

SHAME-BASED IDENTITY AND CHRONIC POST-TRAUMATIC STRESS
DISORDER IN HELP-SEEKING COMBAT VETERANS

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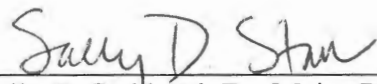
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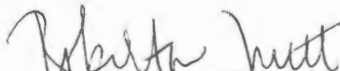
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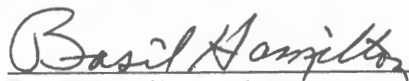
To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a dissertation written by Patricia K. Jackley entitled "Shame-based Identity and Chronic Post-traumatic Stress Disorder in Help-Seeking Combat Veterans." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Counseling Psychology.



Sally D. Stabb, Ph.D., Major Professor

We have read this dissertation
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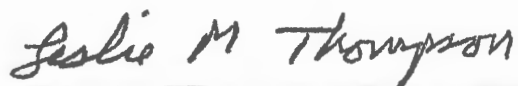

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Shame-based Identity and Chronic Post-Traumatic Stress Disorder (PTSD) in Help-
Seeking Combat Veterans.

Patricia K. Jackley

August, 2000

ABSTRACT

The long-term effects of post-traumatic stress disorder (PTSD) have been previously investigated. However, developmental and identity issues around trauma and shame have been less extensively examined. For some combat veterans, relief from the primary symptoms of PTSD is a struggle for much of the postwar adjustment period. Moreover, secondary problems associated with living with trauma have substantial impact on veterans' sense of self, capacity for interpersonal relationships, and making meaning of their lives. The current investigation examined relationships between self-reported symptom distress and shame on postwar adjustment of combat veterans. Specifically, the study investigated how shame and sense of self were related to PTSD, depression, trait anxiety, vulnerability, self-handicapping, hope, and overall quality of life.

This investigation used archival data that are part of a larger longitudinal study. Correlational, repeated measures, and multivariate analyses examined how symptom distress and resilience measures were related to premilitary, military, and postmilitary factors. Participants completed self-report symptom distress measures and family of origin and demographic questionnaires. Repeated measures on symptom distress were

collected at baseline, 2 months, 6 months, and 12 months post-baseline. Twelve hypotheses were postulated regarding how chronic PTSD and shame were related to long term adjustment.

Findings contributed substantive new information on relationships among shame, symptom distress, and psychological trauma. Correlational analyses showed significant and positive relationships between shame and symptom distress measures including depression, trait anxiety, vulnerability, PTSD, and self-handicapping. Shame was negatively associated with hope and quality of life. Longitudinal data showed chronic PTSD and shame were amenable to treatment. While treatment data showed initial improvement in all symptom distress measures, maintenance of treatment gains was difficult, with six and twelve month symptom measures returning to near baseline. Multivariate analyses yielded no differences on family factors of chaos, loss, and ethnicity. Socioeconomic status was associated with decreased hope and quality of life. Convergence among the findings indicated a reciprocal relationship between shame and PTSD which warrants continued empirical investigation. Implications for theory, research, and practice are discussed.

TABLE OF CONTENTS

COPYRIGHT.....	iii
ACKNOWLEDGEMENTS.....	iv
ABSTRACT.....	viii
Chapter	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	12
History and Development of Trauma.....	12
Origins of Traumatic Stress.....	14
Historical Antecedents for Classification Schemes.....	15
Prevalence and Epidemiology of PTSD in the General Population.....	18
Prevalence and Epidemiology of PTSD in Vietnam Veterans.....	20
Current PTSD.....	20
Other Descriptive Factors.....	24
Lifetime PTSD.....	25
Theoretical Formulations of PTSD.....	27
Theoretical Formulations of Combat Trauma.....	36
Developmental and Post-Trauma Adjustment Issues in Vietnam Veterans.....	40
Chronic Adjustment Challenges	44
Identity Issues and Challenges in Combat PTSD.....	45
Interpersonal Contexts Affected by PTSD.....	46
Shame.....	49
History and Development of Shame as a Clinical Manifestation.....	52
Clinical Perspectives and Theoretical Formulations on Shame and Guilt.....	54
Impact of Shame on Identity Development and Interpersonal Dynamics.....	60
Shame and PTSD as Reciprocal Agents in Identity and Interpersonal Contexts.....	67
Hypotheses.....	64
III. METHODOLOGY.....	68

Participants.....	68
Instrumentation.....	70
Procedure.....	84
Statistical Analyses.....	88
IV. RESULTS.....	92
Demographic Data.....	92
Descriptive Statistics and Basic Correlations.....	94
Descriptive Statistics.....	94
Basic Correlations.....	95
Analyses of the Research Hypotheses.....	99
Correlational Hypotheses.....	99
Multivariate and Repeated Measures Analyses.....	104
V. DISCUSSION.....	140
Summary of Significant Findings.....	140
Findings for Descriptive Analyses.....	140
Findings from Basic Correlations.....	142
Findings for Analyses of Major Hypotheses.....	144
Correlational Hypotheses.....	145
Multivariate and Repeated Measures Hypotheses.....	152
Implications for Theory.....	159
Chronicity in Symptom Distress.....	162
Shame and Distress.....	165
Shame and Self-Handicapping.....	167
Levels of Shame.....	169
Pretrauma Vulnerability and Family Variables.....	170
Implications for Research.....	176
Theoretical Research.....	176
Treatment Research.....	177
Implications for Practice.....	178
Limitations of the Current Investigation.....	180
Sampling Limitations.....	181
Instrument Limitations.....	181
Design Limitations.....	182
Conclusions.....	183
REFERENCES.....	185
APPENDICES.....	245
APPENDIX A:.....	245

APPENDIX B:.....	249
APPENDIX C:.....	254
APPENDIX D:.....	256
APPENDIX E:.....	258
APPENDIX F:.....	260
APPENDIX G:.....	262
APPENDIX H:.....	264
APPENDIX I:.....	266
APPENDIX J:.....	268
APPENDIX K:.....	270
LIST OF TABLES.....	
Table 2.1 Percent of Current PTSD Prevalence and Ethnicity.....	22
Table 2.2 Current PTSD Prevalence Estimates Across Major Study Groups.....	23
Table 2.3 Sociodemographic Characteristics and Current PTSD Prevalence Rates.	25
Table 2.4 Predictors of PTSD.....	30
Table 2.5 Long-term Effects of Trauma on Coping Abilities.....	48
Table 2.6 Differences between Shame and Guilt.....	54
Table 2.7 Shame Continuum and Identity.....	62
Table 3.1 Validation Study Findings Using the Internalized Shame Scale.....	71
Table 3.2 Comparison of Mean ISS Scores and Diagnostic Classification.....	72
Table 3.3 Normative Statistics of QOLI Across Adult and College Samples ...	77
Table 4.1 Age of Sample Participants.....	92

Table 4.2 Ethnicity of Sample Participants.....	93
Table 4.3 Means and Standard Deviations for the Dependent Variables.....	94
Table 4.4 Correlations of Internalized Shame Scale with Family of Origin Factors...	97
Table 4.5 Correlation Matrix of the Sample's Dependent Measures.....	101
Table 4.6 Levels of Shame of Sample Participants.....	103
Table 4.7 Relationship between Level of Shame and Quality of Life.....	103
Table 4.8 Descriptive Statistics on the Internalized Shame Scale Scores Across Time: "Completers".....	105
Table 4.9 AVOVA Summary Table for "Completers" on Shame Across Time.....	105
Table 4.10 Pairwise Comparisons of Mean Differences in Shame Across Time For "Completers".....	106
Table 4.11 PENN PTSD Scores for Total Sample by Shame Level.....	108
Table 4.12 ANOVA Summary Table for PENN Scores Across Time by Level of Shame for the Total Sample.....	109
Table 4.13 Pairwise Comparisons of Mean Differences in PENN Scores by Level of Shame for Total Sample.....	110
Table 4.14 STPI Scores for the Total Sample by Shame Level.....	113
Table 4.15 ANOVA Summary Table for STPI Scores Across Time by Level of Shame for the Total Sample.....	114
Table 4.16 Pairwise Comparisons of Mean Differences in STPI Scores by Level of Shame for Total Sample.....	115
Table 4.17 GVS Scores for Total Sample by Shame Level.....	118
Table 4.18 ANOVA Summary Table for GVS Scores Across Time by Level of Shame for the Total Sample.....	119
Table 4.19 Pairwise Comparisons of Mean Differences in GVS Scores by Level of Shame for Total Sample.....	120

Table 4.20 BDI Scores for Total Sample by Shame Level.....	123
Table 4.21 ANOVA Summary Table for BDI Scores Across Time by Level of Shame for the Total Sample.....	124
Table 4.22 Pairwise Comparisons of Mean Differences in GVS Scores by Level of Shame for Total Sample.....	125
Table 4.23 Predictor Variables and Internalized Shame Scale Scores.....	128
Table 4.24 Summary Data of Between Subjects Effects for Family History of Loss..	130
Table 4.25 Summary Data of Between Subjects Effects for Family History of Chaos..	132
Table 4.26 ANOVA Summary Table for History of Abuse and Symptom Distress...	134
Table 4.27 ANOVA Summary Table for Socioeconomic Status and Symptom Distress.....	136
Table 4.28 ANOVA Summary Table for Ethnicity and Symptom Distress.....	138

CHAPTER 1

INTRODUCTION

Psychological trauma creates a legacy of distress and altered functioning that may be manifested in physiological, psychological, and emotional dysregulation (e.g., Atkinson, Reaves, & Maxwell, 1988; Bremner, Davis, Southwick, Krystal, & Charney, 1993a; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996b). In an early discussion of “traumatic neuroses” as an aftermath of exposure to combat, a prominent psychiatrist, W. H. T. Rivers, described the acute changes in a World War I veteran named Siegfried Sassoon. He had distinguished himself for his bravery and for his war poetry. While still active in military service, this young warrior affiliated himself with pacifism and openly denounced war efforts. Because of this noteworthy act and uncharacteristic response, he was immediately referred for psychiatric treatment. His antiwar position was attributed to his psychological collapse and the medical protocol followed by the military at the time shamed, threatened, and punished afflicted soldiers in order to encourage their return to combat (Yealland, 1918). According to Yealland (1918), Rivers challenged the conventional wisdom of military psychiatrists and advocated for interventions with soldiers that emphasized humane, enlightened treatment and relied on a “talking cure.” Rivers argued that, rather than being shamed, soldiers would benefit from treatment which was based on dignity and respect. Such treatment would actively encourage talking openly about the terrors of war and would foster safety

and consolidate healing through the active use of a therapeutic relationship (Fussell, 1983).

A fellow soldier described Sassoon as having “a bad state of nerves.” He was restless, irritable, and tormented by nightmares. His nickname of “Mad Jack” had been earned as a result of taking impulsive risks and recklessly exposing himself to danger. The historical account of this man’s military service indicated that he survived the war but, like many veterans with combat neurosis, he reexperienced and relived the war for the rest of his life. In his efforts to survive, he became involved with pacifism and wrote war memoirs as a legacy to his fallen comrades. His eloquent reflection voices the testimony of people who survive psychological trauma. He wrote:

Shell shock. How many a brief bombardment had its long-delayed after-effect in the minds of these survivors, many of whom had looked at their companions and laughed while inferno did its best to destroy them. Not then was their evil hour; but now, now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. Worst of all, in the disintegration of those qualities through which they had been so gallant and selfless and uncomplaining—this, in the finer types of men, was the unspeakable tragedy of shell-shock. . . . In the name of civilization these soldiers had been martyred, and it remained for civilization to prove that their martyrdom wasn’t a dirty swindle. (Fussell, 1983, p. 141)

The historical accounts of World War I reported that over eight million men died in four years. The catastrophic destruction ravaged four European empires and shattered the cherished beliefs of many Western civilizations. The devastation of physical property and the deaths of diverse men, women, and children, both military and civilian, were some of the tragic casualties of war. Now, more than 75 years after World War I, human history has recorded another World War, the genocide of the Holocaust, a complicated military and political war in Vietnam, and several other global military operations. In any examination of human history, one is repeatedly reminded that the legacy of survival exacts a substantial, ongoing toll on individuals, families, cultures, and the global community (e.g., Ursano, Fullerton, & McCaughey, 1994; van der Kolk, McFarlane, & Weisaeth, 1996a; Wilson & Raphael, 1993).

The images that we see on the nightly news and in films poignantly remind us that survival exacts great costs physically, psychologically, and relationally. van der Kolk et al. (1996a), in writing about psychological trauma, noted that “Experiencing trauma is an essential part of being human; history is written in blood” (p. 3). These authors further observed that “Despite the human capacity to survive and adapt, traumatic experiences can alter people’s psychological, biological, and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences, spoiling appreciation of the present” (p.4). It is evident that the experience of psychological trauma calls upon an individual’s capacities to adapt, cope, and make meaning of overwhelming experience (e.g., Allen, 1995; Figley, 1985, 1986; Janoff-Bulman, 1992).

The systematic study of psychological trauma has allowed researchers and clinicians a framework with which to organize their observations and, over time, to develop and refine conceptualizations and theories that address common factors, consequences, and effects endemic to trauma. Clinicians and researchers have begun to amass a knowledge base that shows some convergence around characteristic responses and challenges among many types of trauma experiences as well as to articulate how individual differences may be manifested in the interaction between the person and environment (e.g., Ainsworth, 1989; Akiskal, 1990; Fine, 1988; Fossum & Mason, 1986; Foy, 1992; Kaufman & Raphael, 1996). Furthermore, sustained efforts toward systematically investigating psychological trauma have led to the design and implementation of interventions and service delivery models that provide compassionate treatment to trauma survivors that reflect strong empirical support and sensitive practice (e.g., Grinker & Spiegel, 1945; Herman, 1992b; Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, 1988, 1990; van der Kolk et al., 1996a; Wilson & Raphael, 1993).

Herman (1997) described the dialectic of trauma as the essential conflict between voice and silence, between connection and disconnection, between fragmentation and integration, between isolation and community. Herman argued that common to the experience of trauma survivors would be the need to deny the experience of horrible events alternating with the need to tell one's story. This push and pull of denial coupled with compulsion to rid oneself of the horror of the traumatic experience is what she labelled the "dialectic of trauma." In the current diagnostic conceptualization and

formulation of PTSD included in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), numbing and reexperiencing are explicated as two hallmark characteristics of PTSD. Both clinical lore and empirically-derived treatment protocols have incorporated emerging knowledge regarding how the naming of traumatic experiences contributes to survivor's healing and integration. The empowerment that survivors experience, as a result of being able to label and name their traumas, serves important functions in the recovery processes targeted at mastery, validation, and meaning making in individuals, families, and communities (e.g., Blank, 1993, 1994; Bremner & Marmar, 1995; Breslau & Davis, 1987a; Breslau, Davis, & Andreski, 1995; Carlier & Gersons, 1995; Everly & Lating, 1995; Wilson & Raphael, 1993).

The development of PTSD as a diagnostic category has created an organized framework from which to examine alterations in individual functioning and a collective framework from which to evaluate and measure changes in individuals and specific groups over time. Within the treatment community, identifying PTSD as a diagnostic entity systemically parallels the naming process undertaken by survivors. The validation of PTSD as a clinical syndrome provided both trauma survivors and professional helpers with a way to recognize, label, and seek help on a medical, psychiatric, and societal level for their painful experiences. Diagnostic recognition honored survival efforts and coping strategies and supported survivors in their efforts to heal (Allen, 1995; Caruth, 1995; Chiaramonte, 1992; Cole & Putnam, 1992; Fairbank, Hansen, & Fitterling, 1991; Figley, 1985, 1986; Janoff-Bulman, 1992). Thus, PTSD as a diagnostic category named a

constellation of problems and behaviors that validated survivors' realities and reminded others of the profound changes that may result in coping with the aftermath of traumatic experience (e.g., Eaton, Sigal, & Weinfield, 1982; Everly & Lating, 1995; Wilson & Raphael, 1993).

Investigators such as Herman (1992b, 1997), Pearlman and Saakvitne (1995), and Figley (1985) noted that witnesses as well as survivors must recognize how the dialectic process of trauma and recovery may affect (challenge) the therapeutic and scholarly community. The history of psychological trauma has had its own share of repression, denial, and fragmentation. Catastrophic events, such as those occurring in Kosovo, remind us as a human community that atrocities continue. Part of our adaptation as a global community will be the extent to which we can witness and respond to these acute, horrific events while at the same time providing support and recognition for the lifelong effects of past atrocities. Combat, rape, domestic violence, torture, captivity, and ethnic cleansing are examples of psychological trauma that elicit an immediate survival response. These experiences also contribute to chronic adaptational difficulties and changes in both the self and the relational world of the survivor (e.g., Abeles & Schilder, 1935; Archibald & Tuddenham, 1965; Engdahl, Dikel, Eberly, & Blank, 1997; Kahana, Kahana, Harel, & Rosner, 1988; Ursano, Fullerton, Kao, & Bhartiya, 1995; Ursano & McCarroll, 1994).

Interest in psychological trauma has ebbed and flowed across almost a century of clinical and scholarly writing. Generally, these writings conclude that systematic investigation of psychological trauma has evidenced fits and starts based on political

sentiment and societal reactions and is often not sustained when the immediacy of any one prevailing experience fades from our awareness. Historically, the lack of sustained interest in psychological trauma allows clinical and research findings to become fragmented and poorly integrated into larger scientific and scholarly paradigms. The intrusions created by traumatic experiences are often not sufficient to sustain investigation beyond the initial shock value of the event. However, over the past two decades or so the field of traumatology has emerged as a legitimate clinical and scientific field that has begun to empirically validate both acute and chronic effects of many forms of psychological trauma. (e.g., Alexander, 1992; Beal, 1995; Blank, 1994; Davidson & Foa, 1993; Wilson, Harel, & Kahana, 1988).

Kardiner (1941) published an early clinical and theoretical treatise on war neuroses that identified episodic attentional shifts followed by retreat into collective denial based on an ever-shifting sentiment of public opinion. A few years later, Kardiner and Spiegel (1947) observed that

The subject of neurotic disturbances consequent upon war has, in the past 25 years, been submitted to a good deal of capriciousness in public interest and psychiatric whims. The public does not sustain its interest, which was very great after World War I, and neither does psychiatry. Hence these conditions are not subject to continuous study. . . but only to periodic efforts which cannot be characterized as very diligent. In part, this is due to the declining status of the veteran after a war. . . Though not true in psychiatry generally, it is a deplorable fact that each investigator who

undertakes to study these conditions considers it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything before (Kardiner & Spiegel, 1947, p.1).

In writing about psychological trauma fifty years later, Herman (1997) postulated that “the study of psychological trauma is inherently a political enterprise because it calls attention to the experience of oppressed people...Massive communal atrocities committed during the course of wars in Europe, Asia, and Africa have focused international attention on the devastating impact of violence and have fostered the recognition that psychological trauma is a worldwide phenomenon” (p. 237). Herman (1997) also noted the changing clinical and research initiatives that have come about since the earlier investigations that emerged out of the war trauma writings. A summary of the advances in the field of traumatic research showed that

As predicted, the study of psychological trauma has remained highly controversial. Many clinicians, researchers, and political advocates have come under fierce attack. In spite of this onslaught, however, thus far the field has vigorously resisted being “disappeared”. On the contrary, during the last five years, the scientific enterprise of traumatic stress studies has expanded and matured. The fundamental question of the existence of PTSD is no longer in dispute. With the basic outlines of the field defined, an early pioneering effort has ended and the research has become technically sophisticated and in some respects more ordinary. A new generation of studies has begun to enlarge the scope and increase the

precision of our understanding of the impact of traumatic events. . .

Legitimacy, however, can be a mixed blessing. The next generation of researchers may lack the passionate intellectual and social commitment that inspired many of the earlier investigations. In this new more conventional phase of scientific inquiry, there is some cause for concern that integrative concepts and contextual understanding of psychological trauma may be lost, even as more precise and specific knowledge is gained. . . As the field of traumatic stress studies matures, a new generation of researchers will need to discover the essential interconnection of biological, psychological, social, and political dimensions of trauma (Herman, 1997, p. 239-240).

It is evident from the literature that psychological trauma is multi-dimensional and multi-faceted with biological, psychological, identity, and interpersonal disruptions noted as characteristic of chronic traumatic responses (Allen, 1995; Bowlby, 1969, 1984; Browne & Finkelhor, 1986; Cole & Putnam, 1992; Harel, Kahana, & Wilson, 1993; Herman, Perry, & van der Kolk, 1989; Kernberg, 1975; Lisak, 1993; Mezey & King, 1989; Oates, 1984; Ogata, Silk, Goodrick, Lohr, Westen, & Hill, 1989; van der Hart, Steele, Boon, & Brown, 1993; van der Kolk, 1989; van der Kolk & Fisler, 1994a, 1995; van der Kolk, Hostetler, Herron, & Fisler, 1994c; van der Kolk, Perry, & Herman, 1991). The extent to which shame may be associated with multi-dimensionality in trauma, identity, and interpersonal dynamics is of interest in the current study.

It is the particular focus of the present investigation to examine the construct of shame as it relates to PTSD, symptom distress, and identity in combat veterans. Empirical literature on shame has already demonstrated shame to be a factor in non-specific psychological distress. Shame has been shown to be expressed in varying degrees across clinical populations including substance abuse, affective disorders, general psychiatric patients, PTSD (men only), and eating disorders (women only) (Cook, 1991). Other empirical data have shown shame to be negatively associated with self-esteem and positively associated with depression (Cook, 1989,1991). Empirical findings by Ursu (1984) demonstrated that internalized shame and negative self-esteem are different.

Theoretically, shame has been linked with identity, interpersonal difficulties, and with negative sense of self concerns. According to Harper and Hoopes (1990) chronic shame becomes internalized as part of one's identity. Psychoanalytic theory has emphasized shame's relationship with self-regulation and attachment (Broucek, 1991; Erikson, 1950; Goldberg, 1991; Lewis, 1987, Nathanson, 1987). A developmental theory of shame has evolved from formulations of attachment, identity, object-relations, and ego deficits (Kaufman, 1989; Lewis, 1987; Morrison, 1989; Piers & Singer, 1953). Self-regulatory functions related to both shame and guilt have been linked to identity, interpersonal deficits, and symptom distress (Broucek, 1991; Goldberg,1991; Kaufman, 1985, 1989; Levin, 1967,1971; Lynd, 1959, Nathanson, 1992).

This study is the first to examine the relationship between shame and PTSD in depth and over time. In the next chapter, the existing empirical and theoretical literature on traumatic stress is reviewed, including historical development and current diagnostic

schemas of psychological trauma. More specifically, PTSD is examined with regard to prevalence and epidemiology in military and civilian populations. Combat PTSD is discussed and the post-war adjust challenges of veterans reviewed. The chapter concludes with an examination of the theoretical and empirical findings on shame. It is suggested that shame and PTSD as reciprocal agents in identity, interpersonal contexts, and adjustment. Method, results, and discussion chapters follow a review of the literature.

CHAPTER 2

REVIEW OF LITERATURE

History and Development of Trauma as a Diagnostic and Conceptual Framework

According to Kihlstrom (1994), there have been writings on the aftermath of trauma for at least four thousand years. Historical writings about hysteria by Veith (1965, 1977) revealed the theory of a migrating uterus as a seminal, somatic-focused explanation for hysteria, originating from a medical model, and the only developed framework for such investigations at that time. As early as the seventeenth century, investigators began to associate an emotional component to prominent features of hysterical syndromes (Sydenham, 1697). Near the end of the next century, Cullen (1796) used the labels of neurology and neurosis to postulate initial formulations for psychosomatic manifestations to life experiences and subsequent adjustment difficulties. Nearly a hundred years later another neurologist, Charcot (1877/1888), would link hysteria and suggestibility together and would formulate early conceptions around psychic trauma and dissociation that continue to be more fully investigated and refined currently in the field of traumatology (e.g., Krystal, 1988; van der Kolk et al., 1994c; van der Kolk et al., 1996b; van der Kolk & van der Hart, 1989; Weisaeth & Eitinger, 1993; Yehuda & McFarlane, 1995; Zucker & Gombert, 1986).

Conceptual foundations in psychiatry and psychology have been substantially affected by these early writings on hysteria. In an historical analysis of psychology, Ellenberger (1970) examined how Freud and Janet, both of whom were students of

Charcot, were heavily influenced by him. Both Freud (Breuer & Freud, 1893, 1895/1955; Freud, 1905/1953) and Janet (1889, 1894/1901, 1907) postulated psychogenic theories for the origins of mental illness that were based in traumatic experience. Psychogenic formulations for mental illness were a marked departure from the prevailing somatogenic medical models, representative of mainstream thinking during this historical period (Kihlstrom, 1994; van der Kolk et al., 1996a). Twentieth century analyses of hysteria and mental illness have explicated a biopsychosocial model for understanding the impact of psychological trauma and subsequent efforts to adapt (e.g., Bates & Wachs, 1994; Blank, 1993; Bremner, Southwick, & Charney, 1995; Figley, 1985, 1986; Green, Grace, Lindy, & Gleser, 1990b; Herman, 1992a, 1997; van der Kolk et al., 1996b).

Contemporary clinical and empirical interest in trauma has been fundamentally influenced by Freud's and Janet's early formulations regarding the ways in which individuals respond to distress and overwhelming experiences (e.g., Bremner & Marmar, 1995; Briere, 1988; Browne & Finkelhor, 1986; Cole & Putnam, 1992; Davidson & Foa, 1993; Janoff-Bulman, 1985, 1989; Krystal, 1978; Lazarus & Folkman, 1984; Marsella, Friedman, Gerrity, & Scurfield, 1996; Reedy & Hofball, 1995; Stamm, 1996; Ursano et al., 1994; van der Kolk & van der Hart, 1989; Wilson, Harel, & Kahana, 1988; Wilson & Keane, 1997; Wilson & Raphael, 1993; Zucker & Gombert, 1986). In an early observation offered by Janet (1919/1925), he stated, "All the famous moralists of olden days drew attention to the way in which certain events would leave indelible and distressing memories—memories to which the sufferer was continually returning, and by which he was tormented day and night" (p. 525). This observation, offered nearly

seventy-five years ago, suggests that intrusive memories and arousal have long been recognized as responses overwhelming human experience (van der Kolk, Weisaeth, & van der Hart, 1996c). Multiple sources, such as case reports, survivor narratives, clinical observations, and empirical investigations, noted similarities in coping strategies following traumatic exposure. Avoidance, hyperarousal, and reexperiencing have all been commonly identified as acute and chronic responses used by individuals to cope with the aftermath of overwhelming experience (e.g., Alford, 1992; Caruth, 1995; Danieli, 1985; Herman, 1992a, 1997; Shay, 1994).

Origins of Traumatic Stress

Clinical reports and empirical studies have debated many issues related to traumatic stress, including the etiology of responses to trauma and developmental trajectories of post-trauma adjustment (Andreasen, 1980; Brown, 1994; Card, 1987; Cicchetti & White, 1990; Creamer, Burgess, & Pattison, 1992; Flach, 1990; Foa, Steketee, & Rothbaum, 1989; Foy, Rueger, Sipprelle, & Carroll, 1984; Green, 1994b; Horowitz, 1976; Jones & Barlow, 1990; Kirmayer, 1996; Krystal, 1968, 1988; Lating, Zeichner, & Keane, 1995; Putnam, 1989; Weisaeth, & Eitinger, 1993). Clinicians and investigators in the field of psychological trauma have even struggled to define trauma. Some authorities have proposed definitions of trauma as an event, while others have defined trauma as an individual's subjective response to and interpretation of an experience. Some investigators have examined the ways in which preexisting vulnerabilities moderate, mediate, or exacerbate individuals' responses to experiences such as childhood abuse and neglect, sexual trauma, catastrophic events and natural

disasters, war, torture, and captivity (e.g., Card, 1987; Cole & Putnam, 1992; Eaton et al., 1982; Kahana et al., 1988). During the Civil War medical authorities reported several new categories of physical affliction including nostalgia, insanity, irritable heart, and sunstroke. In retrospect, one suspects that stress disorders were being described by such euphemistic labels. Treatment for any of these conditions resulted in transfer to an “insane” asylum and may have contributed to the 300,000 men who deserted from both Union and Confederate armies (Dean, 1997). Dean (1997) described post-war adjustment problems associated with both Civil War and Vietnam veterans distinguished the commonalities of psychological casualties and post-war adjustment problems in men whose combat experiences were roughly one hundred years apart. Clinical perspectives have addressed a host of variables related to resilience and recovery that may in part explain the variability of findings that emerge from reviews of sources such as autobiographical accounts, clinical and anecdotal reports, cross-sectional, longitudinal, retrospective, and prospective investigations (e.g., Barrett & Mizes, 1988; Bradshaw, Ohlde, & Horne, 1991; Flannery, 1990; Fontana & Rosenheck, 1993; Schlenger, Kulka, Fairbank, Hough, Jordan, Marmar, & Weiss, 1989, 1992).

Historical Antecedents for Classification Schemes

In the early writings by physicians and philosophers, the individual was the primary focus of investigation with little effort given to classification schemas or nosological considerations (Grob, 1991; Kihlstrom, 1994). However, in the mid-nineteenth century, several classification schemes were developed that organized psychopathology beyond existing individual observation and formulation. Works by

Cullen (1796), Kant (1798/1878), and Pinel (1806/1962) had attempted to categorize functional and organic manifestations of mental illness in different ways. These works had little impact on the treatment that individuals received as a result of their diagnostic classification. Also in the early 18th century, social data bases became more sophisticated. These data, along with data from the newly formed Census Bureau, formed the foundation for modern epidemiological investigations (Kihlstrom, 1994). In 1918, the forerunner organization of the American Psychiatric Association issued the first edition of a diagnostic manual entitled Statistical Manual for the Use of Institutions for the Insane (Committee on Statistics, 1918). This publication was adopted by the United States Census Bureau in 1920 and would go through nine editions to eventually be recognized in the clinical and research community as the Diagnostic and Statistical Manual of Mental Disorders (DSM), now in its fourth edition (American Psychiatric Association, 1994).

The debate about how to understand traumatic experiences and the adjustment efforts of survivors is substantive and a political concern that our culture and mental health professions have struggled with for over a century (e.g., Green, Wilson, & Lindy, 1985; Herman, 1992b, 1997; Kihlstrom, 1994, van der Kolk et al., 1996c). In evaluating the history of psychological trauma, Herman (1997) commented:

To study psychological trauma is to come face to face with both human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events. When the events are natural disasters or “acts of God,” those who

bear witness sympathize readily with the victim. But when the traumatic events are of human design, those who bear witness are caught in the conflict between the victim and the perpetrator. It is morally impossible to remain neutral in this conflict. (p.7)

Attempts at neutrality within clinical and empirical investigation have resulted in an effort toward building a knowledge base that is characterized by fits and starts. van der Kolk et al. (1996a) detailed the development of PTSD as it is recognized today by observing that “Awareness of the role of psychological trauma in the genesis of various psychiatric problems has waxed and waned throughout the history of psychiatry” (p.47). Formulations of “traumatic neuroses” during the last 100 years have often been silenced, lost, and rediscovered based on cultural values and tolerances of a particular period (Da Costa, 1871; Herman, 1992b, 1997; Myers 1870; Myers, 1915,1940; Sargant & Slater, 1941; Spiegel & Cardena, 1991; van der Kolk et al., 1996c). Early debates captured the essence of what remain contemporary struggles, namely, how to adequately understand the biological and psychological manifestations of traumatic experience; how to identify what is genuine breakdown from malingering and the potential for secondary gain; how dissociation and the fragmentary nature of traumatic memory affect integration, identity, and interpersonal effectiveness; the associations among characteristics of vulnerability, predisposition, and resiliency in survivors; and how chronic maladjustment shows evidence of nomothetic and idiographic variation (e.g., Archibald, Long, & Miller, 1962; Bartemeier, 1946; Blatt & Blass, 1990, 1992; Bowlby, 1977; Grinker & Spiegel, 1945; Janet, 1904; Jones, 1996; Kardiner, 1941; Kernberg, 1975, 1990; Klein, 1948; Kolb,

1987; Laufer, 1988; Lisak, 1993; Main, 1996; Mazure, 1995; Nemiah, 1989; 1995; Putnam, 1989; van der Hart & Friedman, 1989; van der Kolk, Herron, Hostetler, 1994b; van der Kolk & van der Hart, 1989).

Psychosomatic explanations of traumatic experience have resulted in descriptions that ranged from Briquet's hysterics to more current diagnostic categories which label manifestations of psychological distress along dissociative, somatoform, affective, and anxiety dimensions. There have been repeated attempts to examine and explain the complex relationships among mind, body, and culture that result from overwhelming experience. If the legacy of trauma is our "scientific elephant," it appears that interested clinicians and researchers have been describing important parts of the "black whole of trauma" without fully integrating the knowledge in the disciplines over that past century (e.g., Cicchetti & Toth, 1994; Cicchetti & White, 1990; Cole & Putnam, 1992; Figley, 1978b; Finkelhor & Browne, 1984; Gelles & Strauss, 1979; Haley, 1974; Herman, 1981, 1992a; 1997; Horowitz, 1986; Krystal, 1968, 1978, 1988; McFarlane & van der Kolk, 1996; Ursano et al., 1994).

Prevalence and Epidemiology of PTSD in the General Population

Epidemiology was defined by Last (1983) as the study of the distribution and determinants of disorders in populations. van der Kolk et al., (1996a) have noted that epidemiological investigations are important in conceptualizing and understanding PTSD. The methodological framework used in epidemiological investigations allows researchers and clinicians to systematically consider the relative contributions of factors related to exposure and factors related to vulnerability and resilience. Intensity of

exposure is demonstrated by increasing prevalence rates. Estimates of vulnerability and resilience highlight the characteristics of individuals who do develop PTSD and those who do not, even after similar levels of exposure. Prevalence data can help to define the size of an affected population and can also provide essential information about the chronic nature of symptoms and the level of disability (Blank, 1993; Breslau et al., 1995; Davidson, Hughes, Blazer, & George, 1991; Norris, 1992).

According to van der Kolk et al., (1996a), some of the most sophisticated and well-designed psychiatric research has emerged regarding the epidemiology of PTSD. The National Vietnam Veterans Readjustment Study (NVVRS) (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, 1988) was one of the largest investigations of its kind. The results of this study revealed that 15.2% of male theater Vietnam veterans suffered from PTSD almost twenty years after the war. In addition to those who met full criteria for PTSD, another 11.1% of veterans demonstrated partial PTSD symptomatology. These authors estimated that as of 1989, 960,000 Vietnam veterans had experienced full-blown PTSD at some time after leaving Vietnam. Recent investigations have reported PTSD symptoms increasing as Vietnam veterans are reaching retirement age and experiencing pressures to adjust to developmental life events (Yehuda, Kahana, Schmeidler, Southwick, Wilson, & Giller, 1995). In several epidemiological investigations, using both retrospective and prospective designs, a quantitative dose-response relationship emerges between severity of stressor exposure and severity in PTSD symptomatology. The dose-response relationship consistently emerges, despite evidence of marked individual variation reported across these studies and taking into

account differences in parameter estimates and definitions of PTSD. The dose-response findings suggested that the intensity of exposure to traumatic events resulted in increased likelihood of more severe symptomatology. These findings are among the most durable conclusions cited across multiple investigations of prevalence and epidemiology (Archibald & Tuddenham, 1965; Breslau & Davis, 1987b; Breslau et al., 1995; Buydens-Branchey, Noumair, & Branchey, 1990; Card, 1987; Fontana & Rosenheck, 1993, 1994; Foy, Carroll, & Donohoe, 1987a; Foy, Resnick, Sippelle, & Carroll, 1987b; Foy et al., 1984; Goldberg, True, Eisen, & Henderson, 1990; Helzer, Robins, & McEvoy, 1987; Jordan, Schlenger, Hough, Kulka, Weiss, Fairbank, & Marmar, 1991; Weiss, Marmar, Schlenger, Fairbank, Jordan, & Kulka, 1992; Yehuda, Southwick, & Giller, 1992).

Prevalence and Epidemiology in the Vietnam Veterans

Current PTSD.

The NVVRS (Kulka et al., 1988) used an operational definition of a prevalence rate as the percent of a specified population group or subgroup that has a given disorder during a specified period. Prevalence rates are indices of occurrence of a disorder in a specified population such as veterans, citizens, or “catchment area” as possible parameters to detail the characteristics of the specified population under investigation. In response to a Congressional mandate, Public Law 98-160 was commissioned to investigate and report on the prevalence and incidence of PTSD and other psychological problems in veterans readjusting to civilian life. The NVVRS took into account both “full” and “partial” PTSD in developing prevalence data. Two reference periods were also specified in this investigation, “current” and “lifetime.” The National Survey of the

Vietnam Generation (NSVG) conducted a study of Vietnam generation respondents with the sample stratified among Vietnam theater veterans; Vietnam era veterans, and nonveteran or civilian counterparts. These groups were operationally defined as: *Vietnam theater veterans*: Persons who served in active duty in the U. S. Armed Forces during the Vietnam era (August 5, 1964, through May 7, 1975) in Vietnam, Laos, or Cambodia, or in the surrounding waters or airspace of these three countries; *Vietnam era veterans*: Persons who served on active duty in the U. S. Armed Forces during the Vietnam era but did not serve in the Vietnam theater; *Nonveterans or civilian counterparts*: Persons who did not serve in the military during the Vietnam era. Members of this group were matched to theater veterans on the basis of age, gender, race/ethnicity (for men only), and occupation (for women only). Current PTSD was operationalized as the percent of a specified population (e.g., theater veterans, era veterans, civilians) who met the criteria for PTSD diagnosis during the six-month period preceding their participation in the study. Lifetime prevalence was operationalized as the percent of the specified population who had met the diagnostic criteria for PTSD at some time in their lives. Current and lifetime prevalence data were determined because they represent two different focal perspectives. Lifetime prevalence may be understood as an index of the total PTSD problem and current prevalence may be understood as a more acute index for recent exacerbation of PTSD. Kulka et al. (1988, 1990) have estimated that, of the 3.14 million men who served in the Vietnam theater, 479,000 met current prevalence parameters. Other findings from the current prevalence data showed that exposure to high levels of war zone stress resulted in a fourfold increase in rates of PTSD over those with low to

moderate exposure to stress. Rates of PTSD were also higher for men who had service-connected physical disability than those without physical injury and higher for those combat veterans who had a lifetime substance abuse diagnosis in addition to meeting diagnostic criteria for PTSD. Theater veterans showed higher current prevalence rates than era veterans who were higher than civilian contemporaries (15.2% vs. 2.5% vs. 1.2%).

The information presented in Table 2.1 suggests that current PTSD prevalence rates among male theater veterans showed ethnocultural variation with current prevalence among Hispanics reported at 27.9 percent, African-Americans at 20.6 percent and 13.7 percent among Caucasian veterans. Veterans of color evidence much higher prevalence rates than Caucasian veterans, with Hispanic veterans showing more than twice the rates of current PTSD when compared to Caucasian theater veterans. Similar ethnocultural variation noted in theater veterans remained consistent when exposure to war zone stress was examined.

Table 2.1 Percent of Current PTSD Prevalence by Ethnicity in Theater Veterans

Race/Ethnicity	%
Hispanic	27.9
African American	20.6
Caucasian	13.7

Note: Condensed from Kulka et al., 1990

The information presented in Table 2.2 reveals that high war zone exposure increases current PTSD severalfold. War zone exposure doubled current PTSD rates

among theatre veterans. War zone exposure resulted in substantially higher rates of current PTSD when comparing era veterans and civilian counterparts (14 times the rate for era veterans and nearly 30 times the rate in civilian populations). Current prevalence data showed similar ethnic variation, with veterans of color being more affected than Caucasian veterans, in era and civilian counterparts but is attenuated to some degree by the marked decrease in overall prevalence in these two subgroups.

Table 2.2 Current PTSD Prevalence Estimates Across Major Study Groups

Theater	High War Zone	Era	Civilian
Veteran	Theater Veteran	Veteran	
15.2	35.8	2.5	1.2

Note: Condensed from Kulka et al., 1990

The current prevalence data from the NVVRS study on “partial” PTSD were estimated at 11.1 %. This estimate suggests that 350,000 veterans had experienced some level of PTSD symptomatology but did not meet full diagnostic criteria. Thus, approximately 930,000 soldiers of the Vietnam war have been affected by PTSD. The NVVRS substantially improved over previous epidemiologic investigations of prevalence by using methods for identifying more representative and comprehensive cases. Findings among several epidemiologic investigations of prevalence in both Vietnam veterans and community samples showed similar results. While the range of estimates for current PTSD was reported as 1.8% to over 25%, the estimates from most studies fall within the 95% confidence interval of the NVVRS study estimates (13.0 % to 17.4%) (Buydens-Branchey et al., 1990; Card, 1987; Carlier & Gersons, 1995; Chemtob, Bauer, Neller,

Hamada, Glisson, & Stevens, 1990; Davidson & Fairbank, 1993; Foy et al., 1987a; Jordan et al., 1991; King, King, Foy, Keane, & Fairbank, 1999; Kulka et al., 1988, 1990; McFarlane, 1988; Norris, 1992; Orsillo, Weathers, Litz, Steinberg, Huska, & Keane, 1996; Schlenger et al., 1989, 1992) .

Other Descriptive Factors

The NVVRS conducted a series of descriptive analyses to establish some understanding of the potential differences in distribution of PTSD among theater veterans. These conclusions should be viewed as tentative, however, because no formal tests of group differences were performed.

The information presented in Table 2.3 suggests that sociodemographic factors associated with lower risk of PTSD include being white, married or in relationship, and more than 20 years of military service. Soldiers who were at least 20 when they began military service in Vietnam, whose tour of duty was less than 13 months, and those not exposed to high levels of war zone stress showed lower overall rates of PTSD. Sociodemographic factors identified as associated with higher risk of PTSD included being unemployed, fewer years of education, incomes lower than \$20,000, and younger ages of entry into military service. In addition to these protective and risk factors, high exposure to war zone stress has been shown to result in PTSD symptoms at four times the rates of other theater veteran exposed to low to moderate war zone stress. Similarly, being injured or wounded in combat resulted in PTSD at two to three times the rates experienced by theater veterans who were not injured during their service. Receiving decoration or commendation for bravery such as a Purple Heart (one in three) or any

combat medal (one in four) predicted substantially higher rates of PTSD. Men who declared no religious preference were among the highest risk for current PTSD (Kulka et al., 1988, 1990). Taken together, these findings would suggest that there are salient sociodemographic, military and post-service factors that influence current PTSD symptomatology.

Table 2.3 Sociodemographic Characteristics and Current PTSD Prevalence Rates

Factors Associated with Increased Prevalence	Prevalence Rate (%)
Unemployed	34.5
Failure to finish high school	28.7
Incomes < \$20,000	26.2
Age of entry in Vietnam: 17-19 years old	25.2
Branch of Service: Marine Corp	24.8
Length of Military Service: 4-20 years	24.8
Tour of service in Vietnam: 13 months or longer	19-20
Born after 1945	18-19
Branch of Service: Army	16.2
Factors Associated with Decreased Prevalence	Prevalence Rate (%)
Born before 1945	4-10
Career military service	5.6
Length of service in Vietnam 12 months or less	12.7-15.3
Condensed from Kulka et al., 1990	

Lifetime PTSD.

According to the DSM-IV (APA, 1994), community-based studies on lifetime prevalence of PTSD estimate a range from 1% to 14%. Lifetime prevalence for at-risk groups (e.g., combat veterans or survivors of criminal violence) have yielded prevalence rates ranging from 3% to 58%. The range of estimates among lifetime prevalence suggested that biopsychosocial factors may substantially influence and impact how, when, and to what degree individuals may be effected by traumatic experience (e.g., Klunik, Speed, Valkenburg, & McGraw, 1986; Lee, Vaillant, Torrey, & Elder, 1995; Mellman, Randolph, Brawman-Mintzer, Flores, & Milanes, 1992; Schlenger et al., 1992; Silverstein, 1994, 1996; Tennant, Goulston, & Dent, 1986; Weaver & Clum, 1993; Zaslave, 1994; Zlotnick, Warshaw, Shea, Allsworth, Pearlstein, & Keller, 1999).

Regarding lifetime adjustment trajectories, the early clinical literature remains salient (Archibald & Tuddenham, 1965; Kardiner, 1941; Kardiner & Spiegel, 1947). The longitudinal course associated with PTSD was characterized by Kardiner (1941) as “deterioration. . .not dissimilar to schizophrenia. . . The diminution of interest and intelligence is due the continuous shrinkage of the field of affective functioning and the gratifications derived therefrom” (p. 249). This observation suggests that both intrusive symptoms and avoidance strategies combine to produce a dramatic impact on the affected veteran over his or her lifetime.

Characteristics associated with increased prevalence in women veterans include rank, total years of military service, and serving in the I Corps or II Corps. War zone exposure for women veterans showed similar pronounced increases in PTSD

symptomatology. For example, women who had service roles in which exposure to the wounded and the dead was part of their military occupational status have seven times the rate of current PTSD as those women with only low or moderate exposure to war zone stress (Kulka et al., 1990). Although the sample sizes are small, being wounded (20.3 percent) or receiving combat medals (15.0 percent) also contributed to higher than average rates of current PTSD in women veterans (Kulka et al., 1990).

The NVVRS study estimated lifetime prevalence of PTSD at 30.9 among male theater veterans. The estimate of lifetime prevalence of partial PTSD was 22.5 percent for male theater veterans. These findings suggest that, over the course of their lives, over half of the male veterans who served in the Vietnam theater have experienced clinically significant responses to stress and almost one million male veterans may be affected during the course of their lives. The nature of trauma has been identified by several empirical and clinical perspectives as an attack on the individual's sense of self and predictability of the world (e.g., Allen, 1995; Boss, 1984; Bremner, Southwick, Brett, Fontana, Rosenheck, & Charney, 1992; Brende, 1983; Danieli, 1980; Figley, 1978a, 1985, 1986; Figley & Leventman, 1980; Foa, Zinbarg, & Rothbaum, 1992; Hendin, Pollinger, Singer, & Ulman, 1981; Herman 1997; Janoff-Bulman, 1979, 1989, 1992; King, King, Fairbank, Keane, & Adams, 1998; van der Kolk et al., 1996a).

Theoretical Formulations of PTSD

PTSD has emerged as a complex biopsychosocial response to a myriad of overwhelming experiences including natural disasters, war, rape, and motor vehicle accidents (Davidson & Foa, 1993; van der Kolk et al., 1996a; Wilson & Keane, 1997;

Wilson & Raphael, 1993). One of the assumptions that guided the initial formulations of PTSD was the belief that PTSD was a normal response to abnormal circumstances (Shalev, 1996). Another dimension of this early theory regarding PTSD explained the acute to chronic phases of the disorder as an outgrowth of the normal response to abnormal events paradigm by focusing on the conditionability and survival value of the acute response to the traumatic experience. Earlier versions of the DSM (American Psychiatric Association, 1980, 1987) reflected this viewpoint in so far as PTSD was defined as a “normal reaction” to an “abnormal” incident. Reactions were viewed within the context of the stressor event and the underlying assumption was that the majority of persons experiencing such an event would present with similar symptoms of distress (American Psychiatric Association, 1980, 1987).

For example, regarding combat trauma, Bremner, Southwick, Johnson, Yehuda, and Charney (1993b) observed:

What was of survival value in, for example, the jungle of Vietnam—an activation of the noradrenergic and the [corticotropin-releasing factor/hypothalamic-pituitary-adrenal] axis systems, the strong engraving of memory traces of the event, promotion of the startle response, and heightened attention and vigilance—may represent pathology when the veteran is sitting at the dinner with family [members] 20 years after the war (van der Kolk, et al., 1996, p. 78).

This case example demonstrated the utility hypothesis, which conceptualized PTSD as a normal response that continues over an extended period of time, which exceeds its usefulness. A similar viewpoint is expressed in the psychodynamic formulations of

PTSD. The psychodynamic model of PTSD viewed traumatic experience as incomplete mental processing. A normal response to an abnormal event that has not been adequately completed. The trauma symptoms are indicative of incomplete processing of the event (e.g., Allen, 1995; Horowitz, 1992, 1996; Pitman & Orr, 1990). Behavioral approaches based on this assumption conceptualized symptoms as normal learned responses that have failed to be extinguished (e.g., Bremner, Scott, Delaney, Southwick, Mason, Johnson, Innis, McCarthy, & Charney, 1993a; Keane, Fairbank, Caddell, Zimering, & Bender, 1985).

The “normal response” hypothesis viewed PTSD as a failure to recover from mental traumatization (Shalev, 1996). This viewpoint suggested that trauma invariably results in psychopathology (McFarlane, 1992; McFarlane, Weber, & Clark, 1993). Such a conclusion does not hold when one examines the quantitative data. The NVVRS study (Kulka et al., 1988, 1990) revealed that only 15.2% of male Vietnam veterans were categorized as “chronic” PTSD.

An alternative viewpoint of PTSD as an abnormal response has not been adequately considered in the theoretical or empirical literature (Shalev, 1996). Data from studies involving civilians and other peacetime experiences including traffic accidents, exposure to criminal violence, and exposure to domestic violence report PTSD symptoms (Burgess & Holmstrom, 1974; Feinstein & Dolan, 1991; Gibbs, 1989; Mayou, Bryant, & Duthie, 1993; Mezey & King, 1989; Norris & Riad, 1997; Resnick, Kilpatrick, Best, & Kramer, 1992). Shalev (1996) concluded that such empirical findings call into question

the “normality” hypothesis of PTSD and argued for the need to examine predictors of PTSD and the chronic course of distress of the disorder theoretically and empirically.

There has been a substantial knowledge base developed over the past thirty years due to the systematic observation and treatment of combat veterans. Most authorities now recognize a model of trauma which viewed the immediate response to the traumatic event as one part in a sequence of events that differentiate individuals who develop PTSD from those who do not develop the disorder (e.g., Foy, 1992; King et al., 1998, 1999; Newman, Orsillo, Herman, & Niles, 1995; Penk, Peck, Rabinowitz, Bell, & Little, 1988; Shalev, 1996; van der Kolk et al., 1996b).

A review of the findings from Table 2.4 suggested that pretrauma vulnerability, magnitude of the stressor, preparation for the event, immediate and short term responses and posttrauma responses contributed to the variability in the findings of these empirical investigations (Shalev, 1996). The empirical work on PTSD predictors to date showed a complex picture associated with the development of the disorder (van der Kolk et al., 1996b).

Table 2.4 Predictors of PTSD

Author	Population/Design	Variables predicted	Predictors
Abenhaim et al., 1992	253 survivors of terrorist attack; survey	PTSD	* Severity of injury ^Sex, age
Basoglou et al., 1994	55 torture survivors; 55 controls (political activists without torture); case control; questionnaires, interview	PTSD and PTSD symptoms	*Torture ^Preparedness, commitment, social supports

Table 2.4 Continued

Predictors of PTSD

Author	Population/Design	Variables predicted	Predictors
Bownes et al., 1991	51 rape survivors	PTSD	*Rapes by strangers; use of physical force or weapons; injury
Breslau & Davis, 1987a	69 Vietnam veterans (inpatients); survey	PTSD, panic disorder, major depression, mania	*(PTSD): participation in atrocities; cumulative exposure to combat stressors
Breslau & Davis, 1992	1007 young urban adults; survey	Chronic PTSD	*Family history of antisocial behavior; female
Breslau et al., 1991	1007 young urban adults; survey	Exposure to trauma; PTSD	*(Exposure): lower education; male gender; early conduct problems; extraversion; family history of psychiatric disorder *(PTSD): early separation from parents; neuroticism; preexisting anxiety or depression; family history of anxiety
Buydens-Branchey et al., 1990	84 Vietnam veterans; survey	PTSD	*Combat intensity and duration; physical injury
Chemtob et al., 1990	57 Vietnam veterans (special forces); survey	PTSD symptoms	*Poor preservice relationships; being wounded; friends MIA; guilt over death of a friend; lack of preparation to leave unit; failure to discuss feelings on return
Clarke et al., 1993	69 young Cambodian refugees of the Pol Pot regime; survey, interviews	PTSD and depressive symptoms	*(PTSD): war trauma; resettlement strain *(Depression): recent stressful events

Table 2.4 Continued

Predictors of PTSD			
Author	Population/Design	Variables predicted	Predictors
Davidson et al., 1991	2985 residents of Piedmont, North Carolina; epidemiological survey	PTSD	*Job instability; family history of psychiatric illness; parental poverty; history of child abuse; parental separation prior to age 10
Feinstein & Dolan, 1991	48 civilian survivors of physical trauma; survey, questionnaires (GHQ)	PTSD; psychiatric morbidity	*Distress postinjury ^Severity of the stressor predicts initial distress but not 6-month morbidity
Foy et al., 1984	43 help-seeking Vietnam veterans; survey, MMPI profiles, self-reports	PTSD	*Combat exposure; military adjustment; MMPI scores; anxiety ^Preliminary adjustment
Gallers et al., 1988	60 Vietnam veterans (30 with and 30 with PTSD); case control; questionnaire	PTSD and PTSD symptoms	*Traumatic violence; distress at having participated in such acts ^Preliminary adjustment; drug and alcohol use
Gidycz & Koss, 1991	1213 sexual assault survivors; survey, questionnaire	Anxiety and depression	*History of mental health problems; aggressiveness of assault; belief that people are not trustworthy
Goldberg et al., 1990	715 monozygotic twin pairs discordant for military service in southeast Asia	PTSD	*Combat exposure (ninefold increase in prevalence from noncombat to high combat exposure)
Green et al., 1990a	200 Vietnam veterans; survey, interviews	PTSD	*Intensity of the stressor; exposure to grotesque death; level of education; social support at homecoming

Table 2.4 Continued

Predictors of PTSD			
Author	Population/Design	Variables predicted	Predictors
Green & Berlin, 1987	60 help-seeking Vietnam veterans; survey	PTSD	*Combat intensity, current impact of previously experienced events; concurrent level of life stress ^Social support during the first year of return from Vietnam; preservice psychosocial functioning
Kilpatrick et al., 1989	294 adult female crime survivors; survey	Crime-related PTSD	*(PTSD): Life threat during crime; physical injury; completed rape
Laufer et al., 1985b	326 Vietnam veterans	PTSD and PTSD symptoms	*Combat exposure; exposure to abusive violence and killing; subjective "experiential" coping
McCranie et al., 1992	57 Vietnam veterans with PTSD (inpatients); survey	PTSD symptom s and severity	*Negative parenting behaviors predict PTSD symptom severity at lower levels of combat exposure
McFall et al., 1991	489 Vietnam veterans seeking help for drug abuse; survey	PTSD	*Combat exposure; age at war zone duty; duration of war zone duty; physical injury
McFarlane, 1988	469 firefighters exposed to bushfire disaster; follow-up at 4, 11, and 29 months; questionnaires	Post-traumatic morbidity	*Neuroticism; past history for a psychological disorder
Nader et al., 1990	100 elementary school children exposed to a sniper shooting; follow-up at 14 months; after event	Severity of PTSD reaction	*Level of exposure; guilt; knowing the child who was killed
North & Smith, 1992	900 homeless men and women in St. Louis; survey, interviews (DIS)	PTSD	*Childhood histories of abuse and family fighting ^Psychiatric diagnoses

Table 2.4 Continued

Predictors of PTSD			
Author	Population/Design	Variables predicted	Predictors
North et al., 1994	136 civilian survivors of a mass shooting; survey 1 month after event, interview (DIS)	PTSD	*Predisaster psychiatric disorder (MDD) predicted PTSD in women but not men ^Most PTSD subjects had no history of mental illness
Patterson et al., 1990	54 inpatients with major burn injury, weekly follow-up during and after admission	PTSD	*Total body surface area burned; female gender; lack of responsibility for the injury
Perry et al., 1992	51 inpatients with burn injuries; follow-up at 1 week and 2 (n = 51), 6 (n = 40), and 12 (n = 31) months	PTSD	*Subjective variables: emotional distress, perceived social support
Resnick et al., 1993	295 female crime victims; survey	PTSD	*High crime stress; significant interaction among stress level, precrime depression and PTSD
Schnurr et al., 1993	131 male Vietnam-era veterans; studied premilitary MMPI and current PTSD; interviews (SCID)	PTSD and PTSD symptoms	*(PTSD symptoms): MMPI scales of hypochondriasis, psychopathy, masculinity-femininity, and paranoia *(PTSD): depression, hypomania, and social introversion
Shalev, 1992	15 injured survivors of a terrorist attack; prospective follow-up for 10 months	PTSD	^Symptoms of denial and intrusion recorded 1 week after trauma

Table 2.4 Continued

Predictors of PTSD			
Author	Population/Design	Variables predicted	Predictors
Smith et al., 1990	46 hotel employees who survived a jet plane crash; survey, interview 4-6 weeks after the event	PTSD, major depression, GAD, alcohol abuse and dependence	*Predisaster psychiatric histories predict postdisaster psychiatric disorders
Solkoff et al., 1986	100 Vietnam combat veterans (50 with PTSD and 50 without PTSD); case control; structured interview	PTSD	*Combat experience, perceptions of homecoming ^Childhood family history, preservice factors
Solomon, Avitzur, & Mikulincer, 1990	255 Israeli war veterans of the Lebanon war, follow-up at 1 and 2 years of the war, questionnaires	PTSD	*Social support, life events, internal locus of control
Solomon et al., 1991a	348 Israeli veteran of the Lebanon war with combat stress reaction; Miller Behavioral Style Scale	Trauma-related psychopathology	*Blunting coping strategies
Speed et al., 1989	62 World War II POWs; survey, interviews	PTSD	*Proportion body weight lost during captivity; experience of torture ^Weak family history of mental illness; preexisting psychopathology
Sutker et al., 1990	193 World War II and Korea POWs; survey	PTSD	*Confinement; weight loss; lower socioeconomic status; greater hardship; lower military rank

Table 2.4 Continued

Predictors of PTSD			
Author	Population/Design	Variables predicted	Predictors
Zaidi & Foy, 1994	20 Vietnam veterans (inpatients); survey	PTSD symptoms	*History of physical abuse

Note: GHQ, General Health Questionnaire; MMPI, Minnesota Multiphasic Personality

Inventory; DIS, Diagnostic Interview Schedule; SCID, Structured Clinical Interview for DSM-III-R; *, all variables following asterisk indicate a significant finding; ^all variables following carat indicate a nonsignificant finding on outcome measures.

Theoretical Formulations of Combat Trauma

Combat veterans have provided both cross-sectional and longitudinal perspectives on PTSD. The most current empirical investigations have generated structural equation models to facilitate examination of how various pretrauma factors interact with event related responses and posttrauma factors to determine individual differences in response to traumatic experiences (Fontana & Rosenheck, 1994; King et al., 1999; King, King, Gudanowski, & Vreven, 1995). The findings among premilitary, military, and postmilitary factors have produced information that have aided in the development of models that explicate moderating and mediating influences among the various components in an individual trauma response.

For example, in examining the role of constitutional and family factors, a study by True, Rice, Eisen, Heath, Goldberg, Lyons, and Nowak (1993) demonstrated that genetic factors account for 13% to 30% of variance for symptoms in the reexperiencing cluster, 30% to 34% percent of symptoms in the avoidance cluster, and 28% to 32% for symptoms in the arousal cluster. Another consistent finding that emerged from the

empirical literature noted the vulnerability associated with a family history that is positive for alcohol abuse and/ or psychiatric disorders (e.g., Foy et al., 1987b; King et al., 1999). Other factors that have influenced vulnerability toward development of PTSD include personality traits such as neuroticism, introversion, and prior mental disorders; life course events including childhood abuse and neglect; exposure to previous trauma such as repeated combat experience or sexual assault; and family environment factors including negative parenting behavior, early separation from parents, parental poverty, and lower education. These family factors have been shown to predict both vulnerability to subsequent exposure to traumatic events and the development of PTSD following exposure to a range of traumatic stressors including rape, combat, violence and victimization as well as an increased sensitivity to nonspecific stressors (Breslau et al., 1995; Davidson, Hughes, Blazer, & Georger, 1991; Green, Grace, Lindy, & Gleser, 1990b; McCranie et al., 1992).

In evaluating the contribution of the magnitude of the stressor on the development of PTSD, the intensity of overwhelming experience has been examined in terms of combat intensity and duration (Breslau & Davis, 1987a; Buydens-Branchey et al., 1990; Foy et al., 1984; Goldberg et al., 1990; Green & Berlin, 1987; McFall et al., 1991; Solkoff et al., 1986); dangerousness of a sexual assault incident (Kilpatrick et al., 1989; Bownes et al., 1991); severity of torture experienced (Basoglu et al., 1994; Speed et al., 1989), or the extent of physical injuries sustained (Abenhaim et al., 1992). These factors have been identified as significant factors in the subsequent development of PTSD (for a review, see March, 1993). Seven common dimensions of traumatic stressors have been

proposed by Green (1990) including: (1) threat to one's life and body integrity; (2) severe physical harm or injury; (3) receipt of intentional injury/harm; (4) exposure to the grotesque; (5) witnessing or learning of violence to loved ones; (6) learning of exposure to a noxious agent; and (7) causing death or severe harm to another person. The empirical studies in this area have noted the importance of the association between the magnitude of the stressor and the development of PTSD (e.g., Fontana & Rosenheck, 1994; Foy et al., 1984; King et al., 1999).

Symptomatic responses to combat stress have been noted among soldiers in different wars, at different times, and across many cultures, leading to the conclusion that psychological effects are universal for some proportion of combat participants (Archibald & Tuddenham, 1965; Grinker & Spiegel, 1945; Kardiner 1941; Kulka et al., 1988, 1990; Shalev, 1996; Solomon, Laor, & McFarlane, 1996). Solomon (1993) described combat stress as a "labile, polymorphic disorder, characterized by high variability and rapid changes in manifestation" (p. 104). Distress may be observed in various somatic and affective presentations including restlessness, irritability, psychomotor retardation, apathy, psychological withdrawal, startle reactions, anxiety and depression, constricted affect, confusion, abdominal pains, aggressive and hostile behaviors, paranoid reactions, and emotional lability.

One approach to understanding the specific impact of war zone trauma has been to identify specific categories of combat experience and correlate those environmental factors with PTSD symptomatology. Objective measures of environmental conditions have assessed factors such as receiving friendly or hostile fire and how often did the

soldier fire rounds at the enemy (Keane, Fairbank, Caddell, Zimmering, Taylor, & Mora, 1989; Laufer et al., 1985b; Laufer, Gallops, & Frey-Wouters, 1984).

Other perspectives on combat trauma have regarded specification of stressors solely on environmental terms as incomplete (e.g., Fontana, Rosenheck, & Brett, 1992; Lazarus & Folkman, 1984; Wilson, 1989). These investigators advanced an interactionist approach that posited stress or trauma as a product of both the person and the environment. The personal meaning of stressors as part of the focus of the traumatic experience has been a consistent theme in the writing on war traumas. Grinker and Spiegel (1945) commented, "The reactions to the stimuli of combat depend upon the meaning given to these stimuli in terms of recognizing them as a threat and of feeling confident of the ability to neutralize the threat" (p. 122). Threat incorporates a psychological appraisal that requires assessment of both the environmental event and one's personal resources for physical and psychological well-being (Fontana et al., 1992).

The inclusion of psychological meaning into conceptualization of overwhelming experience on trauma models has been espoused by several investigators. Trauma models which incorporated meaning-based perspectives have included components such as threat, loss, fear, and grotesqueness as subjective experiences that potentially impact a person's perceptions and responses to overwhelming experience (Green, Lindy, Grace, & Gleser, 1989; Lindy, Green, Grace, & Titchener, 1983). Rosenheck et al. (1992) elaborated on the concept of psychological meaning by operationalizing meaning as consisting of "both ideational (i.e., threatening) and emotional (i.e., distress) components" (p. 749). These investigators identified four roles

and seven experiences associated with a degree of personal responsibility in evaluating psychological meaning. For example, the roles of target of killing, observer of killing, agent of killing, and failure at preventing killing were regressed on symptom features such as hyperarousal, intrusion, numbing, PTSD diagnosis, general psychiatric distress and number of suicide attempts. The findings from this study reported that the inclusion of psychological meaning contributed to the amount of explained variance over and above that which could be accounted for by the objective criteria alone. The magnitude of effects demonstrated by this study was within the range of those reported in the literature.

The complexity of PTSD and psychological meaning was expressed by Ursano, Kao, and Fullerton (1992) as “Meaning is always of the moment, constructed anew through the interaction of the individual’s past, present, and expected future, all in a particular social context with particular biological givens” (p. 756). The roles engaged in during combat have become embedded as a larger part of the individual’s identity. The Vietnam veteran’s current sense of self has incorporated more than 20 years of living with war experiences and memories including views of the self as victim or agent, acting alone or as a member of a group, with a successful life or a life filled with personal disappointment (Fontana et al, 1992).

The adaptive integration of life experiences has been held as a view of effective psychological (personality) functioning (e.g., Ausubel, 1955; Bates & Wachs, 1994; Blatt & Blass, 1992; Bradshaw, Ohlde, & Horne, 1993; Clark, Watson, & Mineka, 1994). Fontana et al. (1992) investigated how meaning variables such as threat, risk, and responsibility continue to affect individual functioning over and above symptoms,

severity, and persistence of PTSD. The concept of shame and shame-based identity may also contribute to understanding how individuals ascribe meaning to past and current life experiences.

Developmental and Post-Trauma Adjustment Issues in Vietnam Veterans

One of the primary adjustment challenges faced by Vietnam veterans was the transition from active military duty to civilian life (e.g., Foy et al., 1987b; Gallers et al., 1988; Jordan et al., 1991, 1992; Kobak & Sceery, 1988; Kulka et al., 1990; McCranie et al., 1992; Motta, 1990; Riggs, Bryne, Weathers, & Litz, 1998). The Vietnam veterans' homecoming was experienced as a mixture of relief, rage, grief, terror, and blame (e.g., Scurfield, 1993; Wilson, 1980, 1989).

Several environmental and cultural factors have been recognized as contributing to developmental and post-trauma adjustment following military service in Vietnam including: (1) The nature of guerrilla warfare and the promotion of terror through the use of ambush, hit and run tactics, and involvement of women, children, and elderly as guerrilla agents; (2) The body count as a measure of progress in the war rather than terrain objectives; (3) Political versus military decision-making that shaped combat objectives; (4) The one-year tour of duty (12 or 13 months depending of the branch of service) in a maximally stressful environment; (5) The veterans' rejection, betrayal, or non-response by the culture at large upon return to the United States; (6) The lack of adequate health care programs for war-related PTSD and other veteran-specific mental health concerns; (7) The lack of counseling programs for veterans and their families; (8) The unclear military and political initiatives concerning the Vietnamese people; (9) The

difficulties in securing employment and educational opportunities after the war; and (10) The uncertainties of herbicidal exposure (e.g., Agent Orange) and the denial or minimization of responsibility by the government and private industry (e.g., Brende & Parson, 1985; Laufer, 1988; Scurfield, 1993).

Sociocultural factors coupled with individual differences presented a complex set of challenges for the veterans, their families, and the psychological and medical community (e.g., Card, 1983, Figley & Leventman, 1980; Sonnenberg, 1985b; Wilson, 1989). According to Goodwin (1987), appropriate prevention and treatment after return to civilian life were essentially nonexistent for Vietnam veterans. Lawson (1995), in describing veterans' post-war adjustment efforts, commented that

Feeling disenfranchised from the very country for which they were serving and dying, many veterans set out to find a safe place, most often resulting in their own self-imposed social isolation. Lacking a sense of protection, many Vietnam veterans viewed their world from a completely different perspective than individuals who have never been in combat (p. 33).

McCann, Sakheim, and Abrahamson (1988) conceptualized trauma and victimization utilizing "schema theory" that incorporated a cognitive processing component to explain, in part, how individuals process and integrate overwhelming experiences. McCann et al.'s model suggests that humans attempt to create order and meaning through the use of schemas about self, others, and the world. These schemas help to organize life experiences. Schemas and life experiences operate in a reciprocal fashion influencing perception, cognition, and behavior. Discrepancy between schemas

and life experiences produces dissonance and heightened arousal (Mancuso, 1977).

Heightened arousal is also accompanied by increased cognitive processing and increased emotional intensity in feelings such as anger, guilt, fear, or shame (Lawson, 1995).

Schema theory holds that, in general, people attempt to deal with increased arousal through the use of cognitive strategies that: (1) avoid or reject the inconsistent input, (2) attribute the meaning of the input for the best fit between schema and input, or (3) modify the existing schema to provide a better match with the input of experience as a means to reduce arousal and emotional intensity.

McCann et al. (1988) posited that schemas about the self and others develop sequentially in response to life experiences and incorporate dimensions of psychological and interpersonal functioning related to safety, trust, power, esteem, and intimacy. The mutual influence between schemas and experiences is expressed in response patterns that encompass cognitive, emotional, behavioral, biological, and interpersonal adaptation patterns. Adaptation patterns further influence life experiences as evidenced by people seeking out or creating relational situations that are congruent with their schemas (Lawson, 1995).

“America’s first teenage war” is a moniker that has described the Vietnam War (Lawson, 1995). Schema theory is useful in examining the developmental context of the Vietnam War. According to published reports, the average soldier was just under twenty years of age (Kulka et al., 1990; Wilson, 1977). Combat soldiers, in late adolescence, dealing with developmental challenges involving identity and role confusion placed in the context of a civil war with an unacknowledged political/industrial agenda by the

United States government met with demands that severely taxed their physical and psychological resources (Erikson, 1968). According to Erikson's model of identity development, individuals at this age have not yet consolidated a clear and stable sense of self. Ordinarily, late adolescence is viewed as a time in which psychosocial exploration occurs in a relatively safe context and contributes to the development of a personal set of values and a distinct sense of self. The contradictory experiences of the Vietnam War coupled with the dangerousness and horrors associated with survival presented uncertainty, ambiguity, terror, rage, and feelings of helplessness. The lack of safe context in which to consolidate a stable sense of self may have exacerbated how role confusion was experienced by soldiers and contributed to fixed perspectives of the world as dangerous, untrustworthy, and without meaning and purpose (Lawson, 1995; McCann et al., 1988). Combat experiences would likely have promoted negative schemas in the areas of safety, trust, power, esteem, and intimacy and would be the backdrop against which the challenges of adulthood and postwar adjustment would be negotiated (Lawson, 1995).

Chronic Adjustment Challenges

Epidemiological investigations of PTSD have estimated lifetime prevalence of PTSD to range from 8% to 12% (Breslau et al, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resnick et al., 1993). Researchers and clinicians have anecdotal and empirical findings that indicate that for some proportion of persons PTSD has a chronic course (Green et al., 1989; Kulka et al., 1990). Being female, numbing experiences, personality pathology, and comorbidity have been found to be risk factors associated with

chronic PTSD in civilian populations (Breslau & Davis, 1992; McFarlane, 1989). Other findings have identified the role of depression, substance abuse, and childhood trauma as significant co-factors in chronic PTSD (Bremner, Southwick, Darnell, & Charney, 1996; Breslau & Davis, 1992; McFarlane, 1988; Rowan, Foy, Rodriguez, & Ryan, 1994).

Estimates on recovery from chronic PTSD have shown substantial variability ranging from 18% to 50% depending on samples (Breslau & Davis, 1992; Green et al., 1989; Rothbaum & Foa, 1993; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992; Zlotnick et al., 1999). Research with Vietnam veterans with chronic PTSD have shown that alcohol and other substances are an often relied-upon strategy to alleviate their PTSD symptoms (Bremner et al., 1996). Moreover, a history of alcohol use has also been associated with the maintenance of chronic PTSD (Zlotnick et al., 1999). Taken together, these findings illustrate how important “self medication” is in the ongoing coping efforts of veterans who are living with the longterm effects of combat trauma. Issues related to substance abuse and combat PTSD are well documented in the clinical and empirical literature (e.g., Boudewyns, Woods, Hyer, & Albrecht, 1991; Bremner et al., 1996; Daniels & Scurfield, 1994) and are outside the primary focus of the current investigation. However, the extent to which employed coping strategies contribute to sense of self and identity issues across the lifespan will be a focal perspective of this study.

Identity Issues and Challenges in Combat PTSD

Characterological and identity disturbances have been associated in veterans with PTSD (e.g., Bradshaw et al., 1993; Brende & McCann, 1984; Southwick, Yehuda, & Giller, 1993; Wilson, 1977; Young, 1988). The capacity to regulate internal states and

behavioral responses to external stress have been proposed by Cole and Putnam (1992) to be of fundamental importance in the development of an overall sense of self. Their studies with abused children have suggested that lack of development or loss of self-regulatory capacities contribute to problems with self definition including: (1) disturbances in sense of self, such as sense of separateness, loss of autobiographical memories, and disturbances in body image; (2) poorly modulated affect and impulse control including aggression against self and others; and (3) insecurity in relationships, such as distrust, suspiciousness, lack of intimacy, and isolation.

Similar conclusions have been reported from work with adult trauma survivors (e.g, Herman, 1992a; van der Kolk, 1988; van der Kolk & Fisler, 1994a). In summarizing the impact of trauma on character development van der Kolk (1996) pointed out that “The combination of chronic dissociation, physical problems for which no medical cause can be found, and a lack of adequate self-regulatory processes is likely to have profound effects of personality development” (p.195).

Interpersonal Contexts Affected by PTSD

Empirical investigations and clinical reports have identified interpersonal problems as one of the most prominent areas affected by chronic PTSD (Carroll, Rueger, Foy, & Donahoe, 1985; Nezu & Carnevale, 1987; Parson, 1988; Roberts, Penk, Gearing, Robinowitz, Dolan, & Patterson, 1982). According to Kulka et al., (1988, 1990), combat veterans exposed to high war zone stress consistently report poorer levels of adjustment as expressed in marital, relationship, and family functioning. The longitudinal course of PTSD has multiple variations that include acute, delayed, chronic, intermittent, residual,

and reactivated patterns (Blank, 1993). McFarlane and De Girolamo (1996) noted interpersonal dysfunction becoming more prominent across time in individuals with PTSD. In examining risk and resilience factors associated with PTSD, social support has been identified as important environmental resource (e.g., Green, 1994a; Green et al., 1990a; King et al., 1998; King et al., 1999). According to van der Kolk and McFarlane (1996) characterological adaptations that accompany PTSD must be placed in a developmental context that integrates traumatic memories with here and now realities. These authors suggest that

the core in PTSD is that the primary symptoms are not symbolic, defensive, or driven by secondary gain. The core issue is the inability to integrate the reality of particular experiences, and the resulting repetitive replaying of the trauma in images, behaviors, feelings, physiological states, and interpersonal relationships (p.7).

According to van der Kolk (1996), coping with stress involves an individual's capacities to take care of oneself, knowing how to access social support, and being able to rely on protection from others when one's own resources are not adequate to the task. The long-term effects of trauma have been shown to compromise an individual's abilities along all of these dimensions. Table 2.5 summarizes how living with trauma affects adjustment efforts. Problems with self-regulation and emotional control are challenges regularly faced by trauma survivors that fundamentally interfere with interpersonal functioning and sustained social support. Alexithymia and somatization complicate the daily lives of individuals with chronic PTSD. Difficulties in establishing and maintaining

a sense of safety and security result in character changes that include problems with self-efficacy, shame, and self-loathing, as well as problems in dealing with interpersonal conflicts (e.g., Resnick, Foy, Donahoe, & Miller, 1989; Rinsley, 1981; van der Kolk, 1996).

Table 2.5 Long-Term Effects of Trauma on Coping Abilities

Clinical Dimensions	Observable Behaviors and Common Characteristics
Generalized hyperarousal and difficulty in modulating arousal	<ol style="list-style-type: none"> 1. Aggression against self and others 2. Inability to modulate sexual impulses 3. Problems with social attachments demonstrated by excessive dependence or isolation
Alterations in neurobiological processes involving stimulus discrimination	<ol style="list-style-type: none"> 1. Problems with attention and concentration 2. Dissociation 3. Somatization
Conditioned fear responses to trauma-related stimuli	<ol style="list-style-type: none"> 1. Flashbacks with environmental triggers 2. Fight, flight or freeze responses when threatened 3. Avoidance as a primary way to manage daily activities
Shattered meaning propositions	<ol style="list-style-type: none"> 1. Loss of hope, trust, and a sense of personal agency 2. Loss of cognitive flexibility
Social Avoidance	<ol style="list-style-type: none"> 1. Loss of meaningful attachments 2. Lack of participation in future-oriented activities

Note: Adapted from van der Kolk, 1996

One of the enduring aspects of chronic trauma is problematic interpersonal dynamics that are a complication of both hyperarousal and affective regulation capacities (e.g., Herman et al., 1992a; van der Kolk, 1996). Another critical developmental issue

that emerged in chronic trauma populations has to do with the capacity to attribute responsibility properly (van der Kolk, 1996). Several investigations have offered observations regarding how trauma has manifestations that include self-blame, guilt, and shame (Laufer, 1988; Ogata et al., 1989; Wong & Cook, 1992). Self-blame, guilt, and shame are often linked to disordered sense of self, attachment difficulties, and relationship problems. Core sense of self concerns are also conceptualized from shame-based perspectives. Thus, examining how psychological trauma and shame are related provides increased understanding of both domains and offers multiple avenues for intervention when shame and psychological trauma are shared as a clinical concern. A review of shame theory follows to develop an understanding of how PTSD and shame may be articulating similar concerns where sense of self issues and interpersonal concerns are involved.

Shame

Psychoanalytic perspectives on shame have offered most of the initial and continuing formulations on how shame influences identity and psychological functioning (e.g., Broucek, 1991; Erikson, 1950; Fenichel, 1945, Freud, 1905/1953, 1917/1955, 1930/1964; Goldberg, 1991; Lewis, 1987c; Nathanson, 1987a, 1992). Erikson (1950) linked shame with struggles around self-control and autonomy. Whether shame and self-doubt issues become permanent features of the personality is dependent on the interpersonal dynamics in the early family environment of an individual. Erikson's stage-based developmental model suggested that positive and negative emotional outcomes repetitively occurred in a sequential fashion beginning early in life and culminating in

end of life developmental challenges. These developmental sequences were expressed as basic trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus stagnation, ego integrity versus despair. Kaufman (1989) expanded Erikson's perspective around shame as a developmental and identity dynamic by postulating that "the negative pole of each crisis is actually an elaboration of shame, given new or wider meaning. Each subsequent crisis involves, at least in part, a reworking of shame" (p.10).

Other psychoanalytic conceptualizations have posited shame as a difference between the ego and the ego-ideal. This tension between the ego and ego-ideal has also been expressed as the goodness of fit between the tested self and the desired identity (Goldberg, 1991). Bilmes (1967) postulated that shame anxiety is present when there is a disparity between the tested self and the desired identity. This perspective suggests that an ongoing self-evaluative function occurs in which comparison is made between "how I see myself" in reality and "how I desire to be". Thus, the here and now resources of the ego are projected on the aspirational images, fantasies, and intentions of the ego-ideal. Shame is the felt experience of a deficit in individuals' evaluation of who they are with who they would like to be (Goldberg, 1991). Piers and Singer (1953) outlined important distinctions between guilt and shame in which guilt was related to transgressions and shame was associated with failure. According to Piers and Singer, the underlying threat in shame involved abandonment whereas the threat associated with guilt was castration.

More recently, Morrison (1989) advanced Piers and Singer's ideas of shame

through the language of self psychology and operationalized shame as a deficit between the self and the ideal self. Lewis (1987c) integrated attachment theory with shame and symptom formation. Lewis emphasized how the experience of shame and the development of expressions of distress and panic are related to interpersonal responses to the self. According to Lewis (1987c), “Vicarious emotional experience is the foundation of attachment . . . Shame is the empathic or vicarious experience of the other’s rejection of the self. Shame is the state in which one accepts the loss of the other as if it were a loss in the self” (p.103). Several psychodynamic writers have elaborated on the regulatory functions of both guilt and shame, particularly with regard to identity formation, attachment, and interpersonal capacities (e.g., Broucek, 1991; Erikson, 1950; Kaufman, 1985, 1989; Levin, 1967, 1971; Lewis, 1979; Lynd, 1958; Morrison, 1989; Nathanson, 1992).

History and Development of Shame as a Clinical Manifestation

In a synthesizing work on the psychology of shame Kaufman (1989) observed the centrality of shame in both self and interpersonal processes. Kaufman regarded shame as: central to conscience, indignity, identity, and disturbances in self-functioning, this affect is the source of low self-esteem, poor self-concept or body image, self-doubt and insecurity, and diminished self-confidence. Shame is the affect that is the source of feelings of inferiority. The inner experience of shame is like a sickness within the self, a sickness of the soul. If we are to understand and eventually heal what ails the self, then we must begin with shame (Kaufman, 1989, p. 5-6)

The history of shame has evolved from early writings on perceptions of inner states and the language used by Freud and other psychoanalytic writers to account for instinctual drives and other psychosexual crises (Freud 1930, 1914/1957). Kaufman (1989) attributed the neglect of a development of an adequate theory of shame to the predominance of guilt in the early writings and theorizing in psychoanalytic circles.

Adler's (1933) writings on inferiority feelings and the inferiority complex placed shame-related considerations within individual development and personality formation. Alexander (1938) further integrated the concept of inferiority, as a self-evaluative process in which the self is perceived as weaker than others and this weakness is experienced as shame. Horney (1950) linked shame and pride hypothesizing shame and humiliation to be reactions to wounded pride.

Piers and Singer (1953) departed from previously held psychoanalytic writings on shame and guilt by focusing on shame as a tension between the ego and ego-ideal. The experiences of shame were associated with failure and abandonment. Developmental and identity issues involving shame experiences and resolution were articulated by Erikson (1950). In an analysis of Erikson's developmental model, Kaufman (1989) located shame-based experiences within each of the stages arguing that basic mistrust, shame and doubt, guilt, inferiority, role confusion, isolation, stagnation, and despair represent important crucibles for both identity and developmental challenges.

Lynd (1958) expanded Erikson's conceptualizing on identity and development. Lynd postulated shame as a central challenge in the individual's search for identity. In describing the influence of shame on identity development, Lynd characterized shame

experiences as sources of unexpected exposure, incongruity or inappropriateness, threat to trust, and as involving the whole self.

Lewis (1971,1981,1987d, 1988) examined the relationships among guilt, shame, identification, and the superego from a psychoanalytic perspective. Shame and guilt are viewed as developmentally similar states that become expressed through different routes of identification (Kaufman, 1989). Lewis argued that shame and guilt are rooted in a common source of internalized aggression. According to Lewis, guilt is generated by identification with the threatening parent and is introjected as an internalized threat. However, “identification with the beloved or admired ego-ideal stirs pride and triumphant feeling; failure to live up to this internalized admired imago stirs shame” (Lewis, 1971, p.23).

More contemporary views of shame emerged from psychoanalytic perspectives offered by Wumser (1981, 1987), Broucek (1982), Fischer (1985) and Morrison (1983). Wumser (1981) conceptualized shame as a control around privacy and intimacy; whereas guilt serves as control on the expansion of power. A unifying theme that emerges from these current perspectives links shame as an affect associated with character problems and disorders in the self system including narcissistic and borderline disorders and self-esteem deficits. The psychological burden of shame appears to be associated with sense of self, attachment, and capacity for interpersonal process.

Clinical Perspectives and Theoretical Formulations of Shame and Guilt

In reviewing the existing literature on shame, guilt is often an implicit companion. From the earliest psychoanalytic writings to contemporary theoretical and empirical

conjecture, guilt and shame are mentioned simultaneously and may appear synonymous. However, there are distinct and notable differences in these psychological constructs (e.g., Freud, 1923/1961; 1917/1955; Lindsay-Hart, 1984). Table 2.6 compares and contrasts shame and guilt along a number of dimensions. The impact on sense of self emerges as a salient feature of shame while guilt is more explicitly identified with behavioral transgressions. The neurophysiological basis of shame reflected by overt autonomic responses suggests an evolutionary and protective function to shame. Guilt is represented as a more cognitively based response based on fear of punishments for transgressions.

Table 2.6 Differences between Shame and Guilt

Dimension	Shame	Guilt
Stimulus	Threat against integrity of self-identity including being treated as inferior, being defeated, feeling disappointed, feeling lack of self-esteem, committing a moral transgression	Committing a moral transgression for which the self feels responsible
Feeling state	Feeling state is strongly aroused, although the affect may not always be conscious. The feeling is always self-referential.	A corresponding feeling state to the event is not intrinsic to the judgment of guilt. For example, to be guilty is not required to feel guilty; nor is not feeling guilty always due to not being guilty.
Primary affect	Inadequacy, deficiency, worthlessness, being exposed, disgusted, disgraced	Feeling bad, evil, wicked, remorseful, responsible
Conscious content of thought	Painful emotion, autonomous responses, rage, blushing, tears, sense of identity threatened, repetitive reviewing and recasting of the event	Not bound to sense of identity, fewer autonomous responses, affect may or may not be present, courses of action to address guilt are rehearsed

Table 2.6 Continued

Differences between Shame and Guilt

Dimension	Shame	Guilt
Physiology	The body is the central object of the experience; overt manifestation of the affect are difficult to conceal or control	Symptoms can be more easily concealed and controlled than with shame
Facial involvement	Shame expressions apparent: facial blush, eyes cast down, body pulled in and downward	Symptoms may not be apparent
Serious characteristic symptoms	Secretiveness and severe shyness, depression, hysteria, affective lability (such as rage) susceptibility to feelings of guilt	Obsessional problems, paranoia, thought confusion
Onset of the precipitating event	Unexpected, possibly a trivial event	Actual or contemplated violation of code or values
Relation of response to magnitude of offense	A very small offense may produce a marked response	Response usually proportional to the offense
The position of the self in the event	Passive, absorbed in how others see the self	Active, self-absorbed in concern about the effect of the self's behavior on the other
Moral sense	"How could I have done that?"	"How could I have done that?"
Ethical imperative	(+) Pride (-) Contempt	(+) Altruism (-) Humility
Central fear	Not belonging in human company, being abandoned by others	Fear of punishment for aggressive and sexual impulses
Origins of the basis of the concern	Positive identification with parents and/or admired others	Need for protection against injurious parents and/or other authority figures

Table 2.6 Continued

Differences between Shame and Guilt

Dimension	Shame	Guilt
Myth of the causes of suffering	Having displeased protective figures	Having competed with powerful authority figures
Primary defenses	Desire to hide and withdraw, denying rage	Obsessive thoughts, paranoid thinking, intellectualization, confession, and seeking punishment
Effect on activity	Subdues	Increases
Effect on competitiveness	Covers up competition, leads to being "closet" competitor	Competition is known, direct and injurious to others
Intersubjective process in an interpersonal process	I can "shame" another in order to make the other feel shameful (example, manipulating another's guilt).	I cannot "guilt" another into feeling responsible, but I can shame another into feeling responsible
Ontological desire	Desire to know intimately	Fear of knowing intimately
Relationship to society	Shamelessness is not regarded as a virtue; a sense of shame is	Being guiltless is a virtue; being guilty is not
Positive functions	Awareness of self's human limitations, discovery of the conditions of one's self worth, opportunity to review and modify one's identity, identification and empathic responsiveness to others, awareness of the means for self-mastery, autonomy, and good will	Moral behavior, capacity for reparation and sublimation
Variants	Shyness, humiliation, embarrassment, chagrin, mortification, feeling ridiculous, painful self-consciousness	Sense of responsibility, obligation, loyalty

Table 2.6 Continued

Differences between Shame and Guilt

Dimension	Shame	Guilt
Form of relief	Acceptance by others, recognition of shame, articulation of feelings, sharing feelings with caring other, changing negative inner voice, changing humiliating interpersonal relationships, building relationships based on caring, concern, and good will	Forgiveness by others, discharge by confession and reparation

Note: Condensed from Goldberg, 1991; Lewis, 1971, 1987

Impact of Shame on Identity Development and Interpersonal Dynamics

Personal identity is a complex, integrative, lifelong process (e.g., Erikson, 1980; Goldberg, 1991; Parson, 1988). Scheler (1954) opined that shame opens a path to the self. The experiences of shame are not bounded by a discrete event as may be the case with guilt. What is mirrored in shame-based experiences is the inadequacy of the self coupled with disconnection in one's relational world. The self is experienced as both unprotected (vulnerable) and unworthy of relationship with the larger world.

The ability to perceive oneself accurately is considered to be a measure of one's adaptive functioning. The distortion of self-perception leads to a variety of clinical and relational challenges. Goldberg (1991) observed that the "self-condemnation and self-loathing that shame precipitates are part and parcel of a pervasive, persistent, and destructive set of emotions that grips the sufferers with a crippling sense of terror and pessimism, preventing them from living harmoniously and confidently" (p. ix). Goldberg observed shame to be a neglected area of psychological investigation with clinical and etiological aspects of shame notably absent in the clinical and empirical literature.

Goldberg cited the lack of a separate subject category in Psychological Abstracts and showed how shame is contained under the subject category of guilt. While there is evidence in the clinical and anecdotal literature that guilt and shame are distinctly different, there has been little empirical attention devoted to examining these constructs separately and developing an integrated theory of how shame affects psychological functioning, identity, and interpersonal capacities (Cook, 1987; Goldberg, 1991; Kaufman, 1989; Nathanson, 1989b).

Several theorists have articulated a need for a theory of shame to guide conceptualization and interventions in psychological and psychotherapeutic models (e.g., Broucek, 1991; Goldberg, 1988, 1990; Lewis, 1987b; Lynd, 1958; Kaufman, 1989; Nathanson, 1987c, 1992). One of the unifying themes that emerges out of the theoretical literature on shame over the past forty years is the consistent view of writers regarding the impact of shame on crucial developmental processes involving identity, relationships, and overall quality of life (Alonson & Rutan, 1988; Amersterdam & Levitt, 1980; Anthony, 1981; Basch, 1976, 1983a; Broucek, 1977, 1982; Evans, 1987; Friesen, 1979; Gorsuch, 1990; Hultberg, 1988; Kinston, 1983; Lansky, 1984; Lewis, 1958, 1979; Lichtenstein, 1963; Miller, 1988, 1989; Morrison, 1983, 1987; Nergaard & Silberschatz, 1989; Pines, 1987).

Shame makes a significant contribution to the development of conscience (Kaufman, 1989). The experience of shame is linked with self-correction in a feedback loop designed to balance the needs of an individual with the needs of others such as family, group, or community. Some theorists have posited a continuum with shame at one

end and pride at the opposite end suggesting a functional value to adequate and appropriately graded doses of shame (Kaufman, 1989; Lewis, 1987a; Nathanson, 1992). However, when shame is experienced without adequate moderating information the effects can become costly to healthy functioning. Several investigators have shown shame to be associated with obsession and paranoid conditions, narcissistic and borderline personalities, and related to low self-esteem and chronic depression (Crouppon, 1970; Harder & Lewis, 1987; Hoblitzelle, 1987; Scheff, 1987, 1988; Severine, McNut, & Feder, 1987; Smith, 1972; Stierlin, 1974; Thrane, 1979a, 1979b; Wumser, 1989).

Fischer (1985) articulated the confusion between shame and guilt asserting that people who are unable to resolve feelings of guilt have difficulty making distinctions between a “bad act” and a “bad person.” Lacking the distinction between behaviors and events as separate from a sense of self and instead attributing life circumstances to be about a defect in the self leads to a shame-based identity. Viewing oneself as flawed or defective has been linked to many forms of distress including anxiety and depression as well as more broadly affected areas spanning social, occupational, and interpersonal functioning (e.g., Blatt & Blatt, 1992; Cole & Putnam, 1992; Goldberg, 1990, 1991; Kaufman, 1989; Lewis, 1987c; Nathanson, 1987d; 1989a).

The negative effects of shame on personal identity are evident in the diverse ways distress is communicated by an individual to his/her interpersonal world. Feelings of helplessness, hopelessness, and rage are common responses to chronic shame (Middleton-Moz, 1990). Shame has been associated with fears of incompetence and

negative self-worth (Erikson, 1980). According to Goldberg (1991), shame occurs at every phase of human development from a variety of different sources including: (1) genetic and biochemical disposition; (2) family of origin; (3) self-induced shame-based thoughts and feelings about one's sense of self; (4) relationships; and (5) contemporary American culture.

While isolated experiences of shame are common for most individuals, chronic experiences with shame may result in a shame-prone identity (Harper & Hoopes, 1990). Individuals with shame-based identities split off feelings as "bad" parts of themselves as a means to get some relief from the negative views of self that emerge from longstanding, unresolved shame experiences (Ahktar & Bryne, 1983; Grotstein, 1981). Splitting off unacceptable aspects of the self has been associated with poor self esteem, depression, and other forms of mental and emotional distress (e.g., Fairbarin, 1963; Masterson, 1985; Masterson & Klein, 1989; Miller, 1988; Scharff & Scharff, 1987).

In examining shame as an emotion, Tompkins (1987, 1984, 1982, 1963, 1962) labeled shame as one of nine innate affects and specified shame as primarily feelings related to inferiority in individuals, families, and groups (Harper & Hoopes, 1990). Designating shame as an innate affect implies that there is a neurophysiological basis to the emotion in which autonomic responsiveness is apparent in the body. The body's response to shame has been described as blushing of the face and the lowering of the eyelids, decreasing tone in the facial muscles, lowering of the head via a reduction in tension of the neck muscles or a tilting of the head in one direction (Kaufman, 1989; Tomkins, 1987). The private cognitive experiences of shame have been variously

described as wanting to disappear, be someone else, or turn back time to undo what is experienced as shameful (Harper & Hoopes, 1990).

Shame is universally experienced and is considered to be a developmentally necessary component in socio-cultural training for desired interpersonal behaviors and cultural mores. Several investigators have suggested that when shame is experienced as a transient emotion it provides certain adaptive functions within families and other groups (Bradshaw, 1988; Izard, 1977; Kaufman, 1989). Episodic developmental experiences with shame provide formative learning about the limits of self, about boundaries, and about interpersonal relationships (Harper & Hoopes, 1990). Schneider (1977) referred to shame as a limiting and controlling affect which sustains the personal and social ordering of the world. Thus, shame experiences contribute to our understanding of who we are and our place in the social world (Erikson, 1956, 1959; Lynd, 1958). However, there appears to be a continuum underlying how shame is experienced and incorporated into one's identity (e.g., Harper & Hoopes, 1990; Slade & Aber, 1992).

Shame is the emotional experience of feeling painful embarrassment or humiliation that includes a sense of being insufficient as a person (Fossum & Mason, 1986). While the ability to feel shame is present from birth, the development of a shame-based identity takes time. Harper and Hoopes (1990) have contrasted healthy identity development and shame-prone identity development on a continuum as a function of several experiences including: (1) the internal experience of the self, (2) the range and quality of emotional expression, (3) the beliefs people develop about themselves as a result of their shame

experiences, (4) the social behaviors which they are most likely to display, and (5) the use of guilt. Table 2.7 summarizes how shame experiences impact identity formation.

Table 2.7

Shame Continuum and Identity

	Healthy Identity	Intermediate	Shame-Prone Identity
Basic Definitions	Experiences shame as an emotion, but not as a part of an internalized identity	Has some aspects of healthy identity; depending on situations, experiences shame as part of identity	Shame is part of identity; experiences shame as more than an emotion; it is better to be bad than to be nothing
Internal Experience of Self	Core is good; Self has limits	Some aspects of self are flawed in some contexts; some aspects of self are good in some contexts	Self is disgusting; flawed at very core
Emotional System	Wide range of affect; not paralyzed by intensity of emotion; emotion is integrated with intellect	Experience is at times entirely emotional; at times emotion and intellect can be integrated; may be blocked to feeling certain emotions are may get stuck in specific emotion	Experience is mostly emotional or totally blocked to emotion; very limited range of affects; can be stuck in intensity of specific emotions, e.g., fear, rage, or humiliation
Beliefs	"I am a good person." "I sometimes behave in ways I do not like, but I can change my behavior." "Others will like me if they will take the time to get to know me."	"I am bad but maybe I can still change." (this belief is situational). "There are people in the world who will not victimize me if I keep searching for them."	"If others discover how bad I am, they will abandon me." "Others will eventually victimize me." "When others offer positive feedback, I believe they do not know me well enough. If they really knew me, they would see me as bad."

Table 2.7 Continued

Shame Continuum and Identity			
	Healthy Identity	Intermediate	Shame-Prone Identity
Social Behavior	Warm, self-disclosing, can have close friends	Sometime sets up situations so that others will victimize them, but can also be "with" others in the right contexts; somewhat close and guarded; can have close friends	Sets up context so that the tendency of others is to do things "to them" (victimize them) or do things "for them" (totally take care of them); closed, guarded, suspicious; close friendships tend to be dysfunctional; discounts all positive information
Use of Guilt	Feels guilt, and it is healthy because the focus is on changing behavior rather than on self being bad	Uses guilt to shame self in certain contexts	Excessive guilt that is used to shame self or total lack of guilt (sociopathic)

Note: Adapted from Harper and Hoopes, 1990

Shame and PTSD as Reciprocal Agents in Identity Issues and Interpersonal Contexts

Feelings of powerlessness and vulnerability are observed as outcomes of both shame-based experiences and traumatic experiences. Investigators in both fields of inquiry have reported that sense of self and interpersonal capacities are affected by experiences of psychological trauma and shame (e.g., Broucek, 1991; Feldman & Guttman, 1984; Fisher, 1987; Goldberg, 1991; Herman, 1997; Kaufman & Raphael, 1984; Stone, 1992; van der Kolk et al., 1996b). In examining the problems associated with traumatic experiences, McFarlane and De Girolamo (1996) noted that "central to the experience of traumatic stress are dimensions of helplessness, powerlessness, and threat to one's life. Trauma attacks the individual's sense of self and predictability of the world" (p. 136). A parallel observation made by Goldberg (1991) on shame reported that

“individuals harbor feelings of shame when they feel like a helpless observer of a grievous event. The inability to avert illness in one’s self or to change the morbid fate of those one cares about leaves a person feeling impotent” (p. 44).

There has been only limited empirical investigation PTSD and shame (Wong & Cook, 1992), with no previous research directly examining how sense of self, post-trauma adjustment and shame may be associated with symptom distress and quality of life. This study examined how sense of self, post-trauma adjustment, and chronic shame are associated with symptom distress, quality of life, and other sociodemographic variables.

Several hypotheses were postulated to assess how chronic PTSD and shame-based identity issues such as isolation, avoidance of social engagement, and negative views of self may affect long term adjustment and present functioning in veterans who seek help for psychological problems. The research questions and hypotheses were:

1. How was shame associated with sense of self?

Hypothesis 1: Shame was negatively associated with sense of self as measured by the Internalized Shame Scale and the Self Description Scale.

2. How was shame associated with depression?

Hypothesis 2: Shame was positively associated with depression as measured by the Internalized Shame Scale and the Beck Depression Inventory.

3. Did shame change as a result of help-seeking? If changes in shame were noted with regard to help-seeking, were those gains in treatment able to be maintained over time?

Hypothesis 3: Shame decreased as a result of treatment. Post-treatment changes in shame were maintained as measured by the Internalized Shame Scale at four points in time (entry into treatment [baseline], after 60 days of inpatient PTSD treatment, six months post-baseline, and twelve months post-baseline).

4. What, if any, was the relationship between vulnerability and shame?

Hypothesis 4: Vulnerability was positively associated with shame as measured by the Internalized Shame Scale and the Glover Vulnerability Scale.

5. What, if any, was the relationship between shame and self-reported symptoms of PTSD?

Hypothesis 5: Shame was positively associated with symptom expression as measured by the Penn PTSD Inventory.

6. What, if any, was the relationship between shame and self-reported symptoms of anxiety?

Hypothesis 6: Shame was positively associated with symptom expression as measured by the Trait Anxiety subscale of the State-Trait Personality Inventory.

7. Did veterans who entered treatment with high levels of self-reported shame respond to treatment differently than veterans who entered treatment with lower levels of self-reported shame?

Hypothesis 7: Veterans with higher levels of shame responded to treatment differently than veterans who entered with lower levels of shame. Veterans with higher levels of shame returned to baseline functioning as measured by the Penn PTSD Scale, the Trait Anxiety subscale of the State-Trait Personality Inventory, the Glover Vulnerability Scale, and the Beck Depression Inventory.

8. What factors in help-seeking combat veterans were related to shame?

Hypothesis 8: Family factors, sociodemographic factors, and sense of self were related to shame. This was an exploratory analysis.

9. What relationship, if any, did level of expressed shame have with self-reported quality of life?

Hypothesis 9: Veterans with higher levels of shame reported less satisfaction with overall quality of life as measured by the Quality of Life Inventory.

10. How did a family history of loss relate to symptom distress and shame?

Hypothesis 10: Help-seeking veterans with a family history of loss (divorce, death of caregivers, or out of home placement) reported higher levels of shame and lower scores on hope and quality of life as measured

by the Internalized Shame Scale, the Future Hope Scale, and the Quality of Life Inventory.

11. How did a family history of chaos or instability relate to symptom distress and shame?

Hypothesis 11: Veterans with a history positive for chaos or instability had higher scores on measures of shame, depression, anxiety, vulnerability and lower scores on hope and quality of life as measured by the Internalized Shame Scale, the Beck Depression Inventory, Trait Anxiety subscale of the State-Trait Personality Inventory, the Glover Vulnerability Scale, the Future Hope Scale, and the Quality of Life Inventory.

12. How did sociodemographic variables such as ethnicity, socioeconomic status, and child abuse/neglect relate to symptom distress and shame?

Hypothesis 12: Non-white ethnicity, low socioeconomic status, and a history of abuse/neglect were associated with increases in symptoms distress and self-reported shame and were associated with decreases in a veterans sense of self, hope, and quality of life as measured by the Penn PTSD Scale, the Internalized Shame Scale, the Beck Depression Inventory, the Trait Anxiety subscale of the State-Trait Personality Inventory, the Glover Vulnerability Scale, the Future Hope Scale, and the Quality of Life Inventory.

CHAPTER 3

METHODOLOGY

This study will examine the chronic effects of PTSD and shame on help-seeking combat veterans. Both primary PTSD symptoms and secondary sequelae will be assessed. Primary symptoms included factors such as anxiety, depression, vulnerability and self-description. Secondary sequelae include the chronic effects of shame and PTSD symptomatology on sense of self, social engagement, and developmental/identity issues related to long-term adaptation to war. Given the paucity of research efforts that have been specifically focused on how shame may operate in both intrapersonal and interpersonal world of combat veterans, this study will examine the extent to which shame-based identity may be associated with distress, symptom expression, and overall quality of life.

Participants.

The participants in the current investigation are help-seeking combat veterans admitted to a specialized PTSD inpatient facility at a regional Veterans' Administration medical center. The combat veteran participants in this study voluntarily sought admission and were accepted into a specialized PTSD inpatient treatment program. Selection for this program included a review of military records and written materials which assessed the veteran's goodness of fit with program goals specifically targeted at resolving trauma and increasing coping skills for the secondary problems associated with chronic PTSD. Participation in this ongoing research investigation is built into the

investigation is built into the programmatic focus of the treatment program. This outcome study was initiated in March, 1996 and continues at the present time. For the purposes of this investigation only data collected by February 19, 2000 were utilized.

The sample under study in this investigation was comprised of 417 respondents. All participants in this investigation were men. Participants in the sample ranged in age from 31 to 76, with a mean age of 50.48. There were some veterans in this study who would have served in active military duty during World War II, Korea, Vietnam and Operations Desert Storm and Shield. However, over 90% of the sample was engaged in active military duty during the Vietnam War. Of the total sample, 380 participants disclosed ethnic identity information and 26 respondents in the sample did not provide this information. Sixty one percent of the sample was Caucasian. Veterans of color included African-American (8.9%), Hispanic (12.9 %), and Native American (5%). More detailed analysis of the sample will be presented in chapter four.

Participants in the current study were part of a more comprehensive, longitudinal study examining outcome and treatment integrity of specialized PTSD programs. All veterans who entered the inpatient program completed an initial research protocol that consists of a consent form for participation in the study, a family of origin questionnaire, a demographic questionnaire, a PTSD treatment unit feedback form given at two-months, six-months, and twelve-months post-baseline, a self-analysis questionnaire based on a state-trait anxiety measure, a specific measure of current depressive symptoms, a vulnerability measure, a self-report measure of PTSD symptoms, a quality of life inventory, a shame scale, a future hope scale, a substance abuse scale, and a self-

description inventory (self-handicapping scale). The specific subset of instruments used in the study are detailed below.

Instrumentation

This study utilized a demographic questionnaire (See Appendix A) and a family of origin measure (See Appendix B) to evaluate organismic variables and identify similarities and differences that may exist within the present group of help-seeking combat veterans. In addition to these two instruments, symptom distress measures utilized in this investigation included the Beck Depression Inventory, the Penn PTSD Scale, the Trait Anxiety subscale of the State-Trait Personality Inventory, and the Glover Vulnerability Scale. The impact of PTSD symptoms on sense of self were examined by the Internalized Shame Scale, the Future Hope Scale, the Self-Handicapping Scale and the Quality of Life Inventory.

Internalized Shame Scale (ISS). The ISS (Cook, 1987,1990) is a 30-item Likert-scaled instrument used in measuring of the affect of shame. Items in the shame scale reflect phenomenological experiences of feelings of inferiority, inadequacy, worthlessness, and alienation (See Appendix C). For each of the 30 items, respondents are asked to rate the frequency (1= never to 5= almost always) with which they find themselves feeling or experiencing what is described in each item stem. The instrument is scored by summing the responses of each item. Possible scores on this instrument range 30 to 150. Lower scores are indicative of lower levels of shame and high scores are hypothesized to reflect higher levels of internalized shame. The ISS yields two basic scale scores including a 24-item shame scale and a 6-item self-esteem scale. The 24-item

shame scale sorts into two subscales, an inferiority subscale (15 items) and an alienation subscale (9 items).

Alpha reliability coefficients are .95 for nonclinical samples and .96 for clinical samples. Table 3.1 summarizes validation studies that have examined concurrent correlations with related variables such as self-esteem in both clinical and nonclinical populations. Cook (1991) reported a -.66 correlation between the ISS and the Tennessee Self-Concept Test obtained on a sample of 118 college subjects. Other findings reported by Cook regarding the ISS showed correlations with other shorter self-esteem measures ranging from .52 to .79. In correlational studies conducted with the ISS and depression measures, findings in nonclinical samples ranged between .72 and .75 depending upon the specific measure given (Cook, 1991). In studies with both clinical and nonclinical populations, the ISS and the Beck Depression Inventory showed correlations of .72 in a sample of 300 college students and .75 in a sample of 185 psychiatric patients.

Table 3.1

Validation Study Findings Using the Internalized Shame Scale

Measure	Sample	Correlation
Tennessee Self-Concept Scale	College Students (N = 118)	-.66
Beck Depression Inventory	College Students (N = 300)	.72
Beck Depression Inventory	Psychiatric Patients (N = 185)	.75

Note: Condensed from Cook, 1991

Table 3.2 provides comparisons for the ISS among nonclinical and specified clinical populations. Mean scores on the ISS showed significant differences among

subgroups suggesting that the ISS distinguished chronic shame experiences from other contextual attributes in individuals. Table 3.2 showed that for eating disordered women and PTSD men higher levels of shame were reported as compared to other clinical groups.

Table 3.2

Comparison of Mean ISS Scores and Diagnostic Classifications

ANOVA Results With the Internalized Shame Scale		
Description of Sample	Sample Size	Mean Score on ISS
Nonclinical	N = 514	33.98
Alcohol/Drug Patients	N = 247	49.34
Affective Disorders Patients	N = 84	48.51
Other Psychiatric Patients	N = 36	48.75
PTSD Patients (Male only)	N = 47	58.59
Eating Disorders (Female only)	N = 25	68.92
$F(9, 547) = 54.31, p < .0001$		

Note: Cook, 1991

Findings reported in Table 3.2 showed that in a comparison of clinical participants and nonclinical participants using the ISS, clinical participants scored significantly higher on the ISS. Post hoc comparisons showed all clinical groups were significantly different from the nonclinical group. The PTSD group and eating disordered group had significantly higher group means among the clinical populations examined.

These data suggested that the ISS is measuring a clinically significant variable related to shame-based self-feelings (Cook, 1989, 1991).

Another study reported by Cook (1991) examined shame and family of origin issues in a sample of alcoholic women. Ninety-two women completing a four-week inpatient treatment program for alcoholism were given the ISS, a brief survey about childhood sexual abuse prior to age fourteen and some treatment related questions. On the treatment related variables, there were no differences on the ISS based on number of times in treatment or early versus late onset alcoholism. Differences on the ISS were reported based on the number of weeks in treatment, with women in the first two weeks of treatment having significantly higher mean scores (57.8 and 53.0) compared to women in the last two weeks of treatment (46.2 and 42.4). When the effects of abuse were compared using the ISS, abused women's (N=40) mean score of 57.6 was significantly different from the nonabused women 45.1 (N=52). Level of abuse (not abused, moderately abused, and severely abused) yielded differences on ISS scores as well with severely abused women scoring significantly higher than moderately abused women or women not reporting previous abuse. Moderately abused and nonabused women did not differ from each other in this study. Cook (1991) observed that "Even with a group of alcoholic women where levels of shame would be expected to be high, these data indicated that severe sexual abuse in childhood leads to significantly higher levels of internalized shame" (p.415).

The ISS has also been found to correlate modestly with a retrospective measure of parental caregiving using the Parental Bonding Instrument (PBI, Parker, 1983). The PBI

assessed parenting along two dimensions: care and protection. Scores were obtained for both caregivers. High care and low protection are hypothesized to promote optimal parenting, promoting secure attachment. Low care and high protection represents parenting that would be expected to produce insecure attachment. The ISS would be expected to correlate negatively with care and positively with protection. The findings reported by Cook (1991) indicated that the lower the level of care and nurturance from either caregiver the higher the level of internalized shame. Higher levels of internalized shame were also reported with higher levels of parental control and overprotectiveness.

According to Harper and Hoopes (1990) the ISS represents the “best developed measure for clinical use . . . The items were developed specifically to assess enduring, chronic shame that becomes an internalized part of one’s identity” (p.142-143).

Alpha reliability coefficients range from .94 for the shame scale to .88 for the self-esteem scale, with test-retest reliability coefficients ranging from .71 to .84. Exploratory factor analysis reported the items to yield two major factors related to shame and self-esteem. The inferiority and alienation subscales correlated at .74 with the overall shame scale suggesting that these subscales are not independent of each other (Harper & Hoopes, 1990).

A series of studies conducted by Cook (1987) compared the ISS with three different self-concept/self-esteem measures and concluded that the ISS was assessing “a trait that contributed more to the development of emotional problems than did low self-esteem alone” (p. 18). Harper and Hoopes (1990) identified shame and self-esteem as “conceptually different” with shame as affective experience and self-esteem as cognitive

evaluation of self. Factor analysis conducted by Cook (1987) supported differentiation between shame and self-esteem as they loaded on distinctly different factors. A study by Ursu (1984) examined measures of shame and self-esteem and concluded that internalized shame and negative self-esteem are different. Comparisons of the ISS with MMPI subscales yielded concurrent validity coefficients ranging from .58 to .76. Highest correlations were reported with the psychasthenia, paranoia, and depression subscales.

Self-Handicapping Scale (Self-Description Inventory) (SHS). The SHS (Jones & Rhodewalt, 1982) is a 20-item, six-point Likert-type scale anchored at end-points by Disagree Very Much and Agree Very Much (See Appendix D). This scale was presented to participants as the Self-Description Inventory due to concern that using the actual title of the instrument may have sensitized respondents to the nature of the study. Examples of scales items included “I tend to make excuses when I do something wrong” and “I tend to not get too intensely involved in competitive activities so it won’t hurt too much if I lost or do poorly.” Scores on the original version may range from 20 to 120 with high cumulative scores reflecting high self-handicapping tendencies. The instrument is purported to measure aspects of attributional style.

The Self-Handicapping Scale has a Short Form version that is a ten-item self-report. As in the original version, a six-point Likert scale assesses participant’s self-handicapping tendencies with high cumulative scores hypothesized to reflect high self-handicapping tendencies. Participants rate the extent of their agreement or disagreement using a 6-point Likert scale response format. High cumulative totals indicated high self-

handicapping tendencies. Low scores are hypothesized to reflect low self-handicapping tendencies.

Psychometric properties reported by Strube (1986) for both versions of the Self-Handicapping scale revealed the original version's coefficient alpha = .62, short form coefficient alpha = .70. High scores on both versions were found to associated with high public self-consciousness, high social anxiety, high other-directedness, high depression, and low-self esteem. Self-esteem has been reported to influence self-handicapping (Strube & Roemmele, 1985).

Quality of Life Inventory (QOLI). The QOLI (Frisch, Cornell, Villanueva, & Retzlaff, 1992) consists of 17 items. These items correspond to areas of life deemed potentially relevant to overall life satisfaction. Respondents are asked to rate each of the areas in terms of its importance to their overall happiness and current satisfaction (0 = not at all important, 1 = important, 2 = extremely important) and in terms of their satisfaction with the area (-3 = very dissatisfied to 3 = very satisfied) (See Appendix E). According to Frisch et al. (1992), the inventory's scoring scheme is based on the assumption that an individual's overall life satisfaction is a composite of satisfactions in particular areas of life rated by their relative importance to the individual. The product of satisfaction by relative importance is computed for the seventeen domains of life and yields weighted satisfaction ratings range from -6 to 6. The overall life satisfaction score is obtained by averaging all weighted satisfaction ratings that have nonzero importance ratings. These authors contend that weighted scoring allows a way to assess quality of life in which irrelevant or omitted areas reflect an overall happiness or satisfaction measure that

captures both normative and ipsative indices, as recommended by Lazarus and Folkman (1984).

Table 3.3 provides normative data collected by Frisch et al. (1992) in the initial validation studies of the QOLI. The participant samples included both clinical and nonclinical populations of adult and college age individuals. The cutoffs for overall life satisfaction used quartile score comparisons, with scores above the 75th percentile and scores below the 25th percentile as indicative of significantly above or significantly below average life satisfaction. In general, the authors reported scores between 2.00 and 3.75 as typical scores for adults. Pearson correlations of total weighted satisfaction scores with QOLI scores are reported as .98 or better. Test-retest reliability coefficients of .91 and .80 were reported. Cronbach's coefficients alpha obtained in the validation study were .86 (VA inpatient), .89 (VA recovered), .77 (general undergraduate), and .83 (counseling center). Other psychometric data reported by Frisch et al. (1992) showed acceptable item-total correlations of .30 or greater (Berstein, 1987). The QOLI showed negative correlations with symptom distress measures including -.45 with the Symptom Checklist (SCL-90-R), -.44 with the Beck Depression Inventory, and -.41 with Millon Clinical Multiaxial Inventory-II subscales of anxiety and depression (Frisch et al., 1992).

Table 3.3

Normative Statistics for QOLI Across Adult and College Age Samples

Statistic	VA inpatient	VA recovered	Private inpatient	Offender	Under- graduate	College Center
Sample size	(n = 54)	(n = 51)	(n = 18)	(n = 19)	(n = 272)	(n = 127)
Mean	.08	2.76	.97	1.73	2.63	1.77
Standard Deviation	1.88	1.38	2.03	1.94	1.11	1.62
75 th percentile	1.60	3.76	2.28	3.20	3.35	3.13
Median	.47	2.76	1.27	2.00	2.76	1.92
25 th percentile	-1.39	1.93	-.63	.31	2.08	.59
Minimum	-3.88	-1.76	-2.94	-2.07	-2.36	-2.00
Maximum	3.94	5.88	5.31	5.41	4.76	5.00

According to Frisch et al. (1992), the QOLI is based on an empirically validated model of life satisfaction. The assumptions of the model hypothesize that an individual's overall life satisfaction is based on the weighted sum of areas deemed important by an individual. The model also assumes that a person's satisfaction with a particular area of life is weighted according to its importance before it is entered into the equation of overall life satisfaction (Diener & Emmons, 1984; Frisch et al., 1992). Thus, satisfaction in highly valued areas of life have a greater influence on overall life satisfaction than those areas of equal satisfaction judged to be of lesser importance.

Penn Inventory for PTSD (PENN). The PENN (Hammarberg, 1992) is a 26-item self-report measure of the severity of posttraumatic stress disorder. Each item of the PENN is comprised of four sentence stems which reflect the presence or absence of PTSD symptoms as well as the degree, frequency, or intensity of each symptom. The structure of the Penn Inventory was modeled after the Beck Depression Inventory. The scale numbers in each item range from 0 to 3 with zero representing the absence of a particular symptom and each corresponding level 1, 2, or 3 as scaled increase, with three representing the most severe/distressing level of a particular symptom (See Appendix F). For example, a series of scaled responses to the presence/absence of traumatic experiences is as follows:

- (0) I have not experienced a major trauma in my life,
- (1) I have experienced one or more traumas of limited intensity
- (2) I have experienced very intense and upsetting traumas
- (3) The traumas I have experienced were so intense that memories of them intrude on my mind without warning

Thus, scores on this instrument range from 0 to 78, with higher scores indicating more severe PTSD, and with 35 being identified as a cutoff or indicator of self-reported PTSD symptomatology.

Hammarberg (1992) described a three-phase validation study completed to establish the validity and internal consistency of this instrument. In phase one, multivariate analyses were used to assess both internal consistency and reliability, and a coefficient alpha of .94 was obtained for an initial sample (n=83), with group differences

ranging from .78 for nonveterans to .94 for all subjects, .86 for those in treatment, .94 for veterans posttreatment, and .92 for veterans without a prior PTSD treatment history.

Cross validation of the PENN was assessed in Phase 2 with a second independent sample and yielded similar results, supporting the PENN as an adequate standardized measure of self-reported PTSD symptom severity. Hammarberg compiled sensitivity, specificity, and hit rate parameters of the instrument. In phase three of the study, sensitivity was reported as 98%, specificity was established at 94%, and the hit rate was 97%. A prevalence rate in the Phase-3 control group of 66% was reported with the acknowledged influence of the prevalence rate in the control group on specificity, sensitivity, and hit rate estimates for this instrument (Hammarberg, 1992). While one would expect high levels of PTSD to be present in help-seeking combat veterans, it appears that this instrument has the capacity to adequately categorize self-perceived PTSD symptomatology.

Beck Depression Inventory (BDI). The BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item, four-point Likert scale, self-reported measure which assesses a participant's subjective perception of the severity of depressive symptomatology (See Appendix G). The questionnaire consists of 21 groups of statements that require respondents to select the statement that best represents how they were feeling the past week including today. For example, item 8 regarding self-perception reads as follows: "(0) I don't feel I am any worse than anybody else; (1) I am critical of myself for my weaknesses or mistakes; (2) I blame myself all the time for my faults; (3) I blame myself for everything bad that happens" (p.1, BDI Questionnaire, 1987). Scores on the instrument range from 0 to 63, with cut-off scores of

0 to 9 indicating minimal depression, scores from 10 to 16 suggesting mild depression, scores of 17 to 29 considered as moderately depressed and scores in the 30 to 63 range indicative of severe depression. The BDI is one of the most widely used clinical and research instruments with robust psychometric properties and strong clinical and research utility (Conoley, 1992). One of the most often expressed cautions regarding this instrument has to do with the obvious and face valid item construction. Several reviewers have emphasized the potential response bias that can occur when less than cooperative subjects with secondary gain potential are given this instrument (Bartelstone & Trull, 1995; Clark & Watson, 1991; Dahlstrom, Brooks, & Peterson, 1990).

Other reported psychometric properties of the BDI include adequate reliability and validity. For clinical samples, reliabilities are uniformly high .79 to .90 (mean coefficient alpha = .86). Item-total correlations ranged from .07 to .68, with most values reported in the .30 or better range. Correlation coefficients between the BDI, Beck Hopelessness Scale, and the Hamilton Rating Scale for Depression ranged from .38 to .76 and from .40 to .87 across six normative outpatient samples. In clinical samples, correlation coefficients between the BDI and the Symptom Checklist-90-Revised and the Minnesota Multiphasic Personality-Depression scale were .76 and .61. The BDI remains one of the most widely used research instruments in clinical populations (Beck, Steer, & Grabin, 1988).

State-Trait Personality Inventory (STPI). The STPI (Spielberger, Jacobs, Crane, Russell, Westberry, Brader, Johnson, Knight, & Marks, 1979) is a 60-item self-report instrument that assesses a respondent's state and trait anger, anxiety, and curiosity.

Respondents are asked to rate “how you generally feel” using a four-point Likert scale response that is anchored from 1 (not at all) to 4 (very much). The 30-item trait scale is divided into three ten-item subscales that assess dimensions of anger, anxiety, and curiosity. The state scale is also comprised of thirty items across three ten-item subscales measuring anxiety, anger, and curiosity. Total scores on the 30-item trait scales range from 30 to 120. The same range of total scores is possible for the 30-item state scales. Higher scores on this instrument are indicative of greater anger, anxiety, and curiosity (See Appendix H). For the anxiety subscale of the STPI the mean for women is 17.98 with a standard deviation of 5.45 and an alpha coefficient of .92; the mean for men is 16.27 with a standard deviation of 4.70 and an alpha coefficient of .88. The curiosity subscale of the STPI has a mean for women of 28.86 with a standard deviation of 5.73 and an alpha coefficient of .95; the mean for men is 30.45 with a standard deviation of 5.64 and an alpha coefficient of .93. For the anger subscale, the mean for women is 18.13 with a standard deviation of 4.82 and an alpha coefficient of .90; the mean for men is 17.41 with a standard deviation of 5.19 and an alpha coefficient of .88. Only the trait scale anxiety subscale score was used in this investigation. Preliminary studies have reported stable psychometric properties for the STPI (Spielberger et al., 1979).

Future Hope Scale (FHS). The FHS (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle, & Harney, 1991) is a 12-item, Likert-scaled response self-report measure anchored at 1 (definitely false) to 4 (definitely true) designed to measure an individual’s cognitive appraisal of goal-related capabilities along two specific dimensions; agency and pathways. Agency scores are derived by adding the

scores of the four agency items. Pathways scores are obtained by adding the scores on the four pathway items. The total hope scale score is obtained by adding the agency and pathway scores together. High scores on this instrument indicate higher levels of hope and low scores are indicative of lower levels of hope. Scores on the Future Hope Scale range from 8 to 32. Average scores reported for college and noncollege age samples is 24, with significantly lower scores reported for people seeking psychological help or persons who are inpatients in psychiatric hospitals (Snyder et al., 1991). Reliability and validity data reported by Snyder et al. (1991) indicated acceptable levels of internal validity, with item-total correlations between .30 and .40. Test-retest reliability studies with intervals of three to ten weeks between administrations have shown correlations in the .80 range (See Appendix I).

Glover Vulnerability Scale (GVS). The GVS (Glover, Ohlde, Silver, Packard, Goodnick, & Hamlin, 1994) is a 21-item self report questionnaire that measures the frequency of experiences associated with feeling vulnerable. Items are rated on a Likert scaled response format anchored at 1(never) to 7 (always). Half of the thirty items are stated in the direction of psychopathology and half are stated in the direction of health to avoid potential response sets. Scores on this instrument range from 35 to 245. High scores on the GVS are representative of increased feelings of vulnerability and low scores indicative of decreased feelings of vulnerability.

Psychometric properties associated with the GVS showed solid internal consistency as indicated by coefficient alpha of .88. Test-retest reliability over a four-week interval was reported by Glover et al. (1994) as .81. Factor analytic studies using

principal components factor analysis using a varimax rotation yielded four factors which accounted for 51% of the variance. The four factors included social comfort, vulnerable affect, paranoia, and family trust. Alpha reliabilities reported for these four factors were, respectively, .84, .74, .73, and .71 (See Appendix J).

Procedure.

The current investigation was part of an ongoing longitudinal study being conducted at a regional veterans affairs medical center. The outcome study was initiated in March, 1996 and is ongoing at the present time. As a psychology intern assigned to the Inpatient Post-Traumatic Stress Disorder Unit it was possible for the author to become involved with ongoing research investigations as a part of her rotation responsibilities. While the author's formal rotation on the PTSD unit occurred from August of 1998 to November of 1998, she remained involved with the research project throughout the internship year and has continued to collaborate with the team. This involvement has resulted in use of archival data for the current investigation.

Participants in the study were drawn from veterans who were admitted to the Inpatient Post-Traumatic Stress Disorder Unit at a mid-western Veteran Affairs Medical Center. In order to be admitted to the inpatient PTSD program, a veteran had to make written application for admittance into the treatment program. A program admission's coordinator reviewed applicant files, verified information through collateral sources, presented the information to the PTSD Unit Chief, and an admissions decision was made. Once a veteran was admitted to the inpatient PTSD Unit, participation in the outcome study was initiated. All veterans were assigned to the same treatment condition.

The twelve-week intensive inpatient PTSD treatment program was designed to evaluate veterans' current functioning and to provide a community therapeutic model and group process treatment modality. Veterans were required to attend all scheduled therapy, educational and activity groups, and classes as part of the PTSD treatment protocol. Psychoeducational groups were provided to give veterans additional information and to increase coping skills for trauma-related adjustment concerns. Veterans were also required to participate in group psychotherapy (3 times per week) throughout the twelve-week program. After approximately two weeks of inpatient treatment, veterans were placed in trauma recovery groups. Trauma groups utilized focused group psychotherapy to assist veterans with direct exposure, catharsis, and integration of unresolved traumatic experiences that are sources of ongoing distress. Trauma groups met three times per week for fifty minutes per session and last for eight weeks.

The therapeutic community model of treatment utilized therapy components (psychotherapy/trauma), psychoeducational components, and leisure skill development to treat issues related to chronic PTSD and adjustment concerns of combat veterans. Consistent with a multi-dimensional and biopsychosocial model of trauma, treatment in the twelve-week specialized PTSD program emphasized trauma resolution in the context of a supportive environment. Trauma resolution work consisted of eight weeks meeting three times per week for 50 minutes for each session. Group size for the trauma resolution groups was small (usually 4). The therapeutic focus of these groups was aimed at resolving longstanding trauma issues. Target interventions included grief work with specific attention to integrating traumatic experiences in a more meaningful way.

Group work and family dynamics were emphasized through the multi-modal treatment strategies. Interpersonal process opportunities and generalization of coping skills were sought throughout therapy and psychoeducational program components. The milieu offered a state of the art conceptualization of trauma recovery programming. The multi-disciplinary treatment team model coupled with the self-governing nature of the veterans community presented ample interpersonal process opportunities. Specific attention was paid to both “here and now” process work as well as “trauma resolution” aimed at integration of combat experiences. Treatment goals emphasized trauma resolution, enhanced coping skills for daily living, improved sense of self, relational skills development, reduction of PTSD symptoms, and enhanced family functioning through psychoeducational classes, didactic family work, and family therapy. Dual diagnosis issues were treated as a part of the milieu with chemical dependency group work available as needed. Continuity of care and planning for discharge were jointly coordinated by veterans and the multi-disciplinary team.

Baseline measures of symptom distress, sense of self, and demographic information were obtained for each veteran during the first week of their admission to the PTSD unit. Survey data were collected once per week for one hour for newly admitted veterans and for those participants who had reached the two-month post-baseline marker in treatment. Veterans were individually notified for their participation in data collection. Baseline data and 60-day post-baseline data are collected while the veterans are inpatients in the PTSD program. Veterans were mailed survey packets for six-month and twelve-month post-baseline follow-up measures. Participants were provided with detailed written

instructions for completion and return of the survey information. The six-month and twelve-month baseline data collection was coordinated through a local university psychology department as a way to safeguard veterans' confidentiality and avoid potential conflicts with compensation and pension issues that might arise for participants.

The current investigation used archival data that was part of this larger longitudinal study examining the efficacy effects of specialized programs that provide inpatient treatment to veterans with chronic PTSD. This study employed both repeated measures and multivariate analyses in examining how shame, depression, anxiety, vulnerability, and quality of life may be related to premilitary, military, and postmilitary factors including symptom severity, chronicity, resiliency, sense of self, and identity issues across the lifespan. Participants had already completed an informed consent (See Appendix K) as well as self-report measures on shame, anxiety, depression, PTSD, vulnerability, hope, quality of life, a self-handicapping scale, and a demographic survey which examined a number of independent variables including age, ethnicity, family of origin history, relationship history, employment history, and coping efforts. Repeated measures for depression, anxiety, PTSD, shame, vulnerability, hope, quality of life, and self-handicapping had been measured at baseline, 2 months post-baseline, 6 months post-baseline, and 12 months post-baseline.

The purpose of this investigation was to examine how shame based identity may be related to symptom distress in chronic PTSD. Self and relational deficits were hypothesized to impact psychological trauma and shame. Several hypotheses were postulated to assess how chronic PTSD and shame-based identity issues such as isolation,

avoidance of social engagement, and negative views of self may affect long term adjustment and present functioning in veterans who seek help for psychological problems. Research questions, hypotheses, measures, and analyses are summarized below.

Statistical Analyses.

<u>Research Question</u>	<u>Specific Hypothesis</u>	<u>Measures</u>	<u>Analysis</u>
1. How was shame associated with sense of self?	Hypothesis 1: Shame was negatively associated with sense of self.	ISS SHS	Bivariate correlations
2. How was shame associated with depression?	Hypothesis 2: Shame was positively associated with depression.	ISS BDI	Bivariate correlation
3. Did shame change as a result of help-seeking? If change in shame occurred was this change maintained over time?	Hypothesis 3: Shame decreased as a result of treatment. Post-treatment changes in shame were maintained.	ISS Time 1 Time 2 Time 3 Time 4	Repeated measures ANOVA
4. What, if any, was the relationship between vulnerability and shame?	Hypothesis 4: Vulnerability was positively associated with shame.	ISS GVS	Bivariate correlation
5. What, if any, was the relationship between shame and self-reported symptoms of PTSD?	Hypothesis 5: Shame was positively associated with symptom expression of severity of PTSD.	PENN ISS	Bivariate correlation
6. What, if any, was the relationship between shame and anxiety?	Hypothesis 6: Shame was positively associated with anxiety.	ISS STPI	Bivariate correlation

7. Did veterans who entered treatment with high levels of self-reported shame respond to treatment differently than veterans who entered treatment with lower levels of self-reported shame?	Hypothesis 7: Veterans with higher levels of shame responded to treatment differently than veterans who entered with lower levels of shame.	PENN STPI GVS BDI at Time 1 Time 2 Time 3 Time 4	Repeated measures ANOVA (Four separate univariate ANOVAs)
8. What factors in help-seeking combat veterans were related to shame?	Hypothesis 8: Family factors, sociodemographic factors, and sense of self were related shame. This was an exploratory analysis.	FOO Demographic	Stepwise multiple regression
9. What relationship, if any, did level of expressed shame have on self-reported quality of life?	Hypothesis 9: Veterans with higher levels of shame reported lower satisfaction with overall quality.	QOLI overall score, self-esteem, relationships item analyses	Bivariate correlations
10. How did a family history of loss relate to symptom distress and shame?	Hypothesis 10: Help-seeking veterans with a family history of loss (divorce, death of caregivers, or out-of-home placement) reported higher levels of shame and lower scores on hope and quality of life.	ISS FHS QOLI	MANOVA with follow-up univariate ANOVAs if significance is obtained
11. How did a family history of chaos or instability relate to symptom distress and shame?	Hypothesis 11: Veterans with a history positive for chaos or instability had higher scores on measures of shame, depression, anxiety, vulnerability and lower scores on hope and quality of life.	ISS BDI STPI GVS FHS QOLI	MANOVA with follow-up univariate ANOVAs if significance is obtained
12. How did	Hypothesis 12: Non-white	PENN	Separate

sociodemographic variables such as ethnicity, socioeconomic status, and child abuse/neglect relate to symptom distress and shame?	ethnicity, low SES, and history of abuse/neglect were associated with increases in symptom distress and self-reported shame and were associated with decreases in veterans sense of self, hope, and quality of life.	ISS FHS QOLI SHS STPI GVS	ANOVAs will be conducted for each organismic variable and the dependent measures
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Descriptive information was obtained from the demographic questionnaire and the family of origin questionnaire. Results were compiled and means and standard deviations calculated. Dichotomous variables were reported with appropriate descriptive statistics. In the multivariate analyses in which significance was obtained, follow-up testing with appropriate univariate ANOVAs was performed. An intercorrelation between dependent measures was performed.

Two repeated measures analyses were conducted. The first repeated measures analysis examined changes in shame across time for the entire sample of help-seeking veterans. The second repeated measures analysis examined if there were differential treatment effects based on the level of shame (high or low) at entry into treatment. This analysis utilized a two way (2x4) repeated measures analysis of variance (ANOVA) with shame and time as factors and symptom distress measures as the dependent variables. Separate univariate analyses were conducted for each of the symptom distress measures (PTSD, anxiety, vulnerability, and depression). Level of shame was categorized as high, moderate, or low based on a cut-off score on the ISS, with time as the repeated factor in the analysis. Given that most of the sample was at clinical evaluations already, an inspection of the distribution was done on ISS scores and a decision was made as to how

to divide the sample into high, moderate, and low groupings on shame. The sample was broken down into quartiles with highest and lowest quartiles scores used to achieve grouping for this analysis. An examination of the distribution was necessary before high, moderate, and low levels of shame could be determined. The organismic variables of “history of loss,” “history of chaos/instability,” and “history of abuse/neglect” were determined by yes or no responses to questions on the Family of Origin Questionnaire. To examine which factors were most associated with shame, a stepwise multiple regression was used. The DV was shame scores and the IVs were scores on the FHS, QOLI, BDI, STPI, GVS, SHS, PENN, and the presence or absence of stigmatizing factors.

CHAPTER 4

RESULTS

Demographic Data

This chapter begins with a review of sociodemographic characteristics of the sample. Tables 4.1 and 4.2 present a breakdown of the sample by age and ethnicity.

Table 4.1

Age of Sample Participants

Age in Years	Frequency	Percent of Sample
30 to 39	4	1.05
40 to 49	191	50.26
50 to 59	177	46.58
60 or older	8	2.10
Total Number Reporting Age	380	91.13
Total Number Not Reporting Age	37	8.87
Total Participants in Sample	417	100.00

Table 4.2 Ethnicity of Sample Participants

Ethnicity	Frequency	Percent of Sample
Caucasian	257	61.6
African American	37	8.9
Hispanic	54	12.9
Native American	21	5.0
Asian	2	.5
Other	13	3.1
Mixed Race	6	1.4
Idiographic Ethnicity	1	.2
Total Number Reporting Ethnicity	391	93.8
Total Number Not Reporting to Ethnicity	26	6.2
Total Participants in Sample	417	100.0

As can be seen, the majority of the participants (96.84%) were in the 40-59 year old age range. The sample was predominantly Caucasian (approximately 62%), with Hispanics and African-Americans representing the largest percentages of minority participants.

Descriptive Statistics and Basic Correlations

Descriptive Statistics

Table 4.3 presents descriptive statistics on the dependent measures utilized in the current investigation. Measures of central tendency, variability, and sample size are presented for each of the dependent measures.

Table 4.3

Means and Standard Deviations for the Dependent Variables

Dependent Measure	N	Mean	Standard Deviation
BDI	371	31.09	10.13
FHS	379	16.42	4.27
GVS	377	104.99	16.61
ISS	370	67.88	18.98
PENN	362	55.15	10.08
QOLI	359	26.28	15.02
SHS	375	38.63	7.32
STPI	377	62.52	9.95

Note: BDI = Beck Depression Inventory; FHS = Future Hope Scale; GVS = Glover Vulnerability Scale; ISS = Internalized Shame Scale; PENN = Penn PTSD Inventory; QOLI = Quality of Life Inventory; SHS = Self-Handicapping Scale; STPI = State-Trait Personality Inventory

The mean score on the BDI indicated that on average, participants manifested a moderately severe level of depression. An average FHS score indicated that participants

were less hopeful than the average score of 24 for nonclinical populations. The mean score on the GVS demonstrated moderate feelings of vulnerability were present in this sample of help-seeking combat veterans. On the ISS, the sample as a whole showed very high levels of shame present. Compared to other clinical samples, the mean scores obtained represent in this sample are at the high end of other clinical comparison groups. The mean score of the PENN exceeded the clinical cut-off score of 35 supporting the PTSD diagnosis obviously present in this sample of help-seeking combat veterans. The mean score on the SHS suggested that participants in the sample were average in their reliance on self-handicapping strategies. Of note, the mean score on the STPI is well above the average norms (16.27) for men. The pronounced elevation of trait anxiety in this sample may be another indicator of the chronicity of the PTSD present in the sample. The composite of the descriptive statistics showed help-seeking combat veterans were severely depressed, with pronounced trait anxiety, profound shame, decreased hope and with average reliance on self-handicapping strategies.

Basic Correlations

Table 4.4 presents a correlation matrix showing how shame and family history factors were associated in the total sample of help-seeking veterans. Shame was examined in association with current family income, father's employment history, school attendance, completing high school prior to entering the military, out-of-home placement in residential treatment or foster care, number of times a family moved during high school, parental loss including death, divorce, or separation; parental absence from the home; peers in trouble with the law; and self in trouble with law.

For the most part, correlational data showed expected and almost “commonsense” relationships between variables. For example, being in foster care was significantly and positively related to parental loss, absence, and abuse. Being in trouble with the law was significantly and positively related to peers who were in trouble, abuse, playing hookey a lot, moving, and not finishing high school. Parental loss, absence, and abuse were all significantly and positively correlated with each other. There were no surprises here with the exception of the ISS. Of note, the ISS was not significantly correlated with any of the family history variables.

Table 4. 4

Correlation of Internalized Shame Scale with Family of Origin Factors

Measure	ISS	FAM\$	FAEMP	HOOK	HSED	INST	MOVE	PLOSS	PMISS	PLAW	SLAW	ABUSE
ISS												
FAM\$	-.02											
FAEMP	-.10	.09										
HOOK	-.03	-.06	.00									
HSED	-.05	.11	.14**	.20**								
INST	-.01	-.02	.11*	.08	.12*							
MOVE	-.08	.06	.18**	.06	.18**	.11*						
PLOSS	-.03	.11	.19**	.06	.12*	.22**	.10*					
PMISS	.02	.03	.25**	.05	.13*	.16**	.13**	.34**				
PLAW	-.02	-.13*	.05	.26**	.04	.08	.02	.07	.03			
SLAW	.01	-.03	-.02	.35**	.07	.06	-.07	.04	-.02	.46**		
ABUSE	-.08	-.05	.17**	.17**	.03	.15**	.08	.17**	.18**	.18**	.21**	

Note: ISS = Internalized Shame Scale; FAM\$ = Current family income; FAEMP = Father's Employment; HOOK = Played

hookey frequently during high school; HSED = completed high school before entering military; INST = lived in foster care,

treatment center , or out-of-home placement; MOVE = moved more than twice during high school; PLOSS = Parents separated, divorced, or died prior to age 18; PMISS = Parent or parents missing prior to age 18; PLAW = Peers in trouble with law; SLAW = Self in trouble with law; ABUSE = abused/neglected by parents, caretakers and/or other family members;

Note: * Correlation is significant $p < .05$; ** Correlation is significant $p < .01$; N = 417

Analyses of the Research Hypotheses

This study proposed six correlational hypotheses examining how shame, psychological distress and quality of life were related. It should be noted that Table 4.5 shows supporting data for hypotheses 1,2,4,5,6, and 9.

Repeated measures and multivariate analyses were also conducted to test an additional six hypotheses (numbers 3,7,8,10, 11, &12) concerning the impact of shame on symptom distress, responsiveness of shame to treatment, differential treatment effects by level of shame, family and demographic characteristics that predict shame, and sociodemographic characteristics relationship to symptom distress in help-seeking combat veterans with chronic PTSD. The findings of the correlational hypotheses will be presented first followed by the analysis of variance findings of the final six hypotheses.

Correlational Hypotheses

Hypothesis 1: Hypothesis 1 stated that shame would be negatively associated with sense of self. This hypothesis was supported. Results showed the correlation between the ISS and SHS as $r = .24$, $p < .01$. The positive association between shame and self-handicapping indicates that as shame increases, self-handicapping increases. The assumption of self-handicapping theory (Berglas & Jones, 1978) is that self-esteem or sense of self is highly valued and protected via self-handicapping strategies. Thus, increased self-handicapping is hypothesized to reflect negative views of self.

Hypothesis 2: Hypothesis 2 posited that shame would be positively associated with depression. This hypothesis was supported. Results show the correlation between

the ISS and BDI as $r = .41, p < .01$. The positive correlation between shame and depression indicates that as shame increases, depression increases.

Hypothesis 4: Hypothesis 4 stated that vulnerability would be positively associated with shame. This hypothesis was supported. Results show the correlation between the GVS and ISS as $r = .46, p < .01$. The positive correlation between vulnerability and shame indicates that as vulnerability increases, shame increases.

Hypothesis 5: Hypothesis 5 posited that shame would be positively associated with severity of PTSD. This hypothesis was supported. Results show the correlation between the ISS and PENN as $r = .34, p < .01$. The positive correlation between shame and PTSD severity indicates that as shame increases, PTSD severity increases.

Hypothesis 6: Hypothesis 6 stated that shame would be positively associated with anxiety. This hypothesis was supported. Results show the correlation between the ISS and STPI as $r = .43, p < .01$. The positive correlation between shame and trait anxiety indicates that as shame increases, anxiety increases.

Table 4.5

Correlation Matrix of the Sample's Dependent Measures

Bivariate Correlation	N	ISS	SHS	BDI	FHS	PENN	QOLI	STPI	GVS
ISS	370								
SHS	353	.24**							
BDI	350	.41**	.19**						
FHS	357	-.32**	-.02	-.41**					
PENN	342	.34**	.18**	.69**	-.44**				
QOLI	351	-.31**	-.13*	-.25**	.24**	-.19**			
STPI	365	.43**	.11*	.27**	-.34**	.26**	-.26**		
GVS	367	.46**	.13*	.32**	-.30**	.35**	-.33**	.44**	

Note: ** Correlation is significant $p < .01$ level (2-tailed)

* Correlation is significant $p < .05$ (2-tailed); BDI = Beck Depression Inventory; FHS = Future Hope Scale; GVS = Glover Vulnerability Scale; ISS = Internalized Shame Scale; PENN = Penn PTSD Inventory; QOLI = Quality of Life Inventory; SHS = Self-Handicapping Scale; STPI = State-Trait Personality Inventory

Hypothesis 9: Hypothesis 9 stated veterans with higher degrees of shame would report lower satisfaction with overall quality of life. Results of the total sample correlation between ISS and QOLI were $r = -.31, p < .01$. The negative correlation between shame and overall quality of life indicates that as shame increases, quality of life decreases. The hypothesized relationship between shame and quality of life for the overall sample was supported.

In addition to the correlational analysis noted above, supplementary exploration of levels of shame and quality of life were conducted. These levels of shame groups were then also used in subsequent repeated measures and multivariate analyses. The sample was divided into three shame levels classified as low, moderate, and high. A quartile breakdown was used to categorize participants' level of shame. Participants in the lowest quartile (P_1 to P_{25}) were placed in the low shame group for all analyses where level of shame was considered; participants in the middle two quartiles of the sample (P_{26} to P_{74}) comprised the moderate shame group; and participants in the uppermost quartile (P_{75} to P_{99}) were categorized as having a high level of shame for subsequent analyses. The breakdown of the sample by level of shame included low ($N = 93$), moderate ($N = 181$), and high ($N = 96$) participants. Table 4.6 stratifies the sample of help-seeking veterans by level of shame and provides frequency and percentage data for the sample with regard to level of shame.

To determine if level of shame was related to overall quality of life, a Spearman's rho was calculated. When participants' initial level of shame was correlated with self-reported overall quality of life a significant association was found $r = -.26, p < .01$ (2-

tailed). Table 4.7 shows the association between level of shame and overall quality of life.

Table 4.6

Levels of Shame of Sample Participant

Level of Shame	ISS Scores	Frequency	Percent of Sample
Low	5 - 56	93	22.30
Moderate	57 - 81	181	43.40
High	82 - 120	96	23.02
Total Number Reporting Shame		370	88.72
Total Number Not Reporting Shame		47	11.27
Total Participants in Sample		417	100.00

Table 4.7

Relationship between Level of Shame and Quality of Life

Correlation Coefficient	Number	Shame Level	Quality of Life
Spearman's Rho			
Shame Level	370	1.000	
Quality of Life	359	-.26**	1.00

Note: ** Correlation is significant at the .01 level (2-tailed)

Multivariate and Repeated Measures Analyses

Before describing the results of the last six hypotheses, it should be noted that hypotheses 3 and 7 dealt with similar questions, but each from a different perspective. Hypothesis 3 examined the variable of shame over time for only that subset of participants who completed shame measures at all four points in time. This reduced the initial sample from 417 respondents to a subsample of 47. This subsample has been labeled “completers.” While this represents a substantial reduction in the number of participants, it allowed for an examination of a subsample with a view toward treatment adherence and the potential avenues for intervention with shame and shame-based identity as a focus of clinical attention.

In contrast, hypothesis 7 used the entire sample. Levels of shame (high, moderate, and low) were used as a grouping variable. Hypothesis 7 examined specific symptom measures by level of shame over time.

Hypothesis 3: Hypothesis 3 stated that shame would decrease as a result of treatment and post-treatment changes in shame would be maintained. This hypothesis was partially supported. Descriptive statistics on shame over time for the subsample of completers are presented in Table 4.8. Results of the repeated measures analysis of variance are presented in Table 4.9. Table 4.10 shows the pairwise comparisons data for shame over time.

Table 4.8

Descriptive Statistics on the Internalized Shame Scale Across Time:

“Completers” (N= 47)

Internalized Shame Scale Scores	Mean	Standard Deviation
Baseline (Time 1)	71.55	21.08
Two months post-baseline (Time 2)	62.21	17.84
Six months post-baseline (Time 3)	69.36	16.54
Twelve months post-baseline (Time 4)	68.43	18.69

Table 4.9

ANOVA Summary Table for “Completers” on Shame Across Time

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Time	2260.82	3	753.61	3.27	.023
Error	31840.93	138			

Note: Computed using alpha = .05

Table 4.10

Pairwise Comparisons of Mean Differences in Shame Across Time for Completers

(I) Time	(J) Time	Mean Difference	Standard Error	Sig.
Time 1 vs. Time 2		9.34*	3.19	.005
	Time 3	2.19	3.16	.491
	Time 4	3.13	3.23	.338
Time 2 vs. Time 3		-7.15*	3.13	.027
	Time 4	-6.21	3.40	.074
Time 3 vs. Time 4		.94	2.64	.725

Note: Based on estimated marginal means; * The mean difference is significant at the .05 level.

The omnibus F-test for shame across time yielded an $F(3,138) = 3.27, p = .02$. The omnibus F-test supported that changes in shame were noted across time. Pairwise comparisons among the four time periods showed significant differences between shame at baseline and two months post-baseline. A mean difference of 9.34 points was noted between initial shame scores and shame scores measured two months post-baseline. This decrease in mean shame scores was significant. Other significant mean differences were reported in shame scores between Time 2 (two- months post-baseline) and Time 3 (six- months post-baseline). Mean shame scores increased by 7.15 points between Time 2 and Time 3. A slight decrease (.94) points in mean shame scores was observed between Time 3 and Time 4, although this difference was not statistically significant. These findings suggested that shame was amenable to treatment and decreased significantly while in a

structured setting; however, the initial reduction in shame was not maintained across time, with twelve-month shame scores returning to nearly the same level as at the participants' initial presentation for help. Taken together, the findings of this investigation tentatively established empirical support for shame as a clinical manifestation that was sensitive to treatment interventions and supported the need for ongoing research in this area.

Hypothesis 7: Hypothesis 7 stated that veterans with higher levels of shame would respond to treatment differently than veterans with lower levels of shame. This hypothesis considered how level of shame impacted specific symptom distress measures of PTSD, trait anxiety, vulnerability, and depression. Descriptive statistics and analysis of variance findings related to hypothesis 7 are presented in the tables below. Table 4.11 shows descriptive statistics for PENN scores by shame level across the four time periods. Table 4.12. illustrates analysis of variance findings between levels of shame and PENN scores across time. Table 4.13 presents pairwise comparison data as a follow-up to the analysis of variance results.

Table 4.11

PENN PTSD Scores for Total Sample and By Shame Level

PENN	Baseline			2 months			6 months			12 months		
Scores	Post-baseline			Post-baseline			Post-baseline			Post-baseline		
	H	M	L	H	M	L	H	M	L	H	M	L
Mean	59.49	55.52	50.74	46.90	46.59	39.91	53.20	49.00	48.36	53.57	51.31	46.11
Standard Deviation	9.38	9.32	10.20	14.73	12.38	13.49	12.28	11.34	10.97	14.25	14.48	13.42
Number	87	168	87	72	122	58	30	50	22	21	39	19

Note: H = High shame level; M = Moderate shame level; L = Low shame level

Table 4.12

ANOVA Summary Table for PENN Scores Across Time by Level of Shame for the Total Sample

PENN PTSD Scores Across Time	Sum of	df	Mean	F	Sig.
	Squares		Square		
PENN at Time 1					
Between Groups	3350.91	2	1675.46	18.32	<.001
Within Groups	30998.61	339	91.44		
Total	34349.52	341			
PENN at Time 2					
Between Groups	2064.46	2	1032.23	5.80	.003
Within Groups	44322.40	249	178.00		
Total	46386.96	251			
PENN at Time 3					
Between Groups	415.13	2	207.56	1.556	.216
Within Groups	13203.89	99	133.37		
Total	13619.02	101			
PENN at Time 4					
Between Groups	588.53	2	294.27	1.46	.238
Within Groups	15237.24	76	200.96		
Total	15861.77	78			

Note: Alpha = .05 for all tests

Table 4.13

Pairwise Comparisons of Mean Differences in PENN Scores by Level of Shame

(I) Shame Level	(J) Shame Level	Mean Difference	Standard Error	Sig.
PENN at Baseline				
	High Shame vs. Moderate Shame	3.98*	1.26	.005
	Low Shame	8.76*	1.45	<.001
	Moderate Shame vs. Low Shame	4.78*	1.26	<.001
PENN at Two-months Post-baseline				
	High Shame vs. Moderate Shame	.31	1.98	.986
	Low Shame	6.99*	2.35	.008
	Moderate Shame vs. Low Shame	6.68*	2.13	.005
PENN at Six-months Post-baseline				
	High Shame vs. Moderate Shame	4.20	2.67	.261
	Low Shame	4.84	3.24	.299
	Moderate Shame vs. Low Shame	.64	2.96	.975
PENN at Twelve-months Post-baseline				
	High Shame vs. Moderate Shame	2.26	3.84	.826
	Low Shame	7.47	4.49	.226
	Moderate Shame vs. Low Shame	5.20	3.97	.393

Note: Based on estimated marginal means;

* The mean difference is significant at the .05 level.

The results of the analysis of variance for PENN scores by level of shame demonstrated significance at two of the four time periods. Significant differences were noted between groups at Time 1 and Time 2. Between group differences were no longer significant at six month post-baseline (Time 3) and twelve-month post-baseline (Time 4). At baseline, mean differences among level of shame groups produced an obtained $F(2, 341) = 18.32, p < .001$. Pairwise comparisons for this time period showed significant differences among the three groups (level of shame). A significant mean difference of 3.98 points was found between high and moderate shame levels. Another significant mean difference of 8.76 points was found between high and low levels of shame. When the moderate shame level group was compared to the low shame level group, a significant mean difference of 4.78 points was noted. Table 4.13 gives the detailed multiple comparison findings.

Penn scores at two-months post-baseline (Time 2) yielded an obtained $F(2, 249) = 5.80, p = .003$. Pairwise comparisons using a Tukey HSD showed significant differences between means for moderate and low levels of shame groups (6.68 points) as well as between high and low levels of shame groups (6.99 points). The mean difference between moderate and high levels of shame of .31 points was not significant.

Six-month post-baseline changes in PENN scores by level of shame were not significant. The obtained F-ratio for this time period was $F(2, 99) = 1.57, p = .216$. Of note is the shift from inpatient to outpatient status for respondents in the sample that occurs between Time 2 and Time 3 distress measures. These findings demonstrated differential PTSD mean scores by level of shame while participants were in an inpatient

program. One possible explanation for these findings may be that as participants moved from the structured, therapeutic community treatment modality to less structured and more variable outpatient care contexts differences in specific symptom distress by shame level were no longer salient. Increased nonspecific stressors as well as the statistical pattern of regression to the mean may have contributed to decreased contribution of shame level to overall group differences. This pattern in scores was also noted at the twelve-month post-baseline data.

PENN scores at twelve-months post-baseline no longer yielded differences by level of shame. The obtained F-ratio for Time 4 was $F(2,76) = 1.46, p = .238$. At one year post-helping seeking PTSD scores by shame level indicated no significant differences.

In general, PTSD scores on the PENN were above the clinical cut-off of 35 and at entry into treatment are at their highest level. A marked drop in scores was noted at two-months post-baseline. With the transition from inpatient to outpatient treatment models, shame levels no longer significantly contributed to between group differences with regard to PTSD symptom distress. A trend that was observed across symptoms distress measures and shame levels was a change pre-baseline to post-baseline with regression toward pre-baseline functioning at six-month and twelve-month reporting periods. This general pattern suggested that initial gains in treatment were not maintained over time. PENN scores twelve-months post-baseline are not as high as initial help-seeking levels but remain above the clinical cut-off of 35 representing a chronic constellation of distress associated with PTSD. However, these observed patterns were not subjected to formal

statistical analyses to determine if these changes in functioning were statistically significant.

Results of the analysis of variance on STPI scores produced significant differences at all four time periods. Table 4.14 shows the STPI scores across the four time periods. Table 4.15 gives the ANOVA summary results and Table 4.16 details the pairwise comparison results that follow-up the analysis of variance findings. At baseline, an obtained $F(2,362) = 32.21, p < .001$ demonstrated differences in trait anxiety scores and level of shame. Significant differences in level of shame and trait anxiety scores were also noted two-months post-baseline. The obtained F -ratio for Time 2 was $F(2,248) = 15.41, p < .001$. These mean differences continued to be significant at six-months post-baseline and again at twelve-months post-baseline. The obtained F -ratio at Time 3 (six-months post-baseline) was $F(2,99) = 4.10, p = .019$. Mean differences at Time 4 were also significant with an obtained F -ratio of $F(2,79) = 6.76, p = .002$. Follow-up multiple comparisons were made using a Tukey HSD statistics. The results are summarized in Table 4.16.

Group differences in STPI scores were present at all four time periods. At baseline, a significant mean difference of 2.96 points was noted between high and moderate levels of shame. The mean difference between high and low shame levels on the STPI was 10.43 points. A significant mean difference (7.48 points) was also obtained in comparing moderate to low levels of shame. Across all other time periods significant mean differences were reported between high and low shame levels. Significant differences in mean STPI scores were also noted between moderate and low shame levels. Only at

baseline were mean differences between moderate and high shame levels significant.

Mean differences between moderate and high shame levels were not significant two, six, or twelve months post-baseline. In this study, low shame level was associated with significantly lower trait-anxiety scores. This pattern was true at initial presentation for help and was a pattern that remained in the sample twelve months post-baseline. This would tentatively indicate that differential symptom distress patterns are present in veterans with different levels of shame.

Table 4.14

STPI Scores for Total Sample and By Shame Level

STPI	<u>Baseline</u>			2 months			6 months			12 Months		
Scores	Post-baseline			Post-baseline			Post-baseline			Post-baseline		
	H	M	L	H	M	L	H	M	L	H	M	L
Mean	66.65	63.69	56.22	60.88	59.22	52.21	63.19	62.48	56.78	62.23	64.13	53.60
Standard	11.74	8.03	8.61	11.48	7.77	9.36	11.02	7.36	8.54	13.58	8.34	10.98
Deviation												
Number	94	178	93	75	119	57	31	48	23	22	40	20

Note: H = High shame level; M = Moderate shame level; L = Low shame level

Table 4.15

ANOVA Summary Table for STPI Scores Across Time by Level of Shame for the Total Sample

STPI Scores Across Time	Sum of Squares	df	Mean Square	F	Sig.
STPI at Time 1					
Between Groups	5543.29	2	2771.65	32.21	<.001
Within Groups	31043.12	362	85.75		
Total	36586.41	364			
STPI at Time 2					
Between Groups	2705.46	2	1352.73	15.41	<.001
Within Groups	21777.71	248	87.81		
Total	24483.17	250			
STPI at Time 3					
Between Groups	645.98	2	322.99	4.10	.019
Within Groups	7790.73	99	78.69		
Total	8436.71	101			
STPI at Time 4					
Between Groups	1518.77	2	759.38	6.76	.002
Within Groups	8877.04	79	112.37		
Total	10395.81	81			

Note: Alpha = .05 for all tests

Table 4.16

Pairwise Comparisons of Mean Differences in STPI Scores by Level of Shame

(I) Shame Level	(J) Shame Level	Mean Difference	Standard Error	Sig.
STPI at Baseline				
High Shame vs. Moderate Shame		2.96*	1.81	.033
	Low Shame	10.43*	1.35	<.001
Moderate Shame vs. Low Shame		7.48*	1.19	<.001
STPI at Two-months Post-baseline				
High Shame vs. Moderate Shame		1.66	1.38	.452
	Low Shame	8.67*	1.65	<.001
Moderate Shame vs. Low Shame		7.01*	1.51	<.001
STPI at Six-months Post-baseline				
High Shame vs. Moderate Shame		.71	2.04	.935
	Low Shame	6.41*	2.44	.027
Moderate Shame vs. Low Shame		5.70*	2.25	.034
STPI at Twelve-months Post-baseline				
High Shame vs. Moderate Shame		-1.90	2.81	.779
	Low Shame	8.63*	3.28	.027
Moderate Shame vs. Low Shame		10.52*	2.90	.001

Note: Based on estimated marginal means; *Mean difference is significant at

.05 level

The analysis of variance findings on the symptom distress measure of vulnerability showed a similar pattern as was present for PTSD scores, in that significant group differences were noted at baseline and at two months post-baseline and then significant group differences were no longer present at the six-and twelve-month intervals. Table 4.17 shows the GVS scores at each of the four time intervals; Table 4.18 presents the ANOVA results. Vulnerability scores across time indicated significant differences by level of shame. GVS scores at baseline were significant with the obtained $F(2,364) = 40.38, p < .001$. The obtained F -ratio at two months post-baseline was $F(2,252) = 6.81, p = .001$. At time 3 (six months post-baseline) a nonsignificant $F(2, 103) = 2.52, p = .085$ was obtained. An F -ratio of 2.97 was reported at twelve months post-baseline. The obtained $F(2,78) = 2.97, p = .057$ was not significant.

Tukey HSD multiple comparisons were made for the significant findings obtained at baseline and two months post-baseline. Table 4.19 reports the findings in detail. Pairwise comparisons of mean differences in vulnerability scores were significant for all comparisons at baseline between level of shame and vulnerability scores. A significant mean difference of 6.42 points was observed between the moderate shame and high shame group. The largest mean difference was noted between high shame and low shame GVS scores (19.33 points). Also significant was the mean difference in GVS scores between moderate and low shame groups (12.91 points). Pairwise comparison data also showed differences at Time 2 (two months post-baseline) with significant differences found between moderate and low shame (9.33 points). The mean difference between high and low shame groups was also significant (10.53 points). A non-significant difference of

1.20 points was observed between high and moderate shame groups. No significant differences were noted among the three shame groups on vulnerability scores at six-and twelve-month intervals. This pattern was also present for PTSD symptom distress. As was noted earlier, the initial finding of shame level differences does not hold in the transition from inpatient to outpatient settings.

Table 4.17

GVS Scores for Total Sample and By Shame Level

GVS	<u>Baseline</u>			2 months			6 months			12 Months		
Scores	Post-baseline			Post-baseline			Post-baseline			Post-baseline		
	H	M	L	H	M	L	H	M	L	H	M	L
Mean	113.19	106.77	93.86	102.6	101.4	92.07	110.13	105.8	100.88	107.45	106.95	96.00
Standard	17.05	13.59	15.65	20.16	16.13	17.64	15.14	14.44	17.06	17.14	15.81	21.61
Deviation												
Number	95	180	92	75	123	57	32	50	24	22	39	20

Note: H = High shame level; M = Moderate shame level; L = Low shame level

Table 4.18

ANOVA Summary Table for GVS Scores Across Time by Level of Shame for the Total Sample

GVS Scores Across Time	Sum of Squares	df	Mean Square	F	Sig.
GVS at Time 1					
Between Groups	18339.31	2	9169.66	40.38	<.001
Within Groups	82659.95	364	227.09		
Total	100999.26	366			
GVS at Time 2					
Between Groups	4303.47	2	2151.73	6.84	.001
Within Groups	79257.20	252	314.51		
Total	83560.67	254			
GVS at Time 3					
Between Groups	1176.87	2	588.43	2.52	.085
Within Groups	24018.13	103	233.19		
Total	25195.00	105			
GVS at Time 4					
Between Groups	1869.78	2	934.89	2.97	.057
Within Groups	24543.35	78	314.66		
Total	26413.13	80			

Note: Alpha = .05 for all tests

Table 4.19

Pairwise Comparisons of Mean Differences in GVS Scores by Level of Shame

(I) Shame Level	(J) Shame Level	Mean Difference	Standard Error	Sig.
GVS at Baseline				
	High Shame vs. Moderate Shame	6.42*	1.91	.002
	Low Shame	19.33*	2.20	<.001
	Moderate Shame vs. Low Shame	12.91*	1.93	<.001
GVS at Two-months Post-baseline				
	High Shame vs. Moderate Shame	1.20	2.60	.889
	Low Shame	10.53*	3.12	.002
	Moderate Shame vs. Low Shame	9.33*	2.84	.003
GVS at Six-months Post-baseline				
	High Shame vs. Moderate Shame	4.33	3.46	.426
	Low Shame	9.25	4.12	.069
	Moderate Shame vs. Low Shame	4.93	3.79	.399
GVS at Twelve-months Post-baseline				
	High Shame vs. Moderate Shame	.51	4.43	.994
	Low Shame	11.45	5.48	.098
	Moderate Shame vs. Low Shame	10.95	4.88	.070

Note: Based on marginal means; *Mean difference is significant at the .05

level

Results of the analysis of variance on specific symptom distress of depression yielded significant findings on three of the four time periods. Table 4.20 shows BDI scores over the four time intervals. Table 4.21 presents the ANOVA results. Only Time 4 (twelve months post-baseline) did not have significant differences between groups. At baseline, the obtained F -ratio for BDI scores was $F(2,347) = 32.03, p < .001$. The obtained F -ratio at two-months post-baseline was $F(2,247) = 9.17, p < .001$. At time 3 (six months post-baseline) the obtained F -ratio was $F(2,95) = 4.06, p = .020$. At time 4 (twelve months post-baseline) the obtained $F(2,73) = 2.96, p = .058$.

Pairwise comparisons were made on all significant findings. The results of the multiple comparisons are detailed in Table 4.22. At baseline, a significant mean difference of 5.78 points was noted between moderate and low shame groups. The observed mean difference of 5.33 points was also significant between high and moderate shame groups. The mean difference of 11.11 points between high and low shame levels was also significant. Depression scores were significantly different for all groups at entry into treatment. Multiple comparison data at two months post-baseline showed significant mean differences on depression scores between moderate and low shame levels (6.77 points) as well as between high and low shame levels (8.00 points). The mean difference between high and moderate shame level of 1.22 points was not significant. At time 3 (six months post-baseline) significant differences in depression scores were observed between high and moderate shame levels (6.09 points) as well as high and low shame levels (7.44 points). No significant differences were noted between moderate and low shame levels (1.35 points). No significant differences were found in depression scores and level of

shame at twelve months post-baseline. Significant differences in depression scores by shame level were noted for the first three time periods. Twelve months post-baseline depression scores were no longer sensitive to level of shame differences and overall depression scores approached pre-treatment levels.

Table 4.20

BDI Scores for Total Sample and By Shame Level

BDI	<u>Baseline</u>			2 months			6 months			12 Months		
Scores	Post-baseline			Post-baseline			Post-baseline			Post-baseline		
	H	M	L	H	M	L	H	M	L	H	M	L
Mean	36.64	31.31	25.53	27.37	26.14	19.37	34.14	28.04	26.70	32.76	33.00	25.15
Standard Deviation	10.44	8.42	9.79	13.20	10.53	10.55	12.13	9.00	11.24	13.22	11.54	12.39
Number	92	169	89	73	120	57	29	46	23	21	35	20

Note: H = High shame level; M = Moderate shame level; L = Low shame level

Table 4.21

ANOVA Summary Table for BDI Scores Across Time by Level of Shame for the Total Sample

BDI Scores Across Time	Sum of	df	Mean	F	Sig.
	Squares		Square		
BDI at Time 1					
Between Groups	5587.50	2	2794.25	32.03	<.001
Within Groups	30269.34	347	87.23		
Total	35857.84	349			
BDI at Time 2					
Between Groups	2373.65	2	1186.82	9.17	<.001
Within Groups	31964.87	247	129.41		
Total	34338.52	249			
BDI at Time 3					
Between Groups	902.18	2	451.09	4.06	.020
Within Groups	10548.23	95	111.03		
Total	11450.41	97			
BDI at Time 4					
Between Groups	888.33	2	444.16	2.96	.058
Within Groups	10938.36	73	149.84		
Total	11826.69	75			

Note: Alpha = .05 for all tests

Table 4.22

Pairwise Comparisons of Mean Differences in BDI Scores by Level of Shame

(I) Shame Level	(J) Shame Level	Mean Difference	Standard Error	Sig.
BDI at Baseline				
	High Shame vs. Moderate Shame	5.33*	1.21	<.001
	Low Shame	11.11*	1.39	<.001
	Moderate Shame vs. Low Shame	5.48*	1.22	<.001
BDI at Two-months Post-baseline				
	High Shame vs. Moderate Shame	1.23	1.67	.747
	Low Shame	8.00*	2.01	<.001
	Moderate Shame vs. Low Shame	6.77*	1.83	.001
BDI at Six-months Post-baseline				
	High Shame vs. Moderate Shame	6.09*	2.50	.043
	Low Shame	7.44*	2.94	.035
	Moderate Shame vs. Low Shame	1.35	2.69	.871
BDI at Twelve-months Post-baseline				
	High Shame vs. Moderate Shame	-.24	3.38	.997
	Low Shame	7.61	3.83	.122
	Moderate Shame vs. Low Shame	7.85	3.43	.064

Note: Based on estimated marginal means; * The mean difference is significant at the .05 level.

Hypothesis 8: Hypothesis 8 stated that family factors, sociodemographic factors, and sense of self would be related to shame. This was an exploratory analysis to examine how a variety of contextual variables may be related to shame. Results show that shame may be related to vulnerability, depression, hope, self-handicapping, and quality of life. The stepwise multiple regression analysis produced an $F(5,196) = 24.80, p < .001$. Given the exploratory nature of this analysis, alpha was set at .01. Table 4.23 presents the regression coefficients and beta weights for the predictor variables. This indicates that shame may be associated with symptom distress including vulnerability, depression, and self-handicapping and decreased resilience as evidenced by lower hope and overall quality of life.

Table 4.23

Predictor Variables and Internalized Shame Scale Scores

Model	Unstandardized	Standard Error	Standardized	t	Sig.
	Coefficients		Coefficients		
GVS	.301	.073	.264	4.15	<.001
BDI	.475	.134	.226	3.54	.001
FHS	-.868	.303	-.180	-2.87	.005
SHS	.423	.156	.155	2.71	.007
QOLI	-.187	.083	-.136	-2.25	.026

Note: GVS = Glover Vulnerability Scale; BDI = Beck Depression Inventory; FHS = Future Hope Scale; SHS = Self-Handicapping Scale; QOLI = Quality of Life Inventory

Hypothesis 10: Hypothesis 10 stated that veterans with a family history of loss would have higher scores on shame and lower scores on hope and quality of life. To determine if a family history positive for loss impacted symptom distress and resilience characteristics the total sample was grouped based on responses to a series of twelve yes/no questions on a range of family history experiences. In this series of twelve family history questions, four were specifically related to loss experiences including one parent missing from home before age 18, both parents missing prior to age 18, parental separation, divorce, or death, and foster home or residential placement prior to age 18. For grouping purposes for this analysis, an endorsement of yes to any item resulted in the respondent being placed the 'loss' versus 'no loss' category. Of the 339 respondents considered in this analysis, 125 were placed in the loss group and 214 were placed in the no loss group based on self-reported family history data.

The hypothesis was not supported. Obtained F-ratios were not significant on the dependent measures hope $F(1, 337) = .125, p = .724$, shame $F(1, 337) = .169, p = .682$, and quality of life $F(1, 337) = .251, p = .614$. These findings suggested that a family history of loss was not associated with hope, shame, and quality of life. Table 4.24 provides the multivariate analysis of variance details for Hypothesis 10. Given that the omnibus F-tests produced findings that were not significant, no follow-up analysis were performed.

Table 4.24

Summary Data of Between Subjects Effects for Family History of Loss

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Loss	FHS	2.20	1	2.20	.13	.724
	ISS	59.19	1	59.19	.17	.682
	QOLI	56.58	1	56.58	.25	.61
Error	FHS	5959.90	337	17.69		
	ISS	118264.50	337	350.93		
	QOLI	74931.35	337	222.35		
Total	FHS	5962.10	338			
	ISS	118323.7	338			
	QOLI	74988.13	338			

Note: Computed using alpha = .05

Hypothesis 11: Hypothesis 11 stated that veterans with a family history positive for chaos or instability would have higher scores on measures of shame, depression, anxiety, vulnerability, and lower scores on hope and quality of life. To determine if a family history positive for chaos or instability impacted symptom distress and resilience characteristics, the total sample was grouped based on responses to a series of twelve yes/no questions on a range of family history experiences. For each yes response, a participant received a one; for each no response a participant received a two. The possible range of scores for this series of family history questions was 12 to 24. Participants with

scores of 18 or less were considered as positive for a family history of chaos or instability. Participants with scores of 19 or more were considered as negative for a history of chaos or instability. Table 4.25 reports the findings of the multivariate analysis. This hypothesis was not supported. Analyses yielded the following F -ratios: for shame, $F(1,326) = .075$, $p = .784$; for depression $F(1,326) = .584$, $p = .445$; for trait anxiety $F(1,326) = .038$, $p = .845$; for vulnerability $F(1,326) = .389$, $p = .553$; for hope $F(1,326) = .666$, $p = .415$; and quality of life $F(1,326) = 1.499$, $p = .222$. No significant differences were found between participants with and without a family history of chaos or instability. The lack of significant findings for the overall F -test did not require any follow-up analyses to be performed.

Table 4.25

Summary Data of Between Subjects Effects for Family History of Chaos

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Chaos	ISS	26.78	1	26.78	.075	.784
	BDI	58.17	1	58.17	.584	.445
	STPI	3.98	1	3.98	.038	.845
	GVS	106.88	1	106.88	.389	.533
	QOLI	328.38	1	328.38	1.499	.222
	FHS	11.64	1	11.64	.666	.129
Error	ISS	115324.60	325	354.85		
	BDI	32377.95	325	99.62		
	STPI	33606.28	325	103.40		
	GVS	89350.03	325	274.92		
	QOLI	71200.84	325	219.08		
	FHS	5684.21	325	17.49		
Total	ISS	115351.38	326			
	BDI	32436.12	326			
	STPI	33610.26	326			
	GVS	89456.91	326			
	QOLI	71529.22	326			
	FHS	5695.83	326			

Note: Computed using $\alpha = .05$

Hypothesis 12: Hypothesis 12 stated that non-white veterans, low socioeconomic status, and a family history of abuse would be associated with increased symptom distress and shame as well as decreased sense of self, hope, and quality of life. Grouping for the univariate analyses of variance were based on participants responses to the demographic and family of origin questionnaire. Ethnicity was evaluated dichotomously as non-white or white. Socioeconomic status was stratified on a range using current family income. History of abuse was categorized according the participants' yes/no endorsement to the question "While growing up, were you abused (physically, verbally, sexually, neglected) by your parents, caretakers, and/or other family members?" There was partial support for this hypothesis. Ethnicity and symptom distress differences were not found. Significant findings were obtained with for history of abuse and socioeconomic status. History of abuse was associated with significant differences on the vulnerability measure. Vulnerability scores produced an obtained $F(1, 373) = 5.45, p = .02$. Differences in vulnerability scores given a history of abuse suggested that interpersonal sensitivity and mistrust remain a salient concern for abuse survivors. Thus, vulnerability scores as a form of symptom distress were significantly different in combat veterans with a family history of abuse. Socioeconomic status was associated with significant differences on hope and quality of life. On the dependent measures hope yielded an obtained $F(6, 230) = 2.28, p = .037$ and quality of life yielded an obtained $F(5, 219) = 2.40, p = .039$. These findings suggest, not surprisingly, that hope and quality of life were significantly associated with

socioeconomic status. Tables 4.26 to 4.28 summarize the analysis of variance findings for symptom distress, hope, and quality of life.

Table 4.26
ANOVA Summary Table for History of Abuse and Symptom Distress

	Sum of	df	Mean	F	Sig.
	Squares		Square		
FHS					
Between Groups	47.56	1	47.56	2.62	.106
Within Groups	6782.91	374	18.14		
Total	6830.47	375			
ISS					
Between Groups	620.33	1	620.33	1.73	.190
Within Groups	131578.80	366	359.51		
Total	132199.13	367			
PENN					
Between Groups	178.15	1	178.15	1.76	.186
Within Groups	36202.82	357	101.41		
Total	36380.97	358			
QOLI					
Between Groups	88.03	1	88.03	.39	.533
Within Groups	80659.59	356	226.57		
Total	80747.62	357			

Table 4.26 Continued

ANOVA Summary Table for History of Abuse and Symptom Distress

	Sum of Squares	Df	Mean Square	F	Sig.
SHS					
Between Groups	2.70	1	2.70	.05	.823
Within Groups	20010.38	372	53.79		
Total	20013.08	373			
STPI					
Between Groups	90.91	1	90.91	.92	.339
Within Groups	37116.64	374	99.24		
Total	37207.55	375			
GVS					
Between Groups	1491.23	1	1491.23	5.45	.020
Within Groups	102054.40	373	273.60		
Total	103545.63				

Note: FHS = Future Hope Scale; ISS = Internalized Shame Scale; PENN = Penn PTSD

Inventory; QOLI = Quality of Life Inventory; SHS = Self-Handicapping Scale; STPI = State-Trait Personality Inventory; GVS = Glover Vulnerability Scale

Table 4.27

ANOVA Summary Table for Socioeconomic Status and Symptom Distress

	Sum of Squares	df	Mean Square	F	Sig.
FHS					
Between Groups	237.28	6	39.55	2.28	.037
Within Groups	3990.35	230	17.35		
Total	4227.63	236			
ISS					
Between Groups	679.38	6	113.23	.27	.950
Within Groups	93748.19	224	418.52		
Total	94427.57	230			
PENN					
Between Groups	660.06	6	110.01	1.25	.282
Within Groups	19273.52	219	88.01		
Total	19933.58	225			
QOLI					
Between Groups	2533.54	5	506.71	2.40	.039
Within Groups	46336.78	219	211.58		
Total	48870.32	224			

Table 4.27 Continued

ANOVA Summary Table for Socioeconomic Status and Symptom Distress

	Sum of	Df	Mean	F	Sig.
	Squares		Square		
SHS					
Between Groups	601.03	6	100.17	1.83	.095
Within Groups	12557.92	229	54.84		
Total	13158.95	235			
STPI					
Between Groups	772.39	6	128.73	1.25	.282
Within Groups	23687.25	230	102.99		
Total	24459.64	236			
GVS					
Between Groups	2638.28	6	439.71	1.43	.205
Within Groups	69866.99	227	307.78		
Total	72505.27	233			

Note: FHS = Future Hope Scale; ISS = Internalized Shame Scale; PENN = Penn PTSD Inventory; QOLI = Quality of Life Inventory; SHS = Self-Handicapping Scale; STPI = State-Trait Personality Inventory; GVS = Glover Vulnerability Scale

Table 4.28

ANOVA Summary Table for Ethnicity and Symptom Distress

	Sum of	df	Mean	F	Sig.
	Squares		Square		
FHS					
Between Groups	192.23	7	27.46	1.52	.160
Within Groups	6667.53	368	18.12		
Total	6859.76	375			
ISS					
Between Groups	2200.12	7	314.30	.87	.532
Within Groups	129913.80	359	361.88		
Total	132113.92	366			
PENN					
Between Groups	1001.03	7	143.00	1.42	.198
Within Groups	35442.56	351	100.98		
Total	36443.59	358			
QOLI					
Between Groups	1617.67	7	231.10	1.02	.417
Within Groups	79070.13	349	226.56		
Total	80687.80	356			

Table 4.28 Continued

ANOVA Summary Table for Ethnicity and Symptom Distress

	Sum of	Df	Mean	F	Sig.
	Squares		Square		
SHS					
Between Groups	129.92	7	18.56	.34	.934
Within Groups	19883.16	366	54.33		
Total	20013.08	373			
STPI					
Between Groups	328.72	7	46.96	.47	.856
Within Groups	36636.86	367	99.83		
Total	36965.58	374			
GVS					
Between Groups	2092.81	7	298.97	1.08	.374
Within Groups	101089.60	366	276.20		
Total	103182.41	373			

Note: FHS = Future Hope Scale; ISS = Internalized Shame Scale; PENN = Penn PTSD Inventory; QOLI = Quality of Life Inventory; SHS = Self-Handicapping Scale; STPI = State-Trait Personality Inventory; GVS = Glover Vulnerability Scale

CHAPTER 5

DISCUSSION

This study examined how sense of self, post-trauma adjustment and shame were associated with symptom distress, quality of life, hope, and other sociodemographic variables. Given that there has been only limited empirical investigation on how shame and PTSD are related, these findings begin to integrate theoretical, clinical, and research perspectives on how shame and psychological trauma impact adaptation and adjustment in help-seeking combat veterans.

This chapter begins with a summary of significant findings from the current investigation. Initially, current findings from the study are tied to the existing empirical literature. Supportive and divergent findings are discussed. Following review of the empirical findings, implications of the current findings for theory, research, and practice are presented. Finally, limitations of the present study are discussed and general conclusions of the overall investigation are summarized.

Summary of Significant Findings

Findings for Descriptive Analyses

Descriptive analyses revealed elevated symptom distress scores for the entire sample. This finding was expected given that respondents were admitted inpatients in a specialized PTSD treatment program. Help-seeking efforts are precipitated by increased symptom distress and a general breakdown of coping and support resources available to

the individual and the family system (Kulka et al., 1990; Schlenger et al., 1992).

Managing a chronic condition such as PTSD has also been identified as an ongoing environmental stressor (Bremner et al., 1995). Having a stress disorder has been shown to exacerbate symptom distress with exposure to subsequent stressors (Green, 1994a; van der Kolk, 1996). The descriptive statistics obtained in this study are consistent with the findings from other investigations on the chronic effects of trauma (Bremner et al., 1995; Breslau & Davis, 1987a; Litz & Keane, 1989).

Readjustment difficulties in combat veterans have been well documented (Atkinson, et al., 1988; Blank, 1993; Brenner et al. 1995; Card, 1983, 1987; Carroll et al., 1985; Egendorf, Kadushin, Laufer, Rothbart, & Sloan, 1981; Figley, 1978a; Foy et al., 1987; Goldberg et al., 1990; Laufer et al., 1985b; Wilson et al., 1988). Elevated symptom distress reported by chronic PTSD veterans has been characterized in literature to include symptoms of PTSD, panic disorder, major depression, mania, generalized anxiety disorder, and somatization (Breslau & Davis, 1987a; Green, 1994a). PTSD has also been associated with comorbidity across a range of psychiatric disorders (Green et al., 1990; Kulka et al., Schlenger et al., 1992). Help-seeking veterans in this study reflected chronicity characteristics including severe depression, pronounced trait anxiety, profound shame, decreased hope, lower overall quality of life, and self-handicapping strategies reflecting a negative sense of self.

Previous findings by Green et al. (1990) indicated that in patient samples of Vietnam veterans, over 75% of veterans with PTSD also met criteria for at least one other diagnosis (e.g., Keane & Wolfe, 1990). Depression and substance abuse were the most

frequently occurring coexisting diagnoses, with personality disorders cited in about 30% of veterans with PTSD (Green, 1994a; Kulka et al., 1990). Chronic symptom distress and treatment resistance were consistently reported in the literature as complications of PTSD (e.g., Green, 1994b; Solomon, 1990; 1993). The strongest correlation that emerged in the current study was between depression and PTSD. Chronic PTSD coupled with severe depression has been linked with poorer prognoses, in general, and has demonstrated treatment resistance, especially in examining treatment gains over time (Fontana & Rosenheck, 1997; Green et al., 1989; Keane & Wolfe, 1990; Jordan et al., 1992; Kulka et al., 1990; Litz et al., 1992; Waysman, Mikulincer, Solomon, & Weisenberg, 1993; Zlotnick et al., 1999). The results of this study regarding high levels of symptom distress are in keeping with other studies on the chronicity of PTSD and lend support to the persistence of the disorder as an ongoing adjustment concern.

Zlotnick et al. (1999) have suggested that common vulnerability factors may be involved in chronic PTSD, alcohol use, and depression. Poorer prognoses in recovery from PTSD have also been linked with poor social support (Solomon et al., 1990) and prior trauma experiences in childhood (Herman, 1992a). Longitudinal data from this study demonstrated a return in symptom distress to near baseline levels at twelve months post-baseline. Durable remission in chronic PTSD has yet to be achieved with reliability (Shalev, Bonne, & Eth, 1996). Findings from the current study demonstrated that maintenance of treatment gains was problematic and suggested that remission from chronic PTSD remains an aspirational rather than achieved outcome of PTSD treatment.

Findings from Basic Correlations

Correlational data showed expected relationships which reflected “commonsense” associations between variables. Expected relationships (significant and positive) were found between parental loss and being in foster care. Being in trouble with the law was significantly and positively associated to peers who were in trouble with the law, abuse, playing hookey a lot, and not finishing high school. Family factors of parental loss, absence and abuse were related to each other.

Premilitary characteristics were extensively investigated in the landmark NVVRS study (Kulka et al., 1990). This study examined over 80 characteristics and experiences that predated military or Vietnam experiences in conjunction with current and lifetime prevalence data. Characteristics that have been reported to contribute significantly to adjustment models include the number of problem behaviors in childhood, meeting the criteria for a diagnosis of antisocial personality disorder before age 18, having been a member of a family who had difficulty making economic ends meet, and having one or more first-degree relatives with a mental disorder. The NVVRS study found four significant predisposition variables among theater veterans: (1) having grown up in a family that experienced economic difficulty, (2) having had drug problems of abuse or dependence prior to entering the military, (3) the presence of an affective disorder before going to Vietnam, and (4) problem behaviors in childhood.

In the current study, correlational analyses were conducted with shame scores and family factors, but produced no significant correlations. This finding contradicts both empirical investigations of traumatic stress studies (Kulka et al., 1990; Schlenger et al.,

1990) and shame theory (Fossum & Mason, 1986; Harper & Hoopes, 1990; Kaufman, 1989). In part, this may be explained by the item content of the ISS being almost exclusively focused on the self and related emotional experiences. The exclusive focus on the self may have limited potential significant associations with other family variables. None of the thirty items on the ISS make specific reference to family. The interpersonal capacities evaluated in the item content of the ISS appear to tap more generic interpersonal dimensions of shame and not domain specific relationships qualities such as family dynamics. The nonspecific references to others in the item content would facilitate general comparisons between self and others, without directly examining family specific, interpersonal dimensions of shame. Given that family factors have been strongly identified as important dimensions in previous trauma investigations (e.g., Allen, 1995; Barret & Mizes, 1988; Boss, 1984; Bowlby, 1984; Bremner et al., 1995, 1993b; Danieli, 1985), the unique finding of this study of nonsignificant association among shame and family factors warrants further investigation. The tentative findings in this study suggested that shame, as measured by the ISS, taps a dimension of psychological and emotional functioning that is independent of family of origin influence or is not detected by the item content of the ISS.

Findings for Analyses of Major Hypotheses

An overview of the general findings is presented next, with a detailed examination of each major hypothesis following this introductory note. The expected correlational relationships among shame, symptom distress, and sense of self measures were found in this investigation. In addition, these significant hypothesized relationships

were in the expected direction. Multivariate and repeated measures analyses provided some evidence of the amenability of shame to treatment. However, changes in shame were found to return to near baseline functioning at twelve months post-baseline. Similar patterns of return to near baseline functioning were found in other symptom distress measures (depression, trait anxiety, vulnerability, PTSD) as well. Differential treatment effects by level of shame provided another view of symptom distress, sense of self, and resilience characteristics, such as hope and quality of life. The exploratory regression analysis of shame on symptom distress and family variables yielded five significant criterion variables that predicted shame (vulnerability, depression, hope, self-handicapping and quality of life). The hypothesized relationships in family history variables were not supported. No significant differences were found in family history variables for loss or chaos across symptom distress, shame, hope, or quality of life. Among the sociodemographic factors that were investigated, analyses of both socioeconomic status (SES) and history of abuse showed significance. Significant differences were found between SES level and hope as well as between SES level and overall quality of life. Obtained differences between hope and quality of life with socioeconomic status were not unexpected. Without adequate economic resources, hope and quality of life would likely be impacted (Bremner et al., 1995; Kulka et al., 1990). History of abuse was associated with significant differences on vulnerability. Alterations in interpersonal functioning following abuse have been well documented (Herman, 1997; van der Kolk et al., 1996b).

Correlational Hypotheses

Hypothesis 1: Hypothesis 1 stated that shame would be negatively associated with sense of self. This hypothesis was supported. The positive association between shame and self-handicapping indicates that as shame increases, self-handicapping increases. The assumption of self-handicapping theory (Berglas & Jones, 1978) is that self-esteem or sense of self is highly valued and protected via self-handicapping strategies. Thus, increased self-handicapping is hypothesized to reflect negative views of self.

Previous empirical investigation of shame has been very limited. One other study by Wong and Cook (1992) examined shame and PTSD, with no direct measures of sense of self or self-handicapping as a part of the study. The use of the SHS in other investigations in performance and attribution studies has been focused on non-clinical populations making direct comparisons to previous findings on either of these measures difficult.

No other empirical findings are available for shame and self-handicapping. This study's finding of a positive association offered tentative support for views of trauma that reflect alterations in sense of self as a consequence of PTSD. The positive relationship demonstrated between shame and self-handicapping empirically validated both shame and self-handicapping as psychological constructs that parallel other symptom distress measures. Taken together, the findings of this investigation along with documented outcomes reported in the empirical literature on chronic PTSD, shame and negative sense of self may also be considered as part of a legacy of distress and altered functioning (e.g., Atkinson et al., 1988; Bremner et al., 1993a; van der Kolk et al., 1996b).

Hypothesis 2: Hypothesis 2 posited that shame would be positively associated with depression. This hypothesis was supported. The positive correlation between shame and depression indicates that as shame increases, depression increases.

The results of this study on shame and depression, while not surprising, establish tentative support for shame as another facet of depression. Similar findings among shame, depression, and PTSD have been reported by Wong and Cook (1992). Their results showed correlations between the ISS and BDI for the total sample to be .70. In their study, a PTSD subgroup showed $r = .56$ for BDI and ISS scores. This study obtained a correlation of .69 on these same measures. While limited empirical findings are also reported on shame and depression, this study's findings are similar to those of Wong and Cook (1992). In Wong and Cook's (1992) study, the researchers compared BDI, ISS, and Rosenberg self-esteem scores among three groups (depression, substance abuse, and PTSD) of hospitalized combat veterans. The PTSD group achieved the highest scores on the ISS and BDI, although these differences were not statistically significant. The positive association between shame and depression obtained in the current study affirmed that part of the psychological expression of PTSD was related to shame and depression. Depression has been widely held as one of the debilitating aspects of PTSD in combat veterans (e.g., Foy et al., 1987b; Goldberg et al., 1990; Green et al., 1990a; Jordan et al., 1991; Kulka et al., 1990; Laufer et al., 1985b). This study extends the findings of depression as a consequence of PTSD and confirms earlier work on the link between depression and shame.

Hypothesis 4: Hypothesis 4 stated that vulnerability would be positively associated with shame. This hypothesis was supported. The positive correlation between vulnerability and shame indicates that as vulnerability increases, shame increases.

This study used two relatively new measures of shame and vulnerability to examine how these two variables were associated with symptom distress in help-seeking combat veterans. Vulnerability and shame were shown to be positively associated. Previous investigations have reported personal vulnerability as an important dimension of subjective experience following exposure to overwhelming stress (Lifton & Olson, 1976; Notman & Nadelson, 1976; Titchener, Kapp, & Winget, 1976). Traumatic events have been shown to significantly alter previously held assumptions of invulnerability (Janoff-Bulman, 1985). Danieli (1985) and Putnam (1985) identified vulnerability as associated with depression, fear, mistrust, phobic avoidance, social withdrawal and isolation. No previous empirical findings have directly examined the link between vulnerability and shame. The significant positive association between vulnerability and shame offered another perspective from which to understand the interpersonal aspects of vulnerability and shame as related to symptom distress in PTSD.

Factor analytic findings by Glover et al. (1990) reported items on the GVS clustered around vulnerability, abandonment, dreams of death/destruction, guilt, depression, and rebelliousness. Obtained intercorrelations by Glover et al. among the five factors were reported between vulnerability and dreams of death/destruction (.44), guilt (.59), depression (.76) and rebelliousness (.82). The obtained correlation in this study between vulnerability and shame of $r = .46$, $p < .01$ established tentative support for a significant

and positive association between shame and vulnerability. This significant, positive association between shame and vulnerability may be partially a function of each measure's interpersonal sensitivity. Both the ISS and the GVS evaluate how interpersonal dimensions are utilized as part of the environmental and self monitoring.

Problematic interpersonal dynamics and relationship difficulties have been confirmed in other investigations of combat veterans (Barrett & Mizes, 1988; Carroll et al., 1985; Jordan et al., 1992; Nezu & Carnevale, 1987; Riggs et al., 1998; Solomon et al., 1990). Vulnerability and shame appear to be associated with increased interpersonal sensitivity, especially in conjunction with both the hyperarousal and hypervigilance that are considered part of self-regulation problems experienced by survivors of PTSD (Danieli, 1985; Herman et al., 1989; van der Kolk., 1996; van der Kolk & Fisler, 1994a; van der Kolk et al., 1996b).

Hypothesis 5: Hypothesis 5 posited that shame would be positively associated with severity of PTSD. This hypothesis was supported. The positive correlation between shame and PTSD severity indicates that as shame increases, PTSD severity increases.

Although all of the respondents in the sample had a confirmed diagnosis of PTSD prior to their admission into the specialized PTSD treatment program, PENN scores indicated that self-reported symptoms of PTSD remained a salient concern for respondents. The significant and positive association between shame and self-reported PTSD symptoms offered another view of symptom distress. Previous findings by Wong and Cook (1992) established shame as one of the psychological dimensions underlying PTSD symptomatology. The current findings extend the conclusions of the previous

research by Wong and Cook. Previous formulations on PTSD have reported guilt and shame as ongoing stressors following combat trauma. However, empirical findings have been virtually nonexistent to support these commonly reported associations.

Psychodynamic theories of trauma have conceptualized guilt and shame as mediators of distress and impaired functioning, but have not subjected this theorizing to empirical validation with standardized measures (Allen, 1995; Blatt & Blass, 1992; Bradshaw et al., 1993, 1991; Figley, 1978a). Therefore, the correlational findings of the current study provided tentative support for shame as corollary of PTSD.

Hypothesis 6: Hypothesis 6 stated that shame would be positively associated with anxiety. This hypothesis was supported. The positive correlation between shame and trait anxiety indicates that as shame increases, anxiety increases.

Trait anxiety and shame may both be markers for the interpersonal monitoring and hypervigilance associated with PTSD. Given that this investigation is one of the first to empirically examine shame and a range of other symptom distress variables, related empirical findings are not available. While no studies directly examined shame and trait anxiety, previous investigation with combat veterans and PTSD have reported comparable findings on chronic anxiety. Fontana et al. (1992) have established threat as an active component in the psychological appraisal processes of combat survivors. Disordered arousal has been empirically validated as an ongoing adjustment issue in combat veterans (Atkinson, et al., 1988; Blank, 1993; Bremner et al., 1996; Foy et al., 1987a; King et al., 1998; Kulka et al. 1990; McFall et al., 1991). The positive correlation between shame and trait anxiety would suggest that shame, as a form of symptom

distress, may be associated with painful introspection as well as interpersonal monitoring similar to the hypervigilance and environmental sensitivity noted in PTSD.

Hypothesis 9: Hypothesis 9 stated veterans with higher degrees of shame would report lower satisfaction with overall quality of life. The significant, negative correlation between shame and overall quality of life indicates that as shame increases, quality of life decreases. The hypothesized relationship between shame and quality of life for the overall sample was supported.

The negative relationship between shame and quality of life reflects a commonsense understanding of these two constructs. While this study is among the first to specifically investigate the relationship between these two variables, the initial findings of this investigation can serve as a point of departure for other investigations. Quality of life has been linked with subjective well being (Frisch et al. 1992). A subjective sense of well being would likely contribute to overall resilience. Previous research by Frisch et al. has demonstrated quality of life as positively associated with multiple measures of well-being. QOLI scores could serve as a potential resilience measure.

Frisch et al. (1992) have conceptualized quality of life as the extent to which an individual's needs, goals, and wishes have been fulfilled. These authors have linked depression and quality of life as indicators of negative self-evaluation and hopelessness. The findings in this study supported resilience theorizing as QOLI scores and BDI scores were significantly and negatively correlated ($r = -.25, p < .01$). Obtained correlations between shame and hope were also significant and negative ($r = -.32, p < .01$). Taken together, the obtained correlations between shame and quality of life, between shame and

hope, and between depression and quality of life lend tentative support to decreased resilience in the sample as a whole. Thus, the role of shame appears to be similar to other symptom distress measures in that shame contributes in some ways to the inability of an individual to have needs, goals, and wishes fulfilled, thereby contributing to a decreased overall quality of life and diminished resilience. Subjective well-being represented by QOLI scores suggests that shame negatively impacts quality of life.

In addition to correlations between shame and quality of life, analyses were conducted using level of shame as a grouping variable. Level of shame was significantly and negatively related to overall quality of life. In other words, as level of shame increased, quality of life decreased. The finding indicated significant differential symptom distress by level of shame and warrants further investigation. Differential distress by level of shame potentially implies the need for targeted interventions that take into account level of shame differences.

In summary, the results of the correlational analyses supported the hypothesized relationships among shame, sense of self, symptom distress, and PTSD. Shame, as measured by ISS scores, was positively associated with depression, vulnerability, PTSD, self-handicapping and trait anxiety. Inverse relationships were noted between shame and hope as well as between shame and overall quality of life. The negative associations reported in the current study provided tentative support for another facet of long-term altered functioning in chronic adaptational patterns. Substantial symptom distress coupled with decreased resilience, as measured by lower hope scores and lower overall quality of

life scores, serve as a potentially important context against which treatment and intervention strategies could be developed.

Multivariate and Repeated Measures Hypotheses

Hypothesis 3: Hypothesis 3 stated that shame would decrease as a result of treatment and that post-baseline changes in shame would be maintained. This hypothesis was partially supported. This analysis used a subsample of the total sample (those who had complete measures at all points in time) and evaluated changes in shame over time. No other studies have empirically investigated shame over time. This study's findings showed that shame responded to treatment in an inpatient setting, but that shame scores returned essentially to baseline levels after veterans went to outpatient status (6 and 12 months post-baseline).

Empirical findings by Wong and Cook (1992) have previously reported shame as an underlying psychological dimension of PTSD in combat veterans. This study adds to these empirical findings on shame as a psychological component underlying symptom distress in PTSD. First, consistent with Wong and Cook's earlier study, shame was reported as a significant component of symptom distress in help-seeking veterans. Second, shame scores followed patterns of other distress measures in a similar overall trend across the four time periods. Baseline scores established a basis for comparison of subsequent scores. Shame scores decreased at two months post-baseline. This significant decrease in shame scores between baseline and two months post-baseline gave partial support to the hypothesis of decreases in shame as a result of treatment. However, as time from baseline increased, shame scores showed a pattern of regression toward baseline

levels. Reduction in shame scores was not maintained at six months and twelve months post-baseline.

Similar patterns in PTSD treatment have been reported in other investigations (Fontana & Rosenheck, 1998; Johnson, Rosenheck, Fontan, Lubin, Southwick, & Charney, 1996; Perconte, 1989; Scurfield, Kenderdine, & Pollard, 1990; Shalev, Bonne, & Eth, 1996). Other findings in community samples have also shown persistence in PTSD symptoms in the general population to have a similar pattern (Kessler et al., 1995). While these studies did not directly evaluate shame per se, comparative results among a broad array of symptom distress measures showed a consistent pattern. The pattern of shame scores obtained in this study yields another indicator of symptom distress associated with PTSD. Shame, as a symptom of distress, showed amenability to treatment and regression to baseline over time. Similar patterns of amenability to treatment and return to baseline functioning were noted for anxiety, depression, vulnerability and PTSD in this study. Other symptom distress measures in this study evidenced similar patterns and will be more fully discussed in the next section. In general, the findings from other outcome studies have demonstrated the chronic nature of PTSD. The common trend in a variety of other symptom distress and outcome studies is to find improved overall functioning prior to discharge, followed by return to baseline levels at follow-up (four months to one year) (Boudewyns, Hyer, Woods, Harrison, & McCranie, 1990; Hammarberg & Silver, 1994; Harmand, Starkey, & Ashlock, 1987; Johnson et al., 1996; Silver, Brooks, & Obenchain, 1995).

Hypothesis 7: Hypothesis 7 stated that veterans with higher levels of shame would respond to treatment differently than veterans with lower levels of shame. This hypothesis considered how level of shame impacted specific symptom distress measures of PTSD, trait anxiety, vulnerability, and depression. Using levels of shame as a grouping factor to examine symptom distress was a unique contribution of this study. Examination of symptom distress by shame levels advances the empirical findings to date. The overall trend in the data did not support this hypothesis. However, this study showed that symptom distress in the high shame group was consistently numerically higher than other groups. While these differences were not statistically significant, such differences may be clinically relevant. Elevated scores on PTSD, trait anxiety, vulnerability and depression by the high shame group may be indicative of poorer prognoses and more compromised defenses. Continued investigation of shame levels and symptom distress is warranted.

Hypothesis 8: Hypothesis 8 stated that family factors, sociodemographic factors, and sense of self would predict shame. This was an exploratory analysis to examine how a variety of contextual variables may be related to shame. Results showed that shame maybe associated with vulnerability, depression, hope, self-handicapping, and quality of life.

Hypothesis 10: Hypothesis 10 stated that veterans with a family history of loss would have higher scores on shame and lower scores on hope and quality of life. This hypothesis was not supported. The findings in the current study of no differences in symptom distress with regard to a family history of loss were not anticipated. Other investigations have reported adjustment difficulties in children who experience parental

loss (Cole & Putnam, 1992; Herman et al., 1989; McFarlane, 1988; Reite, Seiler, & Short, 1978; van der Kolk, 1988, 1989; van der Kolk et al., 1991). The lack of significant differences may, in part, be explained by the measurement insensitivity of yes/no questions in adequately evaluating loss histories. Retrospective reporting bias may have in some way contributed to the outcomes obtained in this study.

Hypothesis 11: Hypothesis 11 stated that veterans with a family history positive for chaos or instability would have higher scores on measures of shame, depression, anxiety, vulnerability, and lower scores on hope and quality of life. The hypothesis was not supported. This finding was somewhat surprising. Previous investigations of family factors have identified both loss and instability as environmental factors that predicted later adjustment difficulties (Bowlby, 1977, 1984; Bremner et al., 1995; Browne & Finkelhor, 1986; Cicchetti & White, 1990; Clark, Pynoos, & Goebel, 1994; Lansky, 1992; Pynoos, 1993; van der Kolk, et al., 1991). Retrospective reporting over a period of decades may have contributed to the findings obtained in this study. The yes/no format provided a more global measure of family instability and may have lacked the discriminatory power to detect differences that were present. It is also possible that chronic symptom distress has been attributed to combat experiences rather than to more distant family of origin experiences, and thus did not contribute significantly to the present functioning of combat veterans.

Hypothesis 12: Hypothesis 12 stated that non-white ethnicity, low socioeconomic status, and a family history of abuse would be associated with increased symptom distress and shame as well as decreased sense of self, hope, and quality of life. There was partial

support for this hypothesis. No significant differences were reported for abuse history and ethnicity. Socioeconomic status was associated with differences in both hope and quality of life.

The findings regarding abuse were surprising. Childhood abuse has been consistently associated with a variety of adjustment problems including personality disorders, self-harm, dissociation, and self-regulation difficulties (Ainsworth, 1989; Browne & Finkelhor, 1986; Burgess, Hartman, & McCormick, 1987; Cole & Putnam, 1992; Herman et al., 1989). The influence of abuse histories on adjustment and overall functioning has been widely reported in a variety of clinical populations including combat veterans (Bremner et al., 1993b; Green et al., 1990a; Jordan et al., 1992; Kulka et al., 1990; Solomon et al., 1990). Mixed findings have been reported on premilitary factors and vulnerability to subsequent traumatic experiences (Figley, 1978; Foy et al., 1984; Keane et al., 1985; Penk et al., 1989, Roberts et al., 1982). However, studies on premilitary factors have reflected substantial heterogeneity in selection factors used, making comparisons across findings and studies impractical or difficult.

Possible explanations for the findings obtained in the current investigation include the lack of sensitivity in the question format to detect differences that may have been present, a reporting bias by participants that minimized histories of abuse, or possible secondary gain associated with citing military factors' effects on current functioning. It is unclear how to interpret multiple influences of premilitary, military, and post-military factors as it was related to adjustment. Continued investigation to address these concerns appears warranted.

The findings on ethnicity and PTSD in this study were somewhat unexpected, although similar to the majority of empirical findings. The sample evidenced sufficient adequate representation by different ethnic groups to examine potential ethnic differences. Yet, the study yielded no differences with regard to ethnicity and symptom distress measures.

The empirical literature also reported mixed findings. The NVVRS study (Kulka et al., 1990), by far the largest study of combat veterans and adjustment, showed some evidence of ethnocultural variation in PTSD prevalence rates. The findings of the NVVRS study indicated prevalence rates of PTSD varied considerably by ethnicity, with 20.6 percent of African-Americans meeting diagnostic criteria and 27.9 percent of Hispanic veterans meeting criteria compared to 13.7 percent of Caucasian veterans who met current PTSD diagnostic criteria. In another study by Rosenheck and Fontana (1996), race and outcome of PTSD treatment were examined. Their findings reported similar degrees of improvement between African-American and Caucasian veterans in outpatient PTSD programs. Three studies which reported ethnic differences (Allen, 1986; Parson, 1985; Penk et al., 1989) used clinician observation and psychometric measures to evaluate psychotherapy outcomes. These studies' findings indicated that African-Americans derived less benefit from traditional psychotherapeutic treatments than Caucasians. The majority of empirical studies, however, reported findings similar to the current study which showed no measurable differences in outcome between racial groups (Roseheck, Fontana, & Cottrel, 1995; Sue, 1988). Issues regarding ethnic diversity, diagnostic concerns, and treatment efficacy are confounded by longstanding cultural

biases including racism, sexism, and homophobia. These broad-based cultural factors warrant due consideration in interpretation of obtained differences. The lack of significant differences in this study suggested that symptom distress, PTSD, and shame are not substantially associated with ethnicity.

Socioeconomic status has been associated with higher rates of PTSD among veterans. The NVVRS data (Kulka et al., 1990) showed increased rates of PTSD among veterans who never finished high school, were unemployed, and had incomes of less than \$20, 000 per year (26.2%). Findings reported by Breslau et al.(1991) linked negative parenting behavior, early separation from parents, parental poverty, and lower education as predictors for both exposure to PTSD and PTSD following exposure. Exposure to traumatic experiences given pre-trauma risk factors such as negative parenting, loss, poverty, and lower educational achievement have been interpreted by Shalev (1996) as different facets of a common socioeconomic factor. Findings in the current investigation would suggest socioeconomic factors not only increase risk, but may also be associated with decreased resilience, via lower hope scores and decreased quality of life scores.

Implications for Theory

The emergence of both biopsychosocial and multidimensional trauma models provide a framework from which to understand and interpret the findings of the current investigation. According to van der Kolk and McFarlane (1996) six critical issues affect how people with PTSD process information: (1) intrusive memories interfere with direction of attentional resources; (2) re-exposure to situations reminiscent of the trauma promote subsequent retraumatization; (3) avoidance of trauma-specific triggers and

emotions and generalized numbing of responsiveness impact interpersonal capacities; (4) diminished self-regulatory capacities exacerbate stress responses and decrease abilities to use body signals as guides for action; (5) generalized problems with attention, distractibility, and stimulus discrimination promote increased frustration; and (6) alterations in psychological defense mechanisms and personal identity increase feelings of vulnerability and change what information is selected as relevant from the environment. The ability to process information effectively is central to adjustment, critical to interpersonal functioning, and an important avenue for social and environmental support. The pervasive deficits in information processing capacities associated with PTSD would exact significant toll in multiple domains of functioning. A biopsychosocial model of trauma captures the complexities associated with chronic PTSD. The cumulative impact of psychological trauma, taken into account by the biopsychosocial model of trauma, allows for a more complete conceptualization of individual functioning.

Four findings of the current study affirmed the importance of a broad context from which to examine adjustment efforts of combat veterans and support the biopsychosocial formulation of trauma. First, the intercorrelations of the dependent measures used in the study supported pervasive deficits in functioning expressed through depression, trait anxiety, vulnerability, and PTSD severity. Second, interpersonal deficits were indicated by significant associations between shame and vulnerability. Third, mean scores on the STPI were more than four standard deviations above the reported norms for men affirming the disordered arousal and diminished self-regulatory components of the

biopsychosocial model of trauma. Finally, alterations in psychological defenses were indicated by the increased level of symptom distress by shame level findings. Taken together, compromised defenses via shame level differences, coupled with increased vulnerability reflected in overall GVS scores, and further supported by the significant correlation between GVS and ISS lend support to the explanatory power of the biopsychosocial model of trauma. Thus, the breadth of symptom distress scores present in this sample showed disordered arousal, interpersonal difficulties, and sense of self concerns which reflect the theoretical tenets of the biopsychosocial model of trauma regarding personal identity difficulties and information processing capacities in the environment.

Trauma survivors' chronic adjustment difficulties and changes in self and relational functioning have been reported by other researchers (e.g., Abeles & Schilder, 1935; Archibald & Tuddenham, 1965; Engdahl et al., 1997; Kahana et al., 1988; Ursano et al., 1995). The results of this study point to biopsychosocial deficits as a consequence of chronic PTSD. The combined impact of depression, shame, trait anxiety, self-handicapping, and vulnerability in the lives of combat veterans with PTSD, along with the negative associations found between shame and hope and overall quality of life, underscore the long-term challenges of living post-trauma. Previous findings have noted that the clinical realities of trauma survivors are multi-dimensional (e.g., Blatt & Blass, 1990, 1992; Kernberg, 1975, 1990; Laufer, 1988; Lisak, 1993; Nemiah, 1989, 1995; Putnam, 1989; van der Kolk et al., 1994b, van der Kolk & van der Hart, 1989). Several correlational findings obtained in this study further suggested that multi-dimensionality

was also an important aspect of compromised individual functioning. Compromised functioning was noted by the range and expression of symptom distress patterns in help-seeking combat veterans. Specifically, the findings showed all correlations between shame and other symptom distress measures were significant. Furthermore, shame was negatively correlated with hope and overall quality of life. The combined impact of symptom distress correlations and decreased resilience correlations support multidimensionality in both PTSD and shame. The significant correlations between self-handicapping and depression, trait anxiety, PTSD, vulnerability, and quality of life reflect multidimensionality, chronicity, and compromised coping abilities. Taken together, these findings speak to the complexity of trauma survivors' adjustment difficulties.

Chronicity in symptom distress

The extant literature on psychological trauma affirmed how multi-dimensional and multi-faceted traumatic experiences are for survivors, families, and communities. Biological, psychological, identity, and interpersonal disruptions have been posited as characteristic of chronic traumatic responses (Allen, 1995; Bowlby, 1969, 1984; Browne & Finkelhor, 1986; Cole & Putnam, 1992; Herman et al., 1989; Lisak, 1993; van der Hart et al., 1993; van der Kolk & Fisler, 1994a, 1995; van der Kolk et al., 1991). The findings of the current study regarding the stability of symptom distress over time, especially measures at six to twelve months post-baseline, illustrate how chronic PTSD is for some veterans. Difficulty in maintaining treatment gains were reflected in return to near baseline levels on shame, trait anxiety, vulnerability, PTSD, and depression. The longitudinal data obtained in the current investigation add to the existing empirical

findings and support the complexity of chronic traumatic experiences and adjustment challenges for survivors.

Epidemiological evidence estimated lifetime prevalence of PTSD ranging from 8% to 12% (Breslau et al., 1991; Kessler et al., 1995; Resnick et al., 1993). Zlotnick et al. (1999) identified the emerging awareness in the clinical and research community that PTSD is often a chronic adjustment challenge. Few studies have examined the risk factors that are associated with chronic PTSD. In civilian populations risk factors associated with chronic PTSD included female gender, numbing experiences, personality pathology, and comorbidity with other psychiatric disorders (Breslau & Davis, 1992; Davidson et al., 1991; Kessler et al., 1995). Depression and substance abuse have been consistently identified as problems related to the course of chronic PTSD (Bremner et al., 1996; Breslau & Davis, 1992; McFarlane, 1988).

While acute and chronic effects of psychological trauma have been systematically investigated, repeated attempts to examine and explain complex relationships among mind, body, and culture that result from overwhelming experiences remain unclear. Empirical and clinical investigations have yielded mixed findings that clarify some aspects of individuals' functioning, while calling into question previously held clinical opinion (e.g., Cicchetti & Toth, 1994; Cole & Putnam, 1992; Figley, 1978b; Herman, 1992b, 1997; Ursano et al., 1994). For example, early formulations of combat trauma espoused timely return to the battle front following acute exposure to shell shock (Grinker & Spiegel, 1945). More recent findings by Solomon et al. (1996), have shown acute dissociative symptomatology at the onset of the combat stress to be predictive of

subsequent PTSD. This more recent study by Solomon et al. complemented the findings demonstrated by other trauma researchers on multi-dimensionality and biopsychosocial models of trauma.

The longitudinal data obtained in the current study expand clinical and empirical understanding on long-term adjustment efforts and chronicity in PTSD (e.g, Alexander, 1992; Beal, 1995; Blank, 1994; Davidson & Foa, 1993; Wilson et al., 1988). An examination of the time sequence of distress scores illustrates two important aspects of symptom distress and chronic adjustment efforts of survivors. First, veterans who sought help for psychological distress improved with treatment. This was apparent in the significant decrease in symptom distress measures between baseline and two months post-baseline. Thus, inpatient treatment is effective in reducing symptom distress in both PTSD and shame. Maintaining treatment gains was problematic. Both six months and twelve months post-baseline data showed significant declines as measured by symptom distress reports. The design of the current study did not utilize multiple comparison groups such as an outpatient only, treatment seeking group or a no treatment control group, so it is difficult to ascertain how the longitudinal component of the study can be interpreted. Continued investigation of these findings of longitudinal data, especially as the sample size of the completers increases, would facilitate a more complete understanding of how chronicity and multi-dimensionality impact long-term functioning in help-seeking combat veterans. In part, the equivocal findings in the psychological trauma arena may also be understood as a reflection of the variability in idiopathic patterns associated with acute and chronic post-trauma adjustment efforts by survivors.

Shame and Distress

The findings of this study regarding shame as a corollary of symptom distress and sense of self index was a unique contribution to the knowledge base in both PTSD and shame theory. Few empirical studies on shame have been conducted and only one other study has examined the impact of shame and PTSD (Wong & Cook, 1992). Their findings affirmed the presence of shame as a strong factor in PTSD symptomatology. In their study, global shame and scores on two subfactors, alienation and inferiority, were significantly different among PTSD, substance abuse, and depression groups in a clinical comparison of combat veterans. Alienation and inferiority were considered by these investigators as important markers for interpersonal dimensions of shame.

Shame theory has espoused both painful introspection and “severing of the interpersonal bridge” as evidence of the clinical manifestation of shame (Kaufman, 1989). Chronic experiences with shame have also been linked with identity disruption and alterations in interpersonal capacities. Disturbance in sense of self have been formulated to underlie a variety of pathological conditions (Broucek, 1991). Kaufman (1989) theorized internalized shame to be present in many forms of psychopathology. Cognitive, affective, behavioral patterns conceptualized by Harper and Hoopes (1990) in shame-based identities included a constricted range of feelings, an inappropriate matching of intensity of emotions with events, a feeling of badness regardless of context, denial and defending against feelings, perceptual focus on the negative, polarized thinking style, subjective reasoning and poor reality testing, and a pattern of unstable and intense interpersonal relationships.

The findings in this study supported several aspects of shame theory. First, high levels of shame present in the sample confirmed shame as a symptom of psychological distress. Second, positive correlations between shame and other symptom distress measures suggest shame as a component of other recognized symptoms of psychological distress. Finally, shame levels were negatively correlated with overall quality of life supporting a constriction of affective capacities and a negative view of life.

In PTSD, anxiety and avoidance components, as well as reliance on entrenched interpersonal distance, are used to control and manage hyperarousal. These durable and chronic biopsychosocial expressions of PTSD could become linked with shame via feelings of alienation and inferiority culminating in shame bound identity and a negative sense of self. Kaufman (1989) held the “severing of the interpersonal bridge” as a behavioral manifestation of shame-bound personalities. The combined effects of chronic PTSD and shame bound sense of self likely contributed to increased symptom distress and a negative sense of self consistent with the results found in the combat veterans in this study.

Two findings in this study lend support to the conclusion about the reciprocal influence on symptom distress in PTSD and shame. First, vulnerability scores as measured by the GVS were positively associated with both shame and PTSD. This means that as levels of shame and/or PTSD become more severe, so did vulnerability. Shame and PTSD as forms of symptom expression showed similar increases in interpersonal discomfort reflected in increased GVS scores. Vulnerability scores captured the interpersonal distress associated with both PTSD and shame.

Glover (1987) summarized the PTSD literature and identified four syndromes representative of the majority of cases of PTSD. According to Glover, primary emotions and affects underlying PTSD include fear, guilt, shame, and feelings of mistrust secondary to experiences of betrayal of trust. Cook (1989) identified shame as a central and basic human affect and interpreted the correlation between self-esteem and shame as actually “measuring the extent to which the self is shame-based” (p.561). This study extended Cook’s shame-based identity model to include self-handicapping as another way to gauge a negative sense of self.

Shame and Self-handicapping

Self-handicapping, as a strategy for self-protection, attempts to preserve one’s view of self as good by explaining performance deficits as external and unrelated to internal attributes (Arkin & Baumgardner, 1985). The finding of significant positive associations between self-handicapping and shame scores in the current study was another indicator of shame-based views of self.

To understand this connection, the following tentative analysis is postulated. Self-handicapping theory (Berglas & Jones, 1978) examines attributional style as a way to link esteem motivation with regard to performance attribution. Self-handicapping is one form of self-serving bias (Weary & Arkin, 1981) in which attributions are used to distort the link between performance outcomes and negative self-evaluation. In so doing, one’s sense of self, competence, and self-esteem can be retained. The operative assumption of self-serving bias theory is predicated on a view of self as highly valued, with a goal of protecting sense of self as an important function. Self-handicapping strategies utilize

attributions that obscure the link between self and other externally identified factors. Self-handicapping strategies involve preemptively citing symptoms and problems as the reason for future bad performance. Through the use of self-handicapping strategies, one makes sure that an audience is aware of one's symptoms/problems so that failure to accomplish good things or failure to pass some evaluative standard has a built-in escape designed in the service of self-protection (J. Farrell-Higgins, personal communication, April 20, 2000).

It can also be argued that shame experiences likely necessitate the need for self-protection. One possibility is that effective self-handicapping would be associated with lower shame scores. For example, a common reflection by soldiers describing combat experiences has to do with "I did bad things in combat. I have a sense of shame about these things I have done." Any revisiting of shame-based affect, either through new disclosure to an audience or to a revisited private disclosure to self, such as bad dreams or intrusive thoughts, could evoke distress and a desire in some way to resolve the discomfort associated with the shame affect. Some examples of effective utilization of external attributions (high self-handicapping) might involve reminding oneself of other external causes that contributed to or set one up for bad behaviors (bad officers, bad war, confusion about the enemy, etc). Similarly, during private self-reflection when shame is activated, the attributional scenario regarding bad behavior may be some version of "I am a victim of bad dreams," or "I can't help myself these intrusive thoughts just come over me." The reliance on self-handicapping strategies has a goal of keeping one's sense of self intact. Conversely, low self-handicapping individuals who acknowledged similar

behavioral sequelae as in the above examples would have less self-protection available, and at least theoretically, would be at risk for increased shame and decreased sense of self. Reliance on self-handicapping strategies could prompt veterans to say “I can’t get or keep a job, can’t talk to kids because of my PTSD.” In other words, high self-handicapping individuals preemptively cite PTSD related distress as a priori reasons why they will fail subsequent evaluative situations (e.g., being a “bad dad”, grocery shopping, family get-togethers). Using self-handicapping strategies has a utility for explaining past behavior and maintaining avoidance behaviors while attempting to preserve a positive sense of self.

Levels of Shame

Assessing entry levels of shame and response to treatment allows for an increased understanding of the reciprocal influences between shame and PTSD. For example, if shame was low to begin with, would the need to self-handicap be less? As shame increases, would the need to self-handicap also increase to avoid the negative impact and distressing emotions associated with shame? Time would also be an important factor in this sequence. Changes across time by shame level would provide some indication about the malleability or durability of shame as well as differential treatment effects. In addition, examining symptom distress, shame level, and self-handicapping scores over time could serve as an ancillary measure of self-protection resources. Baseline scores by shame level or baseline scores by self-handicapping level would provide two comparative views of symptom distress and would provide information about symptom distress, sense of self, and self-protection strategies.

In the current study, treatment was the same for all participants at baseline and at two months post-baseline. More variability in treatment was introduced in transition from inpatient to outpatient status so that changes in scores at six months and twelve months post-baseline would be to some degree confounded by the outpatient treatment context. However, there are some data available in the “completers” subsample which allowed for each respondent to serve as his own control. This subsample of respondents would minimize the potential variability in the inpatient/outpatient confound by examining two sets of scores as an inpatient and two sets of scores as an outpatient for each respondent in the completers sample. This additional level of statistical control would provide information to a limited degree about the issues of shame, symptom-distress and self-handicapping across time that would be unavailable by cross-sectional analyses of the data. The longitudinal data provided by “completers” suggested motivational differences may play some part in continued treatment. For example, one might assume that completers are more motivated as they maintain contact more frequently with the VA, complete measures at four points in time, or encourage others to seek treatment in specialized programs given their personal experiences with the therapeutic community model.

Pretrauma vulnerability and family variables

Previous research and empirical investigations have yield mixed findings with regard to preexisting vulnerabilities and potential moderating, mediating or exacerbating influences. This study hypothesized family history variables as a potential context for both increased shame and increased symptom distress as a response to early family

environment factors and experience. Family history factors such as loss, chaos, or abuse were not significantly associated with shame or symptom distress. There have been mixed reports in the clinical and empirical literature with regard to preexisting vulnerabilities and subsequent exposure to traumatic stress (e.g., Breslau & Davis, 1992; Foy et al., 1984; Goldberg et al., 1990; Green, 1994a; Resnick et al., 1992). Examining individuals' responses to experiences such as childhood abuse and neglect, sexual trauma, catastrophic events and natural disasters, war, torture and captivity have yielded mixed results. While the variability in findings may, in part, be explained by design considerations, such as longitudinal versus cross-sectional designs, or related to differential data sources such as autobiographical accounts or anecdotal records, variability of findings appears to be the norm (Barrett & Mizes, 1988; Bradshaw et al., 1991; Flannery, 1990; Fontana & Rosenheck, 1993; Schlenger et al., 1989, 1992; Zlotnick et al., 1999).

Childhood trauma has been strongly associated with high rates of PTSD (Rowan et al., 1994). Childhood trauma has also been shown as a predictor of time to remit from PTSD and has been implicated as a factor in the course of other chronic psychiatric disorders (Brown, Harris, Hepworth, & Robinson, 1994). Sociodemographic variables in the current multivariate analyses did not support the expected relationships. Specifically, family history factors including loss, chaos, and abuse did not yield significant differences with regard to symptom distress, shame, hope, or quality of life. One possible explanation for the divergence of the findings in the current sample could be the amount of time that has passed since these childhood experiences given that the vast majority

(96%) of the sample was in the 40-59 year-old age range. The resolution of combat trauma and post-trauma adjustment challenges were a primary target of intervention for help-seeking combat veterans. This study found that family history factors had less impact on the current functioning and chronic adjustment challenges than one would expect given the clinical and theoretical perspectives.

The issues involving pre-trauma vulnerability remain equivocal. Using the NVVRS data, Kulka et al. (1990) examined the issues surrounding adjustment patterns and predisposition variables in Vietnam veterans, Vietnam era-veterans, and civilians. Variables that significantly contributed to theater veterans' predisposition adjustment models included four factors: (1) having grown up in a family that had difficulty making ends meet economically, (2) having had symptoms of drug use or drug dependence before entering the military, (3) having had symptoms of an affective disorder before going to Vietnam, and (4) problem behaviors in childhood. These predisposition factors reflected a mixture of economic and mental health related variables. Despite the evaluation of pre-trauma influences, Kulka et al. (1990) noted the substantial impact of Vietnam war experiences, over and above predisposition differences. These investigators used both current prevalence and lifetime prevalence data in support of the impact of combat stress. In a similar fashion, the findings in the current study of nonsignificant differences among family history variables may be less about family history findings per se and more related to the primacy of the combat trauma as a salient factor in ongoing symptom distress. Kulka et al. summarized the results on predisposition and variability in PTSD symptomatology:

Taken together, these results are consistent with a model of PTSD that posits a role for individual vulnerability (potentially including, biological, psychological, and sociodemographic factors) *and* a role for exposure to environmental factors (specifically, war-zone stressors), in determining who among theater veterans gets PTSD. However, it is clear that exposure to war-zone stress makes a substantial contribution to the development of PTSD in war veterans that is independent of a broad range of potential predisposing factors (p. 85).

Similar mixed findings have also been reported by other investigations on chronic trauma and adjustment issues (Baum, O'Keefe, & Davidson, 1990; Carroll et al., 1985; Foy et al., 1987b; Green, 1990; Hendin & Haas, 1984; King, King, Gudanowski, & Vreven, 1995; Lazarus, DeLonghis, Folkman, & Gruen, 1985; Resnick et al., 1989).

More recent advances in statistical models have attempted to address these questions by examining direct and indirect influences reflected in structural equation models. Structural equation models have utilized multidimensional trauma models and attempted to derive factors that describe direct and indirect influences. For example, a structural equation modeling study by King et al. (1999) detailed multiple influences including family history variables, war-zone stress, and resilience characteristics. In men, nine variables accounted for 70% of the variance and were directly linked to PTSD. Factors accounted for by King et al.'s structural model included pre-war variables of early trauma history and age of entry into Vietnam; war-zone stressor of atrocities/abusive violence, perceived threat, and malevolent environment; post-war

additional stressful events, hardiness, and functional and structural social support. These findings prompted the following conclusion:

Early trauma history was directly linked to additional stressful life events in the post-war period, thus affirming Bremner et al.'s (1995) commentary that prior life stress predicts later life stress. . . . And the hypothesized direct and negative relationships between family instability and both forms of social support were found for men, suggesting that a chaotic family environment characterized by parental dysfunction and disorganized attachment may very well compromise one's ability to build, foster, and benefit from a support network in later years (p. 168).

It appears that structural equation modeling would be another approach to multidimensional influences and adjustment in chronic PTSD. The findings by King et al. (1999) disagree with the family factor findings of the present investigation. The discrepancy in findings may be in part a function of measurement differences and statistical analyses employed. Additional investigation would help to clarify the findings in vulnerability factors and stress response.

Another perspective that was cited across the findings of several empirical studies has noted the importance of subjective, meaning-making components in resolution of traumatic life experiences. Furthermore, meaning-make perspectives and personal appraisal processes have been characterized as a complex interaction that involves experiencing and responding to stressors amidst cyclical, multifactorial person-environment relationships (Davidson & Baum, 1993; Janoff-Bulman, 1989, 1992;

Solomon, Mikulincer, & Hobfall, 1987). Systematic observation and treatment of combat veterans for over thirty years has made a substantial contribution to the current models of psychological trauma. The consensus among the findings with regard to traumatic responses across time has identified a heterogeneous set of factors that influence the course of PTSD symptomatology. The immediate response to the traumatic event is one part in a sequence of lifelong adjustment and adaptation. Vietnam veterans, like Holocaust survivors, live their lives against a backdrop of memories, some of which are painful intrusions and horrific reminders of past events (e.g., Foy, 1992; King et al., 1998, 1999; Newman et al., 1995; Penk et al., 1988; Shalev, 1996; van der Kolk et al., 1996b).

Theoretical perspectives have linked the sequelae of childhood trauma with affect regulation and heightened physiological responsivity. Affect dysregulation and heightened physiological responsiveness have been identified as components of chronic PTSD (Rowan et al., 1994; van der Kolk & Fisler, 1994a). While this study did not find support for the majority of family factors as associated with symptom distress, abuse history was associated with increased vulnerability. It is possible that the broadband yes/no format was not sensitive enough to distinguish the impact of childhood trauma on other current symptom distress measures. It is also possible that there was some reluctance on the part of men to acknowledge abuse given the strong gender role socialization that would have been a part of these veterans' childhood environments (Fine, 1988; Lisak, 1993). In addition, there were other family factors that were not measured in this study that contributed to the findings. It is also possible that

compensation-seeking and secondary gain associated with military trauma factored in to the self-report response format. Compensation and pension review in the veterans affairs system evaluate the extent to which other factors may influence current functioning. Disclosure of premilitary influences could impact current income through a lower rating.

In the current study, there was a trend in the data for increasingly less acknowledgement of explicit types of abuse. Of the 417 sample participants, 91 endorsed a history of abuse. Further inspection of the frequency data in this area showed a pattern of willingness to broadly endorse abuse but less willingness to endorse specific abuse. Fifteen percent of respondents endorsed physical abuse, fourteen percent endorsed verbal abuse, four percent of the respondents endorsed neglect/abandonment and three percent explicitly endorsed a history of sexual abuse. The Family of Origin questionnaire asked a single, three-part question on abuse. In the first part of the question, respondents were asked “While you were growing up, were you abused (physically, verbally, sexually, neglected) by parents, caretakers, and/or other family members?” The next part of this question asked respondents about the nature of the abuse, with directions to check as many as apply regarding physical abuse, verbal abuse, sexual, abuse, or neglect/abandonment. The third part of this question surveyed the frequency of the abuse (long term, occasional, one time). These data should be cautiously interpreted however, due to the small number of participants in the total sample who acknowledged any level of childhood abuse (22%). This area appears to be an avenue for further investigation with more attention given to the family history measurement parameters. A more

sensitive measure might have been able to detect differences within the sample that were not demonstrated given the dichotomous format of the current instrumentation.

Implications for Research

Theoretical research

Shame theory has largely emerged out of psychoanalytic and psychodynamic perspectives and has not developed sufficient means to empirically test the constructs related to sense of self and interpersonal aspects associated with shame-based functioning. Continued research is needed to test and refine shame theory. This study has initiated empirical validation of shame theory by demonstrating links between shame, self-handicapping, depression, hope, PTSD, quality of life, trait anxiety, and vulnerability. Further research should operationalize and examine integrated constructs such as shame-based identities and shame-bound family dynamics as well as the reciprocal impact of shame on symptom distress associated with PTSD.

Treatment research

Continuing longitudinal investigation is warranted to address treatment integrity issues and promote more effective maintenance of gains produced in the therapeutic community treatment model. Thus, the continued expansion of the “completers” subsample may provide additional information regarding how treatment adherence is related to symptom distress, sense of self, and post-trauma adjustment.

Assessing the impact on symptom distress through effectively increasing resilience capacities is an emerging focus of clinical PTSD research initiatives (e.g., Fontana & Rosenheck, 1997, 1994; King et al., 1999, 1998). In addition, consolidating the

trauma resolution gains achieved while in the inpatient program affords important reframing opportunities. Such reframing provides a means to regain a sense of control and purpose and decrease the helplessness and powerless that may have been part of war zone experiences. Continuity of care issues have become an important focus in health care delivery models and chronic PTSD. Research that can substantiate “best practices” will offer both consumers and helping professional ways to match client needs with effective practice. Continued research is needed which more fully explores the associations between PTSD, shame, and resilience characteristics as they relate to treatment. Differential treatment practices may be necessary given the tentative findings of shame level differences in symptom distress patterns. While there was partial support for changes in shame over time, the findings merit additional investigation to more fully examine how shame, time, and symptom distress can be understood.

This may also mean that the first three time periods (baseline, two months post-baseline and six months post-baseline) would be important inspection points to establish what relationships exist between shame, shame-levels, self-handicapping, and sense of self. Such findings would also contribute to an increased understanding of differential treatment effects and symptom distress expression. One can argue that if shame is treatment resistant, then self-handicapping would be unchanged across time. If treatment decreases shame then what was the impact on self-handicapping? It is also possible that these potential relationships over time were not linear and that other studies with different designs and analyses will provide increased understanding for how multidimensionality and biopsychosocial processes are expressed in PTSD and shame.

Research is still needed on family and other pre-PTSD factors. Post-war factors on hardiness and social support are needed to clarify the problematic interpersonal dynamics that are consistently reported by survivors and families. Finally, our combat veterans are aging and there are little empirical data to understand how developmental issues are affected by traumatic experience and chronic stress.

Implications for Practice

Assessing shame levels may offer differential treatment approaches given the noted symptom distress patterns that have emerged in these findings. Shame theory (Lewis, 1971, 1987c) posited three patterns of shame in symptom distress including acknowledged shame, unacknowledged shame, and by-passed shame. Acknowledged shame is overt and consciously experienced shame. Acknowledged shame is characterized by a lowering of the head, averted gaze, blushing, an acute sense of confusion and painful self-consciousness. Unacknowledged shame exists when the overt signs of shame are clearly present but the person does not consciously recognize or acknowledge shame affect. By-passed shame is characterized by a person experiencing a shaming event without reference to shame per se but directly deals with the shame experience by obsessive thoughts and preoccupation about the role of the "self." The lack of a measure of defensive functioning limits how the current findings can be fully understood, but low levels of shame appeared to be associated with significantly lower trait anxiety. Defensive operations like denial could explain, in part, how both unacknowledged and by-passed shame were present in the low level shame group and

these defenses were not utilized in the same way or to the same extent in moderate and high level shame groups.

Targeting shame as an avenue for treatment could provide relief for nonspecific distress as well as allowing depression scores to be interpreted in a broader context such as shame-bound identity and sense of self concerns. Given that shame has conscious, unconscious, and by-passed ways of presenting in treatment, clinicians would benefit by having a multi-modal approach to evaluation and treatment. Since shame is characterized as a disorder of the self, with an adjunct interpersonal component, thoughtful attention should be given to the therapeutic alliance. Part of the therapeutic process involves painful disclosure to promote healing. With shame-based constellations, be that, individuals, couples, or families, it would be important to moderate the pace that is set in therapy with sufficient attention given the threshold of stress tolerance and defenses exhibited during therapy. Structured, cognitive-behavioral techniques can be used to supplement self-awareness and interpersonal work in therapy. Assessing social support, constructing a genogram with specific inquiries about trauma and shame will help the therapist to more fully understand the context that a client brings to therapy. Over time, group work and family therapy would be beneficial for both PTSD and shame.

Resilience characteristics such as those indicated by hope scores and overall quality of life scores offer an additional interface for treatment. Specifically addressing ways in which to increase a sense of personal agency, coupled with effective planning and problem solving, can contribute to information processing capacities and would

allow for new perspectives about “self” and “other” to be incorporated into the client’s world.

With regard to the current study, the inpatient treatment model was explicitly developed to integrate self- disclosure and interpersonal capacities and increase a sense of connection with others. Veterans may benefit from incorporating more psychoeducational materials directly related to shame and shame-based identities. Identifying shame as an emotion and developing coping strategies for use when shameful feelings arise would allow veterans more direct access to emotions and could decrease the use of numbing and avoidance. The ability to forgive oneself and others is part of the substantial challenge that faces combat veterans. Helping veterans with shame may become part of the forgiveness process. War changes people and those memories of war are veterans’ companions throughout their lives. Therapists must have skills that include connection, compassion, and containment. Understanding the context variables related to shame and PTSD is of paramount important in effective practice with chronic PTSD veterans.

Limitations of the Current Investigation

Sampling Limitations

The current sample was limited by representativeness concerns that reduce the extent to which these findings may be applied. Including women and increasing the number of participants in age categories outside the 40-59 year old range would provide important dimensions to the existing data. As the number of ethnic participants increased, more meaningful comparisons could be made between veterans of color and Caucasian veterans.

The conclusions of this study must be cautiously interpreted as the entire sample was help-seeking and also potentially compensation-seeking. It is uncertain how representative help-seeking and/or compensation seeking combat veterans are as compared to combat veterans who have not sought help or compensation for combat PTSD. However, the longitudinal component of the study extends the capacity of the study to examine differences in this help-seeking sample over time. The extent to which these findings would be applicable to veterans who have not sought help are unclear, so that caution in generalizing these findings appears warranted. Findings in regard to shame level must be viewed as tentative. The small sample size provided initial findings but further testing of shame levels is indicated.

Instrument Limitations

In interpreting the results of this study, caution should be taken due to the self-report nature of the instruments. Self-report measures and retrospective reporting are subject to recall and reporting biases.

In an archival study, instrumentation limitations are fixed. The data set is as it is. This study was particularly interested in examining symptom distress, shame, PTSD, and sense of self. The lack of a direct assessment of self-esteem was a clear instrument limitation. However, protection of research participants by institutional review board policies necessitated choices regarding how much and what kind of data was collected. Therefore, some instruments in the original proposal including the Rosenberg Self-Esteem Inventory, were dropped from the study. Thus, the inferential observations on self-handicapping and vulnerability as indices of sense of self are open to criticism, but

afforded a reasonable approach for the construct of “sense of self” to be evaluated. The strengths, potential weaknesses, and psychometric properties of each instrument have already been noted in the method section and will not be reviewed here.

The obtained findings may have been limited by the lack of sensitivity of the dichotomous format of the family history questionnaire. Incorporating a standardized family history measure may have allowed for detection of group differences that were not detected by the yes/no format of the current family of origin questionnaire.

Design Limitations

This study had both longitudinal and cross-sectional dimensions that provided important contrasts for the current investigation. However, only a small subset of the total sample provided longitudinal data. It unclear how to understand the differences among the participants who “dropped out” and those who “completed.” It is also important to note that this is a continuing investigation, initiated in March of 1996. While a relatively large number of respondents have contributed cross-sectional data, the number of respondents who have reached twelve months post-baseline is substantially less ($N = 47$) than the cross-sectional data ($N = 417$).

Another limitation of the study was the partially complete sets of measures. The determination of which instruments were completed and those which were not completed was multi-determined. The overall effect of missing data limits the findings and impacts the power of the study to detect differences that may be present.

A comparison “no treatment” control group was not used in the design of the current investigation. Potential differences between inpatient and outpatient treatment

context could not be fully evaluated, given that an outpatient treatment group was not utilized. Thus, between group differences in help-seeking and symptom distress could not be evaluated, either between treatment efficacy or in mode of treatment for PTSD. The issues of who drops out of treatment, at what point in treatment this occurs, and the implications these factors have for differences that emerge or fail to be detected were a limitation. Taken together, these sampling, instrument, and design limitations impose constraints on the generalizability of the findings. Consideration of both the cautions and findings are the context against which reasonable interpretations of the data are made.

Conclusions

This study contributed substantive new information regarding the relationships between shame, symptom distress and psychological trauma. The repeated measures analyses of both the “completers” subsample and the total sample examined by shame level provided alternative ways to examine symptom distress, sense of self, and shame. Significant changes in shame were noted as a result of treatment. The amenability of shame to treatment was an important finding of the study. Few other empirical investigations of shame have been done, so that the initial findings of the current study add to the existing albeit small knowledge base on shame and PTSD. The multiple perspectives on shame obtained in this study revealed shame as an important dimension of psychological distress associated with PTSD. The level of shame analysis pointed to a need for both research and practice initiatives to consider direct assessment of shame and to utilize shame as a potential outcome measure for psychotherapeutic intervention and change.

Shame-based identity in help-seeking veterans may not be a durable identity construct but may be more effectively viewed as a symptom distress indicator. However, veterans who entered treatment with high levels of shame also reported higher levels of symptom distress, which reiterates how painful shame experiences were.

Another trend in the data addressed the potential of shame to change as a result of treatment and differential treatment effects by shame level. This trend was observed only in the group of veterans who entered treatment with low shame levels. Over time, shame scores increased, suggesting that treatment was effective in integrating emotional experiences that had been previously avoided. However, this pattern was based on a small sample of participants ($N = 19$). Replication studies of entry shame level and treatment effects would clarify the findings observed in the current investigation.

Taken together, the findings that emerged on shame from this investigation highlighted the importance of shame as a clinical phenomenon. The need for assessment of shame and for interventions developed to specifically address shame-based views of self appear to be of value for future work both in service delivery functions as well as in ongoing empirical investigation. Post-trauma adjustment challenges indicate a multi-dimensional approach to treatment that builds current coping resources, provides avenues for interpreting and resolving traumatic experiences, and builds interpersonal capacities to strengthen individuals' and families' coping resources.

The entrenched isolation endemic to those with chronic PTSD combined with feelings of shame were also apparent in the vulnerability scores of help-seeking veterans. Shame was most highly correlated with vulnerability. The interpersonal component of

mistrust highlighted by vulnerability was strongly associated with avoidance of interpersonal situations as measured by the ISS (shame scores). Shame theory (Kaufman, 1989) has argued that one behavioral manifestation of shame is the disconnection from others. The exploratory findings from the regression analysis also provided insight into these two distress measures. Exploratory analysis on variables predictive of shame included vulnerability, depression, hope, self-handicapping, and quality of life. Predictors of shame captured the self-deficits, interpersonal perspectives, and the lack of resilience reflected in lower hope and quality of life.

This study affirmed the need for ongoing clinical and research initiatives for PTSD and shame-based identity. Psychological trauma requires lifelong adjustment. Treatment models need to reflect effective science and sensitive practice. Studying both cross-sectional and longitudinal perspectives informs the discussion from distinct vantage points.

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Demographic Questionnaire

1. Date of Birth (use numbers) : Month_____ Day_____ Year_____

2. Patient status: Inpatient_____ Outpatient_____

3. Sex: Male_____ Female_____

4. Education (check the highest) :

_____ none	_____ No college degree
_____ GED	_____ Associate's degree
_____ High School diploma	_____ Bachelor's degree
_____ Trade school	_____ Master's degree
_____ Business college	_____ Doctor's degree

5. Current employment status (check one) :

_____ Work full-time	_____ Unable to work due to disability
_____ Work part-time	_____ Unemployed (for how long?) _____ months
_____ In on-the-job training	_____ Other (specify) _____
_____ Student	

6. Current marital status (check one) :

_____ Single
 _____ Married
 _____ Separated
 _____ Divorced
 _____ Widowed

7. How many children have you personally had? _____

8. Which best identifies your race (check one) :

_____ Caucasian	_____ Native American
_____ Black	_____ Asian
_____ Mexican-American	_____ Other (specify) _____

9. Educational level: (check the highest one that applies to you, to your father, and to your mother:

	Yours	Father's	Mother's
a. No formal education	_____	_____	_____
b. Attended vocational or other training school	_____	_____	_____
c. Less than 8 th grade	_____	_____	_____
d. 8 th grade	_____	_____	_____
e. some high school	_____	_____	_____
f. completed high school or high school equivalent	_____	_____	_____
g. some college	_____	_____	_____

- h. graduated from college _____
- i. graduated from _____
graduate school _____

10. How much money do you and your family make a year

(check the one that applies to you and to your family):

- | | Your Own
Income | Total Family Income |
|----------------------------------|--------------------|---------------------|
| a. None | _____ | _____ |
| b. Less than \$8,999 per year | _____ | _____ |
| c. \$9,000 to \$13,999 per year | _____ | _____ |
| d. \$14,000 to \$19,999 per year | _____ | _____ |
| e. \$20,000 to \$24,999 per year | _____ | _____ |
| f. more than \$25,000 per year | _____ | _____ |

11. Your parent's income level before you left home (check one for each parent if it applies):

- | | Father's | Mother's |
|----------------------------------|----------|----------|
| a. None | _____ | _____ |
| b. Less than \$5,000 per year | _____ | _____ |
| c. \$5,000 to \$6,999 per year | _____ | _____ |
| d. \$7,000 to \$9,999 per year | _____ | _____ |
| e. \$10,000 to \$14,999 per year | _____ | _____ |
| f. more than \$15,000 per year | _____ | _____ |

12. How well do you get along with your wife/girlfriend or husband/boyfriend (check one) :

- _____ Very well; we rarely argue or disagree
- _____ Fairly well; we disagree occasionally but like spending time with each other
- _____ Okay; some days are better than others
- _____ Very poorly; we continually argue and disagree—rarely any peace at home
- _____ No wife/girlfriend or husband/boyfriend at this time

13. Over the past few months, how satisfied have you been with your sex life (check one):

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither satisfied nor unsatisfied
- ☐ Very unsatisfied
- ☐ Not important to me

14. Where do you live now?

- | | |
|---|---|
| <input type="checkbox"/> No regular place | <input type="checkbox"/> Relative's home |
| <input type="checkbox"/> Boarding house | <input type="checkbox"/> In a house or mobile home I own |
| <input type="checkbox"/> Hotel | <input type="checkbox"/> In a house or mobile home I rent |
| <input type="checkbox"/> Apartment | <input type="checkbox"/> Institution (specify) _____ |
| <input type="checkbox"/> Friend's house | <input type="checkbox"/> Other (specify) _____ |

15. Check the item best describing the number of people in your hometown (check one):

- ☐ City of one million or more (where?) _____
- ☐ City of 100,000 - 99,999 (where?) _____
- ☐ City of 10,000 - 99,999 (where?) _____
- ☐ Under 10,000 (where?) _____
- ☐ Farm or ranch (near what city?) _____

16. Where do you live now (check one):

- ☐ City of one million or more (where?) _____
- ☐ City of 100,000 - 99,999 (where?) _____
- ☐ City of 10,000 - 99,999 (where?) _____
- ☐ Under 10,000 (where?) _____
- ☐ Farm or ranch (near what city?) _____

Appendix B

Family of Origin Questionnaire

FAMILY OF ORIGIN QUESTIONNAIRE

1. Family History (check each item 'YES' or 'NO':

YES NO

- a. Was one parent missing from your home before you were 18? ____ (1) ____ (2)
- b. Were both of your parents missing from your home before you were 18? ____ (1) ____ (2)
- c. Did your parents separate or divorce or did one or both of your parents die before you were 18? ____ (1) ____ (2)
- d. Did you live in a foster home, residential treatment center or orphanage at any time before you were 18? ____ (1) ____ (2)
- e. Did your family move more than twice while you were in high school? ____ (1) ____ (2)
- f. Were there seven or more children in your home? ____ (1) ____ (2)
- g. Was your father out of work more than a quarter of the time when you were growing up? ____ (1) ____ (2)
- h. Was your family income less than \$5,000 when you were growing up? ____ (1) ____ (2)
- i. Did you have less than a high school education before you entered the military? ____ (1) ____ (2)
- j. When you were growing up, did you have any friends who got in trouble with the law or school officials? ____ (1) ____ (2)
- k. Did you yourself get into trouble with the law or school officials? ____ (1) ____ (2)
- l. Did you play hockey frequently while attending high school? ____ (1) ____ (2)

2. As a child, did you attend and participate in church activities on a regular basis?
 ____ (1) YES ____ (2) NO

3. As a child, was going to church meaningful to you?
 ____ (1) YES ____ (2) NO

4. Today, do you attend and participate in church activities on a regular basis?
 ____ (1) YES ____ (2) NO

5. Is going to church now meaningful to you personally?
 ____ (1) YES ____ (2) NO

6. Denominational Membership: (check one in each column):

	While Growing Up	Now
Catholic	____ (1)	____ (2)
Jewish	____ (1)	____ (2)
Protestant (specify) _____	____ (1)	____ (2)
Other (specify) _____	____ (1)	____ (2)

7. Did either of your parents have any of these problems? (check Yes or No for each):

	FATHER		MOTHER	
	Yes	No	Yes	No
Alcohol	____ (1)	____ (2)	____ (1)	____ (2)
Drug	____ (1)	____ (2)	____ (1)	____ (2)
Legal	____ (1)	____ (2)	____ (1)	____ (2)
Financial	____ (1)	____ (2)	____ (1)	____ (2)
Medical Illness	____ (1)	____ (2)	____ (1)	____ (2)
Emotional Illness	____ (1)	____ (2)	____ (1)	____ (2)
Other (specify) _____	____ (1)	____ (2)	____ (1)	____ (2)

8. Rate how well you got and now get along with your parents (check for your father and mother while growing up and now):

	FATHER		MOTHER	
	While growing up	Now	While growing up	Now
Excellent	____ (1)	____ (2)	____ (1)	____ (2)
Very good	____ (1)	____ (2)	____ (1)	____ (2)
Fair to good	____ (1)	____ (2)	____ (1)	____ (2)
Very poor	____ (1)	____ (2)	____ (1)	____ (2)
Horrible	____ (1)	____ (2)	____ (1)	____ (2)

9. How would you describe your growing up years? (check one)

- | | |
|--|-----------------------|
| ____ (1) Unhappy | ____ (4) Fairly happy |
| ____ (2) Somewhat happy | ____ (5) Happy |
| ____ (3) Sometimes happy, sometime unhappy | |

10. Parents' occupational group while you were growing up:
(check one for your mother and one for your father):

	Your <u>Father's</u>	Your <u>Mother's</u>
a. Laborer	_____ (1)	_____ (1)
b. Blue collar worker	_____ (2)	_____ (2)
c. Tradesperson	_____ (3)	_____ (3)
d. White collar worker	_____ (4)	_____ (4)
e. Professional	_____ (5)	_____ (5)
f. Unemployed	_____ (6)	_____ (6)
g. Homemaker	_____ (7)	_____ (7)
h. No job—deceased	_____ (8)	_____ (8)

11. Current general occupational group:
(check one for your mother and one for your father)

	Your <u>Father's</u>	Your <u>Mother's</u>
a. Laborer	_____ (1)	_____ (1)
b. Blue collar worker	_____ (2)	_____ (2)
c. Tradesperson	_____ (3)	_____ (3)
d. White collar worker	_____ (4)	_____ (4)
e. Professional	_____ (5)	_____ (5)
f. Unemployed	_____ (6)	_____ (6)
g. Homemaker	_____ (7)	_____ (7)
h. No job--retired	_____ (8)	_____ (8)
i. No job—deceased	_____ (9)	_____ (9)

12. With whom did you live the longest time while growing up? (check only one)

- ☐ (1) Lived with natural parents
- ☐ (2) Lived with adopted parents
- ☐ (3) Mother alone
- ☐ (4) Father alone
- ☐ (5) Mother and stepfather
- ☐ (6) Father and stepmother
- ☐ (7) Foster parents
- ☐ (8) Relatives
- ☐ (9) Institution (example: orphanage)
- ☐ (10) Other (specify) _____

13. While growing up, were you abused (physically, verbally, sexually, neglected) by your parents, caretakers, and/or other family members?

a. ☐ (1) Yes ☐ (2) No

b. Nature of abuse (check as many as applies):

- ☐ physical
- ☐ verbal
- ☐ sexual
- ☐ neglect/abandonment

c. Frequency of abuse:

- ☐ long term
- ☐ occasional
- ☐ one time

Appendix C

Internalized Shame Scale

The Internalized Shame Scale is a copyrighted instrument that can be obtained by contacting David R. Cook, Ph.D., University of Wisconsin—Stout, 237 Harvey Hall, Menomonie, WI 54751.

Appendix D

Self-Handicapping Scale

The Self-Handicapping Scale is a copyrighted instrument that can be obtained by contacting E. E. Jones, Department of Psychology, Princeton University, Princeton, NJ 08540 or Frank Rhodewalt, Department of Psychology, University of Utah, Salt Lake City, UT 84112.

Appendix E

Quality of Life Inventory

The Quality of Life Inventory is a copyrighted instrument that can be obtained by contacting National Computer Systems, P. O. Box 1416, Minneapolis, MN 55440 or by telephone at 1-800-627-7271.

Appendix F

Penn Inventory for Posttraumatic Stress Disorder

The Penn Inventory for Posttraumatic Stress Disorder is a copyrighted instrument that can be obtained by contacting © 1990 Melvyn Hammarberg, Ph.D., University of Pennsylvania, Department of American Civilization, Suite 400, 3440 Market Street, Philadelphia, PA 19104-3325.

Appendix G

Beck Depression Inventory

The Beck Depression Inventory is a copyrighted instrument that can be obtained by contacting The Psychological Corporation, 555 Academic Court, San Antonio, TX 78204 or by telephone at 1-800-211-8378. Online information about this instrument is available at <http://www.hbtpc.com>.

Appendix H

State-Trait Personality Inventory

The State-Trait Personality Inventory is a copyrighted instrument that can be obtained by contacting C. D. Spielberger, Department of Psychology, BEH 339, 4202 E. Fowler Ave, University of South Florida, Tampa FL 33620. Telephone 813-974-2492 or Fax 813-974-4617. Email address: spielber@chuma1.cas.usf.edu.

Appendix I

Future Hope Scale

The Future Hope Scale is a copyrighted instrument that can be obtained by contacting C. R. Snyder, Doctoral and Postdoctoral Training Programs in Clinical Psychology, Department of Psychology, 305 Fraser Hall, University of Kansas, Lawrence, KS 66045.

Appendix J

Glover Vulnerability Scale

The Glover Vulnerability Scale is a copyrighted instrument that can be obtained by contacting © 1990 Hillel Glover, M. D., 500 East 77th Street, No. 439, New York, NY 10021.

Appendix K

Consent Form

CONSENT FORM

- 1. The purpose of this study is to help us understand what things work best in the treatment program you are about to enter. It will take you about an hour to fill out the questions we will ask.
- 2. In this package of information, you will find twelve questionnaires to fill out. We will ask you to fill out the same questions in two months, and then in four months after that.
- 3. Answering these questions should not cause you any discomfort or inconvenience other than the time you spend doing so.
- 4. There are no expected risks of the study.
- 5. The expected benefits of the study are a better understanding of how the PTSD program helps people feel better.
- 6. You may choose not to fill out the questions and receive the same treatment as someone who does fill out the questions.
- 7. The results of this study will be used to make the treatment of PTSD better for the veterans who need it. They will in no way be available to the VA for determination of pensions or compensation. The only information that can be used will be information that relates to a group of veterans and never one person's information. The information will be identified only by number, not by name. Only Dr. Bowman from Washburn University (no VA appointment) will be involved in the analysis of the information.
- 8. You may decide not to take part in this study at any time and there will be no penalty for you.

Subject	Date	Witness	Date
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