following

2 Specifically these mortality rates were associated with tuberculosis, infectious diseases, coronary disease, lung cancer and violent death including accidents, homicide and suicide.
liberation. Matussek (1975:250) concluded that "The internal and external life histories of the inmates, their individual dispositions and also social factors are all inextricably linked in determining the various ways in which these people overcame the horrors of life in a concentration camp."

The major focus of survivor research began to shift during the middle of the 1960's from an emphasis on the effects of the Holocaust upon survivors to concerns over how those same factors affected the offspring of survivors. Clinical studies by Trossman (1966), Rackoff (1966, 1969), Sigal and Rackoff (1971), and Rustin and Lipsig (1972), for example, all noted a common pattern of high parental expectations; a tendency among the children toward dependence; alienation; guilt; hostile attitudes; and identity confusion. Later case studies of survivor children conducted by Krystal (1968, 1978), Brody (1973), Kestenberg (1972, 1973), and Boracas and Boracas (1979) tended to confirm these previous findings, all of which were supported by the published "self-reports" of survivor children (Steinitz and Szonyo, 1975). Labeled the "second generation" effect, the pattern of parent-child relationships appeared to be one in which parents frequently viewed their children as replacements for those lost in the Holocaust. Accordingly, survivor parents were found to be overprotective, overindulgent, and had a tendency to project their own aspirations and fears towards their children. Parental reluctance to encourage independence, adolescent challenges to parental authority, and the guilt which children developed as the result of rebellion against their parents often resulted in a pathology of symptoms among the children not dissimilar from those displayed by the parents.

A majority of scholars investigating the effects of the Holocaust tend to accept the validity of second generation effects (e.g., Karr, 1973, Prince, 1975). However, other efforts to verify these findings using non-clinical subjects have met with mixed results. Fishbane (1979) and Leon, et al. (1981) found little evidence to support the contention that extreme social and psychological impairment existed among children
of survivors. Tauber (1980), on the other hand, sug-
ggests that the problem is more complex than previously
thought. The extent and nature of reference group in-
volvement by the children, according to Tauber, is in-
strumental in establishing their "self-identification"
as children of survivors and their feelings of aliena-
tion from the larger society.

Studies of the effects of the Holocaust did not
begin to appear in the Israeli literature until the
late 1950's. However, these studies may be consi-
dered unique for two reasons. First, Jewish survi-
vors immigrating to Israel were received with open
arms by the small, homogenous Israeli society. Sec-
ond, Israeli analysts were more sensitive to survi-
vors and understood the importance of community sup-
port for the adjustment process. Studies of psychia-
tric patients revealed a pattern similar to the psy-
chopathology previously noted. Dor Shav (1978) exam-
ined a group of 42 Holocaust survivors and a control
group of 20 non-Holocaust survivors matched on age,
ethnic background and occupation, and concluded that
Holocaust survivors exhibited more constricted per-
sonalities compared to the controls.

In a study of 600 youths, (20 percent of whom
were children of Holocaust survivors) Gay (1972) re-
ported that the most striking difference found between
the two clinical groups was in the area of parent-
child relations. Similar to the findings reported by
Eitinger, the age gap between parents and children was
greater in survivor families. In a more recent study,
Davidson (1980:13-14) identified a number of problems
the most common of which are: over-anxiety and ex-
tremely protective behavior on the part of the mother;
intense emotional investment in the children; strong
identification of the child with lost siblings; and
the projection of the parent's experiences and fears
resulting in the children experiencing feelings of
guilt and shame and low self-esteem.

Studying 25 survivor families Klein and Reinharz
(1973) found that for most survivors who joined a
Kibbutz, the adjustment process was successful. Al-
though "low tolerance" toward others who shared their
traumatic memories was found to exist, the subjects saw themselves "as people who had achieved, and had pride in that." The authors ascribe this successful adjustment to the kibbutzim ideology which stresses collective group meaning and support, and provides structure to the lives of its members. Parent-child relationships among kibbutzim families were good, as reflected in a motif of "re-birth" or restoration and a family closeness and affection for one another. The authors concluded that while families had achieved satisfactory adjustment to their new life, survivors continued to cope with the memories of the Holocaust by intellectualization, ritualization, sublimation, and idealization of the family. Group life minimized the post-traumatic shock through collective identification and by legitimizing the expression of loss and mourning (Klein and Reinharz, 1973:318).

In a study of non-clinical survivors conducted by Davidson (1979), little evidence of the "symptomology" of the survivor syndrome was found. This group of 15 men and 15 women was unique in several aspects, however. All were adolescents at the time of their internment, spent from one to two years in a concentration camp, and had rehabilitative treatment following liberation. Friendships developed during rehabilitation persisted long after the subjects left the treatment communities, and these friendships provided the basis for support in later life.

In sum, research on Holocaust survivors and children of survivors identifies not only the nature of the physical and psychological shock experience of survivors, but the research also points to the likely consequences of this experience for the offspring of survivors. To the extent that the results reported accurately reflect the reality of the post-traumatic shock experience, it can be used as a benchmark to study the effects of other catastrophies upon traumatized survivors. Unfortunately, in both a theoretical sense and for methodological reasons, the utility of Holocaust research is limited.
CRITIQUE

Studies of Holocaust survivors draw heavily upon a Freudian or neo-Freudian conceptual framework. While it is generally acknowledged that this approach has merit for clinical purposes, its utility for scientific research is limited. Psychoanalysis represents a weak research paradigm for several reasons. First, it lacks clearly defined concepts. For example, critical to any analysis which deals with the consequences of traumatic shock are the concepts "normal" and "adjustment." But what is "normal" in reaction to stress, and what constitutes "adjustment" to the post-Holocaust world is dependent in part on the judgment of the analyst. Psychoanalysts' theory per se does not provide definitions in other than a relative sense (Ginsberg, 1968: 315-340).

Second, as a conceptual framework useful to identify a client's condition, the predictive capability of psychoanalysis is weak in that it fails to specify a clearly defined set of relational rules by which to forecast future behavior (Hall and Lindsey, 1957:71). Thus, it is not clear at what point and under which conditions an experience becomes traumatic. Similarly, it is not clear when certain coping techniques come into use, or why some techniques are employed and others are not.

Finally, because its explanatory focus is upon inner psychological and biological processes, the Freudian perspective tends to overlook the significance of interactional and environmental factors shown to be important in other contexts (Benner, et al., 1980). What is needed is an alternative conceptual framework which incorporates a psycho-social perspective recognizing that the dynamic nature of post-traumatic stress disorder is caused by the continuous interaction between the individual and the environment. The framework should be conceptually clear and would permit systematic testing of theoretically derived hypotheses.

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Most promising in this area is the work of Lazarus and his associates (Lazarus, 1966, Lazarus, Ave-rill and Opton, 1974; Lazarus, 1982). Approaching the problem from a cognitive and phenomenological perspective, Lazarus conceptualizes the conditions of stress as emerging from a disturbance in the person-environment relationship. Stress, defined as a physiological and psychological state of being, results from the individual's perception of the environment as disruptive, e.g., the situation is seen to be either challenging or threatening. Furthermore, stress is viewed as being a mental state emerging from a person's awareness of the environmental situation—an awareness to which evaluative meaning is assigned. Lazarus refers to this process as cognitive appraisal, wherein a judgment is made as to the nature and seriousness of the environmental disturbance. Having defined the situation, individuals attempt to "cope" with the disturbance in an effort to minimize the disturbance, e.g., shape the environment to reduce the threat or by redefining the meaning of the threat. The entire event is, in Lazarus' terms, "a transactional process," in that it changes over time as the individual shapes and is shaped by the environment.

Delimiting as the conceptual framework used to analyze PTSD has been for scientific study, it is the methodology which truly sets limits upon scientific utility of our theories. Reported research suffers from inadequate sampling techniques. That is, subjects by and large have been those who either sought psychiatric assistance or those who sought to qualify for assistance under the German Indemnification program. For this reason, any generalizations made from the findings reported are of limited value. This problem is further complicated when the results of the few studies which draw upon nonclinical subjects are considered (see, for example, Leon, et al., 1981; Tauber, 1980, Fishbane, 1979, Klein and Reinhart, 1972; Davidson, 1979). Little evidence of the "survivor syndrome" has been found in these studies, although the after-effects of the Holocaust experience are well-defined. Whereas it has been suggested that those seeking therapeutic assistance constitute a minority of Holocaust survivors (Eitenger, 1980), no
information exists as to the actual number of living survivors.3

In addition to neurological and general medical examinations has been the therapeutic interview. But as Horowitz (1964) observed, distortions in interpretation inevitably occur when the analyst combines several functions simultaneously, and as a result of patient reaction to analyst intervention. Moreover, the lack of control over extraneous factors within the context of the interview process itself, as well as the absence of rules for systematic inference from the data obtained, increases the difficulty in replicating the findings reported. Unfortunately, implicit or explicit generalizations are made. And given the emotionally sensitive nature of the subject matter, objective detachment is extremely difficult, if not impossible. In the absence of alternatives, reliance upon the therapists' subjective interpretations for confirming the existence of psychic or psychosomatic conditions continues, albeit remain suspect.

In spite of an extensive body of literature, research on the post-traumatic effects of the Holocaust for survivors is of limited utility. Reasons for this, we have argued, are found in the dominance of a theoretical framework which focuses upon the individual within the context of therapeutic session. Excluded is what Benner, et al. (1980) have called the exogenous factors surrounding the survivor's life. Additionally, the predominate use of methodologies that ignore the canons of science merely exacerbates

3 Accurate figures on the number of survivors immigrating to Canada and the United States are not available. Cath (1981) reports that 50,000 immigrated, while Tauber (1980) believes the number of immigrants was 92,000. Neither figure can be verified in part because of the absence of official records and in part because of disagreement over the definition of "survivor." For some scholars, survivors are those who were in concentration camps, while for others the term "survivor" includes those who hid or were active in the resistance.
the problem. Given the horrors of the Holocaust, perhaps it was inevitable that social scientists and psychologists would be reluctant to conduct research involving Holocaust survivors. But to have endured so much and still to have gone on with one's life in the post-Holocaust period is a reaffirmation of the human will to survive and to overcome the effects of adversity caused by man's inhumanity to man (Frankl, 1959).

Is it possible that the majority of survivors cope by drawing strength from this tragedy? After four decades the need to know the answer to this question has never been greater.

NEEDED RESEARCH

The need for methodologies that incorporate random sampling techniques, matched control groups, and standardized measures is apparent. Without further studies in which these methodological practices are employed, hope of providing scientific understanding beyond clinical studies is limited. That many analysts are cognizant of this problem and acknowledge their difficulties in remaining emotionally detached from their clients' problems offers some promise of future change (Russell, 1980; Eitinger, 1980).

Ideally, a variety of measures could be used to assess the long-term effects of the traumatic experience of the Holocaust upon survivors. Now, as survivors approach old age, the need to conduct such research seems urgent. Research strategies which could have been employed, such as cross-cultural comparisons of survivors' adjustment or the comparative assessment of the adjustment of Holocaust survivors with other survivor groups, are no longer applicable. Of necessity future efforts must focus upon either retrospective data, or on the current circumstances of survivors as they reach old age. The following appear to us to represent the more important areas in which research is needed.

Studies of survivors who have not sought mental health care are needed. Similarly, little is known
about the social status, occupation, educational achievement level, religious affiliation, and pattern of community involvement of survivors. Knowledge of such matters would remove much of the ambiguity surrounding adjustment to post-traumatic shock. Accurate social and demographic information on survivors would undoubtedly shed additional light on a collective group response to post-traumatic shock as well as on the collective social and psychological costs incurred during the adjustment process.

Frequently referred to in the literature but never fully explored is the effect of socio-cultural milieus upon adjustment. Beyond the presence or absence of support systems, which serve to facilitate (or retard) recovery from post-traumatic shock, perhaps answers to these questions lie in the weltanschauung of the host society. Socially conservative and staid Norwegian society provides a very different cultural world-view of man's place in the order of things than that of the American culture (Wright, 1984). For many Jewish survivors, the state of Israel represented a highly desirable cultural milieu. Culturally supportive and religiously homogeneous, the Israeli struggle for national survival also provided a context within which the survivors could redefine the meaning of their existence. North American societies, on the other hand, were exactly the opposite. No struggle for national survival existed. Holocaust immigrants were foreign to the American culture and, in most instances, were identified as being members of a minority religious group. Such variables very likely affect the adjustment experience.

At minimum three research questions should be addressed: what mechanisms did survivors develop to cope with the problems of readjustment in a strange land? how significant are family ties, friends and community contacts in making a successful transition to life in America? and finally, has the pattern of physical illness and social unrest among survivors who settled in America been similar to that reported for Norwegian survivors? Perhaps the most pressing need, however, is to study the effects of survivor aging.
The events concomitant with aging are difficult at best for any group. There are many reasons to suspect that these events would have been considerably more difficult for Holocaust survivors.

Having immigrated to America during their late teens and twenties, most survivors are now approaching or are past retirement age (Ornstein, 1981). Old age is a time of remembrance and, as Danieli (1980-1981) observes, may very likely constitute a traumatic event for Holocaust survivors with their memories of concentration camp. The likelihood of such a development is enhanced when survivors enter a nursing home. Institutional parallels between nursing homes and concentration camps are not obvious, but are no less real. A loss of independence, no matter how benign the motivation, still results in restriction. Eating meals on schedule, group requirements, impersonal custodial care, sterile rooms and poorly orchestrated medical treatment all have their parallels with survivor concentration camp experiences (Hirshfeld, 1977; Goldberg and Haught, 1983). Facing such conditions, even under the best possible arrangement, could be a traumatic experience not unlike that suffered in the past.

Evidence exists that the aging process has accelerated among Norwegian Holocaust survivors (Eitinger, 1980). And Gay's (1972) findings that survivor parents tended to be more frequently ill and more psychologically exhausted suggest that early aging is not uncommon among this group. Unfortunately, comparable data are currently unavailable for survivors residing in the United States. Epidemiological studies are essential if the future health care needs of survivors are to be anticipated.

Whether these kinds of research will be conducted in the future is uncertain. The information gained from such studies, however, could provide valuable insights for social workers, counselors, and health care professionals into problems associated with the long-term effects of post-traumatic stress. In a practical sense, such information could provide a basis for the development of therapeutic counseling
and treatment models for persons who, having experienced severe traumatic shock early in life, must now experience the trauma of institutionalization and pending death. If the experience of the Holocaust has any redeeming value at all, it must rest in the opportunity for survivors to contribute to greater understanding of how to cope with extreme adversity—a legacy which could assist other victims of extreme traumatic shock.

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THE EFFECTS OF THE HOLOCAUST:
PSYCHIATRIC, BEHAVIORAL, AND SURVIVOR PERSPECTIVES

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ABSTRACT

In this paper the authors review perspectives related to Holocaust victims, limitations of Holocaust studies are discussed, and suggestions for viewing the long-range post-traumatic effects of the Holocaust upon its victims from social and behavioral science perspectives are advanced. The views of survivors toward post-war adjustment, drawn from interviews with Holocaust victims, are also presented.

INTRODUCTION

Considerable interest has existed in the scientific and professional communities regarding the long-range effects of psychic-trauma. It is not surprising, therefore, that the World War II Holocaust stimulated scientific and professional interests in post-traumatic stress. Unique in the annals of history, the Holocaust was an extreme event. Accounts of this event typically focus on the conditions which characterized the concentration camp experience, the resistant and adaptive reactions of the victims, and the effects of the traumatic experience upon survivors.

In large part scientific curiosity has focused on matters relating to the human capacity to endure
extreme suffering, the nature of adaptive survival mechanisms employed by Holocaust victims, the pathological consequences of the trauma, and the adjustment of survivors to post-war conditions. Professional interest has largely been directed toward the pathological effects related to the Holocaust experience, including its impact on the children of survivors, and only to a limited extent on methods which can be used to aid survivors to adjust socially and psychologically to post-war conditions.

Beliefs held by public officials and health and human service professionals concerning the needs of vulnerable individuals largely determine allocation of resources, treatment strategies and care practices (Perrow, 1967, Harel, 1978). For this reason, an exploration of the needs of Holocaust survivors, based on perceptions held by the public, professional groups and by survivors themselves, is important. Common perceptions of these problems are more likely to facilitate communication and understanding between survivors and members of the helping professions as well as with the general public.

The perception that a public is empathetic toward survivors of the Holocaust experience is likely to enhance the integration of survivors into the mainstream of community life, whereas a perception that the public is disinterested and holds malevolent views are more likely to have an alienating effect. Moreover, a perception that professionals are sensitive and understanding of survivor needs is of paramount importance if these individuals are to seek the services provided by health and human service professionals. For these reasons, then, our discussion is intended to 1) explore the implications of stress among survivors, 2) to evaluate the perceptions of the Holocaust held by survivors, 3) to assess the impact of their traumatic experiences on the adjustment process, and 4) to present an overview of survivor reaction to the attitudes of the general public and members of the Jewish community toward the Holocaust.

In the sections that follow, selected empirical studies of Holocaust survivors are reviewed and the
theoretical and methodological imitations of this research are discussed. Second, the validity of the research conclusions, based on medical and psychiatric perspectives, is questioned and a suggestion to view the long-range effects of the Holocaust from social and behavioral science perspectives is advanced. Finally, observations based on interviews with survivors are presented in an effort to highlight the long-range effects of stress on survivors, and to suggest ways in which Holocaust victims can be assisted in adjusting to the demands of everyday life.

THE HOLOCAUST LITERATURE

A review of the literature dealing with the effects of the Holocaust on survivors reveals an overwhelming pathological emphasis; an emphasis which, retrospectively, may have been inevitable. Reports of the psychological and physiological damage inflicted upon Holocaust victims circulated within a few years after the end of World War II; however, it was not until the sixties that an extensive body of literature began to appear on this subject (Chodoff, 1966). These findings documented a wide range of physical and psychic impairments suffered by Holocaust survivors including severe headaches and heart palpitations, nonrational fears and anxieties, dependence and indecision, and various forms of social maladjustments. In turn, these symptoms were interpreted as constituting a syndrome characteristic of individuals subjected to the peculiar trauma experienced by Holocaust victims (Eitinger, 1961; Trautman, 1961; Engel, 1962; Strom, et al., 1962; Chodoff, 1963; Klein, 1974; Oswald and Bittner, 1968).

Chodoff (1966), in summarizing the immediate effects of massive psychic-trauma, has shown that bitterness, resentment, depression, weight loss, emotional and autonomic lability, irritability, apathy, low self-esteem, and difficulty in concentration were commonly manifested among survivors. As for long-term effects, Chodoff identified two clusters of symptoms, the first of which included tendencies toward social
isolation, apathy, helplessness, and a high degree of dependence. Such persons also were described as being passive and fatalistic. Characteristics identified in the second cluster suggested that Holocaust survivors were inclined toward suspicion, hostility, and distrust. These individuals also had a tendency to demonstrate despair, envy, bitterness, cynicism, and belligerence toward others.

Various configurations of these two clusters of symptoms, referred to as "concentration camp syndrome," imply severe psychological and social impairment (Chodoff, 1966). Survivors also have been described as being characterized by "survival guilt"—a guilt consisting of feelings brought on by the fact that they survived the Holocaust, while relatives and friends had not survived (Chodoff, 1963). This perspective, according to Krystal (1968), is based on the fact that after 1,500 years of degradation, Jews learned to accept and internalize their enemies' views about them. In concentration camps this perspective led survivors to believe that death was actually deserved.

During the sixties, a number of comparative studies were introduced into the literature. Nathan, et al., (1964), for example, studied two survivor groups, concentration camp survivors and "Russians" (i.e., Polish Jews who had been exiled in the Soviet Union). In this study it was found that survivors of concentration camps were more likely to engage in "atypical" behavior than were members of the comparison group. Kanter (1970) observed that pathological tendencies were less pronounced among ethnicly conscious Jews than among Jews who had an assimilational background. A comparison of former concentration camp inmates admitted to mental hospitals with a group of psychiatric patients in Finland and Israel by Eitinger (1962) revealed that pathological tendencies were much greater among Holocaust survivors. In discussing these differences, Eitinger (1965) noted the difficulty survivors experienced when they returned to their pre-war locations to re-establish instrumental and social anchors. Many had no home to return to and often were the sole survivors of entire families.
While clearly not exhaustive, the above studies are representative of the research reports which concentrated on survivors. What is most striking about this research literature is the agreement held by the analysts that survivors had suffered lasting physical, psychological, and social impairment. This view is also held by many survivors as indicated in the following:

We've all been damaged, doctor, and I think we are all a bunch of rotten apples. We may look okay on the outside, but when you get to know us you will see that we are different and sick inside and no matter what happens our lives will never be normal again (Oswald and Bittner, 1968, p. 1398).

THEORETICAL AND METHODOLOGICAL LIMITATIONS OF THE RESEARCH LITERATURE

The Holocaust literature has several theoretical and methodological limitations. First, in terms of a conceptual approach, most studies draw exclusively on the psychoanalytic literature while completely neglecting behavioral and social science perspectives. Second, in explaining the behavior of survivors most studies tend to draw theoretical inferences which are well beyond the scope of their data to be justified from a scientific standpoint. The result is that a serious gap exists in the theoretical utility of these studies (Des Pres, 1976).

The effort to bring behavioral science perspectives to bear on the problem of the long-range effects of the Holocaust experience on survivors has been more recent. In one such study, Matussek (1975) reported evaluating 245 survivors 15 years after their confinement. Contrary to the findings reported by Chodoff (1965) and Krystal (1968), Matussek concluded that no identifiable concentration camp syndrome existed. Moreover, Matussek suggested that a number of pre-war factors (family structure and relationship) and post-war factors (employment and marital harmony) may have
affected the adjustment and well-being of survivors. Matussek also found that the nature and duration of stress emerging from the concentration camp experience, were related to passivity, retreatism, and the lack of initiative demonstrated by survivors. In a follow-up study conducted by Dor Shav (1978), a comparison of concentration camp survivors (N = 42) with a control group (N = 20) indicated that survivors were more likely to be intellectually impoverished and to suffer from a constricted personality than were subjects in the control group.

In another project (Leon, et al., 1981), 52 survivors and 47 children of survivors living in a midwestern city were compared on psychological adjustment variables with adults and children of similar religious and cultural backgrounds. No significant psychological adjustment differences were found to exist between survivor parents and members of the control group. Where differences were found, these differences were more likely to be related to cultural factors than to concentration camp experiences. Moreover, no significant differences were found to exist between children of survivors and a control group of children in their attitudes toward their parents. Based on these findings, previously accepted notions of survivor guilt, the presence of emotional blunting in survivors, and the alleged maladaptive psychological influence of survivor parents' experiences on their children, can be questioned.

In sum, must studies have employed small and non-representative samples drawn for the most part from those seeking help (e.g., Chodoff, 1963, Eitinger, 1961, 1962; Kanter, 1970; Klein, 1974; Nathan, et al., 1964; Oswald and Bittner, 1968; Trautman, 1961), or those who applied for restitution from the German government (e.g., Chodoff, 1966; Engel, 1962; Oswald and Bittner, 1968). While freely generalizing about the entire survivor population, many investigators did not use comparison groups (see, for example, Chodoff, 1966; Eitinger, 1962; Engel, 1962; Oswald and Bittner, 1968; Strom, et al., 1962; Trautman, 1961). As a result, recent studies which employ social and behavioral science perspectives and more appropriate
sampling techniques raise serious questions about the conclusions derived from clinical observations and from studies based on nonrepresentative samples (Harel, 1983).

THE STRESS LITERATURE

The stress literature provides a useful perspective for understanding the coping strategies used by Holocaust survivors to deal with their environment (Appley and Trumbull, 1967; Levine and Scotch, 1973; McGrath, 1980). Much of the stress research tends to focus on assessing the effects of stimulus conditions on physiological and psychological response repertoires (Appley and Trumbull, 1967). However, a review of this stress literature suggests that the medical perspective may be too limited to provide an adequate understanding of the effects of post-traumatic stress on survivors.

The work of Lazarus (1967) is representative of one group of stress researchers who perceive of stress as a dynamic process involving cognitive psychological mediation. In refining their conceptualization of stress, Coyne and Lazarus (1979) suggest that coping with stressful situations involves an ongoing process of cognitive appraisals revolving around person-person and person-environment transactions. This involves the person's appraisal of the threatening event, individual capabilities to respond adequately to the stressful demand, the anticipated cost of the response(s), and an appraisal of the consequences.

While not minimizing the importance of emotional and physiological reaction, for the purposes of this discussion it is important to note the emphasis that Lazarus (1967) and Coyne and Lazarus (1979) place on problem solving directed coping strategies. Coping with stress, according to these analysts, involves: the stress condition or the environmental demand; the cognitive appraisal and the subjective definition of the demand condition; the cognitive appraisal of the response repertoire; problem solving directed coping patterns; and appraisal of the impact of the response.
Research evidence seems to justify the conclusion that individuals who suffer extreme stress will experience immediate and long-term physical, social and psychological impairment (Levine and Scotch, 1973). While the stress research tends to support this position, other conclusions are also suggested. The research indicates that substantial differences exist in the manner in which individuals perceive and react to stressful situations and conditions (Lazarus, 1967). The effects also vary because stress is mediated through subjective psychological processes which include physiological, cognitive, and emotional components.

In McGrath's (1970) view, the effects of stress are mediated through various psychological processes such as cognitive appraisals of the threat and coping resources. In turn, these are affected by the personality structure of the individual and the organization of the social milieu in which he/she is involved. Stress and stress responses vary as a consequence of the social experience and the ability of individuals to cope with or to avoid the consequences of stress.

Some analysts prefer the term "extreme situations" (Haas and Drabek, 1970). One such analyst, Torrance (1965), suggests that distinctive elements emerging from extreme situations of stress are the breakdown of conventional social structures and the inability of individuals to anticipate or predict outcomes. Life in concentration camps was characterized by physical degradation, deprivation, lack of food, extreme cold, and prolonged isolation. An additional factor was the absence of a conventional social structure. Conventional modes of behavior were rarely applicable in such situations, and the human capacity to endure unpredictable. As a consequence, individuals were called upon to respond to conditions for which they were unprepared. At the same time, concentration camp inmates were aware that failure to respond adequately held severe consequences for them, including the threat of death (Des Pres, 1976).
THE PERSPECTIVE OF SURVIVORS

The perspective presented in this section is based on responses to surveys and interviews with survivors living in the United States and Israel. Interviews were conducted with twenty-five individuals who attended a gathering of Holocaust survivors in Washington, D.C. during April, 1983, and with twenty-five survivors now living in Israel. The interviewing took place during the summer of 1983. Selected data from a survey of 263 survivors who attended the Washington gathering and from an ongoing cross-national research project on the mental health implications of stress are also included in the discussion.

In evaluating their Holocaust experiences and post-war adaptation, survivors present two general concerns. First, survivors indicate that the Holocaust still affects their lives, and that they frequently reflect upon their traumatic experiences. At the same time, they convey a sense of pride and attribute a positive meaning to their ability to survive. Second, in response to questions about their perception of professional approaches toward survivors, a concern that members of professional and scientific communities do not adequately understand the nature of their individual and collective needs was expressed. Survivors are generally apprehensive about the general public's perceptions of them and of the manner in which professionals relate to the symbolic meaning of the Holocaust. A collective concern revolves around the Holocaust as a symbolic representation. Survivors fear that the memory of the Holocaust will be trivialized, forgotten or denied. Because of the orientation that characterizes contemporary life in the United States and Western Europe, survivors fear that expressions of hostility toward Jews and recent demonstrations of antisemitism could lead to organized assaults on their life and property.

Survivors also expressed their concern that the research literature has contributed to the development of misconceptions about survivors and their children.
which label them as being emotionally and socially impaired. While resentful of being so labeled, survivors are cognizant of the fact that they have been scarred by their experiences. Proud of their accomplishments, and those of their children, survivors appear to be perplexed by the fact that members of science and the helping professionals have created pathological characterizations of survivors, while few studies document the extent of adjustment, personal well-being and the contributions that survivors have made to the well-being of others.

Although admitting to having experienced adjustment problems, survivors attribute this difficulty in part to community reactions toward them including open hostility, indifference, and a social attitude that tends toward "blaming the victim." Generally appreciative of expressions of bravery on the part of righteous gentiles who risked their lives to save Jews and their concentration camp liberators, survivors appear troubled by the expressions of hostility toward them in their countries of origin and in other locations around the world. They are also troubled by the disinterest in commemorating the Holocaust.

Survivors state that adjustment of stress victims is likely to be aided by a more sensitive and more understanding attitude both among the general public and within the professional and scientific communities. The survivor perspective is important because, unlike other perspectives, it addresses the perceived collective needs of survivors. One of these needs relates to the symbolic commemoration of the Holocaust.

SUMMARY AND CONCLUSION

The literature offers a general conclusion that Holocaust survivors have been traumatically affected by their experience and that they suffer from a variety of physical, psychological, and social impairments. As a result, survivors are perceived as being emotionally handicapped. Although some evidence exists to support the notion that survivors have been severely

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scarred by their Holocaust experiences, there is also evidence to indicate that a large number of Holocaust survivors have adjusted, and that survivors enjoy reasonable states of psychological and social well-being. Recent findings suggest that earlier research conclusions about Holocaust victims may have been overstated (Harel, 1983). These findings also suggest that behavioral and social science perspectives may offer a more useful framework for developing an understanding of the long-range effects of the Holocaust on survivors.

Holocaust victims have had to focus their energies almost exclusively on survival. It is not surprising, therefore, that much energy was directed toward coping with stress in ways that would ensure survival. Unfortunately, Holocaust victimization studies have relied exclusively on psychoanalytic perspectives. For these reasons the research literature has not dealt with the coping strategies employed by survivors, while Holocaust analysts have generally ignored the environmental demands and realities with which survivors were forced to contend.

Socio-environmental theory suggests that human behavior is affected by objective environmental conditions, by perceptions of environmental demands and challenges, and by individual responses to their social environment (Germain, 1978; Gump, 1974). Holocaust survivors have been confronted with at least three major challenges: first, they had to cope with their traumatic experiences related to their incarceration in concentration camps; second, they had to cope with the loss of family members and friends; and finally, they were challenged by the demands associated with relocation to new political, cultural and social environments. It is important to note, however, that a majority of Holocaust survivors accepted the demands, challenges, and opportunities afforded to them, and used effective coping strategies to adjust to their post-war living conditions.

Early conclusions about the effects of the Holocaust may have produced an unintended burden on survivors. This burden is reflected in the fact that
both survivors and their children have been labeled as emotionally and socially impaired. Survivors, on the other hand, emphasize that they directed their energies toward achieving goals, establishing personal and occupational identities and assuring their socio-economic well-being. They have reestablished themselves as family members and have contributed to the enhancement of Jewish communal life in the United States and elsewhere. It is essential, therefore, that the factors which contributed to this adjustment be explored more fully in order to develop a better understanding of the consequences of post-traumatic stress on survivors.

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HOLOCAUST SURVIVORS AND POST-TRAUMATIC STRESS DISORDERS: THE NEED FOR CONCEPTUAL REASSESSMENT AND DEVELOPMENT

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ABSTRACT

The recent interest in various aspects of the Holocaust focus on survivors and their children. One major part of this research has focused on the medical and psychological sequels of the concentration camp and other Holocaust related experiences for which Eitinger (1981) identified seven distinct areas of inquiry. The literature in each of these areas is extensive; however, this work is fraught with problems both at the conceptual and at the treatment levels. This paper is specifically concerned with reviewing research and treatment programs, identifying the major problem areas, and concludes with a suggested conceptual alternative to the prevailing clinical models.

INTRODUCTION

Following liberation in 1945, the greater majority of Jewish concentration camp survivors were kept in displaced persons camps. These camps served as interim placement centers and also represented a unique opportunity for interested observers to conduct physical and psychological analyses of the survivors. The most obvious consequences of the camp experiences, it was noted, were the extreme physical disabilities. Based on preliminary interviews conducted with survivors at this time, it often appeared that the conditions of liberation overshadowed the variety of traumatic problems that had developed during the Holocaust.
years. This supposed "symptom-free interval" presented one of the first difficulties encountered in evaluating psychological problems anticipated as a consequence of the prolonged trauma (Luchterhand, 1970).

During the late 1940's and the early 1950's the delayed effect of the Holocaust experience began to manifest in survivors and these were subsequently documented in the literature (e.g., Chodoff, 1963; Eitinger, 1980, 1981; Luchterhand, 1970). Apparently the major psychological effect of these experiences began to take effect after the survivors had resettled and had created new lives for themselves in unfamiliar surroundings. The consistancy of the psychological disorder that emerged among survivors became identified in the early literature as the "Concentration Camp Syndrome" and the "Survivor Syndrome," clinical descriptors that later gave way to what is currently referred to as post-traumatic stress disorder (PTSD).

PTSD: A Clinical Approach

Post-traumatic stress disorder is characterized by a constellation of behaviors for which there is a wide consensus for diagnosis and a distinct classification in the DSM III (1980). With minor exceptions employed for diagnostic clarity, the criteria for PTSD listed in the DSM III differ little from those described by Neiderland back in 1968.

While general agreement exists on the characteristics of the behavioral dimensions of the disorder, there are significant differences regarding the theoretical or conceptual framework within which PTSD can best be explained. In evaluating the psychological and medical effects of the concentration camp experience, for example, Eitinger (1981) identified two major areas of difficulty: first, the unexpected, long-lasting symptoms related to PTSD often are not conducive to psychotherapy. Second, the prevailing psychiatric and psychological theories are inadequate to account for treating the sequels of massive psychic trauma. Moreover, Eitinger points out that in spite
of these inadequacies, an alternative theory has yet to be developed.

Efforts to Deal with PTSD

It is important to note that the accepted conceptual framework for understanding the problems of Holocaust survivors was developed in early research studies conducted to meet the demands of the Restitution Laws. Enacted by the Federal Republic of West Germany during the ten-year period following the end of World War II, Restitution Laws required that a causal connection be clinically established between the traumatic experience and an impaired state of health (Engel, 1962). Toward this end it became necessary to create a clinical syndrome and to deal with the emerging patterns of disturbed behavior manifested by this group of survivors.

More systematic approaches to analyzing the effect of the Holocaust were also attempted. For example, Boder (1949, 1954) sought to explain the nature of the traumatizing experiences and the behavioral responses to those experiences, for which the Traumatic Inventory and the Traumatic Values Scales were developed. While Boder's work appears to have had some potential for establishing responsible research programs, perhaps one reason this approach was ignored results from the shift to a specifically clinical approach for restitution and treatment purposes. As discussed by Engel (1962), the efforts to derive a diagnostic model to conform to requirements of the Restitution Laws, and to provide therapeutic assistance were initiated primarily by psychiatrists.

Luchterhand's (1970) view of the conflicting interpretations that began to proliferate in the Holocaust and survivor research literature established that there is general agreement on the behavioral dimensions of the PTSD problem. There is also significant disagreement over the etiology and the theoretical significance of characteristics common to pathological disturbances.
Two etiological models identified by Luchterhand (1970) appear in the work done by psychiatrists and psychoanalysts. The neurobiological model stresses brain pathology with deficits and impaired capacities, loss of controlled behavior and a lowered personal organization. The dynamic model includes the basic concepts of survivor guilt, repressed aggression, transference, projection, denial and other Freudian or neo-Freudian tenets. Luchterhand points out that existing theories offer a narrow view of the behavior problem experienced by survivors, placing almost all of these into a clinical, pathological framework. This limited view of PTSD totally ignores the behavioral strengths of survivors and often disregards the conditions under which the survivors lived during the Holocaust period. Luchterhand, a sociologist, also raises the concern of the over clinicalization of this area at the expense of a broader and possibly more productive psycho-social analytical framework.

Solkoff's (1981) review of the literature on the children of survivors raises a basic question of the heuristic value of the existing research. Once again, the research is considered to be narrow in scope, the case studies reported often skew toward a clinical orientation, and the research results do not emerge as a product grounded in acceptable techniques of research design. Solkoff's argument is that PTSD is social-psychological in nature and, therefore, should not be limited to a single theoretical approach. In this regard, Dimsdale (1980) clearly demonstrates the need for an expanded conceptual framework if the effects of Holocaust upon its survivors are to be understood.

Dehumanization: A Preliminary Exploration

Yet another common theme emerges from the general clinical literature on Holocaust survivors. That theme is dehumanization. Described by Bernard, et al. (1971) as a psychic-defense mechanism, dehumanization can be conceived of as a means by which individuals, when exposed to extreme traumatic experiences, diffuse some of the pain by denigrating themselves. The intent, of course is to buffer some of the damage.
anticipated from the inhuman treatment they are subjected to.

Dehumanization would seem to qualify for placement into existing models, but it is perhaps more important to understand the use of the term within a psycho-social framework. As an alternative to existing models, Kelman (1973) conceptualizes dehumanization as a process which deprives both victim and victimizer of their self-identity and sense of community. While Kelman focuses on counter-measures to the establishment of the conditions related to dehumanization, the idea that "dehumanization" may be used as an alternative to conceptualize the conditions under which survivors survived is also theoretically attractive.

An effort to clarify the nature of dehumanization as a condition of living, as a goal sought by victimizers, and as an evolving state of the victim is currently in progress by the author. Scales are being developed that will focus on the dehumanizing experiences and will allow the consequences thereof to be more fully evaluated. In the section that follows, an overview of this current effort is presented.

Survivor Research: A Time for Reevaluation

Early researchers sought to identify clinical pathologies among survivors. In focusing on these debilitating effects, the analysts failed to recognize the important aspects of reference group influences. As the product of their cultural and social histories, the makeup of humans is characterized by an evolving personality and patterns of behavior which represent a composite of experience, tradition and life conditions. Consequently, when faced with continuous or overwhelming trauma, the behavioral responses expected are determined to a degree by historic stimuli and the degree to which the trauma establishes a precedent in that person's life style or within a tradition the individual identifies with. It is within this framework that an understanding of the Holocaust and its effect on survivors must be reconceptualized.
Before clinical analysts began to dominate the Holocaust research, Boder (1949, 1954) recognized the need to evaluate the impact of a past history on the survivors. Toward this end Boder's Traumatic Index Scale was intended to categorize these experiences, and the purpose behind the Traumatic Inventory Scale was to assess the impact of these experiences on the survivors. The Traumatic Index Scale constitutes a basis for measuring the process of dehumanization. Intended to identify the factors essential to this process, the Traumatic Index is applicable to other human conditions as well. These factors include events, conditions and experiences that contribute to progressive traumatic effects on individuals or groups.

Boder sought to identify the interaction between people and environmental conditions and to establish a conceptualization of survivors without relying upon pathological interpretations. Factors thought to influence the dehumanization process include: the abrupt removal from an environment; inadequate substitutes for the conditioning framework of normal life; introduction of new stimuli that do not relate to past experiences or legal and moral references; inadequate facilities for personal and community hygiene; the withdrawal of basic rituals of decency and dignity; and brutal punishment for trivial transgressions of rules or for the alleged offenses.

These factors serve as a starting point for the author's current effort to reconceptualize survivor experiences. When combined, assessment of the effect of traumatic events and the subsequent behavioral responses intended to deal with these conditions will enhance the efforts of professionals to assist and to treat victims of traumatizing events.

While it is perhaps surprising that the psychoanalytic model has predominated in survivor research, some important efforts to view survival in non-pathological ways, and to consider survival as a triumph of human spirit and adaptability can be found in the work of Des Pres (1976), Kren and Rappoport (1980), Trunk (1979) and Kopecky (1982). The concepts
dehumanization and rehumanization assume even greater possibilities as explanatory constructs for overarching traumatic conditions and human responses. The term survivor, as it is currently used in the literature, must assume a broader meaning in order to insure that the legacy of the Holocaust experience may serve to contribute broadly to our understanding of post-traumatic stress and subsequent efforts to cope with stress. It is not enough to view survivors as living martyrs or as clinically disturbed products of extremis.

It is clear that the clinical approach to Holocaust survivor research interferes with development of certain kinds of knowledge. It is also important to recognize that the further Holocaust survivors are removed from the mainstream of research on human survival in general, the less likely this kind of research can be related to the more generic issues involving human behavior, and the more likely survivors of the Holocaust will continue to be viewed as an historic anomaly.

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ABSTRACT

This paper describes how Holocaust survivors learned to help themselves and to reestablish their sense of community and self-worth. Sixteen female survivors were interviewed regarding their post-war adjustment. Data from the interviews revealed three themes which the women employed to cope with their post-war stress. These important factors in the adaptation process include establishing a family, building a community, and using work as therapy.

INTRODUCTION

By the end of World War II only 400,000-500,000 Jews had survived the Holocaust (Rabinowitz 1976). Many survivors emigrated from Europe to locations where they could make a fresh start; Israel and the United States were among the countries the survivors were most interested in settling.

Approximately 92,000 Holocaust survivors emigrated to the United States between 1945 and 1951 (Rabinowitz 1976). The responsibility for settling the survivors was assumed by a number of Jewish agencies, American relatives, and other sponsors.

It was the philosophy of the American Jewish leadership that these emigrates be encouraged to assimilate into American society. The idea of allowing the refugees to concentrate in New York City or other large Jewish population centers, for example, was an anathema to the leadership which wanted to prevent the "ghettoization" of survivors. Little consideration was given to the desires and needs of survivors, however.
The war experience had exacted a substantial cost in terms of the physical and emotional state of survivors. In addition to starvation, survivors suffered from a variety of diseases including typhus, typhoid, tuberculosis and dysentery during their internment (Levin 1973:727; Rabinowitz 1976:57-75; Ringelblum 1974:131,421). Their physical condition was further weakened by the trauma that resulted from beatings, accidents, frostbite, and medical experimentation (Tillion 1975:79-92, Levin 1973:244; Epstein 1979:101). However, the long-term effects of the Holocaust on the psychological well-being of the survivors were not anticipated. A partial explanation for this was that many survivor problems did not surface until about ten years after their liberation from the concentration camps (Epstein 1979:101).

Interest in survivors began to develop within the psychiatric community at the time thousands of survivors underwent mandatory medical and psychiatric examinations to qualify for reparations from West Germany (Epstein, 1979). Then, during the late 1950's and early 1960's psychiatrists and psychologists noted a number of similar complaints from survivors. Soon thereafter, articles that concentrated on the pathological effects of the "concentration camp syndrome" or the "survivor syndrome" began to proliferate in professional journals (Chodoff 1963; Eitinger 1961; Neiderland 1968; Krystal 1968; Jaffe 1968; Shuval 1957).

Although based upon clinical observations of both males and females, available evidence suggests that females in particular have had difficulties in their mother-child relationships (Rakoff 1967; Epstein 1979). Survival mothers have been found to be overly protective of their children (Rakoff 1967); they also expressed a fear of losing their children because of their inability to resolve their previous losses during the war (Neiderland 1968). Because of these tendencies, female survivors often are described as engulfing their children in the pathological world of the concentration camp experience (Kestenberg 1972; Trossman 1968; Dor-Shav 1978).
PROCEDURE

The data presented in this paper result from open-ended interviews conducted during 1981-1983 with sixteen women who survived the Holocaust and are now residing in a large metropolitan area in the western United States. The women, who ranged in age from 55 to 64 years, represent a mixture of national backgrounds; ten were Polish, two were Czechoslovakian, two were Hungarian, and two were Greek. Each had lived from one to five years in either a concentration camp or an extermination camp.

The subjects were selected from a group of volunteers after requests were made to two survivor organizations. Each subject was interviewed twice for a period lasting from two to three hours. Originally a tape recorder was used, but its presence was found to inhibit the respondents. Taping was later abandoned in favor of note taking and this procedure resulted in a more relaxed, informal atmosphere.

DATA AND DISCUSSION

The psychiatric view of survivors is preoccupied with pathology. That is to say, the strengths and adaptive abilities of survivors are not considered. From the interviews conducted with the female survivors for this study, however, a different picture emerged. These interviews revealed that the women were rather exceptional in their ability to cope with the traumatic aftermath of the Holocaust years. While none of these women appeared to formulate a conscious strategy, three common factors emerged when respondents were asked to explain how they were able to cope after the war: (1) establishing a family, (2) building a community, and (3) using work as therapy.

Establishing a Family

Establishment of new family ties after the war was critical to adaptation. Indeed, each woman
interviewed mentioned the importance of family life numerous times. For example, to the question: "How were you able to cope after the war?," one Polish survivor responded:

I was liberated by the British on April 15th (1945) at Belsen. I was skin and bones and full of lice. I had heard through reliable rumors that my parents had been gassed in Auschwitz. It's funny I really didn't have anything to live for, but I was determined to go on living. I met my husband two weeks later at a British Army installation. We decided to get married and have a baby right away. I did not want to wait, I knew that the only thing that could heal me was a new family.

Another survivor responded to this question stating:

Despite what you hear about the camps, the only way you could survive was with a friend. My life was saved many times by friends in Auschwitz, and I saved them too. . . . When the war was over we stuck together in the displaced persons camps and later in America. We became sisters to each other for life. We all had to make new families, if not from relatives, then from friends. If I had not done this, maybe I would have given up.

It is noteworthy that support for the fact that survivors tend to have stable marriages is not documented in the survivor literature. Nevertheless, the women attributed their ability to cope (post-war survival) to a strong marriage.

The importance of the marital role also emerged when respondents were asked the following question: "In times of crisis, who do you turn to?" All respondents indicated that they turned to their husband first, and then to another survivor. It is interesting that none of the respondents had sought assistance
from their children in times of need or crisis. In fact, most respondents spoke of sheltering their children from discussions related to their traumatic experience. As one woman explained:

Knowing your parents were in a concentration camp is enough of a burden, my kids don't need any more burdens. . . . When I am very upset I talk to my husband. He understands me because we have been through the same things. It is different than an American marriage. I could never divorce him, I feel like we were Adam and Eve in the Bible. We started a new world together. With that kind of commitment you stay together. There is a very deep understanding.

One survivor explained how she learned to rely only on herself and her husband in times of crisis:

After our son's Bar Mitzvah I became very depressed. Everyone who should have been there was dead, my parents, grandparents, brothers and sisters. I got so depressed I had to go see a psychiatrist. He really didn't understand me, he only gave me sleeping pills and tranquilizers. I stopped going to him, because all I did all day was sleep. . . . Finally I realized that only my husband could help me. I threw away all the pills.

Building a Community

The second theme which emerged was the effort of survivors to build a community. Survivors spoke about their feelings of being isolated during their first years in America, feelings that were in stark contrast to attention received when they first immigrated to the United States. However, survivors quickly recognized that American Jews felt uncomfortable around them, and they also found that an incredible amount of ignorance concerning the war existed in the minds of
people they encountered. Furthermore, almost all the respondents discussed how uncomfortable they were made to feel, as the following experience suggests:

I was shopping in a dress store in 1951 and the saleswoman asked me what that number was on my arm. I told her it was my phone number. She laughed and said 'boy, you sure must have a terrible memory.'

Another woman mentioned feeling ill at ease when eating around Americans:

Everytime my husband and I had a meal with Americans they would give us more to eat than anyone else. When I complained that I couldn't eat it all, the hostess would say 'I thought you people starved during the war.'

Yet, other survivors encountered remarks pertaining to their morality. Apparently some Americans assumed that they had survived because of immoral behavior such as turning in Jews who were hiding, cooperating with the camp guards, stealing food, sleeping with Nazis, or resorting to cannibalism. One survivor stated:

I was shocked when people asked me if I ate human meat or dogs in the camps to survive. Isn't it sickening enough that I had to eat worms to get protein.

Such reactions not only convinced survivors that they were different but caused them to retreat into themselves. In turn, retreatism created a desire to live in locations alongside other survivors, that is, to create their own communities.

Survivor social and benevolent organizations such as the Lodz Club, Warsaw Club, Cracow Club, or the 1939 Club became the foundation for these communities. These clubs served a number of survivor needs and soon became regular meeting places where members could share information about American life, find a good
doctor or dentist, discuss the American educational system, and pursue business opportunities.

Community organizations took the place of kinship associations and helped the survivors form community-based extended families. One interviewee spoke of the important sense of community that was achieved through membership.

The people in the club are my family. We celebrate holidays, Bar Mitzvahs, birthdays and anniversaries together. In times of trouble, like during the Yom Kippur War in Israel, we got together to discuss it.

Yet another survivor suggested that a feeling of gemeinschaft emerged:

When we go to the club, it is like going back to Europe. Everyone speaks Yiddish and Polish, sometimes we listen to music that was popular before the war.

These organizations prevented survivors from being completely isolated. Not only did these community organizations offer emotional support, but they also provided an important linkage with the pre-war past evoking the mood and memories of a happier time.

Work as Therapy

A third coping strategy discussed was the practice of using work as therapy. This factor can be identified from the emphasis survivors placed on their work. First, the majority of the women worked even though it was not financially necessary for them to do so. Second, they worked long hours, six days a week in small businesses alongside their husbands.

In citing the motivations to work, the women stated that keeping their minds sharp, and having a purpose or goal to look forward to each day were important. In essence, hard work was their salvation.
The women seemed to embody Weber's notion of the Protestant ethic (1958) and the proclivity found among Calvinists for hard work, frugality, and investment. Through their work, survivor women were able to achieve the satisfaction of accomplishment. Beyond personal satisfaction, work served as an emotional outlet. The daily mechanics of operating a business, for example, forced them to concentrate on the task at hand, thereby keeping their minds occupied. A response from one woman who worked at home reveals the therapeutic value which work offered her:

For years I worked for the studios as a seamstress. I made gowns for Carol Burnett, Dinah Shore, and Carol Lawrence. In 1969 I decided to start my own bead work business at home. Can you believe that every day movie and television stars come to my home to have gowns beaded? . . . This work is wonderful for me because I am always busy, the phone is always ringing with customers, and sometimes the ladies come with their chauffeurs. With all this activity and excitement I don't have time to get depressed.

The following statement demonstrates a similar motivation as indicated by another respondent:

I tried to be a typical American housewife, you know like Donna Reed on television, but it made me very nervous. By ten o'clock in the morning I was finished with all my housework. I kept busy by painting and putting up wallpaper myself. But there was no one to talk to. I started thinking about the war too much. I got so depressed. No, I have to work. Too much time is bad for me.

A third survivor spoke of her need to keep busy:

My husband and I have a furniture store in a Mexican neighborhood. I used to work all day and go to night school to learn Spanish so I could communicate with the customers.
I speak fluent Spanish now and I taught my husband Spanish while we worked every day. When I got finished with the Spanish classes I got restless in the evening with nothing to occupy my mind, so I enrolled in a class on the stock market.

On the other hand, there was the view that staying at home could become a dangerous emotional trap. One woman reflected:

Whenever I go to the Club, I can tell which women work and which ones stay home. The ones who stay home still act so green. Their English is bad, and they don't know what's going on outside. It is like they never left Europe.

In sum, work has provided survivor women with a purpose, a sense of identity, and positive self-worth. Many of the respondents also remarked that by working outside of the home, they were forced to take a greater interest in their appearance, learned to speak English, and adapted to American life.

CONCLUSION

The interviews conducted with female survivors of the Holocaust revealed these survivors to be resilient despite their extensive suffering during the war. Moreover, their post-war experiences tended to be less than desirable. Survivors endured displaced persons camps, resettlement in a new country, and the challenge of supporting themselves and their families with few resources and skills to draw upon.

Americans who had not experienced the war failed to understand survivors. Helping professionals who prejudged and labeled survivors as maladjusted may have contributed to this problem. The psychiatric literature with its focus on pathology overlooked the positive adaptive factors.
Survivors invested their emotional energy in their husbands, children, and friends; marriage was the foundation for post-war adjustment. Moreover, friends assumed the place of relatives and served as extended family members.

Encountering little understanding on the part of American Jews, survivors developed their own communities. Within these communities survivors were able to benefit from the exchange of information, and develop supportive networks.

The data also suggest that hard work provided emotional therapy and also buffered the effects of anxiety and depression. Participation in a work setting encouraged the women to learn English and American culture.

In sum, survivor women adapted to the post-war experience by overcoming a series of obstacles. Investing their emotional and physical energies in the future, the women established new families, built their own communities, and used work as therapy.

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