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Traumatic Stress: The Role of the Family and Social Support System

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John and Mary Allen said very little during the 20-minute ride from their home to the Community Hospital. Minutes ago they were telephoned by the City Police Department and informed that their 23-year-old daughter, Paula, had survived a head-on collision with another car that suddenly veered into their lane. Paula's husband, Carl, who was driving her to the airport, was killed, along with the driver of the other car. John and Mary went directly to the reception desk to ask about Paula's condition. Mary was usually the calmer of the two but found herself screaming at the receptionist, who first wanted to know about insurance coverage and home addresses. The initial minutes in the emergency waiting room seemed like hours to John and Mary. Soon, though, they were joined by their other two daughters and several friends and relatives, as the emergency medical team worked to save Paula's life. The friends and family had been together just a week ago to help John and Mary celebrate their silver wedding anniversary. Everyone was so happy then. They waited three hours before receiving word that Paula would survive and, with luck, would recover fully over the next several months. As they waited, there were several more emergency arrivals: an assault victim, a welder injured in an industrial accident, and another auto accident survivor were among the worst of them. Each was joined later by a worried family and friends. The Allens were not alone that night.

Over a month later Paula was released from the hospital to complete her convalescence at her parent's home. The family worried not only about Paula's physical condition, but about her emotional condition as well. During subsequent recovery Paula experienced a collection of symptoms later diagnosed as post-traumatic stress disorder (APA, 1980), a common reaction for victims of catastrophic events. Paula's symptoms included painful recollections of the accident and her initial experiences in the hospital, sleep disturbances, moodiness, emotional withdrawal, jumpiness, crying spells, varying amounts of depression, and guilt associated with surviving Carl. During this recuperative period, Paula's family would be a key factor in her recovery from emotional wounds of her accident. However, they too became affected by the emotional wake of the catastrophic accident. (adapted from Figley, 1983, pp. 3–4)

Today we know more than ever before about the emotional cost to the Allens of this tragic accident as well as the role they play in Paula's recovery. There is little doubt that the family, plus the social support system in general, is the single most important resource to emotional recovery from catastrophe (McCubbin & Figley, 1983; Figley & McCubbin, 1983a). One chapter (Figley, 1983) focuses exclusively on how families, like the Allens, cope with catastrophe. The central thesis of these volumes is that the family is a critical support system to human beings *before*, *during*, and *after* stressful times and that the *system* and its *members* are also affected, sometimes even more than the victim. In this chapter, I would like to capsulize four years of work by answering five questions:

1. What qualifies as a catastrophe, an event that may result in traumatic or post-traumatic stress reactions?
2. What is the meaning of social support provided by the family?
3. How is this support important in both preventing and abating traumatic and post-traumatic stress impairments?
4. Are the family members of survivors of catastrophe susceptible to being traumatized themselves?
5. What should be done for the families of catastrophe?

CATASTROPHIC LIFE EXPERIENCES

As will be discussed throughout this volume, the third revision of the American Psychiatric Association's (1980) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) describes the disorder affecting Paula and others like her: post-traumatic stress disorder (PTSD). The diagnostic

criteria for PTSD include three groups of symptoms: (1) evidence of "reexperiencing the trauma," (2) "numbing of responsiveness to or reduced involvement with the external world" following the traumatic event, and (3) a variety of stress reactions. The most unique facet of the disorder, however, is that the client must have survived a "recognizable stressor (event) that would evoke significant symptoms of distress in almost everyone [p. 238], and outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict [p. 236]." And except for giving examples of such events (e.g., rape, assault, combat, natural disasters, man-made disasters, accidents, and human brutalities) and speculating that those of "human design" may be more traumatic, the manual does not specify what and why certain events induce stress. Thus we consider the first question, *What qualifies as a catastrophe, an event that may result in traumatic or post-traumatic stress reactions?*

Based on reports on victims of a wide variety of catastrophes (Figley, 1975, 1978, 1983, 1985), the characteristics that make these events so troubling is the extent to which they are (1) sudden, (2) dangerous, and (3) overwhelming.

Sudden

Catastrophes are troubling because they happen so suddenly, with very little or no warning to the victims. There is limited or no time to prepare, to devise and rehearse a plan of escape, identify a method of coping, or prevent or avoid the catastrophe. Whereas with normal life changes, there is typically a process of "anticipatory socialization" (Burr, 1973), which enables us to psychologically prepare for new attitudes, values, and behaviors required in a new role, no such process occurs prior to a catastrophe. Behavioral psychologists have noted that fear and general anxiety arousal is decreased as an organism develops repetitious patterns of behavior (Mineka, 1979; Wolpe, 1973); in other words, we become accustomed to various noxious stimuli as we develop a hierarchy of appropriate responses to them. Thus, we are temporarily immobilized when confronted with something which is unexpected and with which we have had little, if any, previous experience. This immobility is especially noxious if associated with the second factor: dangerousness.

Dangerous

Perhaps the most significant element of a catastrophic event which evokes trauma is a perceived sense of danger (Figley, 1979): either for

ourselves, or for someone we care about very deeply. Indeed, we may be perfectly safe ourselves, yet still be traumatized when a loved one is in danger. Fear—of death, annihilation, injury, or destruction—is an energizing element of life which has the potential of leaving a clear imprint on the memory of all who experience it, as others have noted (cf. Weisman & Hackett, 1961; Lifton, 1973).

Overwhelming

An event that is sudden and dangerous is usually also emotionally overwhelming. The sense of being "overwhelmed" is often referred to as "sensory overload," "overstimulation," or "role strain," by psychologists and sociologists (Janis, 1969) when referring to relatively mild sources of social stress. These concepts suggest that the individual's attention to the demands of the environment (be it work, family, or some other setting) is so continuously aroused that he or she becomes ineffective in dealing with all of the demands. American scholars since the Civil War have noted that prolonged exposure to highly demanding environments—such as war (Smith, 1981), the Holocaust (Neiderland, 1968), rape (Burgess & Holmstrom, 1979), weather-related (Smith, 1983) and man-made disasters (Gleser, Green, & Winget, 1981)—induces a sense of exhaustion during, but more often immediately following, the exposure. Similar to the parameters of suddenness and dangerousness, being overwhelmed leads to a sense of temporary helplessness, of being out of control (Figley, 1979); which may, in turn, stimulate the survivor to behave in a way (e.g., panic) that is inconsistent with his or her self-concept—something that one may prefer to have relegated to the realm of the forgotten.

MEANING AND FUNCTION OF SOCIAL SUPPORT

Following a catastrophic event the family has a central role to play as a social support system for the victim. Before discussing this role let us first discuss the meaning and nature of social support in general.

Definition

There has been an upsurge in attention recently to the concept of social support. Recently, for example, the *Journal of Social Issues* devoted two entire issues to this topic (see Volume 40:4 and Volume 41:1). Of

course, a full discussion of this literature is beyond the scope of this paper. What is important here is a clear delineation of exactly what is social support and the extent to which it is important to the emotional well-being of victims, veterans—survivors—of catastrophe. As a result of this attention, a wide variety of conceptualizations and definitions have emerged, as well as a concomitant increase in confusion about the role of social support in mental health (Thoits, 1982).

For our purposes, social support, provided by both family and close friends, is defined as ". . . the degree to which an individual perceives that he or she may rely on one or more people for assistance with either tangible . . . or emotional . . . aid or both in times of need" (Figley & Burge, 1983, p. 2). Thus we conceptualize social support, as we do with stress and trauma, from the point of view of the person being supported. We, of course, assume that there is little discrepancy between the support a subject claims to have and what he or she either has access to or actually utilizes.

Function

In a recently concluded study at Purdue (Burge, 1982; Burge & Figley, 1982; Figley & Burge, 1983), we isolated five major functions of social support that would be important to anyone in times of need, especially persons with PTSD symptoms. These functions form the basis of a new and powerful research and diagnostic tool titled the *Purdue Social Support Scale* (see p. 44). The functions are: emotional support, encouragement, advice, companionship, and tangible aid, confirming the research findings of others. These functions were noted earlier by Hirsch (1980).

Emotional support is the care, comfort, love, affection, and sympathy shown to the victim. It is the extent to which we are convinced that the supporter is on our side.

Encouragement is the praise and compliments offered by a supporter. It is the extent to which we are inspired by the supporter to feel courage and hope, to prevail.

Advice is useful information for solving a problem. It is the extent to which we feel better informed by interacting with the supporter.

Companionship is simply the time spent with a supporter, doing things that are perceived to be mutually enjoyable. It is the extent to which we don't feel alone.

Tangible aid is a practical resource provided by the supporter, such as helping with various chores, providing transportation, lending money, shopping, or some other form of concrete assistance. It is the extent to which we feel relieved of a burdensome task.

Purdue Social Support Scale

I am interested in knowing where people go when they need social support. Please answer the following questions as well as you can. Answer all questions in each section before moving on.

Your participation in this project is, of course, voluntary. All answers will be held in strict confidence.

PART I: Do not feel that you must fill all of the blanks below, but use as many as you want.

1. In times of need, people generally turn to others for help. In the spaces below, please list those people (first names only) who you would turn to.

2. Next to each name, please indicate each person's relation to you—for example, is he/she a friend, neighbor, spouse, parent, uncle, pastor, physician?

Below are six columns representing different ways in which people may be helpful. They are:

(a) EMOTIONAL SUPPORT ..... referring to care, comfort, love, affection, sympathy, being on your side.
(b) ENCOURAGEMENT ..... referring to being encouraging, praising, or complimenting you, making you feel important.
(c) ADVICE ..... referring to advice as well as providing useful information and help with solving problems.
(d) COMPANIONSHIP ..... referring to spending time together, doing things together, visiting each other.
(e) TANGIBLE AID ..... referring to help with chores or projects, babysitting, transportation, and/or lending money when needed.
(f) OVERALL HELPFULNESS ..... referring to being generally helpful when needed.

3. Now, I am interested in knowing how satisfied you would expect to be with the support that these people may provide. In the boxes below, consider each person in the previous list according to the six characteristics defined above and rate your EXPECTED SATISFACTION with each person's help.

Use this scale to rate your satisfaction:

"4" means Very Satisfied
"3" means Satisfied
"2" means Dissatisfied
"1" means Very Dissatisfied
"0" means Wouldn't Seek This

Please fill all six boxes for each person listed.

PERSON(S) (RELATIONSHIP)	EMOTIONAL	ENCOURAGEMENT	ADVICE	COMPANIONSHIP	TANGIBLE AID	OVERALL HELPFULNESS

These functions are relevant to survivors of catastrophe because overall social support is clearly linked to the emotional well-being of people in general and to the speed and completeness of recovery of victims in particular (Drabeck, Key, Erickson, & Crowe, 1975). Social support is the essence of family support.

FUNCTION OF THE FAMILY IN PTSD DEVELOPMENT AND ABATEMENT

"How is this support important in both preventing and abating traumatic and post-traumatic stress disorders?" I have suggested elsewhere that the family in particular and the entire social support system in general serve as an antidote to PTSD in four separate ways: detecting symptoms, confronting the problem, recapitulating the traumatic events, and resolving the trauma-inducing conflicts associated with the events (Figley, 1983). Let us consider each briefly to illustrate the key role family members play in limiting the emotional upset of traumatic events. First, however, it is important to briefly explicate the typical pattern of recovery from catastrophes apart from the contribution of the family and social support system.

Numerous clinical theorists have speculated on the post-traumatic recovery process of survivors diagnosed as having PTSD (cf., Figley, 1979; Horowitz, 1976; Green, Wilson, & Lindy, 1985). These speculations and the discrete criteria for PTSD specified in DSM-III (APA, 1980) have supported my assertion (Figley, 1980a, 1983) that survivors of catastrophe are struggling to master the impressions and memories of the catastrophe in toto and the traumatic induction. The traumatic induction is the imprinting of impressions of sensations and affect associated with feeling out of control, helpless, caught off guard. Thus, soon after surviving the catastrophe, after experiencing a period of safety (Horowitz, 1976), the survivor attempts to answer five fundamental questions. The answers to these questions, I believe, serve as the antidote to PTSD:

1. What happened to me?
2. How did it happen?
3. Why me?
4. Why did I act as I did?
5. What will I do in another catastrophe?

Recently Figley (1983) has attempted to apply this cognitive struggle to

victims of eight different catastrophes and the ways in which the victims and their families have attempted to master or cope with the various stressors (the catastrophes reviewed include chronic childhood diseases, teen drug abuse, death, unemployment, rape, natural disaster, war, and captivity by terrorists).

Detection of the Symptoms

The concept of family is derived from the Latin term *familia*, which means household, including everyone who lives there (slaves, housekeeper, friends, mother-in-law, etc.). Anyone bound by a household—be they biologically or legally tied—becomes well aware of everyone else living in that household simply by being in close proximity. Add to this familiarity the similarities of disposition and temperament and what emerges in most families is a remarkably sensitive "feel" for the moods and traits of fellow family members. Thus, when one member is having a "bad day," we are able to detect it almost immediately and employ various tactics to help.

For family members who have endured an especially traumatic event (e.g., war), and who return to the family, there is an excellent chance that one or more family members will be able to detect emotional upset.

Confrontation of the Problem

In addition to *detecting* a problem, family members are in a key position to urge and help the victim to confront the problem. Clinicians spend untold clinical sessions attempting to establish rapport and trust, identify, and *confront* the problems of a client when the victim's own family is generally better prepared to do it and in less time. On a regular basis and in an endless variety of ways, family members urge each other to face and deal with a problem.

Recapitulation of the Catastrophe

A third way that families provide social support to victims which results in mitigating or abating their traumatic reactions is in assisting them to reconsider the traumatic events, a process known as recapitulation. Family members are able to help the victim recall additional information useful in viewing the events with greater clarity, correcting views that have been associated with feelings of guilt, self-hatred, disrespect, and other characteristic signs of PTSD.

Resolution of the Trauma-inducing Conflicts

Finally, the family can be extremely useful in helping the victim "work through" (Horowitz, 1976) his or her traumatic experiences and conflicts. Most important, a family member serves as a facilitator (e.g., passive or active, mutual self-disclosure or one-sided, confrontive or nonconfrontive) for the victim by encouraging him or her to talk about the troubling experiences while at the same time "cleaning up after" the victim by (a) clarifying insights, (b) correcting distortions, (c) placing blame and credit more objectively, and (d) offering or supporting new and more "generous" or accurate perspectives on the event that was originally traumatic. Thus, in this process the victim will find answers to the questions, noted earlier, of all catastrophe victims: "What happened to me?" "How did it happen?" "Why me?" "Why did I act as I did?" and "What will I do in another catastrophe?"

Summary of Functions of the Family

To summarize the natural family support system function in dealing with traumatic reactions, let us return to the Allen family to serve as an illustration. As Paula became more alert and able to recognize and converse with her family, they began to detect various signs and symptoms alerting them to the fact that she was extremely upset by the accident (apart from the grief of a widow and the physical injuries). Slowly and gently Mary began to urge Paula to talk about her experiences. Mary was convinced, based on numerous other traumatic experiences with which she had helped Paula throughout her childhood and adolescence, that Paula would "feel better" if she "talked about it."

Finally, after being released to her parents for additional recuperation, weeks after the accident, Paula revealed something to her mother that she herself had wanted to forget. She had forgotten about it except in brief episodes of recall, which she fought against more and more effectively as time went by. She recalled that she had consumed three glasses of wine the night of the accident and Carl would not let her drive. Instead, they left early so that she could have several cups of coffee at the airport before attempting to drive back. She became enraged with him for forcing her to ride along since she always drove at night, because of Carl's poor night vision. "Had I driven, we may have avoided the other driver altogether. Instead, Carl died only minutes after I screamed at him for forcing me to ride along like a drunk. I killed Carl!" It did not take clever semantic manipulation or therapeutic wizardry on the part

of Mrs. Allen to help her daughter adopt an alternate perspective on the event, which she did in a relatively brief period of time. There were other ruminations and resolutions throughout the recovery period, each one dealt with in turn.

Elsewhere Figley (1983) has discussed the functional methods families utilize in managing and coping with catastrophic stress in particular and family-related stress in general. The 11 characteristics identified (acceptance of the stressor, family-centered problem, solution-oriented problem, high tolerance, commitment/affection, communication, cohesion, flexible roles, resource utilization, avoidance of violence, and substance abuse) characterize an ideal family environment for employing the family functions noted above and illustrated by the interactions between Mrs. Allen and her daughter, Paula.

EMPATHY AS THE FAMILY'S ACHILLES' HEEL

For the same reasons the family is extremely effective in helping its traumatized member overcome their highly stressful experiences, the family itself is also susceptible to being traumatized in the process: The reason is love. What may be at the root of both love and effective "therapeutic" intervention is *empathy*, a critical attribute of interpersonal competence and social effectiveness (Guerney, 1978). Thus, just as Achilles was effective as a Greek warrior with his only vulnerability his heel, so family members are extremely effective in helping fellow family members work through their traumatic experiences, yet they are vulnerable to the consequences of their assistance by the very mechanism that makes them so effective: Their strength as well as their Achilles' heel is empathy.

This phenomenon is not unlike that of *couvade* (Taylor, 1965; Hunter & Macalpine, 1963), a custom among some isolated cultures in which the father of the expectant child mimics the pregnancy and labor of the mother. In some cases this simulation includes psychosomatic maladies that match the symptoms of their wives including swollen abdomens, complaints of diarrhea, and vomiting in the absence of medical causes (cf. Rabkin & Struening, 1976). Psychosomatic medicine has reported similar phenomena, such as entire families developing various maladies directly associated with some family-centered upheaval such as residential mobility (Mann, 1972) or divorce (Hetherington, Cox, & Cox, 1976).

In Paula's case, for example, the parents not only suffered from more

psychosomatic illnesses (e.g., headaches, skin rashes, colds, coughs) during the recovery period, they also had bouts of sleeplessness and nightmares about the fate of their son-in-law. They were often startled more easily while traveling in an automobile, seemed preoccupied and forgetful at times, and became far more protective of their children, much to the dismay of the children.

Thus, in considering our fourth question—is it possible that those who are most effective in *abating* this emotional stress in others are also more susceptible to being traumatized themselves in the process?—we find that the families of catastrophe are also *victims* of catastrophe—whether they experienced the catastrophe first hand or through a family member—and require the same considerations for treatment that the other victims receive.

INDICATIONS FOR ASSISTING THE FAMILIES OF CATASTROPHE

Our final question, then, is: "What should be done for the families of catastrophe?" This question has consumed a considerable amount of my attention in the last three years since expanding my interest from veterans exclusively to survivors of other traumatic events. This interest assumed new importance when Figley organized a national team of scholars to help the State Department develop a program of assistance for a small but significant group of families of catastrophe (the families of those Americans held hostage in Iran). What was recommended then in a 600-page report (Figley, 1980b; Figley & McCubbin, 1983b) gained considerable importance as that crisis unfolded and is now behind us, since nearly all of our recommendations were followed, including the reentry program and reunion.

Irrespective of the catastrophic event and its circumstances, there are several general principles of policy and practice that should be considered in assisting the families of catastrophe and thereby assisting the immediate victims.

Public Policy

Members of victim families should be viewed as also susceptible to the emotional trauma associated with a catastrophe while at the same time serving as a critical resource for assisting in the recovery. Thus, corporations, governmental entities (including the military), relief or-

ganizations, and the media should deal with them accordingly. This should include abandoning the outdated "next of kin" orthodoxy, which suggests that responsibility for the welfare of the families of victims does not extend beyond notification and payment of funds owed.

As a matter of policy, general public-education programs should be initiated to emphasize the importance of the family, its connection to catastrophes and their wake, and the ways and means of helping family members cope with the resulting emotional upset. Such a program, for instance, was initiated at the end of World War II to inform families of the best methods for handling the homecoming and reintegration of their returning servicemen and women. One product, a 15-cent pamphlet, "When He Comes Back and If He Comes Back Nervous" (Rennie & Woodward, 1944), urged family members to:

1. Love him and welcome him.
2. Listen well.
3. Face the reality of the disability—don't ignore it.
4. Treat him as an essentially normal, upstanding, competent person, not as an invalid.
5. Commend his efforts and successes and ignore the slips.
6. Expect him to be different in some ways.
7. Allow him time and freedom in getting acquainted with the old places and in reestablishing his old contacts.
8. Create an atmosphere of expectancy: encourage him to take up his favorite hobby or sport, to go back to work as soon as he is able, and to lead a normal social life; but avoid pushing or regulating him (like the military).
9. Get professional help if it is needed. Don't just muddle through.
10. Let your own faith and beauty of spirit be your chief stock in trade.

The booklet also included an understandable overview of combat-related stress reactions and a guide to community services and other resources.

Similarly, in-service training for all mental health professionals should include the role of the family in catastrophe and its needs. Medical specialists, for example, would benefit from an understanding of the special sources of stress for families of the hospitalized. Such a program is now underway on an experimental basis at Boston City Hospital, linking with nine other medical facilities. While mental health specialists are now receiving more training in the family area, they still receive little

regarding the special circumstances of the families of catastrophe. Certainly the Veterans Administration and the Disabled American Veterans outreach programs are far head of their contemporaries in their recognition of the importance of the family.

Indeed, the preliminary results of a national study of victim services in the United States suggest that veterans' centers are not only more educated about catastrophe and its impact, but view the family as a client as well as the veteran and rate "relationship difficulties" as the most significant long-term emotional problem (Rich, 1983).

Moreover, there are thousands of professionals who work directly with families: counselors, therapists, clergy, educators, emergency assistance specialists, the Red Cross, and others. Their guidance to families struggling to cope with catastrophes could be invaluable. Training them in the basics of family stress management would create important resources for families (Figley & McCubbin, 1983b).

Treatment

With regard to clinical intervention, it was implied in earlier writings (Figley, 1976a, 1976b; Figley & Sprenkle, 1978; Stanton & Figley, 1978) and explicitly stated in more recent ones (Figley, 1984, 1985; Hogancamp & Figley, 1983) that a group context—be it family or rap groups—is inefficient for ameliorating PTSD in its more advanced and profound forms. To include the family before the victim has effectively confronted and worked through the traumatic aspects of some of these conflicts would undermine or at least slow the progress and solidify the perception of the victim as the identified patient, rather than the whole family. It is appropriate, however, to see the spouses (and, in rare instances, older children) individually or in groups to explore their special stressors and how to manage them.

Eventually it is important to incorporate the entire family relationship (conjoint therapy). The emphasis in the intervention is on integrating the catastrophic experiences and their wake (impacting both the victim/veteran and his/her family) into the family. This is done by first determining (1) how the catastrophic experiences and the family problem(s) in which it is embedded are affecting each individual family member; (2) how the behavior of family members may be reinforcing or exacerbating the difficulties; (3) whether the family members have any understanding of the immediate and long-term consequences of the catastrophe; and (4) how best to cope with these consequences—through either new strategies, new skills, or both. Most often, the catastrophe-

related difficulties fade and are replaced with stressors that have emerged subsequently (e.g., family violence, substance abuse) partly or entirely in an attempt to cope with catastrophe in general or the symptoms of PTSD in particular.

CONCLUSION

War, terrorism, rape, and other violent acts of man and nature rarely result in progress and most often eventuate in countless human tragedies that impact for a lifetime: lost lives, limbs, esteem, confidence, and income, to name only a few. This is the depressive nature of catastrophe: it hurts. However, the *inspiration* that accompanies catastrophes and its wake is equally significant.

Irrespective of the circumstances of the particular catastrophe, of the families it impacts, *families of catastrophe survive*. And more than simply surviving, most go on to lead happy and productive lives. Time does heal the wounds, but only to the extent that with time come perspective and resourceful ways of coping, which most families somehow find and effectively utilize.

By adequate attention to the health and vitality of the family system, victims of catastrophe may rely on a powerful stress-coping resource. And by supplemental consultation to families regarding the functional methods for coping with catastrophic stress, it is possible to more effectively care for the millions of victims of various traumatic events that occur yearly.

REFERENCES

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: American Psychiatric Association.

Burge, S. K. (1982). The social support scale: Development and initial estimates of reliability and validity of a measure of social support. Unpublished master's thesis, Purdue University.

Burge, S. K., & Figley, C. R. (1982). The social support scale. Unpublished manuscript, Purdue University.

Burgess, A. W., & Holmstrom, L. L. (1979). *Rape: Crisis and recovery*. Bowie, MD: Robert J. Brady.

Burr, W. R. (1973). *Theory construction and the sociology of the family*. New York: Wiley.

Drabeck, T., Key, W., Erickson, P., & Crowe, J. (1975). The impact of disaster on kin relationships. *Journal of Marriage and the Family, 37*(3), 481–494.

Figley, C. R. (1975). The returning veteran and interpersonal adjustment: A review of the research. Paper presented at the annual meeting of the National Council on Family Relations, Salt Lake City, August 1975.

Figley, C. R. (1976a). The Vietnam veteran in family therapy: Implications from the research. Paper presented at the annual meeting of American Personnel and Guidance Association, Chicago, March 1976.

Figley, C. R. (1976b). An overview of the research related to delayed combat stress among Vietnam veterans. Paper presented at the annual meeting of the American Psychological Association, Washington, DC, September 1976.

Figley, C. (Ed.) (1978). *Stress disorders among Vietnam veterans*. New York: Brunner/Mazel.

Figley, C. R. (1979). Combat as disaster: Treating combat veterans as survivors. Invited presentation at the annual meeting of the American Psychiatric Association, Chicago, 1979.

Figley, C. R. (1980a). Overview of the trauma of hostage families. Invited address at the annual meeting of the National Organization for Victim Assistance, Portland, Oregon, October 1980.

Figley, C. R. (Ed.) (1980b). *Mobilization. I: The Iranian crisis: Final report of the Task Force on Families of Catastrophe*. Purdue University, Family Research Institute.

Figley, C. R. (1983). Catastrophe: An overview of family reactions. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family, Vol. II: Coping with catastrophe*. New York: Brunner/Mazel.

Figley, C. R. (1984). Treating post-traumatic stress disorder: The algorithmic approach. *The American Academy of Psychiatry and the Law Newsletter*, 9(3).

Figley, C. R. (1985). From victim to survivor: Social responsibility in the wake of catastrophe. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder*. New York: Brunner/Mazel.

Figley, C. R., & Burge, S. K. (1983). Social support: Theory and measurement. Presented at the Groves Conference on Marriage and the Family, Freeport, Grand Bahama Island, 1983.

Figley, C. R., & McCubbin, H. I. (1983a). Introduction. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family, Vol. II: Coping with catastrophe*. New York: Brunner/Mazel.

Figley, C. R., & McCubbin, H. I. (1983b). Looking to the future: Research, education, treatment and policy. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family, Vol. II: Coping with catastrophe*. New York: Brunner/Mazel.

Figley, C. R., & Sprenkle, D. H. (1978). Delayed stress response syndrome: Family therapy indications. *Journal of Marriage and Family Counseling*, 4, 53–60.

Gleser, G. C., Green, L., & Winget, C. (1981). *Prolonged psychosocial effects of disaster: A study of Buffalo Creek*. New York: Academic Press.

Green, B. L., Wilson, J. P., & Lindy, J. (1985). Conceptualizing post-traumatic stress disorder: A psychosocial framework. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder*. New York: Brunner/Mazel.

Guerney, B. (1978). *Relationship enhancement*. San Francisco: Jossey-Bass.

Hetherington, E. M., Cox, M., & Cox, R. (1976). Divorced fathers. *The Family Coordinator*, 25, 417–428.

Hirsch, B. J. (1980). Natural support systems and coping with major life changes. *American Journal of Community Psychology*, 8, 159–171.

Hogancamp, V. E., & Figley, C. R. (1983). War: Bring the battle home. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family, Vol. II: Coping with catastrophe*. New York: Brunner/Mazel.

Horowitz, M. J. (1976). *Stress response syndrome*. New York: Aronson, Inc.

Hunter, R., & Macalpine, I. (1963). *Three hundred years of psychiatry 1535–1860*. London: Oxford University Press.

Janis, I. L. (1969). *Stress and frustration*. New York: Harcourt Brace Jovanovich.

Lifton, R. J. (1973). *Home from the war*. New York: Simon & Schuster.

Lifton, R. J. (1978). Advocacy and corruption in the healing profession. In C. R. Figley (Ed.), *Stress disorders among Vietnam veterans: Theory, research and treatment* (pp. 209–230). New York: Brunner/Mazel.

Mann, P. (1972). Residential mobility as an adaptive experience. *Journal of Consulting Clinical Psychology, 39*, 37–42.

McCubbin, H. I., & Figley, C. R. (1983). *Stress and the family, Vol. I: Coping with normative transitions*. New York: Brunner/Mazel.

Mineka, S. (1979). The role of fear in theories of avoidance learning, flooding, and extinction. *Psychological Bulletin, 86*, 985–1010.

Neiderland, W. G. (1968). Clinical observations on the "survivor syndrome." *International Journal of Psychoanalysis, 49*, 313–318.

Rabkin, J. G., & Struening, E. L. (1976). Life events, stress and illness. *Science, 194*, 1013–1020.

Rennie, T. A. C., & Woodward, L. E. (1944). Two talks to families of returning servicemen: "When he comes back and if he comes back nervous," with guide to community resources. New York: New York Rehabilitation Division, National Committee for Mental Hygiene, Inc.

Rich, R. (1983). Providing services to victims: An empirical investigation. Paper presented at the 7th World Congress of Psychiatry, Vienna, 1983.

Smith, J. R. (1981). A review of one hundred and twenty years of the psychological literature on reactions to combat from the Civil War through the Vietnam War: 1860–1980. Unpublished manuscript, Duke University.

Smith, S. M. (1983). Disaster: Family disruption in the wake of natural disaster. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family, Vol. II: Coping with Catastrophe*. New York: Brunner/Mazel.

Stanton, M. D., & Figley, C. R. (1978). Treating veterans within the family system. In C. R. Figley (Ed.), *Stress disorders among Vietnam veterans: Theory, research and treatment* (pp. 283–284). New York: Brunner/Mazel.

Taylor, E. B. (1965). Research into the early history of mankind and the development of civilization. In R. Hunter & I. Macalpine (Eds.), *Three hundred years of psychiatry 1535–1860*. London: Oxford University Press.

Thoits, P. A. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. *Journal of Health and Social Behavior, 23*, 145–159.

Weisman, A., & Hackett, R. (1961). Predilection to death: Death and dying as a psychiatric problem. *Psychosomatic Medicine*, 33 (3), 389–393.

Wolpe, J. (1973). *The practice of behavior therapy*. Elmsford, NY: Pergamon.