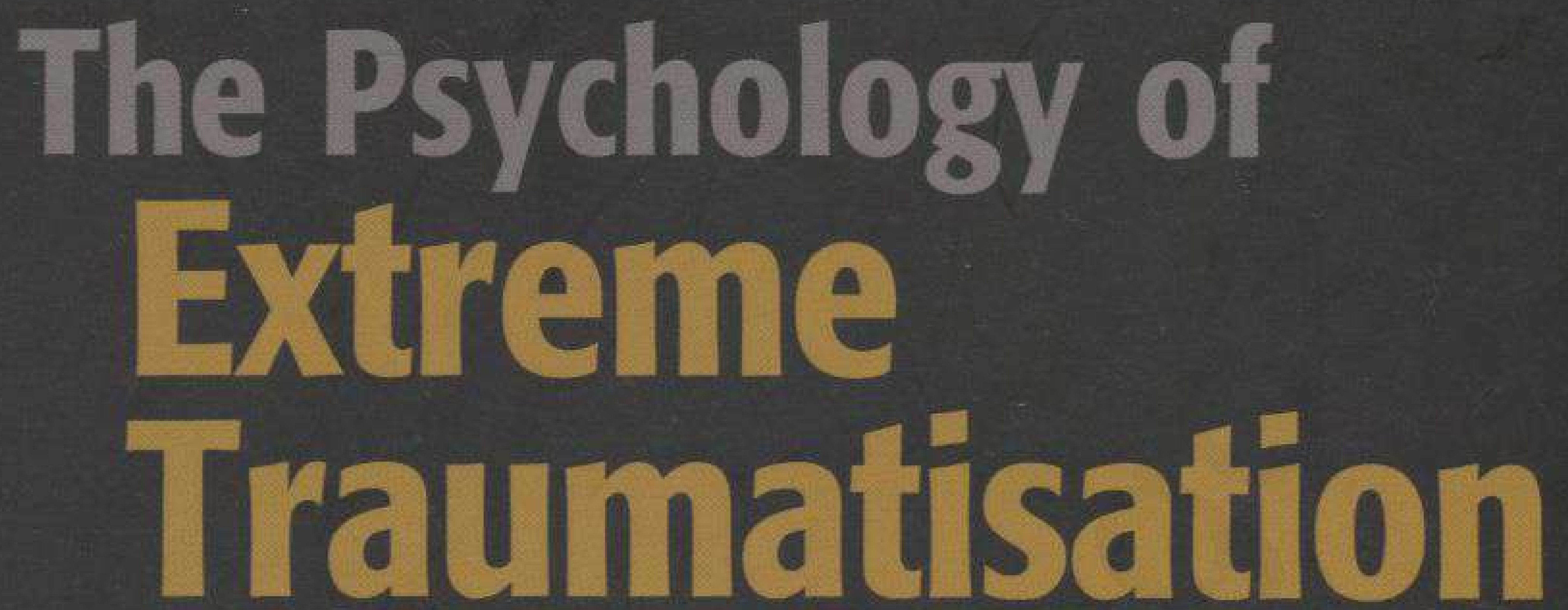


The Psychology of Extreme Traumatisation

The Aftermath of Political Repression

Edited by Danutė Gailienė

The Psychology of Extreme Traumatisation

The history of 20th-century Europe, with its two totalitarian regimes, is marked by repression, persecution and human suffering. Millions of people were killed, and millions of lives were affected.

It only became possible to investigate the consequences of the Nazi and communist regimes after they had collapsed. In this book, researchers from Canada, Germany, Lithuania, Norway and Switzerland draw on different experiences to examine the aftermath of long-lasting traumatisation.

ISBN 9955-463-05-8

The Psychology
of Extreme Traumatisation:
The Aftermath
of Political Repression

www.atmintiesknygos.lt

The Psychology of Extreme Traumatisation

The Aftermath of Political Repression

Edited by Danutė Gailienė

Genocide and Resistance Research Centre of Lithuania

Akreta
Vilnius, 2005

www.atminties knygos.lt

UDK 321.6:159.9(474.5)
Ps-07

General Editor Danutė Gailienė
Language Editors Zuzana Šiušaitė, Joseph Everatt
Designer Gedas Čiuželis

Published by Akreta
Vrublevskio g. 6, LT-01100 Vilnius, Lithuania

© Danutė Gailienė, 2005
© Genocide and Resistance Research Centre of Lithuania, 2005
© Akreta, 2005

First published in Lithuanian as *Sunkių traumų psichologija: politinių represijų padariniai* in 2004

Printed by Spindulys, Lithuania

ISBN 9955-463-05-8

Contents

Foreword 7

DALIA KUODYTĖ
Traumatising History 13

LARS WEISÆTH
Psychotraumatology: An Overview from a European Perspective 26

DANUTĖ GAILIENĖ, EVALDAS KAZLAUSKAS
Fifty Years on: The Long-Term Psychological Effects of Soviet Repression in Lithuania 67

GRAŽINA GUDAITĖ
Psychological Aftereffects of the Soviet Trauma and the Analytical Process 108

MATTHIAS SCHÜTZWOHL, ANDREAS MAERCKER
The Long-Term Effects of Political Imprisonment in the German Democratic Republic: Implications for Treatment and Forensic Assessment 127

VĖJŪNĖ DOMANSKAITĖ-GOTA, DANUTĖ GAILIENĖ, JŪRATĖ GIRDZIUŠAITĖ
The Trauma of War: Research on Lithuanian Veterans of the Afghanistan War after Seventeen Years 154

ANTOON A. LEENAARS
Trauma and Suicide among Aboriginal People: Stories from the Arctic and Australia (with Particular Reference to the Situation in Lithuania) 170

LARS WEISÆTH
Psychological Injury: Disability Compensation in Military and Civilian Veterans and War Victims. A Norwegian Perspective 196

Foreword

Political repression is considered one of the gravest kinds of traumatisation insofar as it is usually especially harsh and long-lasting. The history of Europe in the 20th century, with its two totalitarian regimes, is teeming with instances of repression, persecution and human suffering.

After the end of the Second World War, serious research began in the West into the long-term psychological and psychopathological effects of Nazi repression on its victims. To start with, scholars who initiated this research had to overcome the postulates of traditional psychiatry and psychoanalysis. These affirmed that traumatising experiences do not have a decisive impact on the mental health of the people who suffered them. The predominant belief was that the consequences of such trauma on normal people cannot be long-lasting, as time heals, and that these individuals should recover their mental equilibrium fairly quickly. Even if some do in fact fail to achieve full recovery, this is due to personal characteristics, to the fact that the individuals in question had neurotic disorders even before the actual trauma, rather than to the traumatising experiences themselves.

Decades of research have shown, however, that the traumas of war and political repression have grave, long-term somatic, psychological and psychopathological effects. These effects are hardly

related to personal predisposition, since even people who were totally healthy before suffered numerous disturbances of their mental health as a result of their experiences: fear, nervousness, depression, nightmares, increased irritability and aggression, a reduced capacity for work, and others. Some of the victims even continued to suffer these effects for the rest of their lives. It also transpired that the effects of trauma caused by other human beings (violence, persecution, reprisals) are much graver than "natural" trauma due to natural and technological disasters.

Investigations into the effects of political repression are difficult, as it is almost always the case that such investigations become possible only after significant political transformations have taken place and the repressive regime has collapsed. (It is true, however, that sometimes investigations are carried out in rehabilitation centres for political refugees.) Until the traumatising process is over, it is impossible to give any assessment of the traumatic experience itself. Besides, the success of research into trauma is very dependent on the political and public *recognition* bestowed upon the trauma. Until the society recognises the sufferings of the victims, the latter receive no help, and no research into their traumatic experience is encouraged.

This book presents studies of the effects of political repression in various countries and cultures. Among the objects of research are the effects of Nazi and communist repression in Europe, as well as the long-term effects of colonial genocide in the Arctic and Australia. Researchers from Norway, Germany, Switzerland, Canada and Lithuania examine grave traumas that vary considerably in their duration and in the degree of their recognition, as well as differing in the way their effects were regarded afterwards and the victims were compensated for the damage.

Very methodologically advanced studies of the effects of the *Nazi* occupation have been carried out in Norway. Professor LARS WEISÆTH of Oslo University, one of the most renowned researchers into trauma in the world, presents a critical reflection on theoretical and meth-

odological problems in contemporary psychotrau-matology ("Psychotraumatology. An Overview from a European Perspective"). The second of his studies reveals impressively how many years of academic study, combined with successful collaboration between scholars, the Norwegian Association of Victims, and top-level politicians, led to greater justice in compensating for the damage incurred by the victims ("Psychological Injury: Disability Compensation in Military and Civilian Veterans and War Victims. A Norwegian Perspective").

The effects of the *communist* regime could only be investigated after its collapse. What is being done so far is only an assessment of the conditions of the victims of repression and the formulation of the first recommendations concerning help to the victims. The studies are not exhaustive, however, as communism, unlike Nazism, has not been tried for crimes against humanity, and this is why the attitude towards communism is still ambiguous, both in post-communist countries and worldwide.

The first research into the effects of communist repression started in former Soviet satellite states in Eastern and Central Europe. One of the most exhaustive and methodologically sound studies of the long-term effects of political imprisonment, led by Professor ANDREAS MAERCKER, was carried out in the former East Germany. The main results of the study are presented in his article, written together with MATTHIAS SCHÜTZWOHL ("The Long-Term Effects of Political Imprisonment in the German Democratic Republic: Implications for Treatment and Forensic Assessment").

So far, there have been no comprehensive studies of trauma caused by communist repression and its effects in the former Soviet Union. In 2000, an extensive study "Psychological Effects of Soviet and Nazi Repression" started in Lithuania. It is a result of collaboration between the Genocide and Resistance Research Centre of Lithuania and the Department of Clinical and Organisational Psychology at Vilnius University.

"In 1940, the Lithuanian state disappeared from maps for 50 years. Its citizens, however, remained in place, overnight becoming the hostages of an all-destructive system," writes the historian DALIA KUODYTĖ, the director of the Genocide and Resistance Research Centre of Lithuania. In her paper ("Traumatising History") she describes the extent of the historical trauma in Lithuania in the mid-20th century, as well as characterising the transformations of the mentality caused by them. The traces of these transformations may still be found both in the personal and in the collective memory.

After some 1,500 former political prisoners, deportees and other victims of repression were interviewed, it transpired that their traumatic experience was much more severe than that of the people who had not suffered repression, despite living under the conditions of the communist regime. The long-term effects of trauma still persist: most of the victims have somatic, psychological and social problems of varying intensity. On the other hand, even though they still feel the suffering decades after they were released, this does not mean deficient adaptation. These people, despite being pursued by certain difficulties, often live full lives. Thus, human beings can not only be subject to long-term effects of grave and long-lasting trauma, but they can also have inner resources that help them to overcome the difficulties (DANUTĖ GAILIENĖ, EVALDAS KAZLAUSKAS, "Fifty Years on: The Long-Term Psychological Effects of Soviet Repression in Lithuania").

It has also transpired that the psychotherapeutic process unexpectedly reveals the impact on the next generation of the trauma experienced by the parents. Trauma related to family or national history expresses itself on the level of the family and the cultural subconscious, impacting on the individual's life, on his or her choices and emotional state (GRAŽINA GUDAITĖ, "Psychological Aftereffects of the Soviet Trauma and the Analytical Process").

Apart from individuals who are officially legally recognised as victims of political repression, Lithuania has several other groups

of people who were particularly damaged by the communist regime. One of these groups comprises veterans of the Afghanistan War: men who were forced to participate in the Soviet war in Afghanistan between 1979 and 1989. A study has shown that even now their psychosocial condition is much worse than the conditions of men who underwent compulsory military service in the Soviet army but did not participate in the war (VĖJŪNĖ DOMANSKAITĖ-GOTA, DANUTĖ GAILIENĖ, JŪRATĖ GIRDZIUŠAITĖ, "The Trauma of War: Research on Lithuanian Veterans of the Afghanistan War after Seventeen Years").

One of the most famous researchers into suicidal behaviour in the world, ANTOON LEENAARS, analyses the tragic consequences of the more than a century-long *colonial genocide* carried out in the Arctic and Australia. Its consequences last right up to our days. His study shows how long lasting and extraordinarily grave the effects of unrecognised trauma can sometimes be: they consist of pain, disorientation and an increased suicide rate, which last from generation to generation. In the Arctic and Australia, "*the increase in suicide is related to colonial policy – very much as in Lithuania the increase in suicide is related to Soviet policy*," the study asserts ("Trauma and Suicide among Aboriginal People: Stories from the Arctic and Australia [with Particular Reference to the Situation in Lithuania]").

All of these studies and discussions show that in order to overcome trauma caused by human beings, both public recognition of the trauma and human efforts are needed. Not all wounds are healed by time.

DANUTĖ GAILIENĖ

www.atmintiesknygos.lt

Traumatising History

DALIA KUODYTĖ
Genocide and Resistance Research Centre of Lithuania

The title of this paper ought to be further defined: history is understood here as a set of circumstances in which people find themselves regardless of their will and wishes, rather than as a scholarly discipline. The assumption is made that certain actions performed in respect to these people could have grave and sometimes irreversible psychological consequences. Since the author is not a psychologist, she can only discuss these effects at the level of hypotheses which are borne out by the recollections of the people who suffered violence.

History as an academic discipline considers memoirs to be a secondary source, especially if they are written many years after the events themselves. This is fair if one bears in mind the particular character of history as a branch of research. The historian Saulius Sužiedėlis defines the relationship between history and memory in the following way: history (as a discipline) is defined as the critical study of events and processes, whereas remembered history is the reflection of the same events and processes in the individual or group consciousness (Sužiedėlis, 1996). He contrasts these two ways of understanding, suggesting that problems arise through their confusion: whenever that happens, the academic character of history as a discipline suffers, myths and stereotypes threaten to become "true history", and the danger of politicisation arises. It is hard to

disagree with such statements. The question arises, however, whether there is a way in which historical memory could become an integral part of history as an academic discipline in the sense discussed. One thing is beyond doubt: the methods currently employed by the academic discipline of history may no longer be sufficient here. For it is one thing to speak of extrinsic characteristics, such as political, cultural, social, and economic aspects, and it is something entirely different to address the transformations of mentality, whose signs could be found both in an individual's and in the collective memory. Therefore, the rejection of memory as a historical source would mean the rejection of the possibility of exploring such transformations. And it is hard to believe that a historian who seeks to recreate, at least in part, the authentic chain of cause and effect would choose to ignore the fact that many things can only be explained by focusing on an individual person and his or her subjective motivations.

This, of course, is primarily applicable to the history of Lithuania in the second half of the 20th century: we still have the opportunity to talk to the actual witnesses of events, to analyse, substantiate and verify their reminiscences. And as we do so, we notice a remarkable thing: the witnesses often confuse concrete facts and particular dates, but they are never confused or contradictory when they convey their thoughts or their emotional states caused by what they experienced. This feature reinforces the suggestion that in such cases, methods of psychology may unveil very important truths that have remained, until now, only at the level of assumptions.

On the other hand, as early as 1989 and 1990, when the reading public in Lithuania was overwhelmed by the flood of memoirs by former political prisoners and deportees, and later on by former partisans, it became obvious that, from the point of view of mentality, 50-year-old experiences are far from merely belonging to history. It transpired that people with pain and suffering, with memories that haunt their dreams and sleepless nights, live among us.

And they live both influenced by their past selves and influencing others through it. That is to say, their past influences all of us. Professor Egidijus Aleksandravičius defined this as one of the components of the "threshold of living memory" (Aleksandravičius, 1994).

Therefore, it appears that what is relevant in those memoirs is not so much the facts themselves, such as the descriptions of the process of deportation, of the journey, portrayals of everyday life in exile and of the return. This is especially true since the principal factual features of the narratives are almost identical in all the texts, only the names and toponyms vary. It is only when one realises this that one detects some other, experiential narrative features which prompt one to ask: could such experiences disappear without trace? What are those traces? Do we need to deal with this somehow, if we consider ourselves to be a civilised nation?

Already back then, in 1990, in the first years of comparatively free speech, there were hints that we have a serious problem here, and that specialist research is needed, as well as a functioning system of psychological help to people who suffered political repression. The first to speak out about this was a medic, Professor Alfredas Smailys. In 1990, in the journal *Žaltvykslė*, he published a short article entitled "The Impact of Repression on the National Psychology" (Smailys, 1990). In it he merely hinted at the psychological and psychosomatic effects of the repression, such as deportation, imprisonment and torture. Unfortunately, at that point in time all of this remained in the realm of ideas.

For the last three years, researchers at the Genocide and Resistance Research Centre of Lithuania, along with the Department of Clinical and Organisational Psychology at Vilnius University, have been collaborating on the project "Psychological Effects of Soviet and Nazi Repression". This project is, perhaps, our last chance to catch up with time, that is to say, it is our last opportunity to interview people who actually suffered violence. Without conducting such interviews, the application of methods of scientific psychology is

inconceivable in principle. No less relevant is another question to which I have no answer as yet: namely, the question of the practical resolution of the problems identified during the present research project. My suggestion would be that it lies within the sphere of competence of state institutions which are responsible for the mental health of Lithuanian citizens.

The middle of the 20th century was a time of extraordinary shocks and upheavals, not only for the inhabitants of Lithuania, but also for Europe as a whole. The consolidation of totalitarian regimes, the cynical partitions of spheres of influence, the Second World War, occupations, terror, the extermination of the Jews, deportations, concentration camps: all this could not pass without a trace. It seems that it was considerably easier to rebuild the bombed cities than to heal the mental wounds. This is further confirmed by the greater than ever scholarly attention that is devoted to the specific problems of that period, as well as by all the conferences, articles and discussions that have finally reached Lithuania.

Two totalitarian regimes, Soviet and Nazi, inscribed what are perhaps the darkest pages in the history of humanity. It is hardly appropriate to discuss here which of the two was worse and which was gentler. One thing is clear, however: whereas the Nazi policies received international judgement and were condemned, thus becoming a symbol of evil, Soviet policies still await such an assessment. It is likewise awaited by people and peoples who experienced directly the effects of the Soviet totalitarian regime.

In 1940, the Lithuanian state disappeared from maps. Its citizens, however, remained in place, overnight becoming hostages of an all-destructive system. From that point onwards, the history of Lithuania does not follow the usual criteria of periodisation, the internal processes of political, economic and cultural transformation, but according to the changes of the occupying forces: 1940 to 1941 is defined as the first Soviet occupation, 1941 to 1944 as the period of the Nazi occupation, and 1944 to 1990 as the second So-

viet occupation. Over 600,000 Lithuanian citizens became victims of the occupations. Out of those, 250,000 were killed during the Nazi occupation (200,000 were Lithuanian Jews). This means that around 33% of the population of Lithuania suffered from the occupations (either killed or subjected to violence). Over 70% of deportees were women and children. Estimates show that almost 30% of the deportees died because of the unbearable living conditions.

There is an unoriginal but very apt saying that the death of one person is a tragedy, while the death of thousands merely hits the headlines. Nothing is more temporary, however, than headlines. Perhaps some lasting results (and not just in the present case) might be achieved by attempting to put a human face to the statistics.

The years 1940 and 1941 formed a unique period, owing to the fact that the shock at losing their state concerned all Lithuanians. The state did not resist the Soviet aggression, and thus gave a sign to the public that nothing untoward was taking place. This was especially true since Kaunas Radio insisted on 15 June 1940, as it announced the Soviet demands: "In order to avoid undesirable misunderstandings and conflicts, state institutions order the army and citizens with immediate effect not to obstruct the movement of the army of the Soviet Union in the territory of Lithuania" (Stonys, 2001, p. 17). On 16 June, Antanas Merkys, the acting prime minister, asserted: "It is unlikely to have any impact on our domestic social, cultural, economic and political affairs ..." (*ibid.*, p. 19). As a result of these assertions, citizens actually failed to perceive any real danger, whereas the removal of President Antanas Smetona's regime was seen by many as a positive change which opened up an opportunity for the Lithuanian state to renew itself.

As early as July 1940, however, the purges of state institutions, arrests and terror began. Finally, the first deportations took place from 14 to 18 June 1941. This was not merely the collapse of all illusions. It was already a very clear indication that one way or another everyone's life was going to be affected. The only question

Table 1. **Lithuanian citizens deported by the Soviets in 1941–1953**

Year	People deported from Lithuania
1941	7,368
1945	14,381
1946	2,082
1947	2,782
1948	41,158
1949	33,500
1950	1,335
1951	21,177
1952	2,934
1953	100
	Total 126,817
	Data from the SSSR Ministry of the Interior 128,068

that loomed was: Why? The answer to this question was sought not only by those 16,246 deportees who found themselves in cattle wagons, but also by everyone else, insofar as the sense of security disappeared, and anyone might find themselves among the deportees (see Table 1).

> A lorry screeched to a halt with a loud noise. Someone was knocking at the door. I pretended not to hear, I kept down. I was panting and felt hot. I realised they had come to fetch me. What was I to do? To escape, to resist, all would be in vain. Let them break in, I will lie down … The thought was flickering in my head that this was the greatest injustice, derision, defilement of all the proclaimed beautiful communist ideas. Perhaps it was a mistake? I couldn't understand why my family was condemned. What for? (Markauskas, 2001, p. 112-115).

People who suffered in the first deportation of 1941 were civil servants, army officers, leaders of public organisations and political parties, teachers at the universities and gymnasia: all those who ran the state, who were engaged in the creation of its value system. This deportation was the first step in a consistent occupation policy: the extermination of the state and the community began with the removal of the nation's leaders. It was hardly by accident that the first wave of deportees were those who found themselves in the

destinations with the most severe living conditions, where cold, famine and exhausting work left almost no hope of surviving.

> I felt a strange feeling when the Chekist shouted "Number seventeen". Am I number seventeen? I came to my senses only a few minutes later, the blood went to my face, I even felt my heart beating faster. Number seventeen from carriage number nineteen – this is what I am … For the first time I felt that I was a thing … I stood before them, pale in the face and felt the terrible hatred and protest of a slave … I turned my head and saw my mother … A look of pain … We understood each other and both felt nervous; we didn't broach the subject again … (Grinkevičiūtė, 1997, p. 39-40).

The deportees, just like prisoners of Nazi or Soviet concentration camps, experienced especially painfully the intention to destroy their personality, to turn a person into a thing or a number. That was not the only emotion they felt, however. It is strange and paradoxical, but in their emotional responses one can also detect a feeling of subconscious guilt. This feeling is paraphrased in many a memoir: "What had we done wrong? I don't know. Was there in fact any fault at all?" (Kontrimaitė, 1989, p. 6). Perhaps this feeling was an attempt to find some logic behind what was happening.

One more characteristic of the 1941 deportations consisted of the fact that the deported men were immediately separated from their families (3,915 men), and, without any sentencing or any kind of formal pretext, taken to concentration camps where almost all of them died. Due to the terrible conditions of the life and the work, they were afflicted not only by physical but also by mental and emotional exhaustion, where the only goal was to survive.

> Of course, he is happy now: he is disabled. He was such a wretch … He is lucky: he chopped off his hand. Officially it was an accident. But I saw it. We were working with wood together. We were frozen stiff, there was no energy left to move. Not only could I not speak, I couldn't even groan: there was only pain, only a mad dread in our eyes. And then Laureckas reached down for an axe and placed his hand in its glove on a log … He hunched his back in a strange manner, and then … chop. It wasn't enough … Once more: chop … His bloody glove fell down (Norbutas, 1989, p. 143).

Table 2. **Prisoners sent to the Gulag**

Year	Number of prisoners
1941	7,349
1944	1,338
1945	31,661
1946	16,182
1947	19,324
1948	20,837
1949	14,948
1950	12,194
1951	12,763
1952	12,332
	Total 148,928

Until 1953, over 150,000 Lithuanians found themselves in the concentration camps and prisons of the Soviet Union (a total of over 200,000 were arrested on political grounds. See Table 2).

The testimony of those who were held in custody or in prison in Lithuania is no less eloquent:

> They stopped torturing me and let me get some sleep only a week after my arrest ... (Kitkauskas, 1989, p. 155).

Beatings and torture in order to extract information were, as a matter of fact, not only tolerated but legally sanctioned by the Soviets. This is attested to by the correspondence of the highest officials: for example, a letter by the MVD (Interior Ministry) Army, Lithuanian Frontier District prosecutor S. Grimovich to the secretary of the Lithuanian Communist Party Central Committee Antanas Sniečkus, on 8 August 1953. It says that:

> The SSSR State Security Ministry issued special instructions, on the basis of which, in some cases, when detainees were interrogated on a charge of crimes against the state, it was permitted to apply means of physical impact (*Lietuvos partizanų kovos ir jų slopinimas MVD-MGB dokumentuose 1944–1953 metais* [The Lithuanian partisan struggle and its suppression in MVD-MGB documents in 1944–1953], 1996, p. 263).

It would not be inaccurate to say that this was routinely experienced by all detainees. Only very rarely, mostly accidentally, did facts come to light that were considered "transgression of revolutionary legality" by the Soviets. For example:

> Novikov detained citizen Rudėnas, applying means of physical impact, and beat the latter till he died; he used to beat the detainees systematically, and, failing to secure the requisite testimony, he executed five persons by firing squad in the courtyard of the KPZ; during a house search of the citizens Griška and Petrikas at the farmstead of Šamuliai, he beat them. Besides, members of their families were beaten too (ibid., p. 156-157).

Members of the armed resistance – partisans, their supporters and messengers – were especially cruelly interrogated. Their testimony is very restrained, as though it were almost indecent to speak about it:

> They interrogated us in pairs, they "worked" in turns, and when both got tired, they used to let the drunken *stribai* in who sought to outstrip each other in resourcefulness ... After three days I woke up in a puddle of water, my clothes were wet, the cell was full of rats. It seemed that they were very hungry, because they were rather bold. It was not possible to get a rest from them after the interrogations (Avižinis, 2001, p. 227-228).

> They beat me on the buttocks and the back with a stick, and hit my face with their hands, as well as pulling out my hair. They beat me till I fainted. Then they would pour cold water over me, revive me, and throw me into a small dark room ... A few hours later, they would start the tortures again. When I was all bruised and beaten, I would faint quicker. That was my salvation. Just before fainting, the pain started to diminish, it seemed that it disappeared altogether, and then I had this pleasant sensation and I lost consciousness ... (Gedvilaitė-Andriulienė, 2001, p. 418-419).

During the ten-year period of the armed resistance after the Second World War, about 22,000 partisans, their messengers and supporters were killed. Their families usually failed to escape deportation: at least 50,000 were arrested, tortured and imprisoned (see Tables 3 and 4).

Table 3. **Partisans killed by the Soviet army in 1944–1945**

Year	Month	Number of killed
1944	October	39
	November	265
	December	2,056
1945	January	1,207
	February	1,301
	March	1,030
	April-15 May	1,613
	June	1,135
	July	1,436
	August	710
	September	416
	October	238
	November	249
	December	343
		Total 12,038

Table 4. **Soviet military action against the Lithuanian partisan movement in 1946–1953**

Year	Number of partisans killed
1946	2,143
1947	1,540
1948	1,135
1949	1,192
1950	635
1951	590
1952	457
1953	198
	Total 7,890

It is not by accident that I speak at such length about the deportees, political prisoners and participants in the armed resistance: these people experienced Hell on Earth. Despite this, most of them speak about the things which helped them to survive. For some it was their faith:

> Whenever they took me for interrogation, I used to pray, turning to the saints, and implored God that I would not wake up anymore once I fainted (Gedvilaitė-Andriulienė, 2001, p. 419).

> I remember that I myself, whenever I was sworn at or beaten during the interrogations, was fortified by the sign of the Cross which I would secretly make (Kitkauskas, 1989, p. 159).

Others were sustained by a strong person nearby:

> When Antanas Miškinis [a poet and member of the resistance] left, the cell became even drearier, but I felt that the greatest horror was already in the past, that I had ceased seeing through the walls, or at least it seemed so to me, that I had straightened again. I felt an immense debt of gratitude to that wonderful black-bearded little man who had not seen the sun for half a year, and who managed to help a weaker one, who himself managed to shine at others "at the very bottom of this dirty life" (Lisauskas, 2001, p. 219).

Yet others were helped simply by their ability to mobilise all their inner strength:

> I feel tenacity, strength, the will to live, to fight against life and to win, being born inside me. The will to confront it, so that I can get what I wish, rather than letting life throw me about. We won't give in ... (Grinkevičiūtė, 1997, p. 50-51).

Whenever we speak of resistance to occupations, we usually have in mind active resistance, the armed partisan struggle or secret underground activities. Dalia Grinkevičiūtė extended the concept of resistance, however:

> There are various ways of resistance:
> To survive when you are supposed to die.
> To remember when you have to forget.
> To think when you must not think.
> To notice when you are made to ignore.
> To strive to know when you are ordered not to know anything.
> (Grinkevičiūtė, 1997, p. 19)

One might add to this: to testify for those who cannot testify for themselves, to speak out, for only this will bring relief. Hundreds of memoirs, recorded, filmed, written about in books: is this not a wish to tell, to speak out, to be heard, perhaps even understood? We will have to accept the fact that these people will never receive any psy-

chological help. Their wish to speak out, the only means of natural therapy, is, unfortunately, nowadays ignored and rejected by the society in which they live. Perhaps this is a common tendency in post-communist countries, relishing as they do the stylistics of postmodernism (which, in itself, is not an evil): the consumerist attitude to these painful experiences. In other words, these experiences were interesting while they were novel, sensational, ultimately while they served as an argument for the recovery of independence. After that, a point of saturation was reached, and these experiences were unconditionally rejected. No mothballs are needed in the creation of a modern society. It is almost impossible, however, to realise what we are, what we are doing, and why, if we fail to link the present to the past: this is where the problem lies. This is why the psychological investigation already mentioned, just like, by the way, purely historical research, is far from rooting about in the past: it also provides an opportunity to act better in a world of opening possibilities. Otherwise, just like Germany, we will have to come back to the same issue decades later, and it will be even more complicated to come to terms with it then.

I have failed to mention other groups that suffered. They could also be an object for investigation on the assumption that they suffered trauma. Some of these have already received scholarly attention (such as the victims of the Holocaust and the participants in the war in Afghanistan); others still remain a subject for potential research (people who were involved in liquidating the aftermath of the Chernobyl nuclear disaster, and those who suffered from the actions of the Soviet army on 13 January 1991). I have also failed to discuss some further crucial questions: whether the process of collectivisation in Lithuania was not yet another source of historical trauma, whether the self-censoring mode developed by intellectuals was not a consequence of some such trauma, and so on. Also, do scholars encounter the issue of control groups, and should we perhaps be thinking of the possibility

of an international research project? The most important thing, however, is that the research currently under way should be continued and developed.

References

Avižinis, S. (2001). Mane išaugino Dzūkijos giria. *Juodųjų dienų sakmės*. Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 220-232.

Aleksandravičius, E. (1994). Gyvosios dabarties slenkstis lietuvių istoriografijoje. *Kauno diena*, 1994 m. gruodžio 3 d., 282 (14 395):22.

Gedvilaitė-Andriulienė, S. (2001). Kas mus užgrūdino? *Juodųjų dienų sakmės*. Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 408-428.

Grinkevičiūtė, D. (1997). *Lietuviai prie Laptevų jūros*. Vilnius: Lietuvos rašytojų sąjungos leidykla.

Kitkauskas, N. (1989). Mes – politiniai. *Amžino įšalo žemėje*. Vilnius: Vyturys, 154-186.

Kontrimaitė, M. (1989). Mano vaikystės tėvynė. *Amžino įšalo žemėje*. Vilnius: Vyturys, 6-19.

Lietuvos partizanų kovos ir jų slopinimas MVD–MGB dokumentuose 1944–1953 metais. Laisvės kovų ir kančių istorija (dokumentų rinkinys) (collection of documents). Kaunas, 1996.

Liongino Baliukevičiaus – partizano Dzūko dienoraštis. 1948 m. birželio 23 d.–1949 m. birželio 6 d. (2002). Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras.

Lisauskas, A. (2001). Rezistencijos laikotarpis. *Juodųjų dienų sakmės*. Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 207-219.

Markauskas, K. (2001). 1941 metų birželis. *Juodųjų dienų sakmės*. Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 111-131.

Norbutas, S. (1989). Antroji Velykų diena. *Amžino įšalo žemėje*. Vilnius: Vyturys, 140-153.

Smailys, A. (1990). Represijų įtaka tautos psichologijai. *Žaltvykslė*, 3:12-17.

Stonys, J. (2001). Aš mačiau, iš kur atsirado toji „tautos valia". *Juodųjų dienų sakmės*. Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 7-55.

Sužiedėlis, S. (1996). Istorijos politizavimas išeivijoje ir Lietuvoje. *Priklausomybės metų (1940–1990) lietuvių visuomenė: pasipriešinimas ir/ar prisitaikymas*. Vilnius: Pasaulio lituanistų bendrija.

Psychotraumatology: An Overview from a European Perspective

LARS WEISÆTH

Norwegian Centre for Violence and Traumatic Stress Studies
Department of Psychiatry, Medical Faculty, University of Oslo, Norway
Joint Armed Forces Medical Services

Introduction

History deals with the past and is seen by some as a thing of the past. A contemporary military medical historian has, however, stated that the doctors of the current PTSD generation are going through the same learning process as did their colleagues during the First World War (Shepard, 2000). He points out an apparently recurrent cycle in respect of war neuroses: "at first denied, then exaggerated, then understood and finally forgotten".

At the start of the 21st century we seem to have entered the phase of this cycle characterised by exaggeration, both with regard to the frequency of so-called traumatic events and their psychiatric consequences. One reason for this is that many clinicians do not stick loyally to the rather strict stressor criterion of the ICD-10 and allow less severe stressful life events to qualify as stressors.

When the stressor is often referred to as "psychic trauma" in the literature, it ought to be termed "potential traumatic events" (PTE) or "stressful event" in order to avoid the impression that traumatisation is a necessary effect of exposure to such an event.

Another unfortunate usage of language is the following: in psychoanalytic jargon the term "traumatic" has been used in two ways: about the possible effects of an extremely threatening external event,

and about the pathological response of the Ego towards its internal threats, eg forbidden impulses becoming conscious.

Another unfortunate usage of the term "traumatic" is the recent introduction of so-called "traumatic grief". What is alluded to here is not the death of a close one that occurred in such a way that it had a potential traumatic effect, rather, "traumatic" refers to pathological grief, a complication in the bereavement process and seen as a type of stress-related disorder as well (Jacobs, 1999).

A note on history

Traumatic neurosis played an important part in 19th-century physicians' discovery of the human unconscious, and inspired the development of psychotherapy. The debate about somatic and psychological injuries inflicted by railway accidents played an important role in this process (Caplan, 1995). It was Freud who made the connection between traumatic experience, its repression in the unconscious, and the need to lift the repression in order to remove the symptoms. He created treatment techniques which established the starting point for the development of psychotherapy. Thus, his trauma theory for the etiology of neurosis, which he soon gave up, had a very significant effect, and not only upon the field of traumatic stress but upon psychiatry in general. Today more researchers and clinicians probably think that Janet's emphasis on pathological dissociation as the most important pathogenic mechanism in the traumatisation process is closer to the clinical reality than the concept of repression. Whereas the cardinal feature of dissociation to Janet was amnesia, which made dissociation a discontinous phenomenon, his followers came to see it as a process that existed on a continuum. Traumatised persons suffer from their painful memories about the trauma, although repression is also sometimes seen.

While its scientific heritage is only about 150 years old, the history of psychological trauma and its sequelae, and thus the clinical experience, are as old as mankind.

Shay (1994, 2002) has interpreted the two first books written in European literature, the *Iliad* and the *Odyssey*, as dealing with traumatic stress: The *Iliad* describes what effects war has on soldiers, while Odysseus' eight years of perilous homebound travels after the end of the Trojan War is an illustration of how long it takes and how many risks are involved before a combat veteran is integrated into civilian society. These two books were the equivalent of textbooks for young men in ancient Europe. Then the Bible took over, no less a valuable source on what psychic trauma can do to a person.

It can be assumed that stress response syndromes, such as post-traumatic stress reactions, because of their adaptive value, must have been an important and integrated part of man's evolutionary development. Any response pattern that increased his chances of surviving dangers that imperilled his existence would surely be more likely to be genetically transferred to future generations. The fight and flight aspects of post-traumatic stress syndrome can be seen in this context. One can also imagine that the three symptom categories of post-traumatic stress disorder (PTSD) reflect vital adaptive defences: repetition syndrome reinforcing the learning experience from events that were severely threatening to life; avoidance symptoms serving to prevent new exposure before the person was ready for it; and hyper-arousal symptoms ensuring preparedness that would elicit a rapid and adaptive response.

The idea that post-traumatic stress response is a basic adaptive response (Brewin, 2003) has its opponents, although there is increasing evidence that it has a distinct neurological basis. In his book with the alarming title *The Harmony of Illusions – Inventing Post-Traumatic Stress Disorder*, Allan Young (1995) argued that a new kind of painful memory emerged during the 19th century. It was unlike the memories of earlier times in that it originated in a previously unidentified state, called "traumatic" and was linked to previously unknown kinds of forgetting, called "repression" and

"dissociation". Young does not deny the reality of PTSD, but sees it as a historical product.

Post-traumatic stress disorder has been variously seen as a conditioned response, as a sleep disturbance with a characteristic change in the sleep cycle, as an information processing disorder, as a fright neurosis, as an intra-psychic conflict disturbance, as a dysfunction of memory, and as an attention deficit disorder that prevents new learning and de-conditioning.

Main themes in the scientific history of PTSD

PTSD-related literature spans a century and a half and is very extensive: any review must necessarily be highly selective.

The concept of traumatic neurosis, a term coined by Oppenheim (1889), and the most common term used before 1980 on PTSD-like conditions, has a complex, but extremely interesting history. This history carries some important learning lessons for therapists and researchers of today and probably of tomorrow. Let us follow some themes that run through its history.

Perhaps the most important finding is the frequent connections that appear between cultural, social, historical and political conditions and traumatic stress theory and practice (Fischer-Homberger, 1975). Traumatic neurosis appears as an "epidemic" illness, where psychiatric explanations and theories reflect the spirit of the age, for better or for worse.

Its history demonstrates psychiatry's dependence on external forces, more so than other branches of medicine, such as pressure from military, legal and political actors and from public opinion. This is still very much an ongoing process.

Another striking and consistent theme in the history of traumatic stress has been the periodic denial of psychic trauma and its consequences (Herman, 1992; Shepard, 2000). Remarkable losses of insights once gained, have caused a repetition of serious errors in diagnostic and treatment practices, and could be unique to the

field of traumatic stress. Psychiatry's amnesia of the importance of psychic trauma has caused a strange form of "repetition compulsion". Because of these periodic denials the interest in psychic trauma waxed and waned during the last century.

On the whole, the attitude of health personnel paralleled those of the public. In some contrast to general public opinion, medicine only reluctantly accepted severe life events as causes of psychiatric illness. Those few researchers who carried out continuous research activity in the field of traumatic stress often had a direct experience with psychic trauma themselves, for example during the First World War or the Second World War. The doctors who described concentration camp syndrome in 1947 (Helweg-Larsen et al, 1952) were themselves survivors, as were a number of the eminent researchers in this field (Eitinger, 1964; Krystal, 1964). The doctor who first described war sailor syndrome in Second World War convoy sailors had himself been torpedoed in such service (Egede-Nissen, 1978). Many times during the last century a few dedicated professionals have done what they could to lift psychiatry's amnesia of the importance of psychic trauma. War has regularly been necessary to break the denial. The work of the dedicated again succeeded in the 1970s, in the wake of the Vietnam War and women's struggle for equal rights. As one would expect when denial is lifted, the result is ambivalence in many, and in some enthusiasts a tendency to inflate the concept of trauma, and, as mentioned above, to exaggerate the frequency of psychic trauma as well as the severity of its effects.

A third striking theme in the history of psychic trauma research is how much explanations and theories of traumatic neurosis have varied for reasons within the health sciences themselves. Unfortunately, the picture is not only flattering to mental health professionals. The dominating schools of thought, fashions in medicine, therapist ideology and what particular role the researcher had in relation to a particular trauma population, seem to have contributed to

a one-sidedness that at times was remarkable, harmful to patients, and led to severe and unproductive controversies within the field.

Traumatic neurosis, the forerunner of PTSD, was understood either as an effect of organic brain injury, a psychological condition and or social illness. The latter point of view emphasised the secondary gain as terms such as secondary gain syndrome, Rentenneurose, were coined. (Bonhoeffer, 1926; Miller, 1961 a and b; Fischer-Homberger, 1975). After 1926 in Germany, the compensation laws were seen as causing the chronicity of war neuroses from the First World War.

There has been a continual controversy between those believing in a physical etiology and those who saw manifestations of trauma as a psychological disorder. A "somatisation" process runs through the entire century, very much inspired by doctors. Neurology has been competing with psychiatry, today clearly seen for example with regard to whiplash traffic injuries. The disabling effects of these injuries vary enormously between nations, indicating that iatrogenic causes, among others, may be at work. The preference of a somatic versus a psychological etiology appear to be a part of a larger split between a biomedical approach to trauma on the one hand and a psychosocial approach on the other. Cardiovascular symptoms in traumatised persons, particularly soldiers in war, gave rise to a long-running tradition of diagnoses focusing on this aspect of what has probably often been a somatic equivalent of post-traumatic stress syndrome, another anxiety disorder or a cardiac neurosis. It started (Myers, 1870; Da Costa, 1871) with "irritable heart", and "soldier's heart". The condition was frequent during the First World War when it was also given the respectable diagnosis "disorderly action of the heart" (Merskey, 1991), or "neurocirculatory asthenia". Twenty years after the First World War, 39,000 British soldiers were still disabled by this disorder. Recently, a possible relationship with mitral-valve prolapse has been suggested (Wooley and Boudoulas, 1988). Also in panic disorders similar cardiac symptoms have been reported.

Another controversy has raged between those who saw the disorder as arising after exposure to external or reality trauma and those who saw an internal or fantasy trauma, or which of the two was the more important etiological agent. Unfortunately, on at least two occasions in history, groundbreaking discoveries of the traumatic effect of a severe external stressor have been followed by a surge in interest and acceptance of the accompanying intrapsychic conflict as the most important cause of illness. The first time was when Freud launched his theory of neurosis based upon sexual trauma. In the end, it led to the acceptance of childhood sexuality, downplaying the role of external trauma. The second time was the traumatisation caused by the inescapable shock of artillery warfare in the First World War. It eventually led to the postwar acceptance of unconscious conflict as a symptom generator, while the role of external trauma was again downplayed. Both of these insights were of great benefit in general, creating an acceptance of childhood sexuality and the recognition that unsolvable intrapsychic conflicts generate symptoms. But the insights became harmful to trauma populations because the impressive intrapsychic phenomena took first place, and the external reality came a poor second. The false memory debate is a reminder that the controversy between external reality and fantasy trauma is still not settled.

Lessons learned

The history of European psychotraumatology shows that opposing cultural, social, economic and political forces have influenced scientific development. Inevitably, the theories of traumatic stress reflect the spirit of the age. Several of today's controversies were already evident during the First World War: the risk of reinforcing evacuation and compensation syndromes by legitimising diagnostic labels, increased somatisation when the psychological nature of trauma or a symptom is not understood, and the delete-

rious effect of treating the individual removed from his primary group setting. At the end of the 19th century and the beginning of the 20th century the study of psychic trauma identified important intrapsychic phenomena, and, consequently, there was a neglect of the external stressor.

If there is one impression that comes out of the encounter with the scientific history of psychic trauma, it is probably the risk of professional narrow-mindedness, and of being overly influenced by external demands and rewards upon the psychiatric community. Each generation may need to reformulate things in a new language, speak in a contemporary voice, and stay alert to the statements of their time. This may not matter much as long as the true nature of the phenomena is understood and communicated. Is there yet a risk that psychic trauma and its consequences will be denied? With the descriptive and objective nature of the PTSD criteria firmly anchored in the diagnostic classification systems of the ICD-10 and the DSM-IV, it is not very likely. But voices are already heard that want to abandon the A stressor criterion and base the diagnosis only on symptom criteria as in other psychiatric disorders. The abandonment of the concept of neurosis in the USA may perhaps over time lessen the understanding of the deeper and individual meaning of trauma.

A biomedical approach has its merits in its natural science attitude to trauma, to study and treat the human organism as a chemical-physiological structure interacting with the environment. This approach has produced impressive progress in illness prevention and treatment. The psychosocial approach has its strengths in providing an understanding of psychological and social factors. It makes the therapist a participating observer and focuses on communication, interpersonal relations, motivation, illness behaviour and patient and helper roles. Ideally, a good researcher/therapist should be able to integrate the biomedical and the psychosocial approaches.

Diagnostic criteria: The stressor and the stress response

Whereas PTSD is classified in the DSM-IV as an anxiety disorder, it is placed among stress-related disorders in the ICD-10. When there are still so many views about the true nature of PTSD (Davidson & Foa, 1993), it comes as no surprise that there still remain many unclarified issues about the development of the disorder.

PTSD, (309.81 in the DSM-IV and F43.1 in the ICD-10) and enduring personality change after catastrophic experience (F62.0) are as rare phenomena in psychiatry as etiological disorders. Along with a few other conditions such as induced delusional disorder (F24), formerly referred to as folie ą deux, and disorders accociated with the puerperium (F53), post-traumatic diagnoses are not defined solely on the basis of the signs, symptoms and course. PTSD contains an explicit assumption that the cause of the disorder is known, it is identifiable. Another assumption of the ICD-10 is that the immediate response to the trauma is a normal reaction since the stressful event is characterised as likely to cause pervasive distress in almost anyone. This consequence of the stressor is no longer a part of the DSM-IV. The diagnosis of PTSD is based on the causative influence of an exceptionally threatening or catastrophic stressful event, which is the term used in the ICD-10 (WHO, 1992) or on a traumatic event or an extreme stressor, the term used in DSM-IV (American Psychiatric Association, 1994). The stressful event is the primary and overriding causal factor, and the post-traumatic stress disorder would not have occurred without its impact. As one would expect, since its introduction in the psychiatric nomenclature in 1980, PTSD diagnosis has had a dramatic impact on forensic psychiatry and the law.

The provision of both clinical diagnostic guidelines (WHO, 1992) and research diagnostic criteria (WHO, 1993) of the ICD-10 is one important difference from the DSM-IV approach. The diagnostic guidelines are basically a prototype approach to classification, in contrast to the categorical research diagnostic criteria. The de-

scription of the stressor criterion however, is identical in the two ICD-10 versions: the patient must have been exposed to a stressful event or situation (either short or long-lasting) of an exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone. From the examples listed, it is clear that the event must involve a severe threat to or loss of life: natural or man-made disaster, combat, serious accident, witnessing the violent deaths of others, torture, terrorism, rape or other crime.

The DSM-IV subdivides the exposure into direct exposure to, witnessing of, or confrontation with the traumatic event. Among the traumatic events that are experienced directly, being diagnosed with a life-threatening illness is also included. Thus, also a common life event is considered a stressor A criterion. In contrast, the ICD-10 classifies serious physical illness only as a stressful life event likely to give rise to adjustment disorder, not PTSD. Although PTSD may develop in severely ill patients (Shalev et al, 1993), it is exceptional (Van Driel and Op den Velde, 1995). Difficult childbirth is associated with PTSD (Ballard et al, 1995). In addition to witnessing serious injury or unnatural death, the DSM-IV also lists unexpectedly witnessing a dead body or parts. Events experienced by others that are learned about include, but are not limited to: violent personal assault, serious accident or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. From the point of view of this writer, one of the provocative challenges of the PTSD stressor criterion in the DSM IV is its vast range: from the common threats to life occurring sooner or later in most people's lives, to the most extreme and long-lasting, such as concentration camp experience and genocide. Is this tenable?

The DSM-IV has added a subjective threat response as imperative to the diagnosis. Thus, criterion A is no longer limited to the

objective, external stressor, but also demands a certain quality of the immediate response:

A. The person has been exposed to a traumatic event in which both of the following were present:
   1) The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of the self or others;
   2) The person's response involved intense fear, helplessness or horror. (In children, this may be expressed instead by disorganised or agitated behaviour.)

This additional aspect introduces the need to document a subjective experience, with all the possible methodological problems that may arise. One reason for including this subjective response variable, thus departing from the earlier strictly objective stressor-based definition, is the importance of the subjective perception and appraisal in response to an event (Davidson, 1994). Some authors have argued that the stressor criterion should be abolished altogether, or be defined as an event shocking the individual (March, 1993). Another reason is the need in the USA to be restrictive because of the exorbitant demands for financial compensation for trauma victims.

In both diagnostic systems, the post-traumatic stress syndrome is organised around the three core elements of intrusive re-experiencing, avoidance and psychic numbing, and physiological arousal.

The *clinical description and diagnostic guidelines* of the ICD-10 are as follows. Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks") or dreams, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is commonly a fear and avoidance of cues that remind the sufferer of the original

trauma. More rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor (WHO, 1992).

It appears that, while the diagnostic guidelines require the repetitive symptoms, avoidance or psychic numbing are not absolutely mandatory: in the ICD-10 the numbing components are more a characteristic of the personality change entity than of PTSD. If the symptom pattern of PTSD occurs in response to a stressor that is not extreme, a diagnosis of adjustment disorder (F43.2) is appropriate.

The ICD-10 symptom *criteria for research* are more categorical:

B. There must be a persistent remembering or “reliving” of the stressor in intrusive “flashbacks”, vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor;

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor;

D. Either of the following must be present:

1) inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor;
2) persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
   - difficulty in falling or staying asleep;
   - irritability or outbursts of anger;
   - difficulty in concentrating;
   - hypervigilance;
   - exaggerated startle response.

E. Criteria B, C and D must all be met within six months of the stressful event or of the end of a period of stress. (For some purposes, onset delayed more than six months may be included, but this should be clearly specified.)

Long-term effects

The course of PTSD according to the ICD-10 description fluctuates, but recovery can be expected in the majority of cases. In a small proportion of patients, the condition may show a chronic course over many years and a transition to an enduring personality change (F62.0). (In the DSM-IV the PTSD is termed "chronic" already after three months.) According to the ICD-10 diagnostic guidelines, the late chronic sequelae of devastating stress, those that manifest themselves decades after the stressful experience, should be classified as an enduring personality change. Thus, the ICD-10 makes a clearer distinction between the two disorders, based upon their entirely different courses and development.

The diagnosis of *personality change* recognised in the ICD-10, but not yet in the DSM system, requires exposure to catastrophic stress, such as concentration camp experience, torture, disaster, prolonged exposure to life-threatening circumstances (for example hostage situations, prolonged captivity with an imminent possibility of being killed). The stress must be so extreme that it is unnecessary to consider personal vulnerability in order to explain its profound effect on the personality. The personality change should have been present for at least two years, be significant and represent inflexible and maladaptive features, as indicated by the presence of the following features not previously seen (WHO, 1993):

1) a permanent hostile or distrustful attitude towards the world;
2) social withdrawal;
3) a constant feeling of emptiness or hopelessness;
4) an enduring feeling of being "on edge" as if constantly threatened without any external cause;

5) estrangement; a permanent feeling of being changed or of being different from others.

While the diagnostic guidelines do not require more than one of the above, the criteria for research require the presence of at least two of the features.

A personality change meeting the above criteria is often preceded by a post-traumatic stress disorder. The symptoms of the two conditions can overlap, and the personality change may be a chronic outcome of a post-traumatic stress disorder. However, an enduring personality change should not be assumed in such cases, unless, in addition to at least two years of post-traumatic stress disorder, there has been a further period of no less than two years during which the above criteria have been met. The diagnostic guidelines state that a long-term change in personality following short-term exposure to a life-threatening experience such as a car accident should not be included in this category, since recent research indicates that such a development depends on a pre-existing psychological vulnerability (WHO, 1992). Usually the personality change has to be confirmed by a key informant.

The mechanisms operating during the "latency period", the "symptom free interval" as it is called, lasting often several years from the trauma exposure to the start of the delayed PTSD or the enduring personality change, still remain somewhat unclear, and hardly any detailed prospective studies of this phase have been carried out. But the people do seem to have become more defensive, and something has happened with their perception and awareness.

Diagnosis of the acute stress response

In the ICD-10, acute stress reaction is defined as a transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress and which usually subsides within hours or days.

In addition to the PTSD stressor criteria, an unusually sudden and threatening change in the social position and/or network of the individual is included in the description of the stressor. Examples are multiple bereavement and domestic fire (WHO, 1992).

The symptoms usually appear within minutes of the impact, and often disappear within hours or two to three days. The more categorical research criteria (WHO, 1993) state that the stressor is followed by symptoms within one hour, and that if the stressor is transient or can be relieved, the symptoms should begin to diminish after not more than eight hours. If exposure to the stressor continues, the symptoms must begin to diminish after not more than 48 hours.

The symptoms show great variation, but typically they include an initial state of "daze", with some constriction of the field of consciousness and narrowing of attention, an inability to comprehend stimuli, and disorientation. The diagnosis includes previously used labels such as combat stress reaction, combat fatigue, acute crisis reaction, crisis state, and psychic shock. Withdrawal from the surrounding situation may follow to the extent of dissociative stupor (F44.2), or by agitation or overactivity (WHO, 1992). For research purposes, the acute stress reaction may be graded (WHO, 1993). The milder form has the symptoms of generalised anxiety disorder (F41.1). In the moderate and severe forms respectively, any two or four of the following symptoms must be present: (a) withdrawal from expected social interaction; (b) narrowing of attention; (c) apparent disorientation; (d) anger or verbal aggression; (e) despair or hopelessness; (f) inappropriate or purposeless overactivity; (g) uncontrollable and excessive grief (judged by local cultural standards).

A dissociative stupor will also qualify for a diagnosis of severe acute stress reaction; there is a profound diminution or absence of voluntary movements and speech and of normal responsiveness to light, noise and touch (WHO, 1993).

In sharp contrast to the acute stress reaction of the ICD-10, the acute stress disorder (ASD) of the DSM-IV should only be consid-

ered if the symptoms last for at least two days, it may occur within four weeks of the traumatic event (in the ICD-10 this is the maximal onset latency of the stressful event preceding the adjustment disorder), and does not persist beyond four weeks after the traumatic event. The ASD symptom criteria are essentially the PTSD symptoms plus at least three of the following five dissociative symptoms: 1) a subjective sense of numbing, detachment, or absence of emotional responsiveness; 2) a reduction in awareness of his or her surroundings ("being in a daze"); 3) derealisation; 4) depersonalisation; 5) dissociative amnesia (the inability to recall an important aspect of the trauma).

The ASD criteria were strongly influenced by the work of Spiegel and his group (Spiegel, 1994). While an early diagnosis of PTSD can be made according to the ICD-10, supposedly often preceded by an acute stress reaction, there is no such possibility in the DSM-IV; the diagnosis for a proportion of those exposed may satisfy the ASD criteria, for the remainder one month has to pass before the PTSD diagnosis can apply. In the meantime, a diagnosis of adjustment disorder (309) will have to be made.

The diagnosis of acute stress reaction fits well with the clinical presentations of most combat stress reactions, and the crucial importance of early intervention for a favourable prognosis. A 90% return to duty is expected when the principles of forward treatment are practised (Belenky, 1987). Only comparative research between the ICD-10 and the DSM- IV can clarify which of the two formulations of acute post-traumatic stress responses is closest to clinical reality. Their predictive validity of later PTSD would be their greatest clinical and research relevance (Bryant, 2000, has produced some promising findings).

The post-traumatic stress spectrum

Traumatic stress response disorders constitute a spectrum of trauma-related disorders including acute stress reaction, acute

PTSD, chronic PTSD, multiple trauma response disorders, personality disorders related to chronic/early trauma, such as enduring personality change after catastrophic stress, borderline personality disorder/ multiple personality disorder, or what Herman (1992) termed complex PTSD, a diagnostic entity not accepted by the DSM-IV forum. European and American criteria differ substantially, as briefly reviewed below.

A "pure" PTSD is a relatively straightforward disorder that occurs after a catastrophic stress in individuals without previous traumatisation and without pronounced premorbid vulnerabilities. Preselected and trained persons, such as uniformed personnel, are likely to develop a "pure" PTSD.

A person with significant psychological vulnerability is not only more prone to develop PTSD, but also comorbidity, most often depression, substance abuse, anxiety disorders, etc. Nearly all PTSD patients complain about somatic symptoms, such as pain.

A child exposed to multiple traumas, such as violence or sexual abuse, is at risk in adulthood of suffering from any of a number of psychiatric disorders: PTSD, depression, anxiety disorder, suicidality, dissociative disturbances, eating disorders, psychosis, substance abuse and personality disorders.

Positive and negative consequences of PTSD diagnosis

The lack of a unifying clinical and diagnostic concept had, until 1980, many negative consequences. Some national diagnostic systems, however, included special diagnoses which to some degree made up for the shortcoming: accident neurosis, post-traumatic neurosis, war neurosis, concentration camp syndrome, war-sailor syndrome, etc. This practice may have been more problematic in the USA, where the term "neurosis" was often equated with a psychoanalytic etiology, than in Europe where the term retained more of its original descriptive meaning: a group of psychiatric disorders

that could be differentiated from psychoses on one side and from personality disorders on the other. However, the lack of a generally accepted diagnostic concept hindered both the public and the professional understanding of the post-traumatic suffering. Focusing on the etiological role of such a psychic trauma by introducing the PTSD diagnosis (American Psychiatric Association, 1980) has had many positive effects. The new diagnosis helped to see the true relationship between the trauma and the sequelae, a sine qua non for correct treatment. The previous practice of using ordinary psychiatric diagnoses on trauma patients because of what appeared as symptom overlap with traditional psychiatric illnesses was often unfortunate and harmful for the poor victims who needed to understand and accept their psychological problems. Instead, the social stigma of being a general psychiatric patient could follow. The PTSD diagnosis has given due recognition to people who have undergone exceptional suffering (Yehuda and McFarlane, 1995).

At this point, however, there may also be reason to ask some critical questions about the possible negative effects of introducing a diagnosis that emphasises the environmental dimension to such a degree and the "normalcy" of the response. How does PTSD as a diagnostic concept affect primary and secondary gain (emotional, financial, social) and the motivation for treatment? Are there negative effects of a high public awareness of diagnostic criteria, of a "diagnostic culture"? What are the effects upon personal initiative of defining life experiences in terms of diagnoses (Stuhlmiller, 1995), of "medicalising" life events? Since the post-traumatic stress syndrome is described as a normal response, does expectancy influence the frequency and course of the response? There is a risk of the pathogenic effects of exaggerating the severity of traumas on the one hand, and the frailty of the human organism, physically or mentally on the other. The iatrogenic contribution to poor prognosis in whiplash neck injuries after traffic accidents in Scandinavian countries is a well-recognised example. Doctors with experience limited to patient

populations have tended to wrongly predict too negative effects of stressful events. The "mass psychoses" predicted before the First World War never appeared, neither did the "mass neuroses" expected during the Second World War. The resilience of the human being has been underestimated. What about mass PTSD in the future? Does emphasising the external origin of trauma lessen the sense of personal responsibility for the acute and long-term responses to it? What is the effect of terming PTSD "chronic" (as in the DSM-IV) already after three months of symptoms? What is the effect on a person who is inclined to reorganise his entire life history around a trauma, on the relocation of blame "into the gaping hole called trauma"?

The introduction of PTSD in 1980 coincided with the removal of the concept of neurosis from the American diagnostic system. This may not matter much as long as the true nature of the phenomena is understood and communicated. As far as diagnostic discussions go, the development since 1980 has been very positive in the field of traumatic stress. However, when it comes to a fuller understanding of a single case, one sometimes misses the interest in the dynamic aspects and in clinically useful concepts such as the deeper meaning of the trauma, its relationship with intrapsychic conflicts, primary and secondary gain, resistance, transference, or meaningful synonyms for these concepts.

Furthermore, why should a stress reaction that reflects real life experience and is seen as a normal response, require a trained clinician as a therapist? Indeed, it looks as if the diagnosis and treatment of PTSD relatively often is left in the hands of less well-trained therapists. This practice contrasts somewhat with the many difficulties often said to exist in treating this patient population.

A framework for understanding trauma

Exposure to trauma and its sequelae are best understood in the context of a bio-psycho-social-cultural model (Danieli et al, 1996), involving a complex interplay of multiple spheres or sys-

tems. Among these are: the physical and intrapsychic; the interpersonal-familiar, social, communal; the ethnic, cultural, religious, spiritual; the educational, professional, occupational; and the material, economic, political, national and international. These systems co-exist along the time dimension and create a sense of continuity in life from the past through the present to the future. Exposure to trauma causes a rupture, and often a regression and a state of being fixated, in contrast to the normal free flow and psychological access to and movements within all these dimensions. A sense of discontinuity was among the most frequent phenomena reported half a year after a sudden shock trauma (Weisæth, 1984). The time, duration, extent and meaning of the trauma for the individual, and the survival mechanisms the individuals utilise to adapt to it, will determine the degree of disruption and disorganisation.

In order to understand the full impact of a trauma upon a person it is necessary to look at the whole traumatic situation, its biological, psychological, social and existential aspects, and often also other dimensions. It is often necessary to employ several of the well-known frames of psychological references, such as the energy-economical, topographical, developmental, psychodynamic, ego-psychological, adaptive, and social psychological points of view. The learning theory of conditioning obviously has an explanatory power for some of the responses.

Brewin (2003) discusses how some people experience their identities as positive and optimistic selves, when confronted with a potential traumatic event. A "competent self" has been triggered and rises to the occasion. In others, the stressful event triggers an undesired or feared self "in which the person feels overwhelmingly weak, inadequate or alone". In describing what a traumatic impact does to the individual's identity, Brewin lists seven core themes, which may occur alone or more often in combination: 1) the Self as powerless; 2) the Self as inferior; 3) the Self as non-existent; 4) the Self as

futureless; 5) the Other as abandoning; 6) the Other as betraying; and 7) the Other as hostile.

In my opinion, these underlying meanings of the experience of being traumatised are very useful to the therapist, and add to the value of a diagnostic evaluation as a starting point for therapy.

In the remaining part of this chapter, the stressor is examined as an etiological factor for acute, chronic and delayed PTSD. The discussion will also have relevance for the diagnosis of acute stress responses (acute stress reaction of the ICD-10 and acute stress disorder of the DSM-IV) and post-traumatic personality change.

Life threat as objective stressor

As stated above, a severe threat to or loss of life is a prerequisite in order to qualify as a PTSD stressor. Danger to life in military combat has been the classic stress exposure, studied by generations of stress researchers. The severity of the combat exposure may be scaled by various objective measures, intensity and duration often being used. Intensity of combat is traditionally scaled after numbers of soldiers killed (KIA) and wounded (WIA) or missing in action. The ratio of combat stress reactions (CSR, "battle shock", likely to be a form of acute stress reaction) to KIA and WIA is expected to be 1:1:4 in an "average" battle fought with conventional weapons. The risk of developing PTSD has been shown to be associated with the rates of CSR (Solomon et al, 1987). Combat exposure was associated with a high probability of PTSD; 38.8%, in a national sample study (Kessler et al, 1995). In a number of recent studies of combat-related PTSD, a relationship has been found between the severity of the exposure and the risk of PTSD. A methodological weakness in some of these studies is that combat stress exposure indices used in scaling the stressor have been based only upon the soldier's self-report, and have not fully utilised more reliable independent sources of information about his military unit's combat history. On the other hand, such sources also used alone

cannot yield an accurate picture of the experiences of the single soldier.

Goldberg et al (1990) found a positive association between the intensity of combat exposure and the risk of PTSD in monozygotic twins. This is the first study that tested for the possible effect of genetic variability.

In a study of merchant sailors exposed to terror attacks in the Persian Gulf during the Iran-Iraq War, it was found that experiencing more than one attack and having sailed more than 20 tours into the Gulf significantly increased the risk of developing post-traumatic stress symptoms (Lie et al, 1993).

Being physically injured or wounded has been found to constitute a risk factor in several combat, accident and crime studies, but also unrelated in some. Clinical experience indicates that most often an injury adds significantly to the stressor severity, while in some situations, such as combat, a moderate injury may sometimes have the effect of reducing the stress exposure.

Malt, in his detailed prospective study of accidentally injured (Malt, 1988), found a low prevalence of PTSD, according to DSM III criteria only 1%. The lack of avoidance symptoms disqualified some from the diagnosis: applying the new diagnostic ICD-10 guidelines would therefore yield a higher prevalence. The brevity of the exposure to danger in most automobile accidents accounted partly for the low risk of PTSD in his study. However, more than 20% developed anxiety or depressive symptoms of clinical intensity.

In a representative national sample of persons aged 15 to 54 years (Kessler et al, 1995) 65% of men and 45.9% of women who reported rape as their most upsetting trauma developed PTSD. In her study of rape victims, Dahl (1993) found that the objective description of the level of violence, such as the presence and use of a weapon by the rapist, choking the victim, etc, predicted one year PTSD with higher accuracy than the victims' reported subjective experience of death threat.

By slightly varying the way in which the stressor criterion of the DSM was defined, Snow et al (1988) found that PTSD prevalence rates differed by as much as 1.8% to 12.0% in a veteran population. Thus, the stressor definition is of paramount importance. In the DSM-IV, estimates of the prevalences of PTSD among those exposed to a criterion A stressor range from 3% to 58% (APA, 1994). Thus, PTSD may be a relatively rare outcome compared to the prevalence of the stressors. As stated above, one problem with the stressor criterion is its vast range, encompassing daily events such as traffic accidents to massive, extreme and rare traumatisations such as exposure to genocide. Stressors are thought to become traumatic when a person loses all personal sense of control over the outcome of the event (Van der Kolk et al, 1996). Neither is PTSD always the most frequent outcome of traumatic events. It is noteworthy that while only 15% of Cambodian displaced persons suffered from PTSD as a long-term effect of the enormous stressors they had experienced in the 1970s and 1980s, as many as 55% had symptom scores that correlate with Western criteria for depression (Mollica et al, 1993). Despite the reported high levels of trauma and symptoms, social and work functioning were well-preserved in the majority. As some element of loss is nearly always a part of psychic trauma, grief reactions and depressive symptoms are commonly associated with PTSD symptoms, and suicidal ideation is not infrequent. Grief reactions alone, considered to be abnormal because of their form or content, should be diagnosed as adjustment disorder (WHO, 1992).

According to March (1993), bereavement was positively related to PTSD in four out of five field trial studies, and unrelated in one. Witnessing death has been found to relate to PTSD in several studies. Children who witness parental killing are at an extremely high risk of developing PTSD (Black et al, 1993). The risk of PTSD from learning about a stressor A as a criterion has not been very well studied. Only a few studies were found in which hearing about death was positively related to the development of PTSD.

The degree of life-endangering exposure can sometimes be scaled by using quite objective measures, such as geographic distance in metres between the exposed person and the centre of impact if the exact location of the person at the very moment of impact can be established. This was the method chosen in studying the peri-traumatic responses and the prospective investigation of the acute, subacute and long-term reactions to a major explosion that had occurred in an industrial plant (Weisæth, 1984, 1985, 1989 b, c; Weisæth & Eitinger, 1993). Mortality and injuries were dependent upon the distance from the explosion, and the distance was related to the intensity of visual, acoustic, mechanical (air pressure) and other stimuli that made up the stressful impact. The severity of the exposure in turn correlated strongly with the later development of PTSD. In the high-exposure group, PTSD prevalence rates were 36% after seven months, 27% after two years, 22% after three years, and 19% after four years. In the medium-exposure group, the decrease in PTSD rate was from 17% after seven months to 2% after four years. The groups were comparable on pre-traumatic characteristics and had been handled in similar ways after the disaster. Thus, the severity of the stressor constituted an important illness risk as well as a prognostic risk factor. While in both these groups the great majority developed significant symptoms of distress within the first week after the explosion, the frequency and severity of the acute response correlated with the degree of exposure.

For the other employees, just witnessing such a stressor to their workmates, even at a close distance but without facing any danger themselves, was not a severe enough event to cause real PTSD. A minority of them showed distress during the first weeks, and a few sensitive persons developed post-traumatic stress symptoms, thus qualifying for a diagnosis of adjustment disorder; it might have been called "pseudo-traumatic neurosis" before 1980. Such findings lend strong support to the validity of the PTSD stressor criterion. The

narrow escape from a severely life-threatening danger was the dominating traumatic exposure found in this study, and PTSD with low psychiatric comorbidity was the dominating outcome in this population of shift workers characterised by previous good mental health. This demonstrated that the PTSD was mainly caused by the risk to life, an interpretation supported by the positive correlation with physical injuries.

Value of life

The immediate response to a sudden, unexpected and extremely severe life-endangering event may be such a basic human response that it is relatively independent of context. All the A stressors listed in DSM-IV are uncontrollable events, and with the exception of life-threatening illness, they are all external in origin.

Since the threat to life is such a central part of the PTSD stressor criterion, beliefs and attitudes to life and death could influence very much the core etiological factor. Such fundamental existential issues differ very much between cultures. Varying rates of PTSD were found among UN peacekeeping soldiers relative to cultural background (Weisæth and Sund, 1982). Possible death may be an acceptable risk for a well-motivated soldier or torture victim fighting for an important cause, while totally meaningless for a traffic accident victim. Despite the many ethnocultural aspects of PTSD and the publications that have addressed them, relatively little is known yet about the relationship between ethnocultural factors and the etiology of PTSD, although the evidence is accumulating (Marsella et al, 1996). Reflecting the recent history of research in traumatic stress, most of the theory, research and measurements on PTSD have been generated by North American professionals who have studied ethnic groups in the USA. The extensive and intensive study of American veterans of the Vietnam War (Kulka et al, 1990) demonstrated, for example, that Hispanic veterans had higher rates of PTSD than white or black veterans. Still, however, there is a shortage of studies of psychic trauma

in non-Western cultures, and ethnocentric bias may easily result when applying findings cross-culturally.

Special aspects of the stressor

Studies show that shock traumas often produce PTSD, particularly if the shock was severe and inescapable (Raphael, 1986). The pathogenic effect of inescapable shock traumas is also supported by a long history of laboratory research on animals since the days of Pavlov; shock given in an unpredictable and uncontrollable way seems very difficult to handle. Even when severe stressors are escapable, the acuteness and the shock quality of the event may produce acute PTSD prevalences of 20% to 40% in previously mentally healthy populations such as industrial or offshore shift-workers (Weisæth, 1985; Holen, 1990). Series of traumatic events seem to produce PTSD with high comorbidity of other psychiatric disorders, and a complex post-traumatic syndrome (Herman, 1993). Combinations of year-long extreme stress and constant uncertainty and no possibility of control seem to produce delayed PTSD and enduring personality changes and a broad spectrum of other psychiatric problems as well as somatic consequences.

Collective versus single trauma

The collective nature of disaster trauma offers the researcher a cost-effective opportunity to study variance within a population exposed to the same trauma. During an impact, the disaster victim is likely to experience enormous destructions, suffer multiple losses, witness mass injuries and deaths, and may have to make difficult choices between ensuring his own survival and the possibility of helping others. The presence of others, however, also increases the opportunity for leadership and one's own rescue. On the whole, however, a disaster victim probably experiences more intense feelings of powerlessness than the accident victim. This may partly explain the higher PTSD rates found after collective traumatic situa-

tions (Raphael, 1986). Again, because of the magnitude, in the immediate aftermath, the disaster victim is more likely to suffer from the inadequacy of emergency operations, compared to the accident victim who normally benefits from an intact framework. As far as psychological reactions are concerned, there are research observations indicating that the social influence in a collective danger situation may synchronise and reinforce the peritraumatic responses (Weisæth, 1989b) and the post-traumatic stress reactions (Berle et al, 1991). In children, post-traumatic symptom contagion has been reported (Terr, 1985). Group situations open up many possibilities for working through the trauma that a single accident victim does not have. Sociological findings have emphasised the positive effects upon health by the development of an "altruistic community" after disasters.

Finally, disaster victims in Western society become the centre of public sympathy, leading to the participation and support of society's leaders and to enormous media attention, in stark contrast to the lonely fate of many experiencing single trauma.

Studies of extreme and prolonged stress

Some of the early work in the field of traumatic stress, the examination of concentration camp survivors, still rank among the very best, because of their rigid methodology, but they were carried out long before PTSD became an official diagnosis. Long-term follow-up studies, with high response rates in representative samples and adequate control groups (Eitinger, 1964; Strøm, 1968; Eitinger and Strøm, 1973), showed that concentration camp survivors constituted a positive sample of their national populations in terms of their prewar health. After the war, their increased mortality, general somatic morbidity, and psychiatric morbidity were repeatedly documented (Venzlaff, 1966; Hocking, 1970). In the current diagnostic language, it was found that concentration camp syndrome included a PTSD, and often an enduring personality change after

catastrophic experiences as well. The concentration camp experience was a complex trauma with severe biological, psychological, social and existential stressors, and, as expected, the health sequels were complex, often a combination of somatic, psychological and social health problems. Among the consequences is a diminished ability to tolerate stressors later in life.

In recent years, studies from the former Soviet satellite states in Eastern and Central Europe have examined the long-term effects of political imprisonments under the communist regime (1944–1991), when one million died forcibly in these countries. The findings are identical with the studies of the survivors from the Nazi camps during the Second World War (Maercker and Schützwohl, 1997; Müller, 2004). The first studies on the traumatisation of politically repressed people (political prisoners and deportees) from Baltic states, Latvia (Vidnere & Nucho, 1966) and Lithuania (Kazlauskas & Gailienė, 2003), occupied by the former Soviet Union, have been published. The findings are also similar; besides, it appeared that the outcome of different repressions are slightly different (Kazlauskas & Gailienė, 2003).

Studies of merchant sailors from the Second World War Allied convoy service (Askevold, 1976–77), who had up to six years of constant exposure to significant danger, characterised as unpredictable and with low control, also showed very high rates of PTSD, usually in a delayed form, often developing after decades, at that time termed "war sailor syndrome".

Based on the findings from studies of these Second World War victims and participants, it was considered possible by medico-legal experts to estimate an approximate threshold for the duration of the exposure of at least six months, above which the effects would be a highly increased risk of health failure, including PTSD. When this duration of exposure was exceeded, which could be objectively verified from independent sources, the requirement to demonstrate a causal link between the stressor and the illness was lifted; a disabled war pension would be awarded automatically if the work ca-

pacity had been reduced more than 50%. Thus, from the late 1960s, the definition of the stressor criterion made matters much simpler for patients, doctors and the authorities. In a way, this principle of presuming an etiological link for an entire exposed group anticipated the definition of the stressor criterion. This principle was also applied by the United Nations Compensation Commission for the victims of Iraqi aggression before and during the Gulf War.

Studies of torture survivors over the last couple of decades have yielded similar findings (Turner, 1989; Rasmussen, 1990; Basoglo, 1992) on long-term effects. This is not surprising; severe torture, like concentration camp experience, deprives the victim of all basic physiological, psychological and social needs listed in Maslow's pyramid or hierarchy of fundamental human needs (Maslow, 1970).

Torture may contain all the stressors that can contribute core pathogenic factors for PTSD: infliction of physical suffering and pain, exposure to death threats, terrible witness experiences, such as being a helpless witness to family members or companions being raped or murdered, and attacks upon human integrity by all sorts of degrading treatment.

Dutch researchers have drawn attention to somatic complications such as vital exhaustion (Falger et al, 1990) and psychosomatic disorders (De Loos, 1990) as pervasive aspects of the clinical picture presented by Second World War veteran populations with PTSD (Ørner, 1992). They have demonstrated how chronic traumatic stress symptoms both maintain and mediate the pathogenic process that culminates in vital exhaustion, a reduced capacity for adjustment to the stress of everyday life, poor health and a failure to regain good health. European research on the late sequelae of exposure to severe and prolonged stressors during the Second World War suggests that PTSD may be considered a process and prognosticator of adjustment processes.

The undisputed finding from these studies of massive Second World War traumatisations, however, is the devastating effect upon

subsequent health of excessive and long-lasting stress, almost regardless of premorbid factors. Thus, it was demonstrated convincingly that premorbid characteristics have very little, if any, importance in this kind of traumatic setting. This does not rule out the importance of the recovery environment for certain functional impairments.

The nature of the stressor

So far, no attempts have been made to systematise life-threatening stressors in order to create a hierarchy of traumatic events, in terms of their pathogenicity. An adequate typology is not available. However, if we put before us the stressors known to carry a risk of PTSD, it becomes quite clear that there are links between the quantitative and the qualitative dimensions of the trauma. In addition to the threat to one's life and body integrity and severe physical harm or injury, several generic dimensions of traumatic stressors have been proposed: receipt of intentional injury/harm; exposure to the grotesque; witnessing or learning of violence to loved ones; learning of exposure to a noxious agent; and causing death or severe harm to another. Some of these dimensions are included in the description of the DSM-IV stressor criterion.

There is a growing literature that provides evidence about these particular dimensions as being traumatic aspects of the stressor. It has not been established at what level of severity each dimension alone is a sufficient cause of PTSD.

The degree of intentionality appears to be important. Stressors may be natural forces or manmade events. The latter may be perceived as accidental, due to human error, negligence or outright malice, such as interpersonal violence. PTSD prevalence after such events, based on the still scanty comparative studies, increases in the order given.

Nature can do harm, but nature has no evil intent, at least it is not perceived as such by modern man. People have this capability.

The man-to-man context, often with attacks on man's integrity and self-respect, differs from natural trauma. Nature does not threaten man's self-respect, even if it kills him. Technological disasters are not necessary, but avoidable; therefore, they produce distrust rather than acceptance.

There are no comparative studies of responses to a technological danger perceived as accidental and one seen as due to negligence. However, a comparison between the former and a collective violence trauma demonstrated marked differences: the violence produced a higher prevalence of PTSD, the content of the symptoms was of an interpersonal threatening nature in contrast to material/technological dangers, there was social isolation rather than circumscribed phobias, and the anger was a direct reaction to the violence. No aggressive symptoms of this nature were found in those exposed to the technological danger (Weisæth, 1989 a, c). The aggression among the latter was of a neurasthenic type, irritability caused by the traumatic anxiety symptoms and the sleep disturbance, and constituted a very significant complication to the anxiety symptoms of the PTSD. Since 1987 DSM-III-R this type of irritability was included as a PTSD symptom criterion.

A "silent trauma" implies that the individual has no way of discovering the danger which is only experienced when he is informed about it. Exposure to radiation and toxic chemicals may not be an acute, time-limited event, but rather a sequence of events that continue to unfold over several years (Tųnnesen el al, 2002). The belief that one has been exposed to toxic substances may cause long-term uncertainty and stress, and also pose a threat to one's health (Baum, 1986). The toxic disaster may have no clearly defined "low point", and if the dangerous substance is invisible or otherwise impossible for the exposed individual to detect, a particularly difficult stressful situation is at hand. Psychiatric symptoms that may arise, such as "informed about radioactive contamination syndrome" seem to differ from PTSD

symptomatology (Green et al, 1994). The lack of a discrete traumatic event and the ongoing stress may partly explain this. PTSD which develops in people after exposure to invisible dangers that perhaps never materialised, and the accompanying uncertainty, may have a less specific repetitive content in their re-experiences. Such "threat traumas" seem to have produced as high rates of PTSD in convoy sailors who were not torpedoed as in those who were (Askevold, 1976–77). Exposure to the grotesque, particularly dead bodies and body parts (Ursano et al, 1990), carries a risk of PTSD.

A possibly traumatic stressor dimension is the approach-avoidance situation. In a single accident or crime, the victim may be caught between incompatible choices about how to respond, about what to do in order to survive, for example, between fight or flight. But, the presence of other victims poses the question of how much one should do to help others, as opposed to saving one's own life. This stressor quality correlated with survival guilt and depressive symptoms in the study cited above (Weisæth, 1989 c). These symptoms have not, however, belonged to the core symptoms of PTSD since the 1987 revision of the DSM-III.

The unit to focus on in order to understand many trauma responses is the family, or other small groups that the individual is strongly attached to. Were the family members together when the trauma struck? Were they split up and exposed, or were only some members affected? In the latter cases, search behaviour usually predominates throughout the family, both during the impact and in the immediate aftermath. As indicated above, while the stressor criterion includes such experiences, the PTSD symptom criteria may not cover such experiences very well.

Secondary stressors

Some destructive events, such as a disaster, are likely to cause what has been termed secondary stressors: loss of home, loss of

work, poverty in Third World countries. Severe additional stressors of long duration have probably contributed to the extremely high rates of PTSD after major disasters in poor countries (Lima et al, 1991). PTSD may itself contribute to an increase of life-events. Thus, negative self-perpetuating cycles of stressors may be initiated: stressor–PTSD–stressor.

Methodological problems

There are several reasons for the varying correlations between stressor A events and PTSD. One is that the comprehensive assessment of the traumatic event that is needed for the diagnostic work-up is often lacking in research on traumas. Even when objective information about the event is available, such as from military combat reports, police records, video recordings of accidents or disasters, the measurements of the stressor dimensions are often based only upon the description from the exposed person. In collective situations, cross-interviews will increase the reliability both on the degree of exposure and on the immediate responses to the trauma. The methodological failure to describe a stressor in sufficient detail based upon reliable sources may have an effect on the findings. Firstly, the lack of detailed description may leave out that crucial detail that made the stressor traumatic for one person. Secondly, the reported danger is not consistent over time. Rating the stressor upon a report from the victim with PTSD, because of the strong persistent subjective experience of the death threat, is likely to emphasise the danger aspects too much. None-PTSD subjects, because they forget the threat to their life more than the PTSD cases will, probably, decrease the severity of the reported danger (Malt and Olafsen, 1992; McFarlane, 1989).

While much of the research on the stressors can be criticised from a methodological point of view, the research on the post-traumatic responses often also suffers from weaknesses such as non-representative samples, retrospective designs, a lack of control

groups, short observation periods, and low quality in the clinical diagnostic procedure, etc.

The problematic consequences to research of non-response creating unrepresentative samples have not been focused upon much in traumatic stress research. Many studies have been carried out on selected groups, even self-selected volunteers or samples that are otherwise suspect, and with low response rates. In the study cited above, which in the end achieved a 100% response rate, it was found that a potential loss to follow-up caused by strong psychological resistance/avoidance reactions, would include over 40% of those who qualified for a diagnosis of PTSD if the response rate had been 82% (Weisæth, 1989 d). Thus, the logical effect of a bias in non-response would be to drastically reduce the true level of psychopathology. The more pronounced resistance and more frequent refusal in the high exposure group indicated that the losses to follow-up would be higher in the stress exposure. Considering that response rates are often reported to be below 80% in many studies, the dose response relationships that appear may have very poor reliability.

Severe stressors may be simple and unidimensional, involving, for example, mainly a threat to life. The severity of the stressor in terms of its capacity to cause a PTSD seems to be highly dependent on the amount of mastery possible, and the questions of control and predictability are essential. Thus, the speed of the onset, the level of preparedness and warning, the duration and the intensity of the impact are important dimensions.

Equating proximity to stressor with severity of exposure may mean seriously underestimating the empathic quality of the individual who is on the periphery or completely outside the scene of the traumatic event: in a natural disaster that killed more than half of a closely knit military unit, Herlofsen (1994) found that the posttraumatic stress reactions were more pronounced during the first weeks among those not directly exposed, than among the survivors

of the avalanche. The interpretation is that in this particular disaster, for those on the periphery, uncertainty about the fate of their friends and the lack of a possibility to act and help constituted more severe stressors than the perceived life-threat to the survivors. Thus, learning about the event was a very acute stressful event, but the threat to life took more time to work through. In certain stressful events, increasing exposure may actually reduce uncertainty, as well as lack or loss of control and available choices, and thus reduce the severity of the stressor. These are aspects of the stressor rather than mediating variables, such as the meaning of the stressor, and therefore these findings do not weaken the stressor-response relationship. Failure to include them, however, will distort the relationship. The example also illustrates some of the limitations in looking for linear correlations between a simple exposure factor and subsequent PTSD. When defining the stressor, it is crucial to ask the question: What is the most severe aspect of this particular exposure?

Although people may seemingly be exposed to the same event, as in a disaster situation, specific details and characteristics of the event itself may differ. The researcher or clinician may wrongly ascribe such differences to differing threat appraisal among the victims. Another example is offered by the location of survivors by a river boat disaster (Thompson et al, 1995); location on the boat was not related to psychological outcome, and this may have been due to the greater impact of other factors such as the suddenness of the disaster and multiple bereavement. Being separated from close friends and losing close friends led to higher distress scores, as did having difficulty staying afloat after the boat sank.

The objective stressor A criterion cuts across the many factors that may influence the interpretation of the event. It would be somewhat naïve, therefore, to expect strict linear correlations, and the dose-response relationships found may actually be regarded as quite impressive when viewed from that angle.

Conclusion

The evidence that stressful life events affect mental health, although consistent, is weaker in terms of explained variance than the evidence regarding the effects of extreme situations. The PTSD departs from the concept of stressors as nonspecific causes of disease. The stressor criterion has been quantitative, and the PTSD diagnosis is based upon the assumption that these stressors produce a distinct core of psychopathology.

It was documented early on that extreme and long-lasting stressors, such as from the concentration camp experiences described above, produce psychopathological sequelae in nearly everyone, regardless of individual vulnerability factors. In populations exposed to such levels of stress, PTSD appears to be a very frequent outcome, but most patients would also satisfy the diagnostic criteria for depressive or anxiety disorder, and somatic complications. It has been suggested that PTSD is a mediating factor in these complex clinical pictures.

During recent years, the concept of PTSD has inspired much-needed research on the effect of a range of stressors of less extreme intensity and of briefer duration. The bulk of the data seems to support the underlying assumption of the PTSD diagnosis that the stressor is a major etiological factor. For the less severe stressors that satisfy the stressor criterion in its present formulation, the evidence is weak and seems to indicate that particular traumatic dimensions must be present in the stressor if a high risk of PTSD is to be reached. Many studies fail to describe the stressor in sufficient detail or to provide control data on the stressor. Sometimes, too simplistic views of the stressor have been held.

The level of knowledge about the natural course of post-traumatic stress reactions, their type, frequency, intensity and duration following stressors of varying severity is unsatisfactory.

Undoubtedly, the PTSD diagnostic concept has had a favourable effect for victims of extreme stressors which cause PTSD in

previously mentally healthy individuals. It remains to be documented, however, whether individuals with PTSD brought about by less severe stressors and carrying some vulnerability, have been as well served. This justifies focusing on a stricter and more specified stressor criterion for the PTSD diagnosis. The last word has obviously not been said in this debate.

References

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders.* Third Edition, revised. Washington, DC.

American Psychiatric Association (APA) (1994). *Diagnostic and statistical manual of mental disorders* (4th ed). Washington, DC.

Askevold, F. (1976–77). War sailor syndrome. *Psychother Psychosom*, 27:133-138.

Baum, A. (1986). Toxins, technology, disasters. In: *Cataclysms, Crisis, and Catastrophes: Psychology in Action.* VandenBos, G. R., Bryant, B. K. (ed). American Psychological Association, Washington, DC: 53.

Belenky, G. (ed) (1987). *Contemporary Studies in Combat Psychiatry*. New York: Greenwood Press.

Berle, J.Ø., Haver, B., Karterud, S. (1991). Group reactions as observed in crisis intervention programs in hospitals. *Nordisk Psykiatrisk Tidsskrift*, 45:329-335.

Black, D., Kaplan, T., Hendriks, J.H. (1993). Father kills mother: effects on children in the United Kingdom. In: Wilson, J. P., Raphael, B. (eds). *International Handbook of Traumatic Stress Syndromes*, pp 551-559. New York: Plenum Press.

Bonhoeffer, K. (1926). Beurteilung, Begutachtung und Rechtsprechung bei den sogenannten Unfallsneurosen. *Deutsche Med. Wochenschrift*, 52:179-182.

Brewin, C.R. (2003). *Post-Traumatic Stress Disorder. Malady or Myth.* New Haven: Yale University Press.

Bryant, R.A., Harvey, A.G. (2000). *Acute Stress Disorder. A handbook of theory, assessment, and treatment.* Washington, DC: The American Psychological Association.

Caplan, E.M. (1995). Trains, Brains and Sprains: Railway Spine and the Origins of Psychoneurosis. *Bull Hist Med*, 69:387-419.

Da Costa, J.M. (1871). On irritable heart; a clinical study of a form of functional cardiac disorder and its consequences. *American Journal of the Medical Sciences*, 61:17-52.

Dahl, S. (1993). *Rape – A Hazard to Health*. Oslo: Scandinavian University Press.

Danieli, Y., Rodley, N.S., Weisæth, L. (1996). Introduction. In: Danieli, Y., Rodley, N.S., Weisæth, L. (eds) *International Responses to Traumatic Stress*. New York: Baywood, 1-14.

Davidson, J.R.T. (1994). Issues in the Diagnosis of Post-traumatic Stress Disorder. In: Pynoos, R.S. *Post-Traumatic Stress Disorder. A Clinical Review.* Lutherville: Sidran Press, 1-15.

Davidson J.R.T., Foa, E.B. (1993). *Post-Traumatic Stress Disorder. DSM-IV and Beyond.* Washington, DC: American Psychiatric Press.

De Loos, W.S. (1990). Psychotraumatic manifestations of chronic post-traumatic stress disorder. In: Wolf, M.E., Mosnaim, A.D. (eds), *Post-traumatic stress disorder: Aetiology, phenomenology and treatment.* Washington, DC: American Psychiatric Press, 95-104.

Egede-Nissen, A. (1978). *Krigsseilersyndromet (War sailor syndrome).* Tidsskrift for Den norske lægeforening, 98, 469 (English summary).

Eitinger, L. (1964). *Concentration Camp Survivors in Norway and Israel.* Oslo: Universitetsforlaget.

Eitinger, L., Strøm, A. (1973). *Mortality and morbidity after excessive stress: A follow-up investigation of Norwegian concentration camp survivors.* Oslo: The University Press. New York: Humanities Press.

Falger, P.R.J., Op den Velde, W., Hovens, J.E., Schouten, E.G., De Groen, J.H., Dujin, H. (1992). Current posttraumatic stress disorder and cardiovascular risk factors in Dutch resistance veterans from World War II. *Psychotherapy and psychosomatics*, 57:164-171.

Fischer-Homberger, E. (1975). *Die traumatische Neurose, vom somatischen zum sozialen Leiden* (Traumatic neurosis, from somatic to social disease). Bern: Verlag Hans Huber.

Fullerton, C. (ed) (1994). *Trauma and Disaster. The structure of human chaos*, pp 248-266. Cambridge: Cambridge University Press.

Gailienė, D., Kazlauskas, E. (2003). Po penkiasdešimties metų: ar gali traumų padariniai būti ilgalaikiai? Pranešimas tarptautinėje konferencijoje „Sunkių traumų psichologija: politinių represijų ilgalaikiai padariniai", Vilnius, 2003 m. spalio 22–24 d.

Goldberg, J., True, W.R., Eisen, S.A. et al (1990). A twin study of the effects of the Vietnam war on post-traumatic stress disorder. *Journal of the American Medical Association*, 263:1227-1232.

Green, B.L., Lindy, J.D., Grace, M.C. (1994). Psychological Effects of Toxic Contamination. In: *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos.* Eds: Ursano, R.J., McCaughey, B.G. & Fullerton, C.S., pp 154-176. Cambridge: Cambridge University Press.

Helweg-Larsen, P., Hoffmeyer, H., Kieler, J., Thaysen, J.H., Thygesen. P., Wulff, M.H. (1952). Famine Disease in German Concentration Camps. Complications and Sequelae. *Acta Psychiatrica and Neurolica Scandinavica Supplementum*, 83.

Herlofsen, P. (1994). Reactions to trauma: an avalanche accident. In: Ursano, R.J., McCaughey.

Herman, J.L. (1992). *Trauma and Recovery.* New York: Basic Books.

Herman, J.L. (1993). Sequelae of prolonged and repeated trauma: Evidence for a complex posttraumatic syndrome (DESNOS). In: Davidson, J.R., Foa, E.B. (eds). *Posttraumatic Stress Disorder, DSM-IV and Beyond.* Washington, DC: American Psychiatric Association.

Hocking, F. (1970). Psychiatric Aspects of Extreme Environmental Stress. *Diseases of the Nervous System*, 31:544-545.

Holen, A. (1990). *A long-term outcome study of survivors from a disaster.* Oslo: University of Oslo.

Jacobs, S. (1999). *Traumatic Grief. Diagnosis, Treatment and Prevention.* Philadelphia: Brunner/Mazel.

Kazlauskas, E., Gailienė, D. (2003). Politinių represijų metu patirto sunkaus ilgalaikio traumavimo psichologinių padarinių kompleksiškumas. *Psichologija. Mokslo darbai*, 27, 43-52.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., Nelson, C.B. (1995). Post-traumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry*, 52:1048-1060.

Krystal, H. (ed) (1964). *Massive Psychic Trauma.* New York: International University Press.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R. (1990). *Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans' Readjustment Study.* New York: Brunner/Mazel.

Lie, T., Mehlum, L., Weisæth, L. (1994). *Gulfundersøkelsen. Helsemessige følger for besetningen på norske skip etter seiling i den persiske gulf i perioden 1984–1988.* Oslo: Norwegian Maritime Directorate.

Lima, B.R., Shaila, P., Santacruz, H., Lozano, J. (1991). Psychiatric disorders among poor victims following a major disaster: Armero, Columbia *Journal of Neurons and Mental Disease*, 179:420-427.

Maercker, A., Schützwohl, M. (1997). Psychological long-term effects of political imprisonment: A group comparison study. *Social Psychiatry and Psychiatric Epidemiology*, 32:432-442.

Malt, U.F., Olafsen, O.M. (1992). Psychological appraisal and emotional response to physical injury: A clinical, phenomenological study of 109 adults. *Psychiatric Medicine*, 10:117-134.

March, J.S. (1993). What Constitutes a Stressor? The "Criterion A" Issue. In: Davidson, J.R., Foa, E.B. (1993). *Post-traumatic Stress Disorder. DSM-IV and Beyond.* Washington, DC: American Psychiatric Press.

McFarlane, A.C. (1989). The aetiology of post-traumatic morbidity: predisposing, precipitating and perpetuating factors. *British Journal of Psychiatry*, 154:221-228.

Maslow, A.H. (1970). *Motivation and personality.* (2nd ed) New York: Harper & Row.

Merskey, H. (1991). Shell-shock. In: *150 Years of British Psychiatry 1841–1991*, pp 245-267. London: Gaskell. The Royal College of Psychiatrists.

Miller, H. (1961). Accidents neurosis. Lecture I and II. *British Medical Journal*, 919-925, 992-998.

Mollica, R.F., Donclan, K., Svang, T. et al (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand–Cambodia border camps. *Journal of the American Medical Association*, 270(5):581-586.

Müller, J. (2004). Psychological consequences of political imprisonment. *RAHAT Medical Journal*, 2(1):65-80.

Myers, A.B.R. (1870). *On the Aetiology and Prevalence of Disease of the Heart Among Soldiers.* London: J. Churchill.

Oppenheim, H. (1889). *Die Traumatische Neurosen.* Berlin: Hirschwald.

Ørner, R.J. (1992). Post-traumatic stress disorders and European war veterans. *British Journal of Clinical Psychology*, 31:387-403.

Raphael (1986). *When disaster strikes.* New York: Basic Books.

Shalev, A.Y., Schreiber, S., Galai, T. (1993). Post-traumatic stress disorder following medical events. *British Journal of Clinical Psychology*, 32:247-253.

Shay, J. (1994). *Achilles in Vietnam. Combat trauma and the undoing of character.* New York: Atheneum.

Shay, J. (2002). *Odysseus in America: Combat trauma and the trials of homecoming.* New York: Schribner.

Shepard, B. (2000). *A War of Nerves: soldiers and psychiatrists.* London: Jonathan Cape.

Snow, B., Stellman, J., Stellman, S. et al (1988). Post-traumatic stress disorder among American Legionnaires in relation to combat experience in Vietnam. *Environmental Research*, 47:175-195.

Solomon, Z., Weisenberg, M., Schwarzwald, J., Mikulincer, M. (1987). Posttraumatic stress disorder amongst front line soldiers with combat stress reactions: the 1982 Israeli experience. *American Journal of Psychiatry*, 144:448-454.

Solomon, Z. (1993). *Combat Stress Reaction. The Enduring Toll of War*. New York: Plenum Press.

Spiegel, D. (ed) (1994). *Dissociation. Culture, Mind, and Body.* Washington, DC: American Psychiatric Press.

Strøm, A. (ed) (1968). *Norwegian concentration camp survivors.* Oslo: The University Press.

Stuhlmiller, C.M. (1995). The Construction of Disorders. Exploring the Growth of PTSD and SAD. *Journal of Psychological Nursing*, 33(4):20-23.

Terr, L.C. (1985). Children traumatized in small groups. In: Eth, S., Pynoos, R. (eds). *Post-Traumatic Stress Disorder in Children.* Washington: DC, American Psychiatric Press, 47-70.

Tønnessen, A., Mårdberg, B., Weisæth, L. (2002). Silent disaster: A European perspective on threat perception from Chernobyl far field fallout. *Journal of Traumatic Stress*, 15(6):453-459.

Ursano, R.J., McCarrol, J.E. (1990). The nature of the traumatic stressors: handling dead bodies. *Journal of Nervous and Mental Disease*, 178:396-398.

Van der Kolk, B.A., Mc Farlane, A.C., Weisæth, L. (ed) (1996). *Traumatic Stress. The effect of overwhelming stress on the body, individual and society.* New York: Guilford.

Van Driel, R.C., Op den Velde, W. (1995). Myocardial Infarction and Post-Traumatic Stress Disorder. *Journal of Traumatic Stress*, 8(1):151-159.

Vidnere, M., Nucho, A.O. (2000). *Latvian Survivors of Deportations.* Riga: RaKa.

Venzlaff, U. (1966). Das akute und das chronische Belastungssyndrom. *Medizinsche Welt*, 17:369-376.

Weisæth, L. (1984). *Stress Reactions to an Industrial Disaster.* Oslo: The Medical Faculty, University of Oslo.

Weisæth, L. (1985). Post-traumatic stress disorder after an industrial disaster: Point prevalences, etiological and prognostic factors. In: Pichot, P., Berner, P., Wolf, R., Thau, K. (eds). *Psychiatry – The State of the Art.* New York: Plenum Press.

Weisæth, L. (1989 b). A study of behavioural responses to an industrial disaster. *Acta Psychiatrica Scandinavica.* Suppl. 355, 80:13-24.

Weisæth, L. (1989 c). The stressors and the post-traumatic stress syndrome after an industrial disaster. *Acta Psychiatrica Scandinavica.* Suppl. 355, 80:25-37.

Weisæth, L. (1989 d). Importance of high response rates in traumatic stress research. *Acta Psychiatrica Scandinavica.* Suppl. 355, 80:131-137.

Weisæth, L., Eitinger, L. (1993). Posttraumatic stress phenomena. Common themes across wars, disasters, and traumatic events. In: Wilson, J.P., Raphael, B. (eds). *International Handbook of Traumatic Stress Syndromes.* Plenum Press: New York.

Weisæth, L., Sund, A. (1982). Psychiatric problems in UNIFIL and the UN-soldier's stress syndrome. *Revue Internationale des Services de Santé*, 55:109-116.

Wooley, C.F., Boudoulas, H. (1988). From irritable heart to mitral valve prolapse. *American Journal of Cardiology*, 6:895-899.

World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and Guidelines.* Geneva: WHO.

World Health Organization (1993). *The ICD-10 Classification of Mental and Behavioural Disorders. Diagnostic criteria for research.* Geneva: WHO.

Yehuda, R., MacFarlane, S. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry*, 152:1705-1713.

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder.* Princeton, NJ: Princeton University Press.

Fifty Years on: The Long-Term Psychological Effects of Soviet Repression in Lithuania

DANUTĖ GAILIENĖ
EVALDAS KAZLAUSKAS
Department of Clinical and Organisational Psychology, Vilnius University, Lithuania

The available studies of political repression provide little data on the consequences of the communist regime, although millions of people fell victim to Stalinist repression. The victims were exposed to physical and psychological violence, and lost their homes and families. Many died of hunger, extreme cold and exhaustion in the Siberian forced labour camps (Ignatavičius, 1999). Most of those who survived continued to be persecuted, even after they had served their prison or exile sentences. Only a few lived through the atrocities of repression and are alive today. There have been no comprehensive studies of the health effects of Soviet repression to date, either in Lithuania or, to our knowledge, in the other former Soviet republics.

Political repression in occupied Lithuania

In 1939 the Soviet Union and Nazi Germany signed the Molotov-Ribbentrop Pact, dividing Europe into spheres of interest. Lithuania was assigned to the Soviet sphere.

In the summer of 1940, even before the formal incorporation of Lithuania into the USSR, mass arrests and deportations began. The victims were the most educated members of society: public servants, teachers, university professors, high school and university students, farmers, members of public organisations and political parties, and other "anti-Soviet elements".

In June of 1941, Nazi Germany occupied Lithuania, and, with the help of local collaborators, began the mass extermination of the Jews. The Soviet army reestablished its control of Lithuania in 1944, starting a new period of occupation that lasted almost 50 years.

More than a million people, or about 30% of the population, were deported, sentenced to death, imprisoned or forced to emigrate.

The period of the most brutal repression lasted until Stalin's death in 1953. Every year thousands of people from Lithuania were sent to the Gulag camps, or deported in cattle cars to Siberia, where they experienced severe physical and mental suffering. The annual mortality rate in the Gulag was very high in the period between 1941 and 1944, at over 50%, and as high as 93% in some camps. From 1941 to 1944, the first 8,000 political prisoners from Lithuania died of starvation and exhaustion. From 1945 to 1947, approximately 37,000 perished in the camps (Anušauskas, 1996).

The conditions of imprisonment were harsh, the more so because political prisoners were held in the same Gulag camps as common criminals until 1948. Political prisoners were terrorised by criminal inmates, who often stole their belongings and parcels from home.

Those sent to the Gulag or places of deportation were forced to do extremely hard work in forests, clay pits, coal mines and construction sites, and in road building and snow removal. They often did the most degrading, meaningless work, such as digging into frozen soil with a pickaxe or cutting big logs with a handsaw (Gaškaitė-Žemaitienė, 2001). They worked in two shifts, 12 to 14 hours a shift. In some places, they had to walk around ten kilometres to work. Large numbers of prisoners died working in the worst climatic conditions, laying roads or railways in swamps, building factories and toiling in mines.

Long-term persecution after imprisonment and deportation

Most political prisoners and deportees did not come back to Lithuania: some died in Siberia, while others were not allowed to

return. A distinctive feature of the repressive Soviet system was that former deportees and labour camp survivors continued to suffer after they had served their deportation or prison sentences. The repression continued for decades after Stalin's death in 1953. Many political prisoners and deportees were forbidden from returning to Lithuania, and so they were forced to stay in Russia. Some tried to move to areas as close to Lithuania as possible: to Latvia or the Kaliningrad region. A poll of 50 former political prisoners has revealed that, on average, they could not return to Lithuania for ten years after their release from prison (Kazlauskas, Gailienė, 2003).

Many of those who did come back to Lithuania could not find jobs or permanent residence here. They were banned from settling in large urban centres or in the districts where they had lived before their deportation. In the Soviet system, a person without a registration stamp in his or her passport and without permanent residence was considered to be a criminal. The authorities were unwilling to register "enemies of the people" or "bandits". Without a stamp in the passport, a person had no access to regular employment on their return from Siberia. Finding a job was very difficult even for those former political prisoners and deportees who had managed to obtain the *propiska*, registration at a permanent address. Many of the Gulag camp survivors and exiles faced continuous persecution and KGB searches after their return from Siberia. Many struggled to build a life for themselves:

> Persecution, searches. Being followed, being asked questions by the agents at work. Poverty, low wages (S. I., a 68-year-old man);
>
> I couldn't get my property back, it had been divided among the neighbours. I couldn't get along either with the older or the younger generation. Nobody was waiting for me. I had nobody to return to (Š. G., a 76-year-old woman);
>
> I couldn't get a job anywhere. Everybody knew me, they regarded me as a criminal, a bandit. Everybody was afraid to give me a job. I wasn't persecuted in this way in Russia. I had nowhere to return to (B. A., a 72-year-old man);

> For two years, they wouldn't register me, wouldn't give me a job. Then they would give me a temporary job and fire me again. I got a more or less permanent job in 1965 (Ž. C., a 68-year-old man).

Former political prisoners and deportees had no access to higher education. Often it was only with the help of close relatives that a former political prisoner managed to get regular employment. Former Siberian deportees had to hide their past from their co-workers. They risked not only losing their jobs but also subjecting their families to persecution if they spoke publicly about their deportation and the Siberian labour camps. Often, the children of exiles were also persecuted. For example, they were denied access to higher education.

> We who had returned from the Gulag camps continued to live as in some kind of pressurised environment, a pressurised chamber, and we lived this way for two or three generations. All the baggage of our traumas and problems of our future life and adaptation weighed heavily on those close to us (A. Stasiškis, a member of the Seimas of Lithuania, quoted from Gailienė, 2002, p. 124).

Thus, a former political prisoner or deportee lived under constant pressure and in fear that others would discover their true past. There was just a handful of people, their fellow political prisoners and exiles, who they could trust and rely on. Political prisoners often married people who had also lived through the hardships of deportation. The family thus became the only safe haven in a complex and hostile society, as it was only within the family that they felt free to share their past experiences and their views.

Another factor why political repression had a long-term traumatic effect was that persecutions led to the separation of families. Having lost their homes and families, many had to start a new life from scratch. Young people were particularly affected, as their plans collapsed. Young, talented, ambitious people full of ideas and plans for the future were a frequent target of the Soviet repressive structures. Many never realised their ambitions:

I had no opportunities. I wanted to continue my studies to become a doctor, a teacher. The Soviets ruined that (Š. G., a 76-year-old woman);

I had a good voice, I wanted to receive musical training: to study theatre, drama and singing (Ž. L., a 66-year-old woman);

I was arrested while I was in secondary school. I did not receive my certificate, although it was just two months before I was to leave (S. S., a 72-year-old man).

Thus, the victims of Soviet repression were exposed to traumatic experiences for an extremely long period of time, for several decades.

To remember, or to forget?

The success of trauma research first of all depends on the political and social recognition of trauma as a health problem (Herman, 1992). Unless and until there is public recognition and awareness of trauma, trauma sufferers are not recognised either. They do not receive a fair assessment of their sufferings or the assistance they need. If the society acknowledges the sufferings of the victims, it helps to alleviate their anxiety and hostility, and opens the way for serious scientific studies of their traumatic experiences. Periods of recognition have alternated with periods of oblivion throughout the history of trauma research (Shephard, 2000; Weisæth, 2002; Gailienė, 2001). Social and political decisions have also had a positive impact on studies of severe, prolonged trauma that began after the Second World War.

The Second World War ended with the victory of the Allies. After the war, Nazism was condemned as a criminal ideology, and criminals were sentenced and punished. Victims were named and their sufferings were acknowledged. There have been ongoing efforts to redress the harm done to them. Intensive research into traumatic experiences began as a result of persistent efforts by specialists, and continues today. The importance of the research sometimes seems to be overestimated. Some have started

to speak of a victim culture and an "obsession with uniqueness", when the victims are competing with each other not only for recognition but also for preference over others. Some say that it is one or another political, material or psychological benefit, rather than science that motivates researchers to do their work (Valentinavičius, 2001).

The repeated calls not to forget the misdeeds of the Nazis have even given rise to protest, the "apologia for forgetfulness". There has been criticism of the psychoanalytical "defeat your past" imperative and of "re-education programmes", as "half a century on, grief as a genuine feeling is no longer possible, any effort to stimulate it is a moral exploitation of the dead ... forgetfulness would have no bad effects, other than, perhaps, to affect the business" (Burger, 2001, p. 666).

The other totalitarian regime of the 20th century, communism, lasted another 50 years after the war and has not yet been identified as criminal since the collapse of the Soviet Union. The fight against communism has yet to be brought to completion by condemning it for its crimes against humanity. "The commandant of the Auschwitz concentration camp was hanged, while the commandant of Ozerlag draws a colonel's pension" (A. Brossat, quoted from Kubilius, 2003 b, p. 125).

In terms of *scientific research,* the denial of and ambivalence towards the crimes of communism create a major imbalance: while a great deal of research has been done into the traumatic experiences of Holocaust and Second World War victims and of members of anti-Nazi resistance movements, there has been little research into trauma in post-communist countries, and the former Soviet republics in particular.

The Lithuanian experience over the past ten years or so points to the emergence of other problems, moral, political and legal. Since independence in 1990, the basic documents of the state have recognised the Soviet period as a period of illegitimate occupation, and

identified those who suffered from it. But what we lack is a deeper reflection by the society on the effects of the 50 years of occupation. On the contrary, every effort has been taken to forget the past as quickly as possible and to avoid any discussions about it. We come to realise that "our historical memory remains a bleeding wound," which is being ripped open over and over again by opposing ideological positions (Kubilius, 2003 a, p. 3).

In *moral* terms, the idea is raised that the new state has been built on moral compromise. Such historical and present-day stereotypes, inherited from the Soviet past, as degrading the partisan war, political and moral relativism, and a cynical attitude to national history, still prevail in society (Adomėnas, 2003; Kubilius, 2003 a; Streikus, 2003).

In *political* terms, we can see that forgetfulness is not a natural phenomenon and that some benefit from it politically. Lithuania has not received any compensation for the damage sustained during the occupation. Even worse, it has to prove over and over again that it was illegally occupied, while "former KGB agents are daring enough to seek justice in Strasbourg, claiming that legal restrictions on their employment is a violation of their 'human rights'" (Adomėnas, 2003, p. 625).

In *judicial* terms, the procedure for "restoration" of the rights that former Lithuanian partisans were deprived of during the Soviet period is still in place, whereas the traitors who fought against them have not been brought to justice (Gailius, 2003, 2004).

Thus, the lack of a comprehensive and thorough evaluation of the not-too-distant past still remains a problem.

In terms of trauma psychology, the experience of people living in Lithuania, as well as in the other former Soviet republics, is very interesting. People exposed to the most severe traumas as a result of political repression were forced to hide their past for a long time. Many of them did not share their experiences of deportation or the Gulag camps even with their own children for fear of new repression.

However, psychologists have not yet given an assessment of the possible psychological effects of long-term, decades-long traumatisation due to political reasons.

The issue of the control group in Soviet-era trauma research

In studying the effects of Soviet repression, it is necessary to take into consideration the fact that even those people who were not directly subjected to political repression lived in an occupied country under a communist regime.

In a diary written in 1948 and 1949, L. Baliukevičius-Dzūkas, the commander of the partisan district of Dainava, portrayed a grim picture of the occupied country:

> Overwhelming poverty! Not a ray of hope for a more beautiful life. The only entertainment is drinking *samogon*, often followed by a drunken brawl. The village is completely overtaken by samogon. It is brewed and drunk by everyone, even children. Drowned in a sea of blood, tears and black despair, the nation seems to have found its only solace and temporary comfort in samogon. How many idiots, criminals, degenerates, embezzlers, prostitutes and morons will these goddamned years bring to Lithuania? Some say that the years of the Bolshevik occupation and fighting will make the nation stronger. What remains will be steel, they say. Perhaps some will remain, strong as steel, melted and tempered in this struggle. But there will be few of them (Baliukevičius, 2002, p. 112).

The Soviet Union was a totalitarian state, in which no one could feel safe.

> In the Soviet Union, all citizens were truly equal before this sometimes incomprehensible totalitarian machine. Even those who were in the top echelons of the party stress (and sometimes even exploit it for their own benefit today) that they felt just as unsafe. They say that they felt that they could be destroyed any minute and be persecuted, even though sometimes they did not understand why it was so. The individual was utterly helpless. His opinion did not matter, his choice did not matter, and he could do nothing to resist the system. In the Soviet Union, the individual was presumed guilty. This sense of utter helplessness must have, and did, accompany all residents of Lithuania throughout the 50 years (V. Ališauskas, quoted from Gailienė, 2002, p. 125).

Some of them were exposed to extremely severe traumas: for example, they were sent to fight in wars waged by the USSR (in Afghanistan, Czechoslovakia and other countries).

A sociological analysis of the construction of the identity within three generations, based on the biographical method, has revealed how the key factors that determine the socialisation of individuals were changing as the occupying regime was tightening its hold (Kraniauskienė, 2003). Autobiographies of people who grew up in prewar, independent Lithuania reflect not only the influence of family, Church and community values, but also of the national education ideology and active involvement in the activities of civil, political and religious youth organisations. There is also frequent mention of efforts to promote patriotism and a sense of duty to the homeland. Meanwhile, the socialisation of people who grew up under the Soviet occupation was determined by completely different factors: the forced choice between being loyal and not being loyal to the occupying regime, and the great disparity between the "non-authentic" social reality and "authentic" living within the circle of family and like-minded persons; and the sense of meaninglessness and emptiness. Often it was pragmatic need, for example, the need for a place to live, that shaped a person's direction in life.

Thus, for 50 years, from 1940 to 1990, Lithuania lived under successive occupations, first by the Soviet Union, then by Germany, and again by the Soviet Union. Many people suffered directly from political repression, while others lived for decades under the communist regime. The sufferings of the victims were not recognised, and, even worse, they were concealed from the public. The sufferers often did not dare to tell their own children about them. How has this affected the victims of repression? Does the enforced suppression of trauma memories weaken the effects of the trauma too? Does the psychological state of people who were directly exposed to repression differ from that of people who were not exposed? What

coping strategies did the victims employ in order to endure the hardships of repression?

In 2000 the Department of Clinical and Organisational Psychology at Vilnius University, in collaboration with the Genocide and Resistance Research Centre of Lithuania (LGGRTC), launched a study to help answer these and similar questions.

The study "Psychological Effects of Soviet and Nazi Repression"

A study into the psychological effects of Soviet and Nazi repression was conducted in the years 2000 to 2003. This article presents some of the most significant findings of the project.

Survey participants

There are currently approximately 53,000 people in Lithuania who have the legal status of persons who suffered under the occupying regimes between 1939 and 1990. Under the Law of the Republic of Lithuania on the Legal Status of Persons who Suffered under the Occupations of 1939 to 1990, the following people are eligible for this status:

1) persons who were imprisoned, exiled or deported, or otherwise deprived of their freedom by the occupying regimes on political or ethnic grounds;
2) persons who died, were crippled, lost their health or property during the years of occupation as a result of actions by the repressive or other structures of the occupying regimes and secret services of the occupying states;
3) persons who were forcibly conscripted into the army or were subjected to forced labour by the occupying regimes;
4) persons who were persecuted on political grounds;
5) persons who were denied access to education or could not pursue a career on political or ethnic grounds;
6) persons who suffered otherwise from the structures of the occupying regimes (*Valstybės žinios*, 1997).

Under this law, the status of person who suffered political repression may be granted to victims of both the Soviet and Nazi regimes. In the present article, we shall not provide a separate analysis of the effects of the Soviet and Nazi repressions, since people who were subjected to Nazi persecution comprised a very small percentage of the research participants (84 out of 1,598). The majority of the survivors living in Lithuania were victims of Soviet repression.

The law classifies people who suffered political repression into three groups, namely: 1) political prisoners and persons with an equivalent status; 2) deportees and persons with an equivalent status; and 3) other persons subjected to repression. The LGGRTC registers such persons and grants them the formal status of victim of political repression. Deportees make up the largest group of people registered on the centre's database (about 36,000). There are also about 12,500 people with the status of other persons subjected to repression, and 4,500 political prisoners.

We aimed to analyse not only the psychological effects common to all people who were subjected to repression, but also to discover in what way different repression experiences are related to the psychological effects of repression. Therefore, we examined four groups of people: political prisoners (N=774), deportees (N=362), other persons subjected to repression (N=268), and a control group (N=194). A total of 1,598 subjects participated in the study, of whom 52% were male and 48% were female. The mean age of the participants was 73.07 years (Table 1).

Political prisoners

This group consisted of 774 former political prisoners (491 men, 233 women). Their mean age was 75.8 years (range 54–94 years). The mean duration of imprisonment was 7.4 years (range 1–25 years). All the people in this group had the status of political prisoners, as defined in Article 4 of the Law of the Republic of Lithuania on the Legal Status of Persons who Suffered under the Occupations

of 1939 to 1990. This article defines a political prisoner as a person who was convicted under the criminal codes of the Lithuanian Soviet Socialist Republic or the Russian Federation, which imposed restrictions on human rights and freedoms, or were imprisoned on charges of counterrevolution and classified as "socially dangerous individual" (*Valstybės žinios*, 1997).

The subjects' mean age at the time of arrest was 19.9 years (range 15–33). The mean duration of imprisonment was 6.9 years (range 1–17). Almost all of the subjects had been deported to Siberian forced labour camps. The average time since their release from the camps was 47.1 years (range 39–55). The average time since their return to Lithuania was 43.1 years (range 3–55). Not all members of this group came back to Lithuania immediately after their release from prison. Many political prisoners were denied the choice of place of residence after serving their sentences and were not allowed to return to Lithuania. As a result of this, they stayed in Russia or settled in neighbouring countries (Latvia, the Kaliningrad region). The mean duration of exile was 10.3 years (range 1–49). Members of this group differed from the other groups of victims of repression in that many of them had been politically active and had participated in armed resistance to the Soviet regime.

Deportees

This group comprised of 362 former exiles (122 men, 240 women). Their mean age was 69.9 years (range 44–94). The mean duration of exile was 7.4 years (range 1–54). All the people in this group had the status of exiles, as defined in Article 5 of the Law of the Republic of Lithuania on the Legal Status of Persons who Suffered under the Occupations of 1939 to 1990. These are people who were ordered by the repressive structures of the occupying regimes or courts to leave, or were forcibly evicted from, their place of permanent residence, temporarily or permanently, on political or ethnic grounds (*Valstybės žinios*, 1997).

Table 1. **Demographic data on subject groups (in %)**

	Political prisoners (N=774)	*Deportees* (N=362)	*Other victims* (N=268)	*Control group* (N=169)
Survey method				
By post	77	68	62.7	84
Hand-delivered questionnaire	18	32	37.3	16
Personal interview	6.4	–	–	
Gender				
Male	67.8	33.6	33.7	65.5
Female	32.2	66.4	66.3	34.5
Place of residence				
Vilnius	10.7	25.4	11.9	8.2
Large towns	40.4	32.7	40.7	21.4
Small towns	35.5	22.6	26.1	12.2
Rural areas	13.3	19.3	20.9	58.2
Education level				
Primary	50	39.1	44.6	29
Secondary	32	22.4	22.5	21
Vocational	17	18.3	16.9	38
Higher	11	20.2	16.1	22
Marital status				
Married	67	51.8	60.8	52
Single	4	8.6	4.1	4
Widowed	26	30.5	27.6	36
Divorced	3.2	9.1	7.5	9.2
Number of children				
0	15	14.5	11.1	7.6
1	22	23.9	20.6	20
2	44	40.5	42.7	49
≥3	19.7			23.4
Person currently lives with:				
Spouse	59	42.5	49.1	39.5
Spouse and a child/children	9	7.2	8.7	13.4
Alone	25.5	34.5	30.2	24.4
With a child/children	6.6	8.3	7.2	18.5

Other persons subjected to repression

Among the research participants, there were 268 people (178 women, 90 men) who were neither former political prisoners nor deportees but had also suffered as a result of repression. Their mean age was 69.7 years (range 46–84). The status of this group of people is defined in Articles 6 and 7 of the Law of the Republic of Lithuania on the Legal Status of Persons who Suffered under the Occupations of 1939 to 1990. These are people who were born in exile or in prison, or were persecuted for being members of an ethnic, political, religious or social group or organisation. They were detained for interrogation on political grounds, but not convicted. This group also includes people who lost their homes and families due to political reasons, and others (*Valstybės žinios*, 1997).

The control group

Consisted of 194 people, matched by age with the repression victims, who did not have the formal status of persons subjected to repression. Some people in this group reported having suffered from Soviet or Nazi repression and, therefore, their responses were rejected. In total, data on 169 people in the comparison group were used for the purposes of the research project. Their mean age was 70 years (range 50–95).

Assessments

The structure of the questionnaire that the survey participants were asked to complete:

1) cover letter
2) demographic data: age, gender, marital status, education level, etc
3) traumatic experiences:
   a) associated with repression: the duration and period of imprisonment or deportation, difficulties upon return;
   b) lifetime stressful events.

4) effects on physical and psychological health:
   a) self-rating of health and of effects of repression on health;
   b) trauma symptom checklist: interpersonal difficulties, depression, dissociation, sleep disorders, anxiety and somatisation.
5) protective factors:
   a) social, cognitive, existential factors and the perception of the meaning of trauma;
   b) sense of coherence scale.

The instruments applied in this study were revised and modified several times to take into account the age of the subjects and their specific experiences. Most of them were simplified by reducing complex response scales to two-point (yes/no) scales.

Traumatic events

The Lithuanian version (Domanskaitė-Gota, 2000) of the Harvard Trauma Questionnaire (Mollica et al, 1992) was used to assess lifetime traumatic events. In this study, the first part of the questionnaire, which covers traumatic events and experiences, was used. The subjects were presented with a list of 23 stressful events and asked to indicate which of them they had experienced.

Political repression-related experiences

The subjects were asked to answer a number of questions related to their experience of political repression: the duration of political imprisonment or forced exile, and the period of repression. They were also asked about the difficulties they had experienced upon their return from imprisonment or deportation, the loss of family members during the period of repression, and the impact of political repression on their education or professional goals, etc (six questions altogether).

Trauma symptom checklist

The modified Lithuanian version (Domanskaitė-Gota, 2000) of

the Trauma Symptom Checklist (TSC-35) was used to measure trauma symptoms. The TSC-35 is a revision by Elklit (1997) of the Trauma Symptom Checklist (TSC-33) originally developed by Briere and Runtz (1987). The participants were asked to say if they had experienced each symptom in the previous two months.

1. *TSC-35 modification.* Taking into account the experience and age of the study participants, some minor changes in the methodology were made (Kazlauskas, 2001). The scale consists of 35 items organised into seven symptom sub-scales: anxiety, sleep disorders, dissociation, interpersonal sensitivity, aggression, somatisation, and Holocaust survivor syndrome. The subjects were instructed to rate each symptom according to its frequency of occurrence over the previous two months, using a three-point scale: never (1), sometimes (2), and often (3). Symptoms were measured by adding together the scores of the items within each sub-scale. This version of TSC-35 was used to survey 234 participants through postal questionnaires and personal interviews (Kazlauskas, 2001).

2. *TSC-35 modification.* The methodology was further simplified, as it was noticed that subjects found it difficult to fill in the questionnaire and almost half of them failed to complete it. The same questions as in Modification 1 were used, but response options were reduced. The study participants were asked to indicate whether or not they had experienced each of the symptoms on the checklist, using a two-point (yes/no) scale.

Impact of Event Scale

The Impact of Event Scale, Revised (Weiss, Marmar, 1996) was used to measure the severity of post-traumatic stress disorder symptoms. This instrument is a modification of the original scale (Horowitz et al, 1979) composed of the intrusion and avoidance sub-scales. The above-mentioned authors added a third sub-scale to assess hyper-irritability. The scale has been widely used as a measure of the psychological impact of traumas.

The instrument consists of 22 items that participants are asked to rate on a five-point scale: not at all (0), a little (1), moderately (2), quite a bit (3), and extremely (4). The subjects indicated how frequently each of these items had been true for them over the prior seven days. Sub-scale scores were calculated by adding the scores of the items on each sub-scale. The scale was translated into Lithuanian by Evaldas Kazlauskas (2001). This instrument was only used during personal interviews.

Sense of Coherence Scale

The Sense of Coherence Scale (SOC) was developed by Aaron Antonovsky in 1987 on the basis of his concept of salutogenesis. SOC has been widely used in various fields of research worldwide. In this study, we used a shortened version of the instrument, comprising 13 items. Each item is rated on a five-point scale ranging from 1 to 5. Many studies have supported the validity and reliability of this instrument (Antonovsky, 1993).

Coping factors

On the basis of the results of personal interviews with repression victims, we compiled a short, nine-item questionnaire. It included five factors that had been most frequently identified by the study participants as having helped them to endure the repression: social support (support from family and relatives; support from friends who had been exposed to the same form of repression), faith (hope, belief in God), spiritual strength, political participation, physical strength and health. We also added an open-ended question asking the subjects to indicate other important factors that had helped them to cope with repression-related traumatic experiences. They were also asked whether the coping strategies developed during the period of repression had proved to be helpful in later life (ten questions in total).

The present state of health and effects of the repression on health

Six questions dealt with the subjects' present health and the effects of repression on their health. They were also asked whether they had ever sought medical help or had been hospitalised for the symptoms investigated in this study.

The study's design

Two main methods of data collection were employed: 1) personal interview, and 2) a self-administered questionnaire, mailed or hand-delivered.

Personal interview

Semi-structured interviews were conducted with 100 study participants, including 50 political prisoners and 50 members of the comparison group. The former political prisoners were randomly selected from a list of people with this status living in Vilnius and Kaunas and having a telephone number. The subjects were contacted by telephone to arrange a location, date and time for the interview. Four people refused to participate in the study during the telephone contact. None of those who agreed to be interviewed changed their minds afterwards. Almost all of the interviews were conducted at home (one person was interviewed at his workplace). The semi-structured interviews lasted an hour and a half on average, from half an hour to three hours.

Postal survey and hand-delivered questionnaires

The group of people subjected to repression. The majority of the survey participants, 80%, were surveyed by post. They were randomly selected from the LGGRTC's list of all persons subjected to repression. The subjects were contacted by telephone to inform them about the research project and its objectives, and were asked to participate in the study. Those who agreed to participate were mailed a questionnaire with a cover letter describing the objectives of the study

and asking them to complete the questionnaire on their own and as truthfully as possible. It also contained a telephone number to contact for further information and questions. A stamped, addressed return envelope was also enclosed. The response rate was very high, as many as 80% of the questionnaires were completed and returned.

Questionnaires were handed personally to about 20% of the subjects in the study. They were asked to fill out the questionnaires at the LGGRTC office, or at meeting places for survivors, for example, at events, houses of exiles, etc. The results of hand-delivered questionnaires were analysed together with those of postal questionnaires, since in both cases the questionnaires were self-administered.

The control group. For the postal survey of the comparison group, we followed the same procedure as with the group of people subjected to repression. An agreement was concluded with the Lithuanian Population Register whereby the staff of the Register undertook to provide data on 1,000 people. Data was randomly selected from a list of the country's residents on the basis of two criteria: 1) the date of birth of subjects (persons born before 1940), and 2) place of residence; 50% were residents of urban areas, and 50% of rural areas.

Prior to mailing the questionnaires, potential study participants were contacted by telephone and informed about the research. Their telephone numbers were obtained from telephone directories according to names and places of residence. The response rate of the control group was also very high: as many as 70% of the questionnaires were completed and returned.

The results

Traumatic experiences

The majority of those repressed were victims of the second Soviet occupation: 74.6% of the political prisoners and exiles were deported from Lithuania from 1944 to 1950 (Figure 1). Most of them (59%) returned in the 1950s, but some (3.2%) came back to Lithuania in the years after independence (Figure 2).

Figure 1. **Years of repression (in %)**

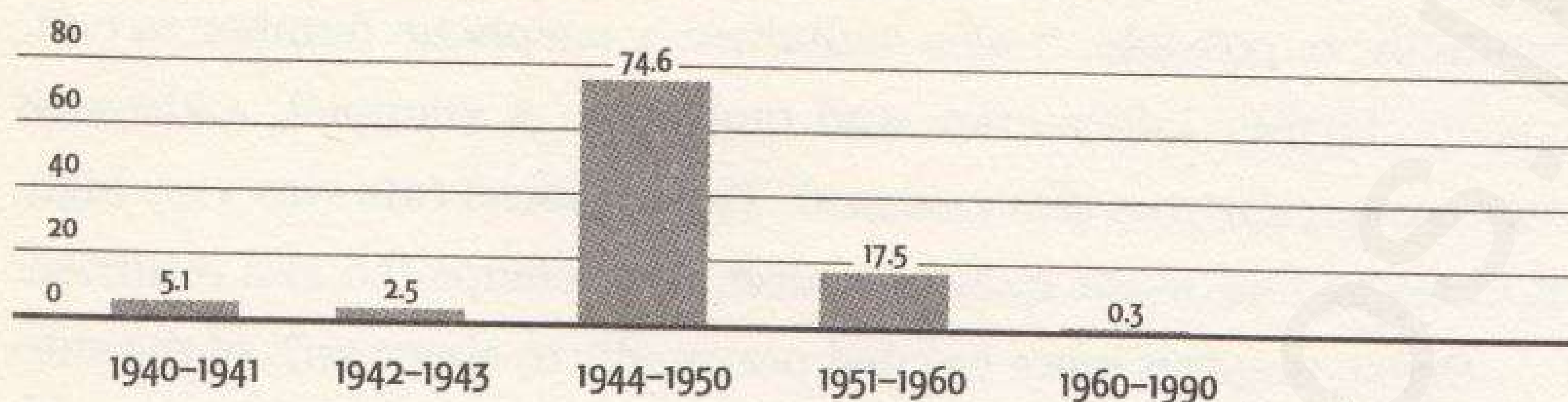


Figure 2. **Year of return to Lithuania (in %)**

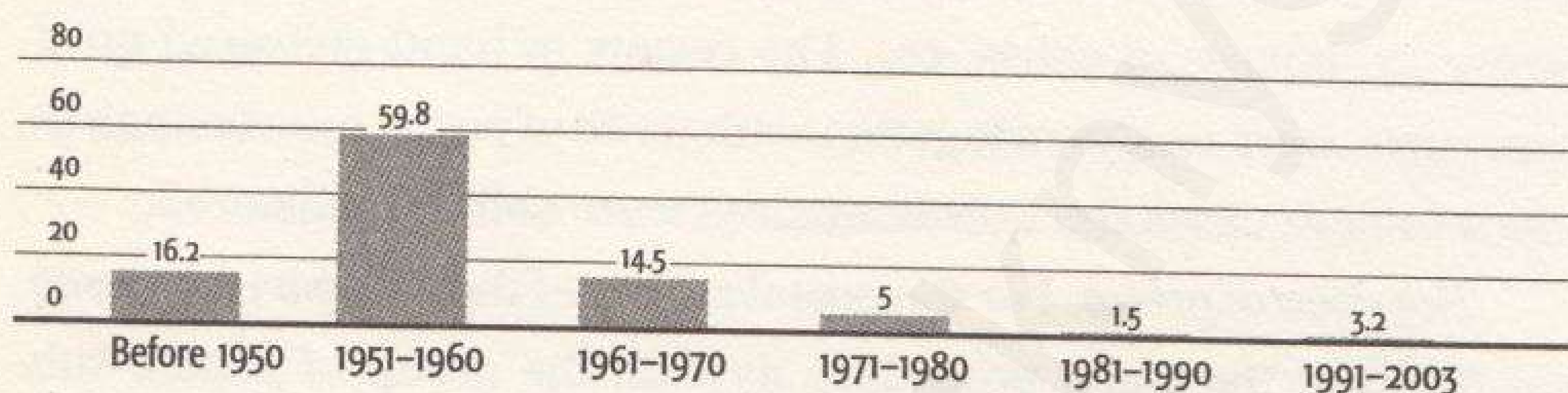
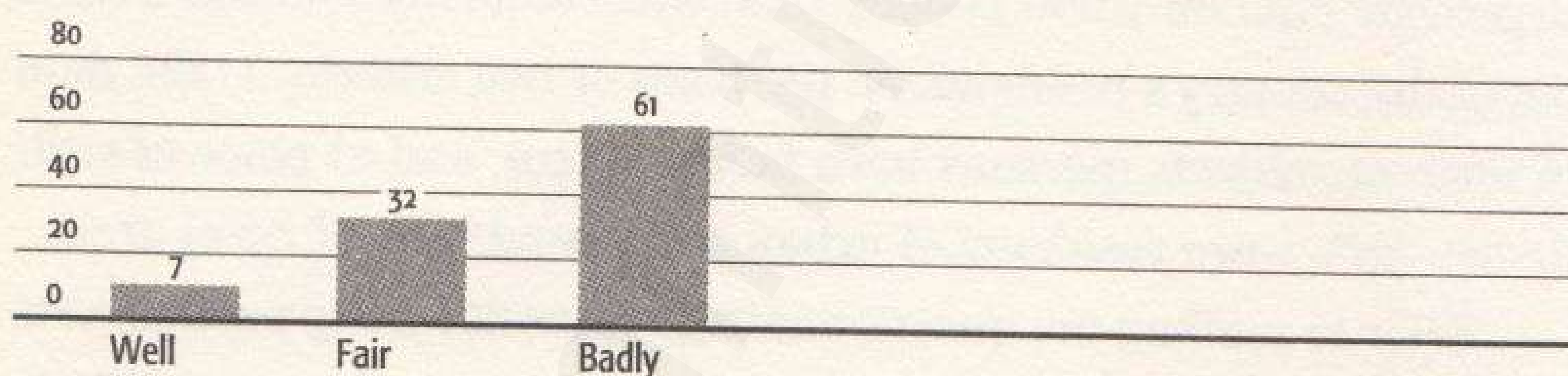


Figure 3. **Answers to the question about how victims were received on their return to Lithuania (in %)**



Their traumatic experiences did not end with their return from imprisonment or deportation. Many (61%) of the repression survivors said that they had met hostility at home and experienced reintegration difficulties. Only about 7% of the study participants said that they had not experienced any major readaptation difficulties (Figure 3).

More than half of the victims (55%) lost close family members as a result of the repression (Table 2); most of them (83.4%) could not pursue their professional and educational goals due to the repression. However, it must be admitted that people in the comparison group were also affected by political repression, although they had not been directly exposed to political violence: 24% of members of the comparison group lost family members or close relatives,

Table 2. **The impact on victim and control groups (in %)**

	Victims (N=1,354)	Control group (N=119)
Loss of close relatives during the repression period**	55	24
Prevented from pursuing professional and education goals**	83.4	29

Note: **$p < 0.01$

Table 3. **Lifetime traumatic experiences in victim and control groups (in %)**

No.	Stressful events	Victims				Control group
		Political prisoners (N=724)	Deportees (N=362)	Others (N=268)	All (N= 1,354)	(N=119)
1.	Dangerous illness	47.2	41.4	40	56.8	42
2.	Loss of a family member	61.3	67.4	69	64.4	61.3
3.	**Violent attack** **	28.7	17.7	22.4	24.5	7.6
4.	Rape	2.1	2.5	2.2	2.2	0.8
5.	**Witnessed an event which caused death or injury to others** **	64.1	44.2	51.9	56.4	20.2
6.	**Experienced an event which threatened death or injury** **	51.7	27.6	39.9	42.9	11.8
7.	**Torture** **	73.8	15.2	24.6	48.2	5
8.	**Threats** **	70	43.1	58.6	60.3	18.5
9.	Near-drowning	9.4	12.7	8.6	10.1	15.1
10.	Attempted suicide	9.7	5	7.1	7.9	4.2
11.	Robbery/theft	28.3	29.6	28	28.5	22.7
12.	Abortion	1.7	5.2	4.9	3.2	9.2
13.	**Divorce** **	6.9	13.5	9.7	9.3	16.8
14.	Sexual violence	1.9	2.8	1.5	2.1	0.8
15.	**Physical violence** **	54	18	23.5	38.3	12.6
16.	Neglect in childhood	6.6	14.4	22.8	11.8	7.6
17.	**Humiliation** **	64.2	52.2	64.9	61	13.4
18.	**Persecution** **	59.8	41.7	58.6	54.7	7.6
19.	Family history of mental illness	6.8	6.1	10.4	7.3	8.4
20.	Absence of parents in childhood	26	30.7	26	31.6	21.8
21.	Car accident	10	11	7.1	9.6	11
22.	Other dangerous accidents	6.4	3.9	5.6	5.5	4.2
23.	Other	5.8			7.3	1.7

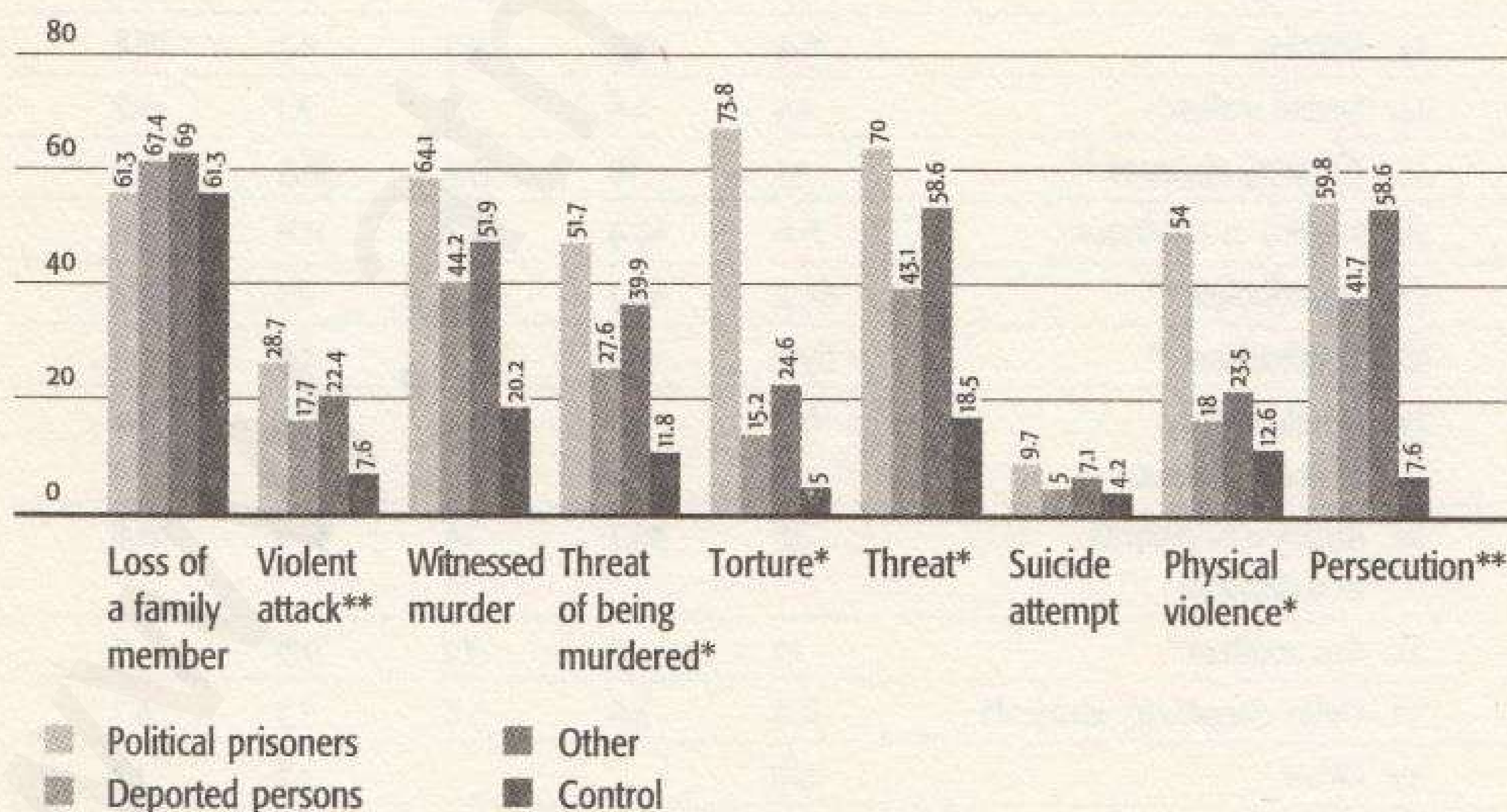
Note: Others = other persons subjected to repression, all = combined scores of all persons subjected to repression, **$p < 0.01$

almost one-third (29%) did not have access to education or could not pursue a career.

The traumatic experiences of people subjected to repression are *much more painful* than those in the control group (Table 3). In the group of victims of repression, there is a much higher number of people who witnessed an event which caused death or injury to others (56%), experienced an event or events involving threatened death or injury to themselves (43%), experienced torture (48%), persecution (55%), threats (60%), or humiliation (61%). The incidence of attempted suicide is twice as high in the victim group, and it is particularly high among political prisoners (10%). Interestingly, divorce is almost twice as common in the control group (17%) as among survivors of repression (9%); the incidence of divorce among political prisoners is particularly low (7%).

The intensity of the exposure to trauma due to political repression varies between the different groups of repression victims (Table 3). *The highest level of trauma exposure is among political prisoners.* They experienced torture, threats, physical violence and death threats more often than other groups of victims of repression (Figure 4).

Figure 4. **Traumatic experience of victim and control groups (in %)**



Note: $*p < 0.05$, $**p < 0.01$

The effects of repression

The impact on health

Table 4. **Health of victim and control groups (in %)**

	Victims (N=1,354)	Control group (N=119)
Present health status**		
Good	3.8	4.2
Fair	37.8	63
Poor	58.5	33
Have sought medical help	76.6	72.9
Have been hospitalised	64	54.2
Impact of repression on health		
Unchanged	15.3	-
Deteriorated	45.7	-
Sharply deteriorated	38.5	-

Note: **$p < 0.01$

The majority of victims of repression (86.7%) said that *repression had adversely affected their health.* As many as 38.5% said that their health had sharply deteriorated. Those repressed complained most often of somatic problems (bronchitis, broken ribs, battered head, etc). Some said that they had suffered from great physical exhaustion as a result of the repression, while others reported having psychological problems, such as constantly crying, flinching at everything, etc.

Both the group of people subjected to repression and the comparison group rated their present health as fair to poor (Table 4). Only a small percentage of the surveyed persons (about 4%) rated their present health as good. Although none of the groups assessed their health as good, there were some significant inter-group differences. From Table 4 we can see that most of the victims of repression rated their health as bad (58.5%), whereas most of the comparison group members assessed their health as fair (66%).

The majority of the victims of repression (66%) attribute their

present poor health to their repression-related experiences. Only 8.2% of the subjects think that their repression experiences had no impact on their health. About 26% could not say whether their present health condition was attributable to the repression. The majority of the surveyed people said that at some point they had sought medical help for the symptoms examined in this study (Table 4). The results showed that the number of persons who had been hospitalised was higher among survivors of repression than in the control group (64% and 52%).

Trauma symptoms

Both the victims of repression and the control group are of an advanced age and in fragile health. Many experience fatigue (64–69%), and almost half of them suffer from headaches, memory problems and sleep disorders.

But the repression victim group showed a statistically reliable prevalence of the following symptoms: flashbacks (48%), nightmares

Figure 5. **Strength of trauma symptoms in victim and control groups (in %)**

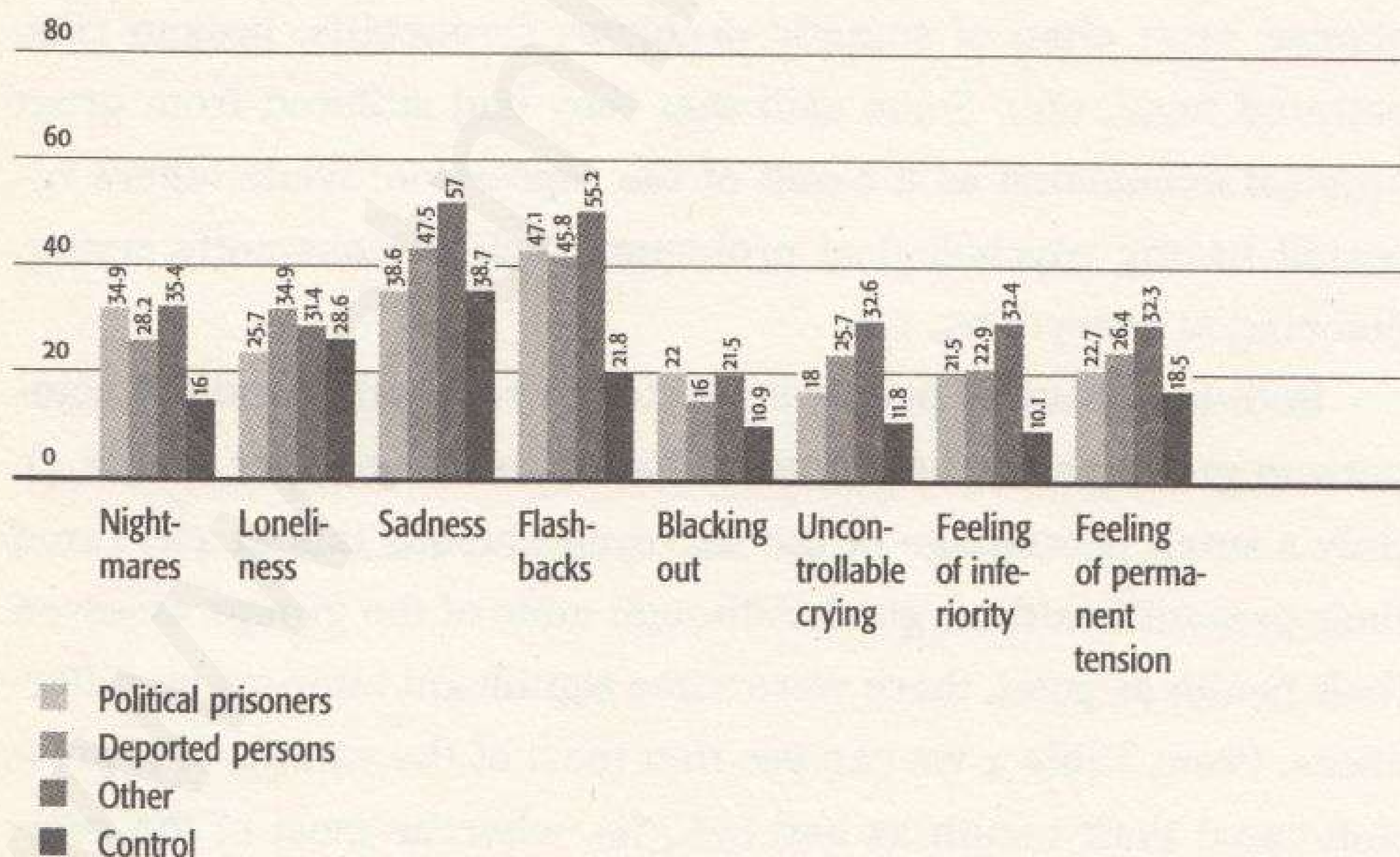


Table 5. **Trauma symptoms in all victim groups and the control group over the last two months (in %)**

No.	Trauma symptom	Victims				Control group
		Polit. prisoners (N=724)	Deportees (N=362)	Others (N=268)	All (N= 1,354)	(N=119)
1.	Insomnia	46.8	56.5	57.5	51.4	52.1
2.	Restless sleep	49.1	59.8	58.5	53.7	52.9
3.	**Nightmares**	34.9	28.2	35.4	33.1	16
4.	Waking up early in the morning	50.1	52.1	57	52	50.8
5.	Weight loss (without dieting)	16.7	17.4	16.4	16.8	16
6.	Feeling isolated	9	10.4	9.1	9.4	5
7.	**Loneliness**	25.7	34.9	31.4	29.3	28.6
8.	**Sadness**	38.6	47.5	57	44.5	38.7
9.	**Flashbacks**	47.1	45.8	55.2	48.3	21.8
10.	**Blacking out**	22	16	21.5	20.3	10.9
11.	Headaches	43.6	50.6	49.2	46.5	47.9
12.	**Stomach problems**	38.4	40.1	43.8	39.9	48.7
13.	**Uncontrollable crying**	18	25.7	32.6	22.8	11.8
14.	Anxiety attacks	21.8	29.9	33.9	26.2	24.4
15.	Mood swings	21.2	22.6	27.5	22.7	15.1
16.	Difficulty getting on with others	12.2	13.1	10.7	12.1	11.8
17.	Anger	23.1	20.5	20.7	21.8	26.1
18.	Dizziness	49.6	48.5	52.7	49.7	49.6
19.	Fainting	9.5	8.9	12.7	9.9	10.9
20.	Desire to harm oneself	1.7	2.7	2	2	1.7
21.	Desire to harm others	1.5	1.5	0.4	1.3	0.8
22.	Sexual problems	4.4	2.4	2.3	3.5	0.8
23.	Fear of men	2.6	3.3	3.7	3	3.4
24.	Fear of women	1.3	0.9	1.6	1.3	1.7
25.	Unnecessary or over-frequent washing	1	2.1	2.9	1.6	1.7
26.	**Feelings of inferiority**	21.5	22.9	32.4	24	10.1
27.	Feelings of guilt	4.7	7.1	12.2	6.1	4.2
28.	Feeling that things are "unreal"	3.6	3.9	3.3	3.6	0
29.	Memory problems	50.5	49	52.3	50.3	47.9
30.	Feeling of being detached from body	6.1	6.2	5.6	7.2	5.9
31.	**Feeling tense all the time**	22.7	26.4	32.2	25.5	18.5
32.	**Difficulty breathing**	25.8	25.4	28	26	16.8
33.	Fatigue	62.8	65.2	69	64.4	68.9
34.	Irritation	26.3	27.9	35.1	28.3	26.1
35.	Difficulty concentrating	30.1	32.1	28.3	29.7	25.2

Note: Others = other persons subjected to repression, all = combined scores of all persons subjected to repression, $^{**}p < 0.01$

(33.1%), feeling tense all the time (25.5%), blacking out (20%), breathing difficulties (26%), uncontrollable crying (22.8%), and feelings of inferiority (24%) (Table 5).

There is a difference in symptoms between the groups subjected to different forms of repression (Table 5, Figure 5) such as depressive symptoms, feelings of inferiority, feeling tense all the time, sadness, uncontrollable crying and loneliness are more pronounced in the groups of exiles and other persons subjected to repression. In the group of political prisoners, these depressive symptoms are less marked, but they display more *post-traumatic stress* symptoms (flashbacks, nightmares).

Coping with trauma

The survey has shown that the key factors that have helped elderly people in Lithuania to cope with the hardships of life are support from the family and close relatives, and a belief in God (Table 6, Figure 6).

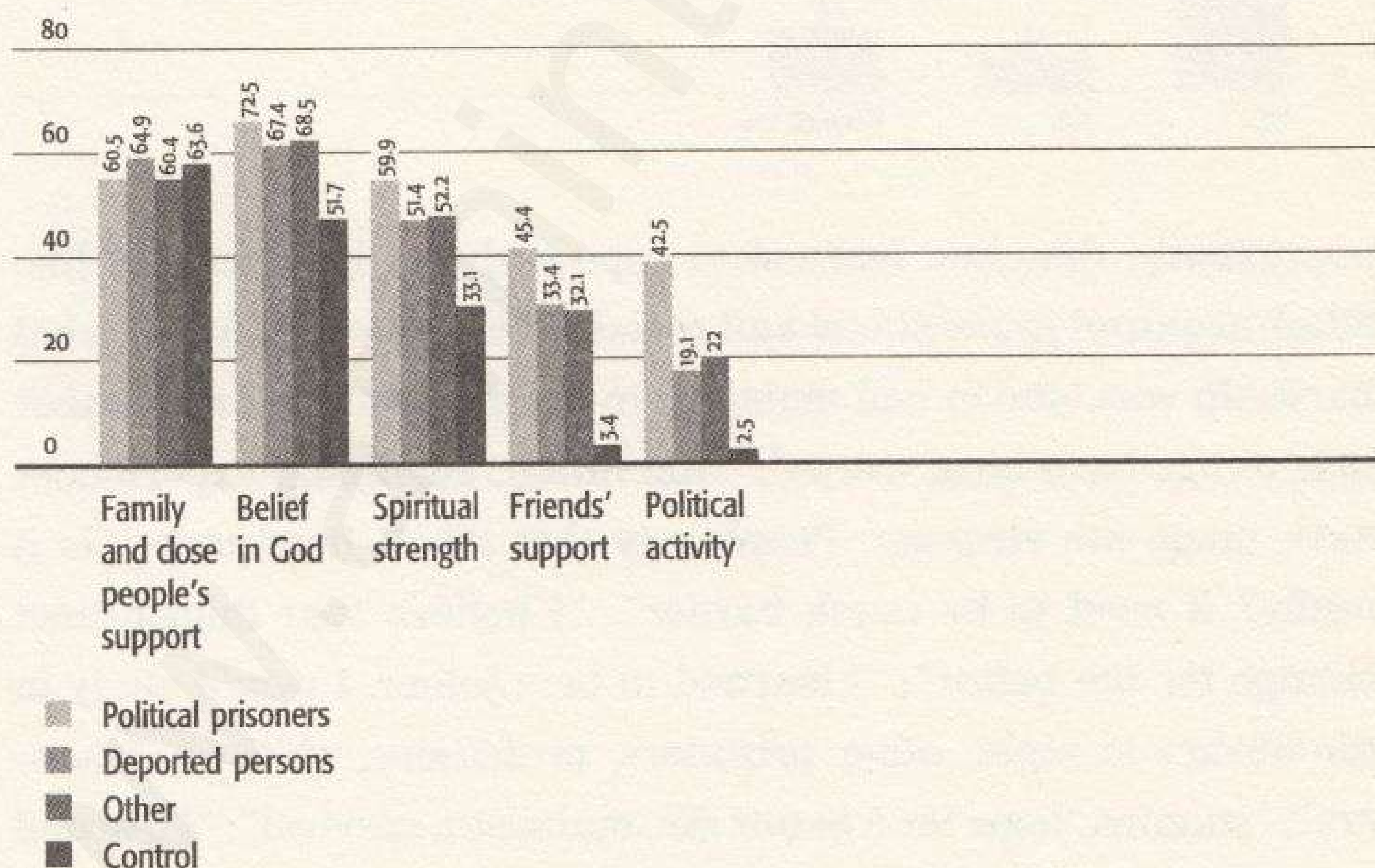
The coping strategies adopted by people subjected to repression differ from those of the comparison group. Firstly, the factor most frequently identified by the victims of repression is a belief in God (in the comparison group it is support from the family and friends). Secondly, the former group identified more coping factors. For example, the victim of repression group mentioned factors such as support from friends who had been exposed to the same form of repression and political involvement more than ten times as often as the comparison group did (39.6% and 3.4%, 32.1% and 2.5% respectively). Political prisoners differ from the two other groups of victims of repression in that they relied more often on support from their friends who had experienced political repression (45%) and on belief in God (75.5%), and that they are politically more active (42.5%) (compared with 19.1% and 22% in the groups of deportees and other victims of repression). Overall, political prisoners mentioned many more coping factors compared to the other groups of people subjected to repression.

Table 6. **Factors for coping with difficulties in victim and control groups (in %)**

	Victims				Control group
	Polit. prisoners (N=724)	Deportees (N=362)	Others (N=268)	All (N= 1,354)	(N=119)
1. Support from family and close relatives	60.5	64.9	60.4	61.8	63.6
2. **Support from friends** (a. who were exposed to repression; b. who experienced the same hardships in life)**	45.4	33.4	32.1	39.6	3.4
3. **Belief in God****	72.5	67.4	68.5	71.9	51.7
4. Chance	6.1	3.6	4.2	5.4	1.7
5. **Physical strength, health****	19.9	13.8	12.3	16.8	7.6
6. **Spiritual strength****	59.9	51.4	52.2	61.5	33.1
7. **Political participation****	42.5	19.1	22	32.1	2.5
8. **Hope****	47.4	38.7	36.9	42.9	25.4
9. Other				6.5	

Note: $^{**}p < 0.01$. Since "hope" was included in the questionnaire later, the results for this coping factor are not accurate: a) relevant to repression survivors, b) relevant to members of the comparison group.

Figure 6. **Coping factors in repressed persons and control groups (in %)**



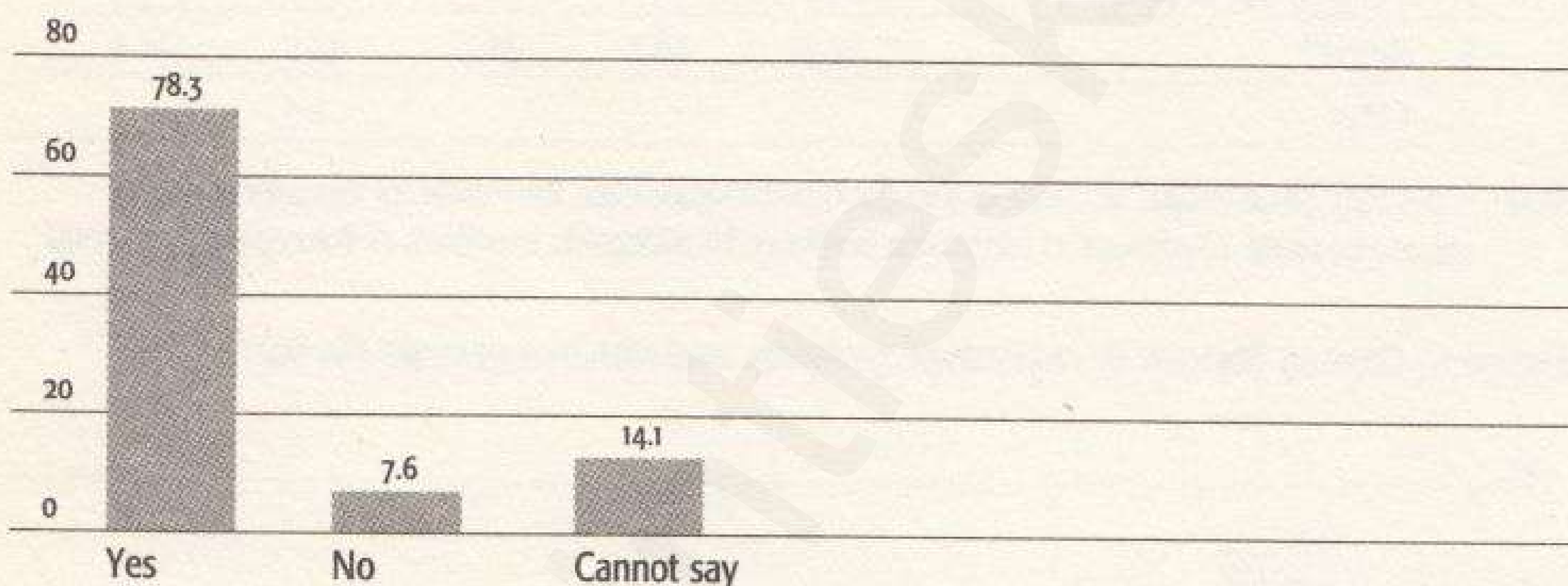
A total of 78% of the victims of repression said that the coping strategies developed during the period of repression had proved to be helpful in later life (Figure 7). The subjects said that, most

Table 7. **The results of the Sense of Coherence Scale (SOC-13) in victim and control groups**

	Victims				Control group
	Polit. prisoners (N=724)	Deportees (N=362)	Others (N=268)	All (N=1,354)	(N=119)
Mean	46	45.8	45.5	45.9	46.4
Min	16	19	16	16	23
Max	62	63	65	65	61,
SD	8.1	8.1	8.9		7.9

Note: *p < 0.05

Figure 7. **Ways of coping acquired during repression helped/help to deal with difficulties in life (in %)**



importantly, they had learned to cope with the hardships of life. Some acquired professional and social skills: “I came to know what hardship was, and in bad moments in my present life, I remember that things have been worse”; “Starvation, emotional experiences have made me stronger. People say that life is hard today. Is it really? It used to be much harder”; “I believe that things must change for the better”; “I learned to be a joiner. I would study in the library at night; other prisoners, professors, were my teachers”; “stamina, hope for a better life, optimism, survival”; “I learned a profession, a builder, an electrician”.

The Sense of Coherence scores did not reveal any statistically significant inter-group differences ($F = 0.38$, $p = 0.77$) (Table 7). The level of the sense of coherence was somewhat lower in exiles and

other victims of repression compared with that of political prisoners and the comparison group.

Comparison of the results obtained through different methods

In addition to the postal survey, personal interviews were conducted with a small group of victims of political repression. An additional analysis was performed to establish if there were any differences between the data collected by using different survey methods, a postal survey and semi-structured interviews. For the purpose of this analysis, two age-matched groups of people who had been exposed to the same form of repression were selected. Different methods were employed to collect data from the groups (postal survey and interview), but the survey instruments were the same for both groups, since some of the questionnaires had been modified in the course of the research. In total, the results from 50 interviews and 71 postal questionnaires were compared.

The data collected does not show any statistically significant differences between the data obtained by post and that from interviews for the assessment of the psychological effects of trauma (Table 8). There is a slight difference in the number of reported trau-

Table 8. **Comparison of the results obtained by postal survey and semi-structured interviews**

	Data collection	N	Mean	SD method
Traumatic events*				
	interview	50	9.3	2.8
	by post	71	7.2	4.2
Trauma symptom checklist				
	interview	50	54.9	9.2
	by post	71	53.8	11.7
Sense of Coherence*				
	interview	50	49.9	5.5
	by post	69	46.7	9.1

Note: *$p < 0.05$

matic events and between scores on post-traumatic coping factors. The interviews gave the subjects the opportunity to express their views and to provide more information. However, the quantitative results are very similar for both groups. We can say, therefore, that there are no essential differences between the data collected through different methods.

Discussion

Data from victims of repression and the control group

The effects of the repression. The majority of the survey participants (75%) were victims of repression of the second Soviet occupation period. During the first Soviet occupation, the repression was particularly severe, and there are very few survivors.

All the survey participants had been subjected to repression for a very long period of time: political imprisonment and/or exile (the mean duration was 7.4 years) and political persecution that lasted up to the collapse of the Soviet Union and the restoration of Lithuania's independence.

Even though the control group consisted of people who had also lived under the Soviet regime, the results of the study show that *the level of exposure to trauma is much higher* among people directly subjected to repression. Their *traumatic experiences* were much more severe than those of the comparison group: they experienced much more threats, humiliation, and life-threatening situations. For example, almost half of the victims of repression (48%) were subjected to torture, compared with only 5% in the comparison group; the percentages of people who experienced persecution are 55% and 8% respectively. Even after they had served their prison sentences or completed their term of deportation, it was decades before they were allowed to return to Lithuania, and when they did come back, they received little social support (only 7% of the victims of repression said that their reintegration had been successful). Political repression has had severe psychosocial consequences

for the victims: they have a lower educational level than the control group because the system prevented them from pursuing their professional and educational goals (83%); it affected their health (87%); and most of them lost family members or relatives during the period of the repression (55%).

The results of the study have confirmed that such severe and prolonged exposure to trauma has long-term effects that last for decades after the trauma occurs. *The health* of people who survived the Gulag and deportation *is poorer* than that of persons who were not subjected to political repression. Although this study did not aim to diagnose psychiatric disorders (eg the percentage of post-traumatic stress disorder), the results are consistent with data from many studies of long-term exposure to trauma, which have revealed that between 30% and 50% of the subjects experience post-traumatic stress disorders (Maercker, Schützwohl, 1997; Basoglu et al, 1994; Ehlers, Maercker, Boss, 2000; Bichesku et al, 2003). Out of the 35 symptoms on the Trauma Symptom Checklist, nine are statistically more prevalent in the group of victims of repression than in the age-matched group of people who were not subjected to repression, namely: nightmares, loneliness, sadness, flashbacks, blacking out, uncontrollable crying, feelings of inferiority, feeling tense all the time, breathing difficulties.

Almost one in four victims of repression display all the symptoms. Almost half of the victims experience invasive memories. Nearly one-third suffer from nightmares. As a result of severe traumatic experiences, some of the repressed persons lack self-confidence, are more sensitive, or have feelings of inferiority. The rate of attempted suicide among them is higher.

Thus, the victims of repression have developed not only post-traumatic stress symptoms, but also other stress responses and personality characteristics. These post-traumatic symptoms are similar to the "concentration camp syndrome" that has been described by Norwegian researchers (Eitinger, 1964; Eitinger, Strøm, 1973) and

to the ICD-10 diagnostic category of "enduring personality change after catastrophic experience" that develops as a result of acute stress (TLK-10, 1997). This confirms that we cannot discuss the effects of severe, prolonged exposure to trauma only in terms of post-traumatic stress disorder (Van der Kolk et al, 1996; Herman, 1993). Clinical symptoms broader than post-traumatic disorder may develop in a person who has been exposed to acute trauma for a long period of time (eg dissociation, a change in attitude towards others).

> My grandfather used to say that the years 1946 to 1948 were the most terrible, the cruellest, the most tragic. Now he says: "I'm happy that this nightmare ended a long time ago, but I won't forget it for the rest of my life. I wouldn't wish it even on my worst enemy, because it still sends shivers down my spine when I remember it." Even now, more than fifty years on, he wakes up at night in a cold sweat, paces the room for a long time, sits by the window and watches, or goes out to the garden to see his bees (Pilipavičiūtė et al, 2002).

Coping. However, we cannot say that all the victims are necessarily sick, unbalanced persons. Many studies have demonstrated that even in a group of people who have experienced particularly severe trauma (Holocaust survivors for example), disorders are diagnosed only in up to 50%. The present study has produced a similar result. Most of the victims of repression, even though exposed to the most severe traumas, live normal lives, started families and raised children; they are happy and strong people. Admittedly, *the family* is particularly important to some of them: the number of divorces is almost three times lower in the group of political prisoners as in the control group. This contrasts with data from a study of political prisoners in the former German Democratic Republic, where the divorce rate was much higher in the study group than in the control group (Maercker, Schützwohl, 1997). Perhaps this could be explained by the fact that, having been deported far away from their native Lithuania, political prisoners often married people who shared their fate, and the family was often the only safe haven for them.

Over the past 50 years, trauma researchers have paid too much

attention to post-traumatic symptoms and have ignored very important information about people's resilience and other protective factors, and coping processes. Our study has revealed that the control group, that is, elderly citizens of Lithuania who have not been exposed to prolonged trauma, usually rely on their families and their belief in God in difficult situations. Meanwhile, the victims of repression report *many more factors* that have helped them to cope with the repression. In addition to a belief in God, they identified other internal representations: hope and spiritual strength. *Political participation and political beliefs* serve as key protective factors. This supports data from other studies which have shown political involvement to be a strong protective factor (eg Basoglu et al, 1994).

Communication with other victims of repression is a very important protective factor for former political prisoners and deportees. In order to survive in the Gulag, they had to communicate and cooperate with other people. During the long years of sharing barracks with scores of other people, they learned to rely on each other. Possibly, many of those who failed to cooperate and share work, food, clothes etc with others did not survive to be alive today.

Another significant coping factor is the victims' ability to give a meaning to their experiences, to see some positive aspects in their severe traumatic experiences. Some 78% of the victims of repression said that their experiences of the repression period had proved useful in later life. Thus, the results of this study have shown that trauma not only leads to post-traumatic symptoms but also brings about some positive changes: realisation of one's internal resources, wisdom, better self-knowledge, and a better understanding of reality. One of the research participants said:

> The Gulag is a university of life. I met many intelligent people of different nationalities. The hardships I endured helped me to mature spiritually and equipped me to cope with the difficulties of life.

Any trauma also involves, apart from many other aspects, an existential factor. This is an important factor, as it shakes the very

core of one's personality and leads to a questioning and reevaluation of the meaning of the world and of one's worth, etc. Existential questions are particularly important in cases of political persecution. The results of our study have revealed that for the victims of repression, spiritual values, beliefs, faith and the ability to find meaning in suffering were vital factors in coping with trauma. During the interviews or in their comments in the questionnaires, many of the former political prisoners and deportees pointed out that it was their faith in the liberation of Lithuania and in their moral superiority over the occupying regime that had helped them to survive in prison and in exile. Thus, this study has brought up questions regarding the positive aspects of trauma, an issue that has been increasingly discussed as part of the post-traumatic growth concept (Calhoun, Tedeschi, 1998; Linley, 2003). Perhaps this explains why the intensity of the effects of trauma on the participants in our research project is similar to the effects observed in other studies of severe exposure to trauma, even though our study dealt with traumatic experiences that lasted for a very long period of time.

Groups of people subjected to different forms of repression: political prisoners, deportees and other victims of repression

The political prisoners differ from exiles and other victims of repression. Their traumatic experiences were much more severe than those of the other groups; they experienced more torture, intimidation, beatings and events involving death threats. They also appear to have experienced desperation more frequently, as they have the highest rate of attempted suicide.

On the other hand, the political prisoner group reported having used more coping strategies. Political involvement and political beliefs are very important to them; they socialise actively with friends who were subjected to the same repressive measures; they place a greater emphasis on factors such as spiritual strength and a belief in God.

The political prisoners differ from the other groups of victims of

repression in terms of post-traumatic stress symptoms, too. Symptoms such as loneliness, sadness, feeling tense all the time, and uncontrollable crying are less prevalent among them. They tend to have *intrusive* symptoms of post-traumatic stress disorder (flashbacks, nightmares), while *depressive* symptoms are more pronounced in the other two groups of victims. However, the intensity of all post-traumatic symptoms among the political prisoners is not higher than in the other groups.

The former political prisoners were participants in an active, usually armed, resistance to the occupying regime. Most of them are former partisans or supporters. Their motivation, determination to resist and risk, their coping strategies, and, probably, certain characteristics of their personalities, had a protective function. This may explain the above-mentioned differences in the consequences of the exposure to trauma.

The deportees and other victims of repression often found themselves in conditions potentially leading to "learned helplessness syndrome". They were often subjected to repression not for what they had done or for choices they had made, but because they belonged to certain ethnic, social or political groups. There were numerous cases where people did not try to flee or hide despite having been warned about impending repressions, for they felt that they had not done anything wrong and did not believe that they could be persecuted without being guilty. Most people in the group of other victims of repression were deported together with their parents, or were born in prison or in exile, or are other close relatives of those repressed. They, too, were persecuted for belonging to groups of "anti-Soviet elements" or "enemies of the people", rather than for their actions. This appears to be the main reason for the prevalence of symptoms associated with "learned helplessness" in these groups.

The issue of the control group

In this study, the control group consisted of people who did not have the formal status of victims of repression, randomly se-

lected from the Lithuanian Population Register and matched by age with the survivors of repression. We cannot say that the control group have never been subjected to any form of political pressure and that they lived in conditions of peace and democracy. As we mentioned above, the entire population lived under occupation and totalitarian rule. Even among people who did not have the formal status of victim, there were some who said that they had suffered from the Soviet or Nazi occupying regimes (therefore, their data was not included in the analysis). Even though they had not been directly subjected to political repression, a quarter of the members of the control group reported having lost close relatives as a result of political repression, and one-third of them said that they had been prevented from pursuing their professional or educational goals.

Specific features of the study

Long duration of trauma exposure and non-recognition. While a great deal of research has been done worldwide on the psychological effects of political violence, there have been few studies to assess the effects of communist repression. To our knowledge, such studies are almost non-existent in the former Soviet republics. Only in Latvia has a survey of victims of repression recently been carried out (Vidnere, Nucho, 2000). In terms of trauma psychology, the experience of victims of repression living in Lithuania, as well as in other former Soviet republics, is interesting due to the extremely long duration of their exposure to trauma, lasting for decades, and to the non-recognition of their traumas, which forced them to hide their past experiences for a very long time.

Random selection of participants and large sample size. Studies of political repression are most frequently conducted at torture victim or refugee centres, or with volunteers who respond to invitations to participate in the research. Often, research subjects are patients of the mental health services. The advantage of the present

study is that it used a non-clinical representative sample. The research subjects were randomly selected from the list of victims of political repression available at the LGGRTC. Another important feature of this research is the very large group of subjects, which is quite rare in studies on political repression. This study involved 1,404 Lithuanian residents with the formal status of victim of political repression. The control group was comprised of people randomly selected from the Population Register and matched by age to the victims of repression.

High response rate. As many as 80% of people invited to participate in the research completed and returned postal questionnaires. The response rate in the control group was also very high, at about 70%. The number of subjects in post-traumatic stress studies is often rather small. This can seriously distort the results, since the most severely affected people do not participate in such studies due to the avoidance behaviour that trauma victims tend to adopt (Weisæth, 1989). Normally, in psychological studies that use postal questionnaires, a return rate of about 50% is considered to be adequate. In the present study, the return rate was approximately 80%. The low rate of refusal to participate in the research increases the reliability of the data collected.

Differentiated groups of research participants. The existence of formal criteria defining the status of victim of repression, established under the Law of the Republic of Lithuania on the Legal Status of Persons who Suffered under the Occupations of 1939 to 1990, enabled us to compare the effects of different forms of repression. We made a comparison between groups of political prisoners, exiles, other victims of repression and residents of Lithuania who had not been directly subjected to political repression. Exiles' experiences are very similar to those of other people subjected to repression. The political prisoners' group differs from the other two groups of victims of repression in terms of the severity of the traumas they experienced, the effects that

the traumas have had on them, and the coping strategies that they have developed.

Methodological aspects. Semi-structured interviews were conducted with some of the survey participants, which enabled us to compare the data collected by using different research methods, a postal survey and interviews. The findings did not show any substantial differences between the data collected by the two methods. Thus, the more economical method, a postal survey, produces sufficiently reliable data.

Limitations. The age of the survey participants certainly had an impact on the results of the study. The mean age of the subjects was 70. This factor had to be taken into consideration both in selecting the research methods and in interpreting the results obtained. (For example, the participants in the study of former GDR political prisoners were 20 years younger on average; see Maercker, Schützwohl, 1997.)

Many of the survey participants complained of poor health. In the present study, symptoms of sleep or mood disorders, which are quite often present in trauma victims, are equally prevalent in the control group as among victims of repression. Recent studies have shown that many elderly people suffer from mood disorders (eg Fiske et al, 1998). Thus, it is probable that we were unable to measure adequately some of the symptoms due to the advanced age of the research participants.

Some practical recommendations

Trauma as an etiological factor of pathology. Severe, prolonged traumatisation may lead to long-term physical and mental disorders. Our research has shown that almost one-third of victims of repression in Lithuania have symptoms associated with traumatic experiences. Thus, when collecting anamnesis of elderly patients, mental health specialists and general practitioners should ask them about their Soviet-period experience. It is possible that exile or the

Gulag is the key factor causing depression and post-traumatic stress symptoms. People who have experienced deportation or other forms of repression are more likely to develop depression than political prisoners are. The latter tend to experience flashbacks of horrible memories and nightmares.

Psychological resilience. The analysis of coping factors has shown the importance of spiritual values, political participation and communication with other survivors of political repression. Therefore, their activities and organisations should be supported, encouraged and given recognition.

The psychology of repression victims. A certain percentage of repression victims (about 20% to 25%) have feelings of inferiority and injustice, so we should show more patience and tact in dealing with them. Official state support and public recognition are of great significance and help to them.

References

Adomėnas, M. (2003). Apie išliekamąją antikomunizmo reikšmę. *Naujasis židinys*, 11-12, 625-626.

Antonovsky, A. (1993). The structure and properties of the Sense of Coherence scale. *Social Science and Medicine*, 36:725-733.

Anušauskas, A. (1996). *Lietuvių tautos sovietinis naikinimas 1940–1958 metais*. Vilnius: Mintis.

Basoglu, M., Paker, M., Ozmen, E., Ozgun, T., Dogan, S. (1994). Factors related to long-term traumatic stress responses in survivors of torture in Turkey. *Journal of the American Medical Association*, 272:357-363.

Bichesku, D., Schauer, M., Rockstroh, B., Elbert, T. (2003). Long-term effects of trauma in Romanian former political prisoners. Paper presented at the Eighth European Conference on Traumatic Stress, May 2003, Berlin.

Briere, J., Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early Data on a New Scale. *Journal of Interpersonal Violence*, 4, No. 2, 151-163.

Burger, R. (2001). Atminties politikos klaidos: užmaršties apologija. *Naujasis židinys*, 12:660–674.

Calhoun, L.G., Tedeschi, R.G. (1998). Posttraumatic Growth: Future Directions. In: Tedeschi, R., Calhoun, L. (eds). *Posttraumatic Growth: Positive Changes in the Aftermath of Crisis. Mahwah.* NJ: Lawrence Earlbaum Associates, 215-240.

Diagnostic and statistical manual of mental disorders (4th ed) (1994). Washington: American Psychiatric Association.

Domanskaitė-Gota, V. (2000). *Lietuvos ir Danijos paauglių psichologinio traumatizmo ypatumai.* Magistro darbas. Vilniaus universitetas, Klinikinės ir socialinės psichologijos katedra.

Eitinger, L. (1964). *Concentration camp survivors in Norway and Israel.* The Hague: Martinus Nijhoff.

Eitinger, L., Strøm, A. (1973). *Mortality and morbidity after excessive stress: A follow-up investigation of Norvegian concentration camp survivors.* Oslo: The University Press.

Elklit, A. (1997). The aftermath of an industrial disaster. *Acta Psychiatrica Scandinavica*, 96, Suplementum, 1-25.

Fiske, A., Kasl-Godley, J.E., Gatz, M. (1998). Mood disorders in late life. In: Bellack, A.S., McHersen, M. (eds). *Comprehensive Clinical Psychology*. Vol. 7. Pergamon, 193-229.

Gailienė, D. (2001). Vienos diagnozės istorija. *Naujasis židinys*, 12:675-683.

Gailienė, D. (2002). Politinių represijų psichologiniai padariniai. *Genocidas ir rezistencija*, 2:121-126.

Gailienė, D., Kuodytė, D., Jakubonienė, G., Kazlauskas, E., Domanskaitė-Gota, V. (2003). Psychological effects of political repressions during Soviet occupations in Lithuania. Paper presented at the Eighth European Conference on Traumatic Stress, May, 2003, Berlin.

Gailius, B. (2003). Partizanų teisių atkūrimo klausimu. *Naujasis židinys*, 5:238-245.

Gailius, B. (2004). Karas, agentai-smogikai ir posovietinė visuomenė. *Naujasis židinys*, 5:228-236.

Gaškaitė-Žemaitienė, N. (2001). Lageris. *Juodųjų dienų sakmės.* Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 520-531.

Herman, J.L. (1992). *Trauma and recovery.* New York: Basic Books.

Herman, J.L. (1993). Sequeale of prolonged and repeated trauma: Evidence for a complex posttraumatic syndrome (DESNOS). In: Davidson, J., Foa, E.B. (eds). *Posttraumatic Stress Disorder, DSM-IV and Beyond.* Washington, DC: American Psychiatric Association.

Horowitz, M., Wilner, N., Alvarez, W. (1979). Impact of event scale: a measure of subjective stress. *Psychosomatic Medicine*, 41:209-218.

Ignatavičius, I. (1999). Fiziniai genocido padariniai: Aukų skaičiavimai. In: Ignatavičius, I. (ed). *Lietuvos naikinimas ir tautos kova 1940–1998.* Vilnius: Vaga, 572-575.

Kazlauskas, E. (2001). *Politinių represijų psichologinės pasekmės*. Magistro darbas. Vilniaus universitetas, Klinikinės ir socialinės psichologijos katedra.

Kazlauskas, E., Gailienė, D. (2003). Politinių represijų metu patirto sunkaus ilgalaikio traumavimo psichologinių padarinių kompleksiškumas. *Psichologija. Mokslo darbai*, 27:43-52.

Kraniauskienė, S. (2003). *Tapatybės konstravimas biografijose*. Daktaro disertacija. Vilniaus universitetas.

Kubilius, V. (2003 a). Apie istorinę savimonę. *Knygų aidai*, 1–2:2-4.

Kubilius, V. (2003 b). Kelias į niekur per lūžtantį iliuzijų ledą. *Metai*, 8–9:124-137.

Lietuvos Respublikos asmenų, nukentėjusių nuo 1939–1990 metų okupacijų, teisinio statuso įstatymas. Nr. VIII-342. (1997). *Valstybės žinios*, 1997, Nr. 66-1609.

Linley, P.A. (2003). Positive adaptation to trauma: Wisdom as both process and outcome. *Journal of Traumatic Stress*, 16:601-610.

Liongino Baliukevičiaus – partizano Dzūko dienoraštis: 1948 m. birželio 23 d.–1949 m. birželio 6 d. (2002). Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras.

Maercker, A. (1999). Lifespan psychological aspects of trauma and PTSD: symptoms and psychosocial impairments. In: *Posttraumatic Stress Disorder: A Lifespan Developmental Perspective*. Maercker, A., Schützwohl, M., Solomon, Z. (eds). Hogrefe & Huber Publishers, 1999, 7-43.

Maercker, A., Schützwohl, M. (1997). Long-term effects of political imprisonment: A group comparison study. *Social Psychiatry and Psychiatric Epidemiology*, 32:435-442.

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., Lavelle, J. (1992). The Harvard trauma questionnaire. *The Journal of Nervous and Mental Disease*, 180:111-116.

Pilipavičiūtė, A., Laivaitė, L., Chaladauskas, M. (2002). Literatūros pamoka. *Prakalbinta praeitis*. Vilnius: Lietuvos gyventojų genocido ir rezistencijos tyrimo centras, 277-285.

Shephard, B. (2000). *A War of Nerves. Soldiers and psychiatrists 1914–1994*. London: Jonathan Cape.

Streikus, A. (2003). Sovietinės praeities mitų spindesys ir šešėliai. *Naujasis židinys*, 6:293-294.

TLK – 10. (1997). *Psichikos ir elgesio sutrikimai: klinika ir diagnostika*. Kaunas: Medicina.

Van der Kolk, B., Pelcovitz, H., Roth, A., Mandel, K., McFarlane, M., Herman, J. (1996). Dissociaton, affect dysregulation and somatization: complex nature of adaptation to trauma. *American Journal of Psychiatry*, 153:7. Supplement, 83-93.

Vidnere, M., Nucho, A.O. (2000). *Latvian Survivors of Deportations*. Riga: RaKa.

Weisæth, L. (2002). The European history of psychotraumatology. *Journal of Traumatic Stress*, 15:443-452.

Weisæth, L. (1989). Importance of high response rates in traumatic stress research. *Acta Psychiatrica Scandinavica*, Suppl. 355, 80:131-137.

Weiss, D.S., Marmar, C.R. (1996). The impact of event scale – revised. In: Wilson, J.P., Keane, T.M. (eds). *Assessing psychological trauma and PTSD*. New York: Guilford Press, 399-411.

Valentinavičius, V. (2001). Holokaustas Amerikos gyvenime: atminties kultūros vingiai. *Naujasis židinys*, 12:667-674.

Psychological Aftereffects of the Soviet Trauma and the Analytical Process

GRAŽINA GUDAITĖ
Department of Clinical and Organisational Psychology, Vilnius University, Lithuania

What can long-term psychotherapy do to cope with the severe aftereffects of political traumas? What impact does a trauma have on the depth levels of the functioning of the human psyche?

In the light of the analytical psychology of Carl Jung, I analyse two cases of long-term psychotherapy in this article that serve as examples of the aftereffects that traumas may have and their dynamics in the therapy process.

Studies of the impact of trauma on the depth level of the personality are traditionally related to the rise and development of psychoanalysis. Analysing stories told by their patients, Freud, Rank and other psychoanalysts at the beginning of the 20th century came up with the hypothesis that trauma buried in the unconscious had an impact on the general state, relationships and possible psychopathology of an individual. This generation of psychoanalysts was particularly interested in childhood trauma and its unconscious manifestations in adult life. They succeeded in detecting certain characteristics of trauma, such as its expression through processes of invasion and inhibition that were later confirmed by modern research.

The analytical psychology of Jung gives a wider understanding of the roots and aftereffects of trauma. In his hypothesis on the unconscious and its structure, Jung widens the concept. Unlike the

representatives of traditional psychoanalysis, he not only writes about the personal but also about the collective unconscious, and also mentions family and cultural levels of the unconscious. The family unconscious includes a certain part of the family history and its secrets, while the cultural unconscious involves the history of a particular country and its culture. Both levels have an influence on the life, choices and emotional states of an individual. It seems that this hypothesis of Jung may serve as a reliable theoretical basis for analysing the long-term aftereffects of traumas, and especially those that are related not only to an individual life but also to the history of a family or a country.

In analysing the experience of trauma, Jung uses the concept of a complex. A complex is a structural component of the unconscious that influences the motivation, emotional responses, behaviour and decisions of a person. The core of the complex is made of a trauma or other intense emotional experience that has been expelled from the consciousness and can be identified with the help of associations or symbolic language. The main characteristics of a complex are its *autonomy and compulsivity* (Jung, 1913; Kast, 2002). This means that a complex acts independently of an individual's conscious decisions or intentions, and that it may be activated every time a suitable situation arises.

In the case of severe trauma, the impact of a complex may become demonic. Like a demon, a powerful complex destroys the integrity of the psyche, splits certain parts off, and has a destructive effect on the individual's life. Jung puts particular emphasis on the dissociative impact of the complex and its relation to pathology. An intense trauma may "incarcerate" the essential aspects of the Self, not letting them manifest themselves, thus limiting a person's growth and expression. The demonic characteristics of a trauma are its compulsive striving for repetition, resistance to being identified, connections to the experience of death, a feeling of inner emptiness, and frightening inner figures that appear in dreams or in other

states of consciousness when the control of the Ego is weakened (Kalsched, 1996). These symptoms may be a component of different affective and personality disorders.

Another important reason for using Jung's analytical psychology in dealing with the long-term aftereffects of trauma is the variety of practical ways of helping those who suffer from them and the model of psychotherapy itself. Usually trauma manifests itself indirectly, through different symptoms and incomprehensible behaviour, and it may also reappear in dreams and nightmares. Analytical psychology pays special attention to the analysis of symbolic material, such as dreams, associations and symbols of active imagination.

The recollection of a trauma is a long and complicated process. Different authors describe different ways to get the unconscious material. Freud wrote about free associations as the most important way to remember what has been hidden in the unconscious. Jung used free associations together with symbol amplifications. Freud wrote that a person should be relaxed and say everything that comes into his mind during a session of psychoanalysis (Freud, 1917). Jung also mentions some other important conditions: concentration on the present moment and the creation of the "enabling space". It is only possible for the unconscious to open up when a person is in the "here and now". *Concentration on the present moment and spontaneity* facilitate the emergence of significant contents of the unconscious that are directly related to the subjective experience of an individual.

In the description of *the creation of the "enabling space"*, Jung uses the metaphor of alchemy. The phenomenology of the process of psychotherapy and therapeutic relations are compared to an alchemical process: for the process of mixing the materials and the transformation of new materials out of old ones to happen, an alchemical vessel is needed. It must stand up to pressure and high temperatures, and fluctuations in the materials. The same conditions are necessary for psychological transformations of human in-

dividuals (Jung, 1946). An analyst serves as an alchemical vessel that may endure all the heat and pressure of emotional experience. In analysing the aftereffects of traumas that are often related to pain, sorrow, horror, hate and other intense experiences, it is important to create an atmosphere in which the client feels safe to open up the most terrifying of his experiences. This also means trusting the analyst and knowing that he will be able to endure it.

Some modern authors emphasise the importance of an adequate therapeutic relationship and empathy as the most reliable ways to get to the unconscious. The empathy of a therapist is also very important, as it helps to bring to the surface and integrate inhibited experiences. An analyst must empathise with the experience of his client, and, helping to reach them from the unconscious, help to restore the Self that has been damaged by the trauma (Kohut, 1977), or to restore the disrupted connection between the Ego and the Self (Jacoby, 1995).

Bearing in mind that symbolic material may be useful in analysing the unconscious and inhibited traumas, we still have to remember that the analysis of dreams, visions and other symbols is only effective and beneficial when it is accompanied by an adequate therapeutic relationship. This relationship is the starting point and the basis of changes in the personality, as they make it possible for the unconscious to emerge into the conscious and to be integrated.

Although in the cases discussed below most attention was given to the analysis of dreams, the creation of the "enabling space" and the analysis of the dynamics of the therapeutic relations were also important parts of the therapy. This was an important precondition for the emergence and analysis of the symbolic material.

The analysis of dreams has been conducted following the traditional model of analytical psychology that includes the following steps:

1) Analysis of the situation in which the dream appeared;
2) Retelling of the dream and specifying the content of it;
3) Associations;

4) Amplification;
5) Interpretation of a dream and its relation to the living reality of the dreamer and to his/her previous dreams (Gudaitė, 2002).

Two dreams of each client will be presented here, one that was experienced at the beginning, and another one at the end of the therapy. A comparison of the dreams will help to reveal the dynamics of the process of psychotherapy.

Two cases of long-term therapy are analysed, and different changes in the traumatic experience can be seen in them. The clients are:

- Ugnė, an architect, who started therapy at the age of 48 which lasted for 156 sessions;
- Dalia, a psychologist, who started therapy at 38 which lasted for 140 sessions.

So how does trauma manifest itself, and how do its aftereffects change over the course of psychotherapy?

Understanding one's difficulties at the beginning of the psychotherapy

Neither of these clients saw her difficulties as being related to the political traumas at the start of the therapy. Their problems came from emotions and interpersonal relations, and they were related subjectively to a midlife crisis. The clients were suffering from low self-esteem, a high level of anxiety (in one case even panic attacks), depression (one client had been diagnosed with a mild depressive disorder), and episodes of incomprehensible fear. Low self-esteem in their professional lives was resulting in an inability to realise completely their ideas, and also in an excessive fear of being criticised. They were concealing their needs and feelings in interpersonal relationships, had reclusive tendencies and were feeling lonely. Both had a fear of conflicts and potential aggression.

They let themselves be exploited by others, were unable to set adequate boundaries and often identified with the role of a victim, thus provoking certain responses from others, such as disrespect, lack of appreciation, rejection or psychological abuse. Not all of these difficulties could be explained solely by the midlife crisis, because some had been experienced by the patients all their lives.

Unstable self-esteem, a desire to be special and a fear of becoming so, dependence on others' opinions and difficulties with emotional control suggested a diagnosis of a narcissistic disorder, but other signs opposed this hypothesis. Their self-esteem did not fluctuate from grandiosity to total devaluation; the clients did not demonstrate their exclusiveness, but on the contrary were afraid of appearing special. So they not only avoided criticism but also praise. Both lacked self-confidence, and their self-realisation had been disrupted. In spite of their abilities, their achievements were rather modest. The fear of exposing themselves could be seen in their inability to finish a dissertation, have pictures exhibited, or pass a final exam.

The Self should be formed in early childhood, when the main psychic structures and the Ego-Self axis emerge. The mother plays an essential role here (Kohut, 1977; Jacoby, 1955). The memories of my clients showed that their primary relationship with their mothers was good enough, so it seemed that the symptoms mentioned and the disruptions of the Ego-Self axis came from elsewhere. Modern research into the impact of traumas shows that the axis between the Ego and the Self may be disrupted also by traumatic experience (Kalsched, 1996), so the basic self-esteem may also be disturbed at a later age or the roots of the disruption could be in the family history. The life stories of my clients confirm the last statement.

None of them related their complaints to the aftereffects of political trauma at the initial stage of therapy, but some facts emerged in the long-term analysis that provided evidence for the presence of certain traumatic events of a political nature in their lives. The

memories of these events were full of intense and repetitive emotional experiences that showed up in dreams, recollections and associations. It turned out that the lives of all of my clients were in one way or another affected by the political repressions that took place in the Baltic countries after the Second World War.

In analysing the life stories of the clients, the following information emerged. Ugnė's mother was imprisoned when her daughter was at primary school. Ugnė had understood at the time that this had happened because of mistakes and the irresponsibility of her mother in her work as an accountant. It became clear later on that the mother, who came from a rich family, was "inconvenient" to the Soviet system, and an invisible confrontation between her mother and this system continued all through her life.

Dalia's life had been affected by political events in a similar way to lots of other Lithuanian families. All of her family had been deported to Siberia.

Each of the clients had only a vague knowledge of these childhood traumas, and their emotional experience was little differentiated. When talking about the imprisonment of her mother, Ugnė mentioned how she used to feel scared when other children made fun of her, and she also had a feeling of being different and of being excluded by them. However, for some time at least, she was sure her mother was guilty of her crime, and she felt guilty and ashamed of what had happened. Incomprehensible guilt and shame were feelings familiar to her through all her later life.

Dalia only said about Siberia: "Everyone was being deported, and that's that."

We can see that the issue of traumatic political events and the emotional experience of them was taboo in the families. It probably came from the strategy of survival, which involved concealing one's own true reactions and beliefs, in order to avoid becoming another victim.

So, at the beginning of the psychotherapy, the psychological difficulties were not related to the political events or their traumatic

aftereffects. The lack of self-confidence, fear and other symptoms were seen as coming from the present situation, even though an analysis of the situation would only result in temporary relief, after which the symptoms would return.

The first recollections of traumatising events

The recollections of the traumatising events didn't come quickly, and at first the already mentioned facts of the family history were only mentioned rather formally. A lot of space was given to the analysis of current difficulties and to the emotional reaction, strengthening of the Ego and the feeling of self-confidence at the beginning of the psychotherapy, because the Ego must be strong enough to be able to make proper contact with the content of the unconscious. A too early opening up of the unconscious may be damaging and manifest itself in the most primitive ways determined by the complexes, such as acting out impulses, decisions that contradict reality, or the repetition of the trauma.

Signs showing that the mentioned facts from the family history were traumatising first appeared in dreams:

> I dreamt that I was in a big room with a high ceiling and a white stove. I was there with a little girl. Then something happened and I saw soldiers. There were lots of them, they were looking for someone, and I understood that if they found us they would kill us. We had to run and hide …

This is an extract from Ugnė's dream, the main subject of which is the war, with soldiers who may kill and a little girl who has to be saved, which has recurred throughout her life.

In the analysis of the dream, associations led to experiences that were in one way or another related to the danger of dying, to the mother and her imprisonment, to regretting having to grow up too fast, and to the violence of the father. As the dream recurred, it was clear that it carried quite a strong complex with it. In spite of the variety of associations and interpretations, it took a while for us to process this dream. At the rational level, we came up with a

hypothesis about a possible trauma, but for some time it was more a theoretical assumption unrelated to the subjective emotional reactions. It was not clear what the traumatising situation was. We were lacking some important message, at least for a time.

There were similar subjects in Dalia's dream, too:

> I dream about a war. The conquerors make everyone go to a bare field, shoot some of the people there, and let others live. There's a pogrom again. We are driven to the field and I am afraid I will be shot. We lie down on the ground. I am with some woman, though I can't see her face and I don't know who she is. Then I suddenly get a feeling of relief and I realise I am no longer afraid of dying, and that depends on the Almighty. If they shoot me, it will only last a short moment, and I can stand such pain. I start praying and tell the woman that I am not afraid and that I am praying for her too.

Dalia said she was left with a feeling of surprise and weirdness after this dream. She had never lived through wars or pogroms. Only one scene came to her from her childhood, of her mother being very frightened by the KGB. Dalia was at home alone with her mother when a man came and said something to the mother. She couldn't understand what the conversation was about and saw that her mother was very scared. When her father came home, her mother cried. Even though at that moment Dalia didn't understand what was happening, the memory was very clear. Later on, she learned that the visit had to do with political issues and reminded them of Siberia. It was only after independence had been proclaimed that Dalia's mother told her all the terrible details of the deportations. It may be that the pogroms in the dreams came from the mother's experience, which was somehow recorded in Dalia's unconscious.

These dreams might be understood as trauma dreams, and we can see either the threat of violence, violence itself, or the aftereffects of violence in the content. An analysis of the dreams and associations showed that there was a general tendency towards meeting both the events and the associations with a certain surprise and non-

acceptance, as if they didn't belong to the personal life of the dreamer. The associations led to the hypothesis that a certain inhibited experience was not only related to the frustration of the personal needs of the dreamer but also to the family and the cultural history, especially because the Ego of the dream was not identified with the victim. The victim is someone else: a small girl, a mother.

Whatever the origins of these dreams were, one message is clear: the situation is threatening, an Aggressor is near.

What are the possible interactions between the Ego and the Aggressor?

Interactions of a dream Ego with an Aggressor

We can see one of the strategies for dealing with an Aggressor in Ugnė's dream: "You have to run and hide." This impulse reveals an instinctive reaction that is in one way or another typical of everyone who has experienced trauma: escaping and avoiding an encounter with an Aggressor who is clearly dangerous. This helps them to survive.

But what happens if this survival strategy becomes dominating, unconscious and autonomous? On the psychological plane, escaping and avoiding may encourage isolation and unnecessary limitations. In Ugnė's case, it meant escaping from recognition, hiding her creativity. She was not only a student of architecture but also a professional artist. From what she said, I had the impression that she had painted quite a lot but that she was afraid of holding an exhibition. In her words, she was successful in selling her paintings to foreigners but she could not have them exhibited in her own country because she was afraid that others would criticise and reject her work. Her anxiety was so intense that it would turn into panic attacks and a rationally unaccountable fear of death.

Analytical psychology understands escaping and avoidance as one of the Ego strategies in facing the dark side of being. Kast, in

her analysis of fairytales, points out that the heroes of the tales use this strategy when the evil is especially powerful and when there is a danger that the hero may be destroyed (Kast, 1992). In Ugnė's case it was difficult to explain her avoidance and feelings of being threatened in situations that seemed not to be threatening at all. However, a different knowing lay in the unconscious, and therefore avoidance seemed to be reducing her anxiety.

A slightly different way of dealing with an Aggressor is seen in Dalia's dream: a prayer and seeking a connection with the Almighty. This is familiar to most of those who have been traumatised: in a case of unavoidable necessity, it remains the only available way of coping. A prayer helps to concentrate and seek a connection with higher powers, thus helping to withdraw from the destructivity of the situation. On one hand, it is also a withdrawal; on the other, it is switching to a relation with someone higher.

We can see that different Ego strategies used for dealing with violence and destruction and their aftereffects appeared in the first dreams. But are these strategies sufficient? This question becomes particularly important when a trauma is already quite old, and coping with its aftereffects becomes an inner problem for an individual. Psychoanalysts studying traumatic experiences have noticed that some individuals are unable to differentiate the traumatic situation and have driven it all into the unconscious. This means that there is not only a victim but also an Aggressor in the unconscious, and the latter becomes part of the personality of the traumatised person. "Identification with an Aggressor", mentioned by Ferenczi, means that a person who has experienced aggression might become an Aggressor himself (cf Kalsched, 1996). An Aggressor becomes an inner shadow figure or a complex, and coping with it becomes an inner problem.

How can the interaction between an Ego and an Aggressor change in the course of therapy? Here is one of Dalia's dreams in the middle of the therapy:

> I have to conduct a test in a prison. I know that one of the convicts is the killer of my grandfather. It's a middle-aged, self-satisfied man. I am surprised by the fact that he can walk freely through all the walls and only comes back for the night. That night, as usual, he returns all satisfied and tells me laughing that he continues with all his shady business. I say that it's not going to go on. He starts throwing chairs at me and tries to knock my head off. I try to avoid the blows; I know that some of my colleagues are behind the wall and that they may come to help me. At the last minute I notice that one of his eyes is bleeding. I understand that he had been fighting with someone and that this person had injured him. I feel very relieved that somebody has recognised him and stood up to him. I am not alone any more. His bleeding eye is like a sign that I can defeat him.

This dream is a continuation of the recurring subject of an Aggressor. Yet so far the Aggressor had had much clearer demonic traits, it used to appear as Satan, its look was piercing, and the dreamer, who would turn numb in its presence, would wake up in fear.

In analysing this dream, not only were the grandparents who died in Siberia and the related painful experiences remembered. There was also the theme of a system as an Aggressor, the dilemma of a relationship between an individual and a system, and a better awareness of one's own limitations. This dream appeared in the second half of the therapy. It was a significant turning point, perceived by the client herself as a clear sign of her improvement: she was less anxious and fearful, more aware of her limitations and more self-confident.

The ability to confront and resist external as well as internal aggression is an important aspect of the growth of the personality. Saying "no" means both personal empowerment and an active position, and it seems that it should prevent the repetition of a trauma.

Facing an Aggressor and fighting with him is a popular subject in hero mythology. This subject has been widely analysed in analytical psychology, where it is interpreted as a stage in the consolidation of the Ego (Gudaitė, 2001). The confrontation with an Aggressor and defeating him in the process of the integration of the

traumatic experience also means the integration of one's personal aggression and the feeling of self-empowerment.

In analysing myths and fairy tales, analytical psychology also hypothesises about other possible interactions between the Ego and an Aggressor: the development of the relationship between the Ego and an Aggressor or the struggle of the Ego against an Aggressor (Kast, 1992). If a hero in fairy tales succeeds in properly getting in touch with the seeming embodiment of evil, this evil turns into good. When there is a distinct Aggressor in the external world, this way is rather doubtful, but if the aftereffects of a trauma have grown into an inner conflict, it may well be applied.

The fight of the Ego with an Aggressor seems promising for self-dependence. In practical work this promise is not so easily achieved because if there are some aftereffects of a political trauma, the very identification of an Aggressor is very complicated. An Aggressor doesn't always take a human form. We are coming to the conclusion that an Aggressor is a system and the confrontation with it is complicated.

Now I would like to quote one of the last dreams Ugnė described in her 121st session. The problems prevailing at this stage of the therapy were related to the acceptance of the totality of life, the development of her spiritual potential and the realisation of the Self. The dream goes like this:

> I was at university. Three guys had invited me to participate in some event or ritual. I was myself, but at the same time I was one of these guys ... We were in a room where the ritual was to take place. Someone brought in a little girl and put her on the sofa. I understood that she had been brought to attract some (maybe black) powers. I wasn't related any more to them. For some reason it occurred to me that these could be satanic powers, and I wanted to protect the girl. I took a little cross off my neck and put it on her. I told her that when it got dangerous she should touch it.
>
> The picture changed. I saw a black cat. It was scary, red-eyed and red-haired. It looked like a real embodiment of Satan. The guys showed the girl to it, and it grew even bigger. It was twilight,

and it was difficult for me to see what was going on. I wanted to save the girl, but I fell. I could feel that the power was very strong. I wanted the girl to take the cross, but she couldn't. It was dark. I was trying to feel the cross, but instead I touched a hand that was cold and white. There was some weird sense of connection. I was praying; it seemed to me that this Satan swelled like a balloon, then deflated and disappeared. I was thinking: "Oh God, what a terrible story."

The girl was in the corner of the room, all black. Maybe she had been burnt. I couldn't believe it and I kept searching. Then an Angel appeared: "She's not here any more. You should look for her somewhere else ..." I understood that the Angel and the girl were together. The room was completely empty.

I went outside. Then I met a man; he was old, maybe 300 years old, and he had a big beard. He said: "You wanted so much to find a lake, so come, I will show one to you." We were walking. It was early morning. It was foggy. A lake appeared that looked silver and magical. I was looking at the lake. The fog was lifting and I could see the first rays of the sun. It was something powerful, but this time also divine. It was indescribably beautiful. A feeling of gratitude rose up in me. And I woke up.

The client said that she had a feeling that something very important had happened after this dream. It seemed to her that some very important stage of her life had ended and that something extremely important had opened up for her.

As we were analysing the dream, the first important figure that appeared in it was the girl. This figure reappeared in different dreams of the client. Many of her childhood memories were related to it. On one hand, these were memories of her helplessness and her fear of death. At the age of only three, she had already lived through a car accident and near drowning, so "it seemed that death was so close." She was scared when her father was beating her mother, and thought he might kill her. The girl in the dream was also associated with loneliness and the knowledge that she was different from others. On the other hand, some episodes of a happy childhood emerged, especially in the second half of the therapy, such as memories of her sitting in a café with her mother and talking, of her father being proud of her, caring for her studies and

wanting to discuss all sorts of issues with her, of her art teacher who greatly loved and appreciated her ... So by the end of the therapy, the life of the girl had become more balanced: there were some difficult experiences, but there were also some good ones.

An analysis of the series of dreams with the girl directed our attention to the fact that the rescue of the girl was possible in the previous dreams but not in the last one. The plot of the dream implied that the girl had been sacrificed. She moved to another space of being, where she was under the constant protection of the Angel.

What meaning did this have for Ugnė?

We came up with the hypothesis of *sacrifice of the childish position and being a victim*. This could also mean sacrificing certain childish illusions, childish expectations, passivity and helplessness.

Analytical psychology sees sacrifice as related to an ability to separate, to say goodbye, and to continue living. Sacrifice is an important moment in the transformation of a personality. However, does this hold true for those who have gone through a trauma? What can a traumatised person sacrifice? What can be sacrificed by those who have been affected by the political repressions of Soviet times? This question itself might sound absurd.

It is paradoxical, and yet the practice of psychotherapy shows that a person, without knowing it, doesn't want to "let go" of his helplessness and his being a victim of some violence. It is as if he finds new aggressors and new forms of psychological abuse. What is it that he can not separate from, what can he not sacrifice?

This paradox is explained by analytical psychology as *the totality of the psychic life*, and the essence of it is the integration of different polarities of being. This principle can be applied not only to explain individual emotional experiences but also for the functioning of archetypal forces. Kalsched (1996) speaks about archetypal systems of protection in his analysis of traumatic experiences. Patients who have suffered some kind of abuse, who have experienced the presence of Satan as very real, also have arche-

typal protection operating in them, which manifests itself first of all through fantasies. Archetypal protection shows in Ugnė's dream in the shape of an Angel. For others, it may be meeting some other kind of divine beings that save, protect and provide life with unearthly colours.

Knowing that in the event of separation from the demons, all unearthly connections may be cut off gets fixated in the human unconscious. Suffering and pain are a way to get in touch with the divine world. But is this the only way?

Ugnė's dream does not end with the sacrifice of the girl. The cat-Satan is another important figure in the dream. In her previous dreams, there had been witches, cruel wicked men who could kill, there was wild aggression, but it had always been expressed through a more human form. The cat-Satan is an embodiment of the evil that had previously been expressed in more fragmented forms.

The theme of God and the devil was quite common in the analysis of Ugnė. On the one hand, it seemed like a search for God, on the other hand it was as if she knew in advance that she was not up to a relationship with God, that God would certainly reject and punish her for being unworthy of His love. She could be punished for her anger, her witch-likeness, her rage; in other words for her aggression or her supposed satanic traits.

One of the associations to the cat-Satan was the novel *The Master and Margarita* by Bulgakov. One of the shapes of Satan in it was a cat that is involved in different satanic deeds together with his companions. When I asked Ugnė what she thought this book was about, she said it was about "the Soviet system and its absurdity". In her words, the Soviet system meant loss and covert abuse of her and her family. In addition to the painful story of her mother, it must be mentioned that the other members of the family had been affected by the Soviet system as well. Ugnė's grandparents had been rich, but they were deprived of their property. For more than a decade, Ugnė had had to pay with abuse and humiliation for having

a place to live. Her father had an important position in a big factory; he was a communist, though "he was too clever to believe in communist ideology." However, to stay in a high position, one had to be a communist. This hypocrisy also meant certain double standards, self-abuse and violent scenes at home, because "it was necessary to earn money for the family." We could go on with such memories, but we can also summarise that, as in Dalia's case, one of the names of the Aggressor is the Soviet system.

Over the last couple of decades there has been a lot of discussion on the impact the Soviet system had on the individual, and also on the phenomenon of *Homo sovieticus.* The authoritarian attitude and elements of magical thinking, immaturity and the most primitive defence mechanisms, the idealisation of the seeming equality of all people and the suppression of any individuality is ascribed to this phenomenon. On the other hand, many studies have been conducted that show that there are no big personality differences between Westerners and former Soviet citizens (Draguns, 1998).

Yet it is evident in the analytical process that the layer of Soviet experience appears not as a stable trait of the personality but as a certain layer of the unconscious (the complex of *Homo sovieticus?*) that affects by way of associations our behaviour, motivation, emotional reactions, expectations and decision making. As with every complex, we have to get to know it, but at the same time not to identify with it.

Bulgakov's novel *The Master and Margarita* is a reflection of the reality of a Soviet citizen, but also more than that. It is a book about an artist's life and sacrifice, about love and pain, about the suffering of Christ and redemption, about the reality of Hell, earthly life and eternity. One of the surprising insights of the book is the idea of Satan being related to the divine world. These are all universal themes. In spite of all the terror of the regime, the hero manages to set himself free. The author integrates the Soviet phenomenon into the much wider context of the psychic life that might be,

for Ugnė at least, a map in dealing with the essential opposites of life. The association that emerged helped her to reach a deeper understanding not only of past experiences but also of the future.

The last episode of Ugnė's dream points to the possibility of enlightenment and liberation. The scene of the lake and the rising sun is an experience of the end of darkness and the connection to eternal things.

Jung states that besides other functions, man has a transcendental one, the essence of which is an ability to reconcile the main opposites of life. The integration of opposites opens the transcendental prospect of the being thus widening the view to new possibilities and opening up the chance for liberation.

In summarising the cases presented here, it is important to mention that psychotherapy has helped my clients to cope with the initial symptoms and psychological difficulties. It may seem that the connection between the Ego and the Self has been renewed. Different inner changes can be seen in each of the cases. For Dalia, a new ability to resist and the possibility of confrontation; for Ugnė, the synthesis of existential opposites, creation and destruction.

Remembering and reliving political events was not the only subject of the analytical process. The long-term therapy included a much wider scale of experience and the opening up of new possibilities, which is an important part of the individuation of the personality. Yet these cases have shown that the history of the family and the country is a component of unconscious complexes and takes a part in the individual's life. Awareness of this inhibited experience can reduce the undesirable aftereffects of these complexes.

References

Draguns, J. G. (1998). Homo sovieticus in the Baltics? Hypothetical and actual manifestation in behavior and personality: their extent and limit. *Multidimensionality of contemporary psychology: social, political and cultural influences. Materials of III(XI) International Baltic Psychology Conference, Vilnius, June 30 July 3, 1998, p.32–35.*

Freud, S. (1917). *Psichoanalizės įvadas. Paskaitos*. Vilnius: Vaga, 1999.

Gudaitė, G. (2002). *Įvadas į analitinę psichologiją*. Vilnius: Vilniaus universiteto leidykla.

Gudaitė, G. (2001). *Asmenybės transformacija sapnuose, pasakose, mituose*. Vilnius: Tyto Alba.

Jacoby, M. (1995). *Individuation and Narcisism*. London and New York: Routledge.

Jung, C.G. (1913). *On the doctrine of complexes*. Collected Works 2. USA: Princeton University Press, 1977.

Jung, C.G.(1946). *The Psychology of Transference*. Collected Works 16. USA: Princeton University Press, 1977.

Jung, C.G. (1952). *Answer to Job*. Collected Works 11. USA: Princeton University Press, 1977.

Kalsched, D. *The inner world of trauma*. London: Routledge, 1996.

Kast, V., Jacoby, M., Riedel, I. (1992). *Witches, Ogres and Devil's Daughter*. Boston: Shambala.

Kohut, H. (1977). *The Restoration of the Self*. New York: International Universities Press.

www.antikvariatas.lt

The Long-Term Effects of Political Imprisonment in the German Democratic Republic: Implications for Treatment and Forensic Assessment

MATTHIAS SCHÜTZWOHL
C.G. Carus University Clinic, Clinic and Polyclinic for Psychiatry and Psychotherapy, Technical University of Dresden, Germany
ANDREAS MAERCKER
Department of Clinical Psychology and Psychotherapy, Zürich University, Switzerland

Introduction

Historians, politicians, judges, psychiatrists and psychologists will for a long time still be engaged in the history of political persecution and imprisonment in the former Eastern bloc countries, although many books and papers have been published and many speeches have been given on the issue. To be mentioned in the context is that many studies have shown that political persecution and imprisonment often led to substantial physical and mental aftereffects. This was reported, for example, for former political prisoners from Bulgaria (Tomov & Guentchev, 1993), the German Democratic Republic (Bauer et al, 1993; Maercker & Schützwohl, 1997), Latvia (Vidnere & Nucho, 1996), Lithuania (Kazlauskas & Gailienė, 2003), Poland (Heitzman & Rutkowski, 1997), and Romania (Anisescu, 2003; Bichescu et al, 2003). Given, furthermore, that there are, at least in a few countries, legal regulations concerning the compensation for mental aftereffects of political persecution and imprisonment, mental health professionals will be concerned both with issues of treatment and with issues of the assessment of mental aftereffects, for example in cases in which payment of compensation is claimed.

Against this background, the present chapter presents findings from a group comparison study on the long-term effects of political

imprisonment in the German Democratic Republic (eg Maercker & Schützwohl, 1997). After a short historical introduction to political persecution in the German Democratic Republic, the main results of this study, which was conducted from 1994 to 1996, will be reported and discussed, with respect to the mentioned issues of treatment and assessment.

Political persecution in the German Democratic Republic

The German Democratic Republic (GDR) was founded in 1949. Political power within the GDR soon shifted to the Communist Party, which then was a close ally of the Soviet leadership under Stalin. Several campaigns were launched to crush the resistance of political opponents, which resulted in high numbers of politically motivated imprisonments. By recent estimates, approximately 180,000 individuals were imprisoned for political reasons in the former GDR (see Bundesministerium der Justiz, 1994). Prison conditions were very hard, at least during the Stalin era (until 1953), with increased mortality rates from starvation and infectious diseases (Weber, 1991). The number of arrests and long-term prison sentences again increased when in 1953 an uprising among labourers was thwarted with the help of the occupying Soviet army. In 1961, a wall was built between East and West Germany and around West Berlin to prevent people from leaving East Germany. Individuals planning to leave East Germany or those who opposed official state policy were subjected to repression by the state authorities, particularly by agents of the increasingly powerful State Security Police (the Stasi). The Stasi also ran the remand prison facilities, where victims were interrogated and were held before trial. After the 1961 erection of the wall, more than 50,000 individuals were imprisoned for extended periods of time. While the prison conditions got better, psychological torture during interrogations was frequently used (Amnesty International, 1989).

Considering the different stressful conditions of imprisonment

and torture, it is reasonable to divide the history of the GDR into three eras of persecution and imprisonment (Maercker, 1995). Work by historians proposed these different political and administrative phases of the organisation of the Stasi security police and penal institutions (Werkentin, 1995). The first era, from 1949 to 1953, was characterised by a high death toll during imprisonment and openly brutal forms of persecution. During these interrogation sessions, pseudo-executions were common, and during the whole period of imprisonment victims suffered from malnutrition. The second era, from 1954 to 1971, was characterised by conditions of overcrowding in prisons and harsh persecution; for instance, many victims reported death threats and threats of the forced adoption of their children. The third era, from 1972 to 1989, showed more civilised prison conditions; however, the Stasi security police ran most of the remand prisons, and continued to apply harsh interrogation methods (eg interrogations at night with systematic sleep deprivation; Amnesty International, 1989).

The study's design

Participants

The study design included two groups. A non-clinical group of N=146 former political prisoners was recruited through advertisements in newspapers and in the newsletters of former political prisoners' organisations. All of the participants had been legally exculpated after 1990. The sample included 76 men and 15 women. Their average age was 53.7 years (SD = 11.8; range 27–82). The average time the participants spent in prison was 38.3 months (SD = 43.3; range 1–216), and, on average, 24.2 years (SD = 11.4; range 5–42) had elapsed since the participants were released from prison. On average, maltreatment was more common during pretrial detention than in punitive prison, with prisoners being subjected to an average of 3.6 forms of maltreatment (SD = 2.2) while on remand, compared to an average of 3.2 (SD = 2.4) while in punitive prison [$t(1,106) = 2.9$,

Table 1. **Description of study participants (N = 146 former prisoners, N = 75 comparison subjects)**

	Former prisoners		Comparison subjects		
	N	%	N	%	χ^2
Sex (% female)	22	(15)	13	(17)	.1
Marital status:					16.8**
single	18	(13)	1	(2)	
married	82	(59)	52	(81)	
widowed	5	(4)	0	(0)	
divorced	34	(24)	11	(17)	
Employment status:					12.1**
employed	51	(38)	46	(62)	
unemployed	30	(22)	12	(16)	
retired	55	(40)	16	(22)	
Period of imprisonment:					–
1949–1953	24	(17)	–	–	
1954–1970	67	(48)	–	–	
1971–1989	50	(35)	–	–	

Note: **p < 0.01

p < 0.01). The most common maltreatment condition in pretrial detention, as assessed using the questionnaire discussed below, was solitary confinement (66%), followed by forms of psychological torture such as verbal abuse or threats (63%), and physical maltreatment (57%). In punitive prison, witnessing torture or violent death (48%), verbal abuse or threats (42%), and physical maltreatment (42%) were most common. Solitary confinement was the least common form of maltreatment, both during pretrial detention (17%) and during punitive imprisonment (11%).

The control group, recruited through posted notices and student outreach, consisted of N=75 former East German citizens who had not been persecuted. The group included 62 men and 13 women, of an average age 52.5 years (SD = 9.3; range 31–74). Four of them (5%) reported traumatic events that fulfilled the stressor criterion for PTSD.

Other characteristics of the two groups are shown in Table 1.

Assessments

Prevalence of psychiatric disorders

A German version of the Anxiety Disorders Interview Schedule – Revised (ADIS-R; German version by Margraf et al, 1994; orig. DiNardo & Barlow, 1988) was used to assess the prevalence of psychiatric disorders. It includes anxiety, mood, somatoform and eating disorders, as well as screenings for alcohol and drug dependency, and schizophrenia.

Post-traumatic stress reactions

The ADIS-R allows for an expert rating of those 17 symptom criteria of PTSD that define the disorder according to DSM standards. In addition, the Impact of Event Scale – Revised (IES-R; Maercker & Schützwohl, 1998; orig. Weiss & Marmar, 1996) was used to assess a self-rating of the frequency of post-traumatic stress reactions; it comprises 22 items and produces subscales of intrusion (range 0–35), avoidance (range 0–40), and hyperarousal (range 0–35). Former prisoners were asked to rate symptoms related to the traumatic event of imprisonment. In the control group, the most traumatic life event reported served as a reference event for the IES-R.

Other symptoms

To assess other symptoms, the Beck Depression Inventory (BDI; German version by Hautzinger et al, 1992), the Beck Anxiety Inventory (BAI; German version by Margraf & Ehlers, 1995), and the Symptom Check-List (SCL-90-R; German version by Franke, 1995) were used.

Anger. The German version of the State-Trait-Anger-Expression-Inventory (STAXI; Schwenkmezger et al, 1992; orig. Spielberger, 1988) was used to assess the extent of experienced anger and methods of anger expression. It produces a total score on trait-anger (TA, range 0–40) and three subscales on anger expression: the anger-in scale (AI, range 0–32) assesses the extent to which feelings of anger are held in, the anger-out scale (AO, range 0–32) assesses the

extent to which feelings of anger are expressed outwardly, and the anger-control scale (AC, range 0–32) assesses the extent to which a person attempts to control his or her feelings of anger.

Trauma severity

This was assessed by an instrument gathering information for the two periods, that is, pretrial detention and punitive imprisonment. It supplied six variables indicating trauma severity:

1) Using a seven-point scale, participants were asked whether imprisonment happened all of a sudden or whether they knew that imprisonment was in store for them;
2) Threat to life during pretrial detention was assessed using a seven-point scale assessing whether former prisoners ever believed during their pretrial detention they were in conditions of mortal danger (1 = "never", 7 = "always");
3) Number of maltreatments during the pretrial detention was assessed by asking participants (yes or no) whether six specific maltreatment categories (solitary confinement, darkroom confinement, special confinement, ie "arrests", physical maltreatment, eg witnessing torture, being beaten, systematic sleep deprivation, verbal abuse/threats) applied to them when they were on remand. The number of reported maltreatments was added to a sum score (range 0–6; Cronbach's a = .71). (The presence or absence of maltreatment conditions rather than their duration was chosen because during the study's pilot phase participants had difficulties remembering the duration);
4) Threat to life during punitive prison was assessed using a seven-point scale assessing whether former prisoners ever believed during their punitive imprisonment they were in conditions of mortal danger (1 = "never", 7 = "always");
5) Number of maltreatments during punitive imprisonment was assessed by adding up the number of maltreatments (same categories as mentioned earlier in this section) participants

experienced during punitive imprisonment, resulting in a sum score (range 0–6, Cronbach's a = .70);

6) Duration of imprisonment was also assessed as an indicator of trauma severity.

Initial reactions

Three scores indicating initial reactions following the imprisonment were derived from a slightly modified version of the UBV (Fragebogen zum Umgang mit Belastungen im Verlauf; Reicherts & Perrez, 1992). In the present context, the questionnaire did not refer to prototypical stress situations but to the imprisonment. Answers to the questions were measured on scales with a range from 0 to 5 ("I felt even-tempered" to "I felt anxious"; "I felt happy" to "I felt depressed"; and "I felt well disposed" to "I felt enraged").

Pre-, peri- and post-traumatic cognitions

Boos and colleagues (1998) and Ehlers and colleagues (2000) developed a rating manual for the following concepts of cognitive processing:

1) political commitment prior to imprisonment;
2) mental defeat during imprisonment;
3) feeling of alienation during imprisonment and shortly afterwards;
4) feeling of permanent change for the worse in personality.

Political commitment was rated on a four-point scale from 0 to 3. Participants who were clearly opposed to the political system and were imprisoned because they actively participated in an opposition group or because they were conscientious objectors to military service received the highest ratings. Participants who opposed the political system but did not engage in any activities to change the system (eg participants who were imprisoned because they wanted to leave the country for personal reasons) received intermediate scores. Participants who did not oppose the political sys-

tem were classified as nonpolitical. A common reason for arrest in this group was that they had been overheard expressing dissatisfaction with or making critical remarks about life in East Germany.

Mental defeat is defined as the perceived loss of all psychological autonomy. Evidence for mental defeat versus an autonomous frame of mind was rated on a five-point rating scale from +2 (mental defeat at some stage during imprisonment) to -2 (clear evidence of an autonomous frame of mind throughout imprisonment).

Likewise, evidence for and against an *overall feeling of alienation* during imprisonment and in the weeks and months immediately afterwards was rated on a five-point rating scale from +2 (strong evidence for an overall feeling of alienation) to -2 (no evidence for an overall feeling of alienation and strong evidence against alienation).

Finally, evidence for the feeling of *permanent change* was rated on a five-point scale ranging from 0 (no negative changes in personality or life goals) to 4 (serious damage to personality or life goals).

Coping

Data on coping strategies employed by the participants in dealing with the aftereffects of political imprisonment at the time of the investigation was collected using the mentioned modified version of the UBV (Fragebogen zum Umgang mit Belastungen im Verlauf; Reicherts & Perrez, 1993). Factor analyses and analyses of the resulting subscales allowed for the calculation of three sum scores:

1) The subscale "Interpersonal Mastery" includes five items, such as "I want to find comfort, advice and help from people who are close to me";
2) The subscale "Blunting" includes five items indicating avoidance and distraction, such as "I try to switch off, distract myself and avoid the situation altogether";
3) Finally, the subscale "Palliation" includes four items indicating efforts to reduce emotional distress, such as "I persuade my inner self (eg encourage myself to tell myself: keep calm)."

Coping efforts can refer to both the environment and the self (Lazarus & Folkman, 1984). With regard to structural equation modelling (see below), in accordance with this differentiation, the subscales are presented as "environment-focused coping" where the subscale "Interpersonal Mastery" is concerned, and "self-focused coping" where those of "Blunting" and "Palliation" are referred to.

Social support was assessed using the short version of the F-SOZU (Fragebogen zur sozialen Unterstützung; Sommer & Fydrich, 1989). This questionnaire, which is well known in Germany, was used to measure two dimensions of social support: the extent of presently perceived "emotional support" (ES) and the extent of presently perceived "social integration" (SI). The ES-scale includes 16 items, such as "Whenever I feel low I know whom I can go to." The SI-scale includes 13 items, such as "Often I meet friends whom I first of all have a chat with."

Psychosocial consequences

Four indicators of psychosocial functioning have been chosen:

1) the degree of education, as rated on a five-point rating scale from 1 (CSE) to 5 (university degree);
2) the trend in the occupational "career" (-1 = predominantly downwards; 0 = predominantly continuous; +1 = predominantly upwards);
3) the percentage of unemployment rate;
4) the divorce rate.

Findings

Prevalence of post-traumatic stress reactions and other symptoms

The prevalence of PTSD symptoms ranged from 16% up to 63% (Table 2). The most common single symptoms were distress at exposure to cues symbolising the traumatic event (63%), recollections of the trauma (62%), stressful dreams or nightmares (58%), and hypervigilance (56%). The least common symptoms were avoidance

Table 2. **Prevalence of PTSD symptoms in former prisoners (N = 146) and comparison subjects (N = 75)**

	Former prisoners		Comparison subjects		
	N	%	N	%	χ^2
The traumatic event is persistently reexperienced:					
1) recurrent and intrusive distressing recollections of the event	91	(62)	2	(5)	42.9**
2) recurrent distressing dreams of the event	85	(58)	0	(0)	44.0**
3) acting or feeling as if the traumatic event were recurring	41	(28)	0	(0)	14.1**
4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event	92	(63)	0	(0)	51.3**
5) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event	69	(47)	0	(0)	30.6**
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness:					
1) efforts to avoid thoughts, feelings or conversations associated with the trauma	47	(32)	0	(0)	17.1**
2) efforts to avoid activities, places or people that arouse recollections of the trauma	24	(17)	0	(0)	6.9**
3) inability to recall an important aspect of the trauma	24	(17)	1	(2)	4.8*
4) markedly diminished interest or participation in important activities	23	(16)	0	(0)	6.5*
5) feeling of detachment or estrangement from others	53	(37)	0	(0)	20.6**
6) restricted range of effect	55	(38)	0	(0)	21.7**
7) sense of a foreshortened future	29	(20)	1	(2)	6.6*
Persistent symptoms of increased arousal:					
1) difficulties falling or staying asleep	74	(51)	0	(0)	34.4**
2) irritability or outbursts of anger	69	(47)	0	(0)	30.6**
3) difficulty concentrating	50	(35)	0	(0)	19.1**
4) hypervigilance	81	(56)	1	(2)	37.1**
5) exaggerated startle response	47	(32)	1	(2)	14.5**

Note: **$p < 0.01$, *$p < 0.05$

Table 3. **Self-rating of post-traumatic stress and other mental symptoms in former prisoners (N = 146) and comparison subjects (N = 75)**

	Former prisoners		Comparison subjects		
	N	%	N	%	p
Impact of Event Scale – Revised					
Intrusion	19.0	(10.3)	11.9	(10.8)	<.001
Avoidance	13.9	(9.2)	8.9	(9.2)	<.001
Hyperarousal	16.9	(10.9)	6.9	(8.9)	<.001
Beck Depression Inventory	14.2	(10.1)	6.9	(5.9)	<.001
Beck Anxiety Inventory	15.7	(14.7)	6.6	(7.7)	<.001
Symptom Checklist SCL-90-R					
Global Symptom Index	1.0	(0.8)	0.4	(0.4)	<.001
State Trait Anger Expression Inventory (STAXI)					
Trait-Anger	21.4	(6.0)*	–	–	–
Anger-In	18.7	(5.1)*	–	–	–
Anger-Out	14.4	(5.1)	–	–	–
Anger-Control	22.5	(5.5)	–	–	–

Note: * percentile > 75

of reminders of the trauma (17%), psychogenic amnesia (17%), and diminished interest in activities (16%). Thus, political prisoners showed a particular pattern of PTSD symptoms in which intrusive and hyperarousal symptoms outnumbered avoidance symptoms. A comparison of average numbers of clinician-rated symptoms showed significant differences between the frequency of intrusive and avoidance symptoms [$t(145) = 11.6$; $p < 0.001$] and arousal and avoidance symptoms [($t(145) = 9.7$; $p < 0.001$]. This pattern is validated by the within-group comparisons of the IES-R subscales (Table 3), which revealed a significant difference between the average scores of the intrusive and the avoidance subscales [$t(139) = 9.5$; $p < 0.001$] as well as between the average scores of the arousal and the avoidance subscales [$t(139) = 6.7$; $p < 0.001$].

The prevalence of post-traumatic stress reactions was throughout higher in the group of former prisoners than in the control group, a finding that was reflected in the participants' self-ratings on the IES-R (cf Table 2).

The political prisoners also had significantly higher scores than comparison subjects on all other self-reported measures of symptoms: depression, anxiety and general psychiatric symptoms (Table 3). They reported, too, a high level of experienced anger: with regard to the existing German standardisation, the mean score on the trait-anger subscale corresponded to a percentile rank of 75. Scores on measures of anger expression indicate that feelings of anger are often kept in and often expressed outwardly (Schützwohl & Maercker, 2000).

Prevalence of psychiatric disorders

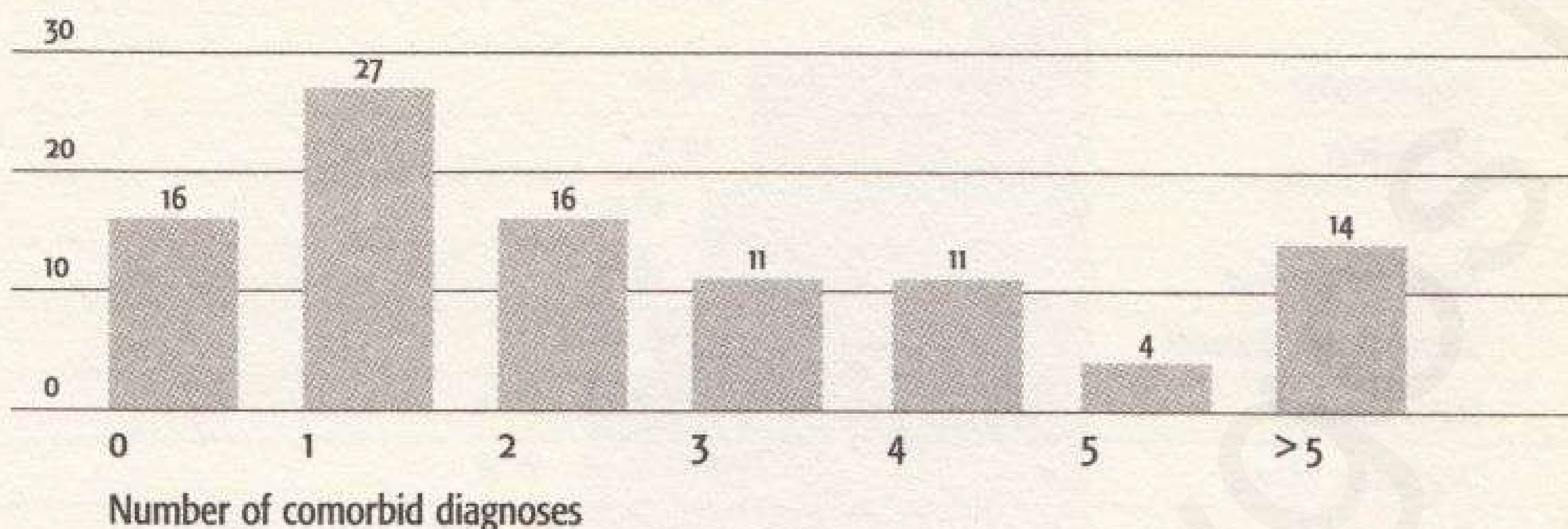
Table 4 shows the diagnoses among the two study groups according to DSM-III-R. The full set of diagnostic criteria for PTSD was met by 30.1% of the political prisoners (26.4% of men and 52.4% of women; $c^2_{(N=146)} = 4.6$, $p < 0.05$). The lifetime prevalence

Table 4. **Psychiatric diagnoses of former prisoners (N = 146) and comparison subjects (N = 44)**

	Former prisoners		Comparison subjects		
	N	%	N	%	χ^2
PTSD, current	44	(30)	0	(0)	17.6**
Partial PTSD, current	43	(29)	0	(0)	16.5**
PTSD, lifetime	87	(60)	0	(0)	49.8**
Agoraphobia without panic disorder	14	(10)	1	(2)	_
Panic disorder without agrophobia	7	(5)	0	(0)	_
Panic disorder with agoraphobia	9	(6)	0	(0)	_
Specific phobia, claustrophobic type	31	(22)	1	(2)	8.7**
Other specific phobia	26	(18)	2	(5)	_
Social phobia	18	(13)	1	(2)	_*
Generalised anxiety disorder	8	(6)	2	(5)	_
Obsessive-compulsive disorder	2	(1)	0	(0)	_
Major depression	19	(13)	3	(7)	0.8
Dysthymia	10	(7)	1	(2)	_
Somatoform disorder	22	(16)	2	(5)	2.7
Substance abuse (screening)	19	(14)	1	(2)	_

Note: **p < 0.01, *p < 0.05
_ Fisher's exact test for small frequencies (no summary test value available)

Figure 1. **Percentage of comorbid diagnoses in former prisoners with PTSD (N = 44)**



for full PTSD was 59.6% (58.1% of men and 71.4% of women; $c^2_{(N=146)} = 1.8$, $p < 0.05$).

The criteria for partial PTSD, as defined by Blanchard et al (1995), were met by N = 43 of the political prisoners, that is, 29% of the group of political prisoners did not meet the full set of diagnostic criteria but the minimum number of symptoms for the reexperiencing criterion and either the avoidance criterion or the hyperarousal criterion. It is important to mention that traumatised persons suffering from partial PTSD may suffer from clinically significant symptoms and may be in need of professional help (Schützwohl & Maercker, 1999).

The other most frequent disorder was specific phobia, particularly the claustrophobic subtype (22.3%). Claustrophobic subjects reported intense fears and avoidance behaviour, related, for example, to dressing cubicles, and a desire to keep windows and doors open even during cold seasons. Other anxiety disorders distinguished the groups significantly as well; whereas depressive disorders did not. Substance abuse showed elevated rates in the former prisoners as well, indicating social breakdown (see Maercker & Schützwohl, 1997).

Figure 1 shows that in former prisoners with PTSD (N = 44), only 16% did not suffer from a comorbid disorder. Every fourth suffered from one comorbid disorder, every other one suffered from more than two comorbid diagnoses. On average, each political pris-

Figure 2. **Comorbid diagnoses in former prisoners with PTSD (N = 44)**

Diagnosis	%
OCD	5 %
Agoraphobia	14 %
Dysthymia	14 %
GAD	16 %
Major depression	16 %
Somatoform disorder	18 %
Panic disorder	21 %
Substance abuse	21 %
Social phobia	23 %
Other specific phobia	23 %
Claustrophobia	36 %

Table 5. **Trauma severity, initial reactions and long-term effects in former political prisoners (N = 146)**

	IES-R Intrusion	IES-R Avoidance	IES-R Hyper-arousal
Trauma severity			
Anticipated vs unreckoned/surprisingly	.12	.11	.07
Threat to life during pretrial detention	.30**	.19*	.24*
Number of maltreatments during pretrial detention	.35**	.05	.24*
Threat to life during punitive prison	.36**	.15	.37**
Number of maltreatments during punitive imprisonment	.25**	-.13	.19
Duration of imprisonment	.06	.06	.03
Initial reaction			
Even-tempered vs anxious	.29*	.19*	.21*
Happy vs depressed	.32**	.26**	.24**
Kindly vs enraged	.32**	.16	.13

Note: **p < 0.01, *p < 0.05

oner with PTSD met diagnostic criteria for 2.9 other psychiatric disorders (SD = 2.7). As expected, the most common comorbid disorders were claustrophobia, other specific phobias, social phobia and substance abuse (Figure 2).

The prevalence of psychiatric disorders is also raised in those former prisoners who do not suffer from PTSD (N=102). As in the

Figure 3. **Prevalence of psychiatric disorders in former prisoners without PTSD (N = 102)**

Disorder	Prevalence
OCD	
Agoraphobia	8 %
Dysthymia	4 %
GAD	1 %
Major depression	12 %
Somatoform disorder	16 %
Panic disorder	7 %
Substance abuse	10 %
Social phobia	8 %
Other specific phobia	17 %
Claustrophobia	16 %

group of political prisoners with PTSD, the most common disorders were claustrophobia and other specific phobias, but also somatoform disorders, depressive disorders and substance abuse showed a prevalence of more than 10% (Figure 3).

Trauma severity and initial reactions as precipitating factors for chronic post-traumatic stress reactions

As is shown in Table 5, the correlations between indicators of trauma severity and chronic post-traumatic stress are, though partly statistically significant, small to medium. The duration of the imprisonment has no impact on the long-term stress reactions following political imprisonment.

Likewise, correlations between initial reactions and post-traumatic symptoms are also small to medium, indicating that later symptomatology is only to a small extent explained by the immediate emotional responses to imprisonment (Maercker et al, 2000).

Pre- and peri-traumatic factors associated with long-term post-traumatic stress reactions

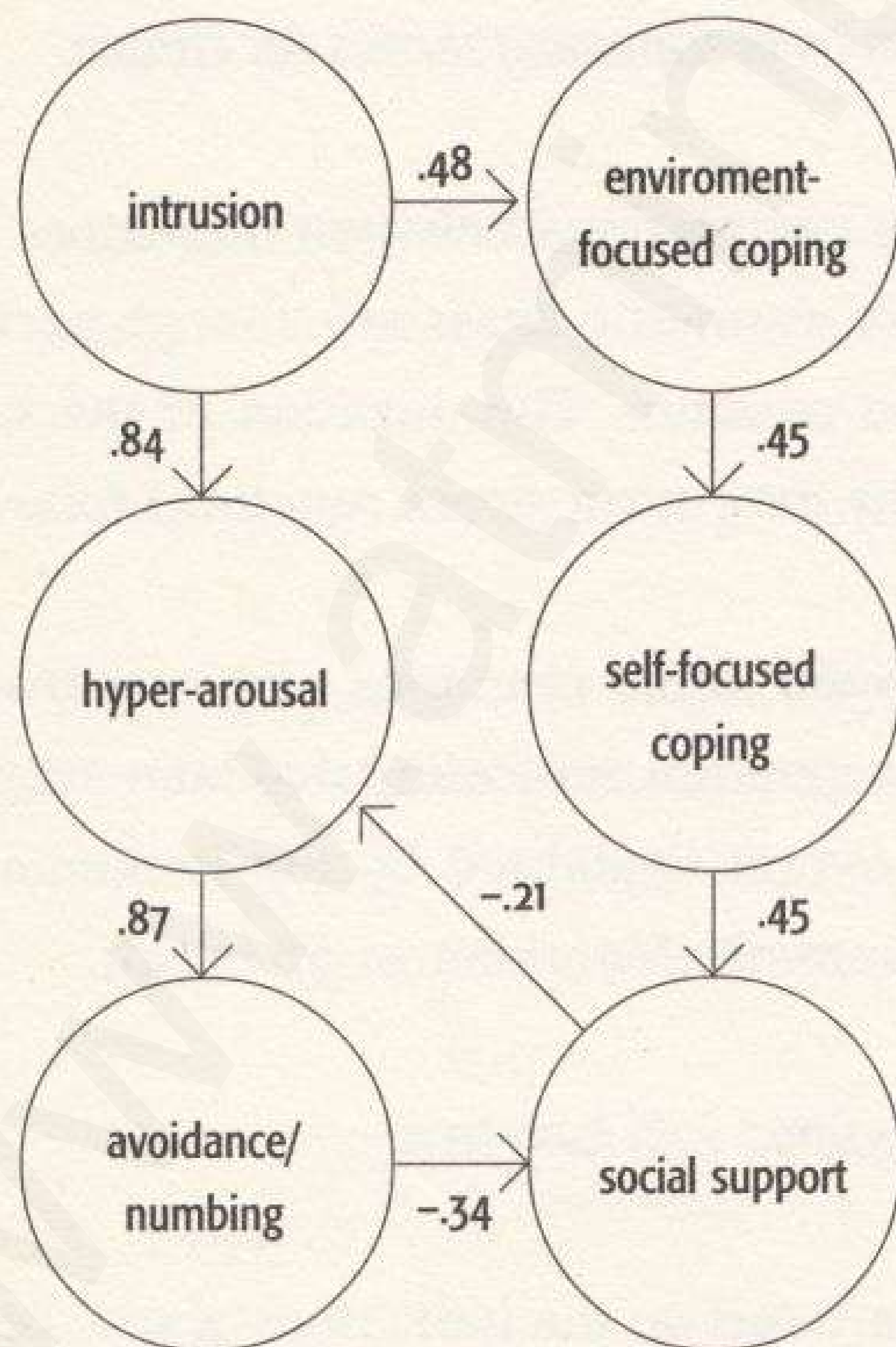
Table 6 shows group comparisons on the indicators of pre, peri and post-traumatic cognitions. The diagnostic groups differed sig-

Table 6. **Pre-, peri- and post-traumatic cognitions and long-term effects in former political prisoners with chronic PTSD (N = 32), remitted PTSD (N = 20), and no PTSD (N = 29)**

	Chronic PTSD		Remitted PTSD		No PTSD		Tukey Test
	M	(SD)	M	(SD)	M	(SD)	
Political commitment prior to imprisonment	1.10	(1.16)	1.55	(1.32)	1.76	(1.15)	2.3
Mental defeat during imprisonment	$.91_a$	(1.22)	$.20_a$	(.95)	$-.79_b$	(.94)	19.4**
Feeling of alienation during imprisonment and shortly afterwards	$.28_a$	(1.22)	$-.10_a$	(1.71)	-1.24_b	(0.91)	11.6**
Feeling of permanent change for the worse in personality and life	2.66_a	(1.23)	$1.95_{a,b}$	(1.39)	1.48_b	(1.40)	5.0*

Note: Means not sharing the same subscript are significantly different.
**$p < 0.01$, *$p < 0.05$

Figure 4. **Structural equation model for the functional relationship between post-traumatic stress reactions, coping and social support in former prisoners (N = 146)**



nificantly on mental defeat, overall feeling of alienation, and permanent change, but not on political commitment. Tests showed that the PTSD groups (chronic PTSD and remitted PTSD) were more likely to have experienced mental defeat and an overall feeling of alienation than those without PTSD. Participants with chronic PTSD also scored higher on permanent change than participants without PTSD.

Long-term post-traumatic stress reactions, coping, and social support

The interrelationship between long-term post-traumatic stress reactions, coping strategies and social support was investigated by structural equation modelling using EQS (Bentler, 1993; see Schützwohl et al, 1999). This method led to the empirical model shown in Figure 4. It shows good characteristics ($c^2_{(33,N=123)} = 39.3$, $p = .21$, and adjusted goodness of fit = .96), that is, the model corresponds well with the empirically acquired data. Consistent with theoretical assumptions, intrusion and hyperarousal seem to indicate the severity of chronic post-traumatic stress reactions with intrusion affecting hyperarousal. The extent of avoidance is significantly determined by hyper-arousal and (indirectly) by intrusion.

With regard to coping strategies, the results indicate that stressful intrusions of the trauma may act as catalysts in the victims' motivation to cope with them. In our study group of former East German political prisoners, about six years after the fall of the GDR, with an increase in stress caused by intrusive recollections we found primarily a need for environment-focused coping, for example a need for comfort, advice and support, as well as a desire to report to other people about their experiences in prison, including blaming the perpetrators responsible for their suffering. The participants obviously subsequently tried harder to calm down.

The extent of perceived social support is lessened by post-traumatic avoidance and increased by self-focused coping behaviour. It directly effects post-traumatic symptomatology, namely hyperarousal.

Lifespan psychological aspects of political imprisonment in the German Democratic Republic: later psychosocial impairment

Former political prisoners achieved a lower degree of education, lower achievements in their careers and a higher rate of divorce.

Table 7. **Psychosocial functioning of former political prisoners (N = 82-146) and comparison subjects (N = 44-75)**

Indicators	Former prisoners	Comparison subjects	p
Degree of education (M (SD))	2.5 (1.4)	3.5 (1.6)	<.001
Career (M (SD))	0.0 (0.8)	0.3 (0.7)	<.05
Unemployment, ever since release (in %)	36.1	29.3	n.s.
Divorce, ever since release (in %)	34.3	22.1	<.05

Discussion

Implications of the diagnostic findings

The diagnostic findings correspond with other findings on the mental sequelae of political imprisonment (eg Basoglu et al, 1994; Bauer et al, 1993; Heitzman & Rutkowski, 1997; Kazlauskas & Gailienė, 2003; Tomov & Guentchev, 1993). Direct exposure to politically justified imprisonment qualifies as a traumatic experience, and many of its victims suffer from severe mental health problems, especially from posttraumatic stress reactions, but also from other symptoms such as depression, anxiety and anger, even many years after release.

Within the assessed PTSD symptomatology, intrusions and symptoms of hyperarousal were the most common; whereas the prevalence of symptoms of avoidance was rather low. This finding supports a similar one of the only other study on former East German political prisoners (Bauer et al, 1993). Two explanations are possible. First, it might very well be that the recruitment strategies did not reach out to subjects who still display avoidance behaviour, particularly towards disclosure. Systematic recruitment would help to decide whether the low avoidance symptom pattern is typical of the type of political persecution studied. A second explanation is also

possible: after the fall of the GDR in 1989, the subjects were encouraged by the political changes to disclose their experiences and to take an active role in societal change. This assumption would mean that the extent of avoidance may vary with the social conditions, implying that the social conditions are affecting the feelings and health of the former prisoners.

A diagnosis of PTSD stood out as the most common disorder. However, we did not assess other stress response syndromes beyond PTSD, such as complex PTSD or post-traumatic personality disorder (eg Herman, 1992), disorders that have been proposed as a response to Type-II traumas such as political imprisonment (Terr, 1991).

In the sub-sample of former prisoners with PTSD, the number of comorbid diagnoses was high, with the highest rates to be found for claustrophobia, social phobia, and other specific phobias. The prevalence rate of psychiatric disorders were also raised in the sub-sample of former prisoners without PTSD, indicating that other disorders than PTSD may very well result from political imprisonment.

Implications for treatment

The diagnostic findings clearly show that a great number of former political prisoners are in need of professional help. With respect to planning for services, the need for services should not be underestimated by estimating the number of prisoners suffering from full PTSD, but by estimating the number of prisoners suffering from any mental disturbances necessitating treatment.

The treatment itself should address post-traumatic stress reactions as well as other symptoms. Within the treatment of post-traumatic stress, clinicians should bear in mind that the treatment can vary depending upon the presence of additional psychological symptoms. In addition, the findings provide further support for the notion that clinicians should be aware of the readiness of traumatised victims to express anger. Given that it is assumed that anger has a

negative impact on the therapist-patient relationship (Burstein, 1986; Chemtob et al, 1997) and on the efficacy of exposure therapy (Foa et al, 1995), treatment for PTSD should, if necessary, address anger, preferably at an early stage of the therapy.

Implications for the forensic assessment of the mental sequelae of political imprisonment (eg in litigation)

The diagnostic findings clearly show that experts should systematically assess post-traumatic stress reactions, but that they should also go for the assessment of other symptoms and disorders which may very well be related to the former imprisonment. If a severity rating is required, experts should bear in mind that traumatised victims may suffer from significant disturbances even if the criteria for PTSD, or any other psychiatric disorder, are not fully met.

Implications of the findings on the effect of trauma severity and initial reactions

The findings confirm that the relationship between traumatising conditions and long-term post-traumatic stress reactions is rather low. In our study, as in prior ones, both the indicators of trauma severity and indicators of the former prisoners' initial reactions account for around 10% of the variance in post-traumatic stress reactions. This finding has clear *implications for the forensic assessment of the mental sequelae of political imprisonment*. Experts should bear in mind that the former political prisoners may suffer from mental disturbance even if they anticipated being imprisoned, even if they did not believe they were in conditions of mortal danger, and even if the imprisonment only lasted a few weeks.

Implications of the findings on the meaning of pre-, peri- and post-traumatic cognitions

Consistent with previous studies and theoretical assumptions (Dunmore et al, 1999), the results clearly suggest that mental

defeat, alienation and permanent change are related to PTSD (Ehlers et al, 2000). This has *implications for the treatment*: if the importance of mental defeat, alienation and permanent change is supported by further research, they will need to be addressed in the treatment of victims of interpersonal violence. PTSD patients who experience mental defeat may benefit from cognitive therapy, which encourages them to reevaluate the implications of mental defeat on their view of themselves. Those who experience an overall feeling of alienation or permanent change are likely to benefit from interventions that encourage them to reestablish contact with friends and family and to take up activities again that they used to enjoy before the trauma ("reclaiming your life"; Ehlers & Clark, 2000).

Implications of the findings on the relationship between long-term post-traumatic stress reactions, coping and social support

The presented empirical model on the relationship between chronic post-traumatic stress reactions, coping and social support supports published clinical observations as well as findings from other studies (see Aldwin, 1993; Schützwohl et al, 1999). Thus, the following *implications for treatment* can be drawn:

First, as chronic hyperarousal as well as avoidance and numbing appear to be largely determined by the maintenance of stressful intrusions, one may consider whether or not that treatment should be primarily aimed at reducing stress caused by intrusions or recurrent recollections. Here, our point of view is that behavioural therapeutic exposure techniques and especially flooding in sensu should be the preferred therapeutic techniques. Both have proved particularly successful in numerous efficacy studies, and it has been shown that exposure techniques not only decrease intrusions but also lead to a reduction of startle reactions, concentration difficulties and irritability (see Foa et al, 1997). This finding is in accordance with the presented func-

tional relationship that exists between stressful intrusions on the one hand and post-traumatic hyperarousal on the other. Thus, individuals who as a result of confrontation treatment and the ensuing habituation no longer suffer from intrusions and recurrent recollections following habituation may also show less psychological hyperarousal. Efforts to put outside or suppress memories, that is, post-traumatic avoidance, are then no longer necessary. Instead, memories can be tolerated and processed, that is, they can be integrated into existing cognitive structures or they can lead to an accommodation of these cognitive structures. This appears to be of central importance in recovering from post-traumatic stress reactions (Greenberg, 1995).

One restriction of our structural equation model is that there is no clue as to what factors determine the frequency of intrusions themselves. As noted by cognitive therapists (eg Ehlers & Steil, 1995) and as supported by our findings (see above), dysfunctional cognitions appear to be important factors involved in the development and maintenance of intrusions. We therefore again propose that exposure techniques should be supplemented by cognitive techniques.

Second, the perception of social support seems to have a beneficial effect on degrees of post-traumatic hyperarousal, and consequently on well-being. Working on the patient's perception of social support or increasing existing degrees of social support may therefore be essential treatment goals. Thus, the therapy of post-traumatic stress reactions can be effectively supplemented by social skills training. Here, a particular emphasis should be placed on the improvement of social skills involved in establishing social contacts and interpersonal relationships (Hollin & Trower, 1986). However, one should bear in mind that an increase of the perceived social support may possibly be achieved indirectly by virtue of the fact that as a result of exposure treatment PTSD victims may less frequently attempt to avoid memories of the trauma and more often reach out for support from others. It appears sensible in this con-

text to train PTSD victims in their ability to share their memories and to advise their relatives.

Third, consistent with other studies (eg Fairbanks et al, 1991; Green et al, 1988), the coping strategies studied seem to have little influence on post-traumatic stress reactions years after a traumatic event. This finding points to the fact that most coping strategies seem not to be essential in overcoming long-term trauma effects. Thus, the training of coping strategies does not seem to constitute a prerequisite for the treatment of post-traumatic stress reactions. Yet we believe that the improvement of coping skills is a goal in the treatment of traumatised individuals. Of course, the EQS-model presented cannot encompass the entire range of psychological and social factors influenced by coping behaviour. We believe that coping behaviour impacts on the development of other psychopathological symptoms and disorders such as alcohol addiction and psychosocial problems such as unemployment and family problems. In line with the current literature, we therefore recommend that coping behaviour and the resulting consequences (eg reactions to the environment) need to be recorded and coping skills improved (Schützwohl, 2003). Even though such treatment modalities will not, as we believe, bring about reductions in post-traumatic stress reactions, we are convinced that they are effective in reducing and avoiding secondary disorders.

Implications of the findings on the psychosocial functioning of former political prisoners

Compared to the comparison subjects, the former political prisoners showed a lower level of psychosocial functioning. It is quite clear that the interpretation of this result is limited, given that it is a cross-sectional study and given that political prisoners were penalised beyond imprisonment. However, it again supports the opinion that political prisoners should be reimbursed for being persecuted and imprisoned.

Final remarks

The study has several limitations. For example, the recruitment strategy did not allow for general epidemiological prevalence estimations, and the long interval between the beginning of the trauma and the point of retrospective data collection may affect the reliability of some data (see Maercker & Schützwohl, 1997; Maercker et al, 2000; Schützwohl & Maercker, 2000). Nevertheless, the study confirmed impressively that the psychological stress felt by many former political prisoners can be substantial many years or even decades after the traumatic event, and that many of them are in need of professional help.

However, having discussed the sophisticated implications for treatment, it should be mentioned that patients suffering from post-traumatic stress often do not seek specialised treatment at all for their mental health difficulties (cf Priebe et al, 2002). This may partly be due to the symptoms of the disorder itself, and mistrust towards institutions and social withdrawal may prevent them from seeking treatment that is available. The stigma of being a psychiatric patient may be another factor. In addition to that, individuals who ask for treatment may not receive it due to various practical obstacles. Some of the non-treatment seekers who have experienced psychological difficulties might have developed successful coping strategies or have found alternative sources of help (as opposed to professional psychiatric help) which might be relevant considering the specificity of the cultural context.

Since, for obvious reasons, most studies have been carried out on the treatment seekers, it remains poorly understood why so many people do not seek or receive treatment despite a high degree of suffering. Thus, providing appropriate care for patients suffering from post-traumatic stress remains a special challenge, not only to mental health professionals but also to politicians and to society as a whole.

References

Aldwin, C.M. (1993). Coping with traumatic stress. *PTSD Research Quarterly*, 4, 1-3.

Amnesty International (1989). *Deutsche Demokratische Republik. Rechtssprechung hinter verschlossenen Türen*. Amnesty International, London.

Anisescu, C. (2003). Repression and extreme traumatization through Securitate (political secret police in Romania 1948–1989). Oral presentation at the Eighth European Conference on Traumatic Stress, Berlin, May 2003.

Basoglu, M., Paker, M., Paker, Ö., Özmen, E., Marks, I, Incesu, C., Sahin, D., Sarimurat, N. (1994). Psychological effects of torture: A comparison of tortured with nontortured political activists in Turkey. *American Journal of Psychiatry*, 151:76-81.

Bauer, M., Priebe, S., Häring, B., Adamczak, K. (1993). Long-term sequelae of political imprisonment in East Germany. *Journal of Nervous and Mental Diseases*, 174:257-263.

Bentler, P.M. (1986). EQS – Ein Ansatz zur Analyse von Strukturgleichungsmodellen für normal- bzw. nicht-normal verteilte quantitative Variablen in Strukturmodelle für Längsschnittdaten und Zeitreihen. In: Möbus, C., Schneider, W. (eds). LISREL. Pfad- und Varianzanalyse. Bern: Huber.

Bichescu, D., Schauer, M., Rockstroh, B., Elbert, T. (2003). Long-term effects of trauma in Romanian former political prisoners. Oral presentation at the Eighth European Conference on Traumatic Stress, Berlin, May 2003.

Boos, A., Ehlers, A., Maercker, A., Schützwohl, M. (1998). Trauma, Kognitionen und chronische PTB: Eine Untersuchung an ehemaligen politischen Gefangenen der DDR. *Zeitschrift für Klinische Psychologie*, 27:244-253.

Bundesministerium der Justiz (1994). *Im Namen des Volkes? Über die Justiz im Staat der SED*. Leipzig: Forum.

Burstein, A. (1986). Treatment noncompliance in patients with post-traumatic stress disorder. *Psychosomatics*, 27:37-40.

Chemtob, C.M., Novaco, R.W., Hamada, R.S., Gross, D.M. (1997). Cognitive-behavioral treatment for severe anger in posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 65:184-189.

DiNardo, P.A., Barlow, D.H. (1988). *Anxiety Disorders Interview Schedule – Revised (ADIS-R)*. Albany: State University of New York at Albany.

Dunmore, E., Clark, D., Ehlers, A. (1999). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, 37:809-829.

Ehlers, A., Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38:319-345.

Ehlers, A., Steil, R. (1995). Maintenance of intrusive memories in posttraumatic stress disorder: A cognitive approach. *Behavioral and Cognitive Psychotherapy*, 23:217-249.

Ehlers, A., Maercker, A., Boos, A. (2000). Posttraumatic stress disorder following political imprisonment: The role of mental defeat, alienation, and perceived permanent change. *Journal of Abnormal Psychology*, 109:45-55.

Fairbank, J.A., Hansen, D.J., Fitterling, J.M. (1991). Patterns of appraisal and coping across different stressor conditions among former prisoners of war with and without posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 59:274-281.

Foa, E.B., Riggs, D.S., Massie, E.D., Yarczower, M. (1995). The impact of fear activation and anger on the efficacy of treatment for posttraumatic stress disorder. *Behavior Therapy*, 26:487-499.

Foa, E.B., Rothbaum, B.O., Molnar, C. (1997). Cognitive-behavioral treatment of PTSD. In: Friedman, M.J., Charney, D.S., Deutch, Y. (eds). *Neurobiological and clinical correspondence of stress: From normal adaptation to PTSD*. New York: Raven Press.

Franke, G.H. (1995). *SCL-90-R. Die Symptom-Checkliste von Derogatis – Deutsche Version*. Göttingen: Beltz-Test-Gesellschaft.

Green, B.L., Lindy, J.D., Grace, M.C. (1988). Long-term coping with combat stress. *Journal of Traumatic Stress*, 1:399-412.

Greenberg, M. (1995). Cognitive processing of traumas: The role of intrusive thoughts and reappraisals. *Journal of Applied Social Psychology*, 25:1262-1296.

Hautzinger, M., Bailer, M., Worall, H., Keller, F. (1992). *Das Beck Depressionsinventar – BDI*. Bern: Huber.

Heitzman, J., Rutkowski, K. (1997). Mental disturbances in persons persecuted for political reasons in Poland in the years 1944–1955. *Psychiatria Polska*, 31:153-164.

Herman, J.L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5:377-392.

Hollin, C.R., Trowee, P. (eds) (1986). *Handbook of social skills training*. New York: Pergamon.

Kazlauskas, E., Gailienė, D. (2003). Complexity of long-term psychological effects of political repressions in Lithuania. Retrieved 12 January 2004, from http://www.leidykla.vu.lt/inetleid/psichol/27/str4.html

Maercker, A., Schützwohl, M. (1997). Long-term effects of political imprisonment: A group comparison study. *Social Psychiatry and Psychiatric Epidemiology*, 32:435-442.

Maercker, A., Schützwohl, M. (1998). Erfassung von psychischen Belastungsfolgen: Die Impact of Event Skala – revidierte Version (IES-R). *Diagnostica*, 44:130-141.

Maercker, A. (1995). Psychische Folgen politischer Inhaftierung in der DDR. *Das Parlament – Aus Politik und Zeitgeschichte*, 38:30-38.

Maercker, A., Beauducel, A., Schützwohl, M. (2000). Trauma severity and initial reactions as precipitating factors for posttraumatic stress symptoms and chronic dissociation in former political prisoners. *Journal of Traumatic Stress*, 13:651-660.

Margraf, J., Ehlers, A. (1995). *Das Beck-Angst-Inventar*. Berlin: Springer.

Margraf, J., Schneider, S., Ehlers, A. (1991). *Diagnostisches Interview bei psychischen Störungen: DIPS*. Berlin: Springer.

Priebe, S., Gavrilović, J., Schützwohl, M., Lečić-Toševski, D., Ljubotina, D., Bravo Mehmedbašić, A., Frančišcović, T. (2002). Rationale and method of the STOP study – Study on treatment behaviour and outcomes of treatment in people with post-traumatic stress following conflicts in ex-Yugoslavia. *Psihijatrija Danas*, 34:145-159.

Reicherts, M., Perrez, M. (1993). *Fragebogen zum Umgang mit Belastungen im Verlauf (UBV)*. Bern: Huber.

Schützwohl, M. (2003). Diagnostik und Differenzialdiagnostik. In: Maercker, A. (ed). *Therapie der posttraumatischen Belastungsstörungen*. 2. Auflage. (S. 53-73). Berlin: Springer.

Schützwohl, M., Maercker, A. (1999). Effects of varying diagnostic criteria for posttraumatic stress disorder are endorsing the concept of partial PTSD. *Journal of Traumatic Stress*, 12:155-165.

Schützwohl, M., Maercker, A. (2000). Anger in former East German political prisoners: Relationship to posttraumatic stress reactions and social support. *Journal of Nervous and Mental Disease*, 188:483-489.

Schützwohl, M., Maercker, A., Manz, R. (1999). Long-term posttraumatic stress reactions, coping, and social support: A structural equation model in a group of former political prisoners. In: Maercker, A., Schützwohl, M. & Solomon, Z. (Hrsg.) *Posttraumatic stress disorder: A life-span developmental perspective*. Hogrefe & Huber Publishers, Seattle, Toronto, Göttingen, Bern.

Schwenkmezger, P., Hodapp, V., Spielberger, C.D. (1992). *Das State-Trait-Ärgerausdrucks-Inventar STAXI*: Handbuch. Bern: Huber.

Sommer, G., Fydrich, T. (1989). *Soziale Unterstützung: Diagnostik, Konzepte, F-SOZU*. Tübingen: Deutsche Gesellschaft für Verhaltenstherapie.

Spielberger, C.D. (1988). *State-Trait-Anger-Expression Inventory (STAXI)*. Odessa, FL: Psychological Assessment Resources.

Terr, L.C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, 148:10-10.

Tomov, T., Guentchev, E. (1996). Post-traumatic stress disorder among victims of organized violence: A report from Bulgaria. *Free Associations*, 30:180-190.

Vidnere, M., Nucho, A.O. (1996). Living through extreme stress: Latvian survivors of deportations to Soviet forced labor camps. Retrieved 12 January 2004, from http://vip.latnet.lv/lpra/vidnere.htm

Weber, H. (1991). *DDR. Grundriß der Geschichte 1945–1990*. Hannover: Fackelträger.

Weiss, D.S., Marmar, C.R. (1996). *The Impact of Event Scale – Revised*. In: Wilson, J.P., Keane, T.M. (eds). *Assessing psychological trauma and PTSD*. New York: Guildford Press.

Werkentin, F. (1995). *Politische Strafjustiz in der Ära Ulbricht*. Berlin: C. Links.

The Trauma of War: Research on Lithuanian Veterans of the Afghanistan War after Seventeen Years

VĖJŪNĖ DOMANSKAITĖ-GOTA
DANUTĖ GAILIENĖ
JŪRATĖ GIRDZIUŠAITĖ
Department of Clinical and Organisational Psychology,
Vilnius University, Lithuania

> When at the end of our service we took off from Kandagar and landed in Sandan, and when later the plane crossed the border of the USSR, when our feet touched the soil in Tashkent, it was the happiest moment in my life.
> *A participant in the Afghanistan War*

Two stages may be distinguished in the history of research into the psychological consequences of the trauma of war: before the Vietnam War, and afterwards. Research carried out before the Vietnam War was based on clinical cases and the theory of psychoanalysis; while experienced trauma was not yet directly related to the consequences (Gailienė, 2001). Research into the consequences of the trauma changed radically after the Vietnam War. Broad and extensive research was initiated by war veterans, which aimed at assessing the impact of the experience of the war on the lives of the veterans. This marked the beginning of the second stage of research into the trauma of war and its psychological consequences.

The research has proved that the long-term mental injuries experienced by some veterans are a direct consequence of the war. Having determined the important and undoubted relationship between the traumatising experience of war and the psychological consequences, in 1980 the American Psychiatrists' Association offi-

cially defined a new disorder, post-traumatic stress disorder. This allowed further steps in the research: to extensively describe the traumatic experience and its psychological impact, and also to look for factors that would serve as mediators between the traumatic experience and the post-traumatic symptoms. In other words, the question as to what could protect an individual against the damaging consequences of the trauma was also tackled.

Thus, today it is beyond doubt that war is a severely traumatising experience, that it has a greater or lesser impact on the participants, and that the duration of the impact depends on the individual and societal factors. We are all aware that some Lithuanians have experienced the atrocities of war, atrocities in the Afghanistan War, when they were sent there while doing their military service in the Soviet army.

The 1979–1989 Afghanistan War and the situation of Lithuanian veterans

From 1979 to 1989, a war took place between Muslim partisans, mujaheddin, and the pro-Soviet Afghan government, which was willingly assisted by the Soviet army. Until March 1990, Lithuania was a part of the Soviet Union, and about 5,000 Lithuanians took part in this war. They were all in active service at the time and most of them went to Afghanistan against their will. Often it was only when they were on the way there that they would find out where they were going.

The war in Afghanistan dragged on for ten years, took the lives of many young men, disabled many others, caused immense material damage, and ended in defeat. According to data from the Lithuanian Organisation of Afghanistan War Veterans, 91 Lithuanians were killed and 98 were disabled in the war. This data was obtained in the late 1980s, after an assessment of the damage caused by the war. But that was all. Nobody was concerned or took care of the veterans of the war. At present, not even the precise number of

veterans of the war in Lithuania is known, to say nothing of how many of them have committed suicide or how many have died.

The Forgotten War is the title of a book of photography compiled by Vytautas Lukšys, a veteran of the war. The title reflects very accurately the situation of the Lithuanians who did their military service in the war.

Compared to fighters in other wars, the situation of the Afghanistan War veteran is special in that the meaning imparted to the war was distorted from the beginning. Soldiers returning from a war are usually loved and respected. Society's favourable attitude helps in giving a sense to the difficult experiences of the war, and reduces the intensity of the symptoms accompanying the trauma. In this particular case, the public was not looking forward to the return of soldiers who had fought in Afghanistan. It was in no hurry to recognise their sacrifice or to help them. Rather, it was the other way round. Everything was kept secret. No information was given about the killed and wounded. Disabled soldiers did not receive any assistance. After the collapse of the USSR, the war was recognised as a major political mistake, and the politicians' attitude was absorbed by the public. The response to the war and participants in it was negative. When Lithuania regained its independence, Afghanistan War veterans were seen as a part of the legacy of the Soviet Union beyond Lithuania's concern. In 1997, the consequences of the Soviet and Nazi occupations were reassessed, and a law on the legal status of people injured by the occupations of 1939 to 1990 was passed. This law does not mention the participants in the Afghanistan War; they were not recognised as injured.

From the point of view of its meaning, the experience of the veterans is similar to that of participants in the Vietnam War. Soldiers returning from Vietnam met with antiwar demonstrations, with accusing and hostile banners and slogans (Goodwin, 1987), although, unlike Afghanistan War veterans, they succeeded in gaining recognition and assistance. Numerous clinical tests were carried out and

medical aid provided, and the public learned of their experience. Classen and Koopman (1993) determined that, compared to fighters in other wars, post-traumatic disorders were more prevalent among soldiers who fought in Vietnam. This was supposedly influenced by the unpopularity of the war and the hostility of the public towards the soldiers during the war and in its final stages. This once again points to the importance of imparting meaning to experience and its links to post-traumatic symptoms.

Although 15 years have passed since the end of the Afghanistan War, Lithuanian citizens who fought in Afghanistan have so far not been recognised as victims, either from a legal or a psychological point of view. What influence do the continuing negation of the consequences of the war and the delayed realisation of their experience have on the mental health of the veterans, on their relationships and on their lives?

The study's design

Between 2000 and 2003, the Department of Clinical and Organisational Psychology at Vilnius University, together with the Genocide and Resistance Research Centre of Lithuania, carried out the study "Psychological Effects of Soviet and Nazi Repression". Part of this survey was an assessment of the traumatic experience of the veterans.

The participants were 268 men who, from 1979 to 1989, did compulsory military service in the Soviet army. They made up two groups: 174 who served in Afghanistan during the war, and a control group of 94 who did their military service in the USSR (see Table 1).

The groups of participants are representative. They are distributed gradually according to age (average 40), place of residence, rank and other variables. The survey was carried out approximately 17 years after the men's return from the war in Afghanistan, and 18 years after leaving the Soviet army respectively. The Lithuanian

Table 1. **Distribution of Lithuanian veterans and the control group by age, the time of the beginning of the service, the duration of the service, the years after the service and military rank**

Variables	Military service			
	In Afghanistan N=174		In the USSR N=94	
	Average	SD	Average	SD
Age	40	3.69	40	5.45
Age at the start of service	19	2.09	19	1.14
Service duration (months)	18.5	5.75	23	9.3
Years after service	17	3.16	18	4.27
	N	%	N	%
Rank				
Private	95	54.7	44	47.4
Sergeant	72	41.5	46	49.6
Warrant officer	1	0.7	0	0
Officer	5	3	3	3.3

Veterans of the Afghanistan War organisation assisted in making contacts with the participants. The men for the control group were gathered after approaching various offices and organisations. All the participants filled in a questionnaire, 76% directly, the remaining 24% by post. The response rate in the veterans group was 50%, in the control group 65%.

Assessments. The data on traumatic experience, post-traumatic symptoms and adaptation was assessed using the Lithuanian versions (Domanskaitė et al, 1998) of-Traumatic Event and Symptom Scales of the Harvard Trauma Questionnaire (Mollica et al, 1992), the Trauma Symptoms Questionnaire (Briere, Runtz, 1987; supplemented by Elklit, 1997) and the Support in Crisis Scale (Joseph et al, 1992).

The following indicators were applied to assess the psychosocial consequences:

1) responses to the question "How successful was your adaptation to life following military service?' (five possible responses, ranging from "very hard" to "very easy");
2) the rate of divorce;
3) the degree of education;

4) the unemployment rate;
5) responses to the questions "Has the experience of military service changed your attitude to life?" and "Has military service hindered you in achieving your personal, educational and professional aims?"

We compared the following in the veterans and the control group:
1) traumatic experience during military service;
2) adaptation on return from the service and at present;
3) present post-traumatic symptoms;
4) psychosocial assistance received from family and friends.

Findings

1. Traumatic experience

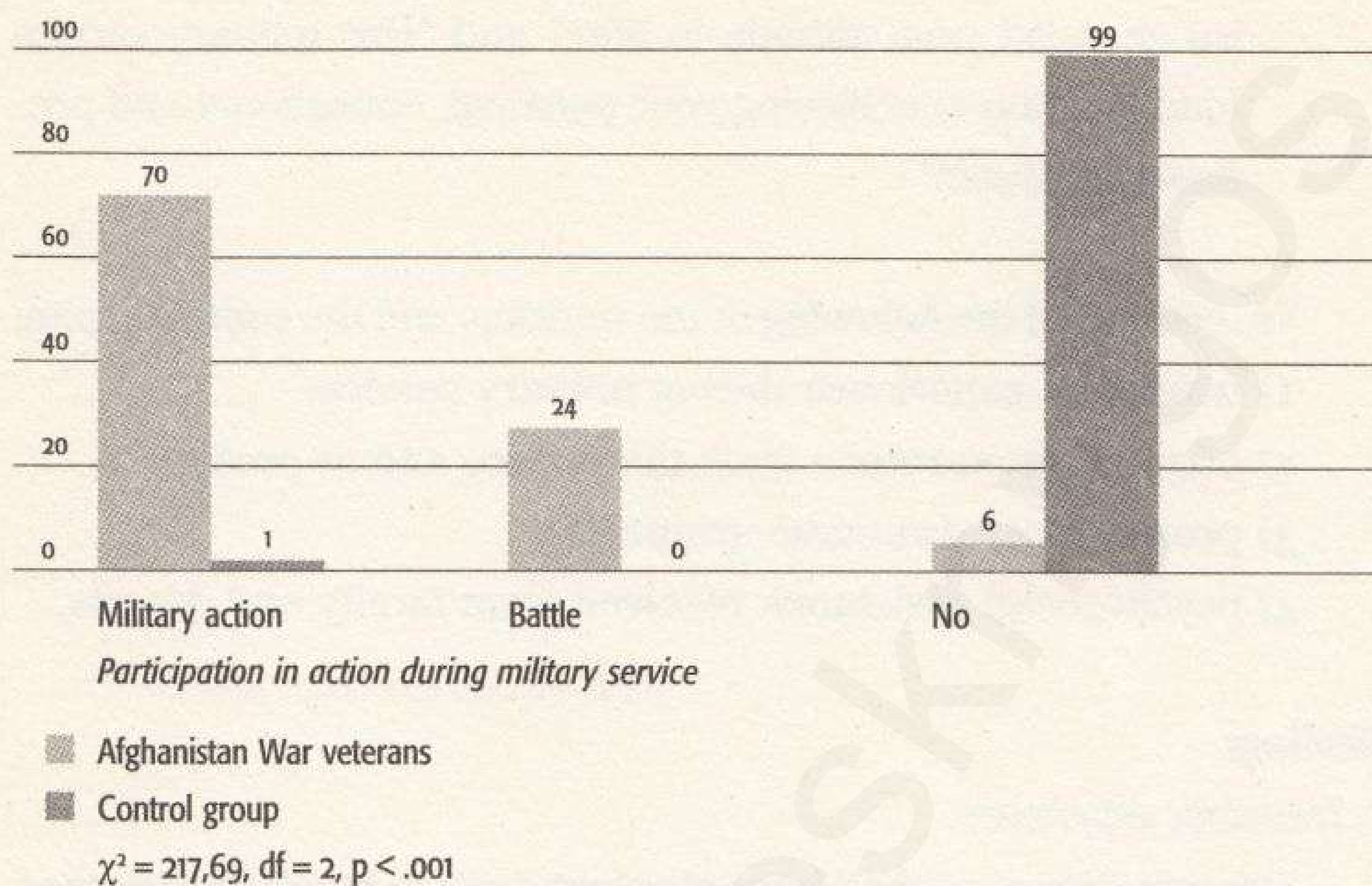
The experience of the Lithuanian veterans is much harder than that of the men who did not participate in the war. The men in the control group served in the army on average half a year longer than the soldiers who fought in Afghanistan, two and 1.5 years respectively; however, the results show that the war experience of the veterans is harder.

As many as 94% of the men who did their service in Afghanistan had taken part in military action; of these 24% had actually fought. Meanwhile, 99% of the control group had not taken part in any military action ($c^2 = 217.69$, $df = 2$, $p < .001$) (see Figure 1).

The length of participation in military action is also important. It has been determined that there is a direct relation between PTSD (post-traumatic stress disorder), various psychosomatic disorders and the time spent in a zone of active military action. The critical limit is six months (Ena, 2000). Lithuanians spent, on average, about a year and a half in the zone of active military action, which *exceeds the critical limit three times*.

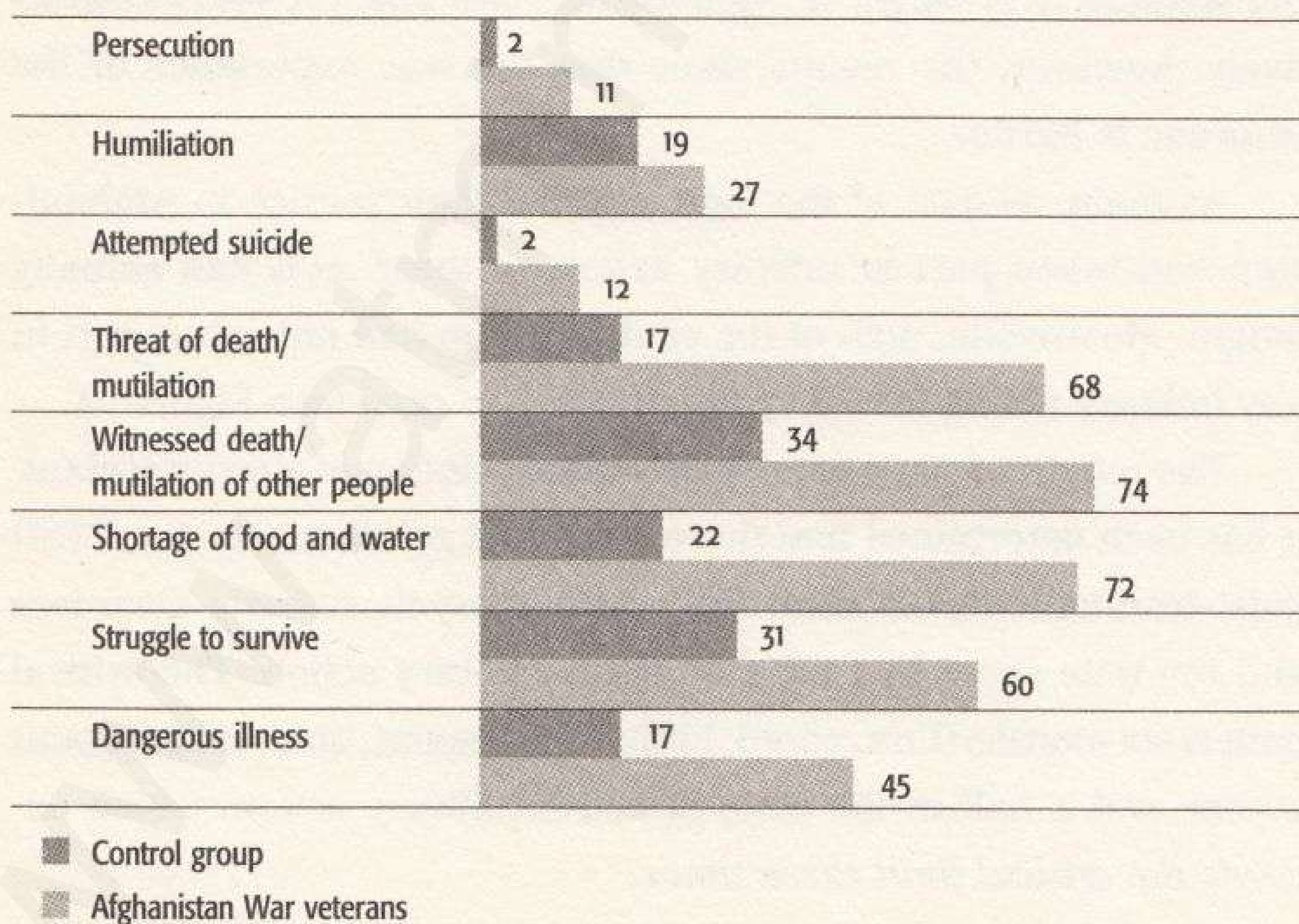
The veterans experienced almost twice as many traumatic events as the control group. The veterans experienced about ten

Figure 1. **The participation of Afghanistan War veterans and the control group in military action (in %)**



$\chi^2 = 217{,}69$, $df = 2$, $p < .001$

Figure 2. **Traumatic events experienced by Afghanistan War veterans and the control group (in %)**



traumatic events each, the control group six (the amplitude 1-36, df = 266, $p < 0.000$).

A comparison of the actual traumatic events points to the fact that veterans of the Afghanistan War experienced the traumatic events listed below considerably more times (see Figure 2):

- *were threatened with death or mutilation* (as many as four times more frequently);
- *saw killing or the mutilation of other people* (two times more);
- *experienced a shortage of food and water* (72%, the control group 22%);
- *had to struggle to survive* (two times more);
- *suffered from a dangerous illness* (three times more);
- *12% of the veterans attempted suicide* (2% in the control group);
- *experienced humiliation and persecution* (six times more).

2. Adaptation after military service and at present

Veterans found it much harder to adapt to normal life after their military service.

In trying to resume a peaceful life on their return from the war, many veterans realised that their feelings, their attitude to other people, life, and their plans for the future had changed considerably. They returned from an environment where they had constantly experienced danger to their life, had to be on the alert and faced the other realities of war. Now they were back to normal life. They not only had to adapt and to impart a meaning to their war experience, but also to consolidate their positions in life. On the one hand, they faced a lack of understanding and even condemnation from the public. On the other hand, they started families, continued their studies, and developed their careers. As many as 27% of the veterans found it *hard* or *very hard* to adapt to normal life; for 59% the adaptation was fairly hard. The control group found it much easier: 76% adapted after military service to

Figure 3. **The re-adaptation to life after military service of Afghanistan war veterans and the control group (in %)**

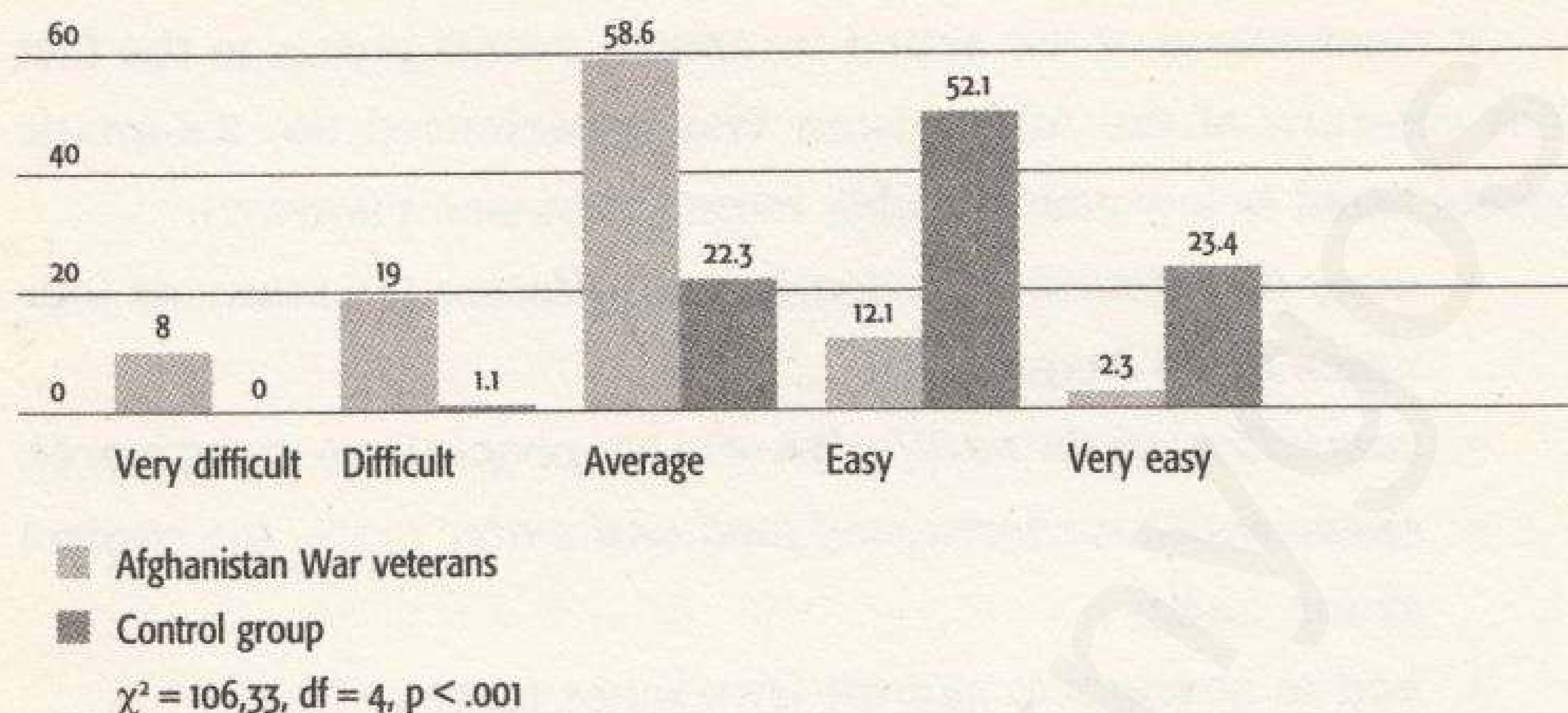
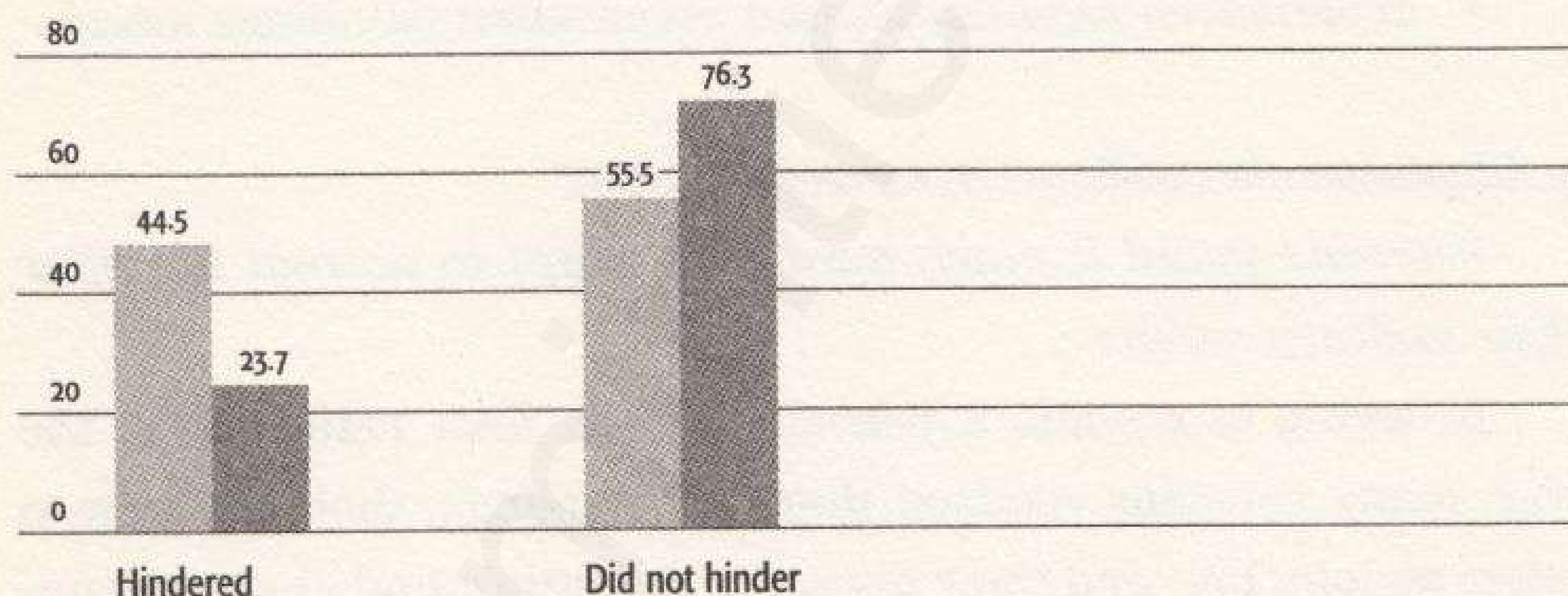


Figure 4. **Evaluation of the influence of military service on individual educational and professional goals (in %)**



normal life *easily* or *very easily*, and only one person found it hard ($c^2 = 106.33$, df = 4, $p < .001$) (see Figure 3).

At present, the psychosocial situation of the veterans is considerably worse:

1) *The divorce rate is twice as high among veterans*: 13% of them are divorced, compared to 6% in the control group.
2) *The level of education is lower.* The number of veterans with a higher education comes to only half that of the control group with a higher education. As many as 33% have only a

secondary education, while in the control group the number is 22%.

3) *Unemployment is 14 times higher than among the control group*: 28% of veterans and only 2% of the control group are unemployed.
4) In addition, the jobs and positions occupied by veterans require a lower education and qualifications; they have changed their jobs much more often. More than half have changed their jobs three times, 23% of these as many as five or more times. Almost a third of the men in the control group have not changed their job since their military service, that is, they have worked in the same job all the time.
5) *War experience essentially changed the Afghanistan veterans:*
   a) *attitude to life*: 84% (in the control group 60%);
   b) *life aims*: for almost half the veterans, military service prevented them achieving their educational and professional aims. In the control group, only 24% share this opinion (see Figure 4).

3. Post-traumatic symptoms

After 15 years or more, 16% of the men who did military service in Afghanistan have PTSD; in the control group the number is zero. Fourteen per cent of the veterans and only 2% of the control group have PTSD of a subclinical level (see Table 2).

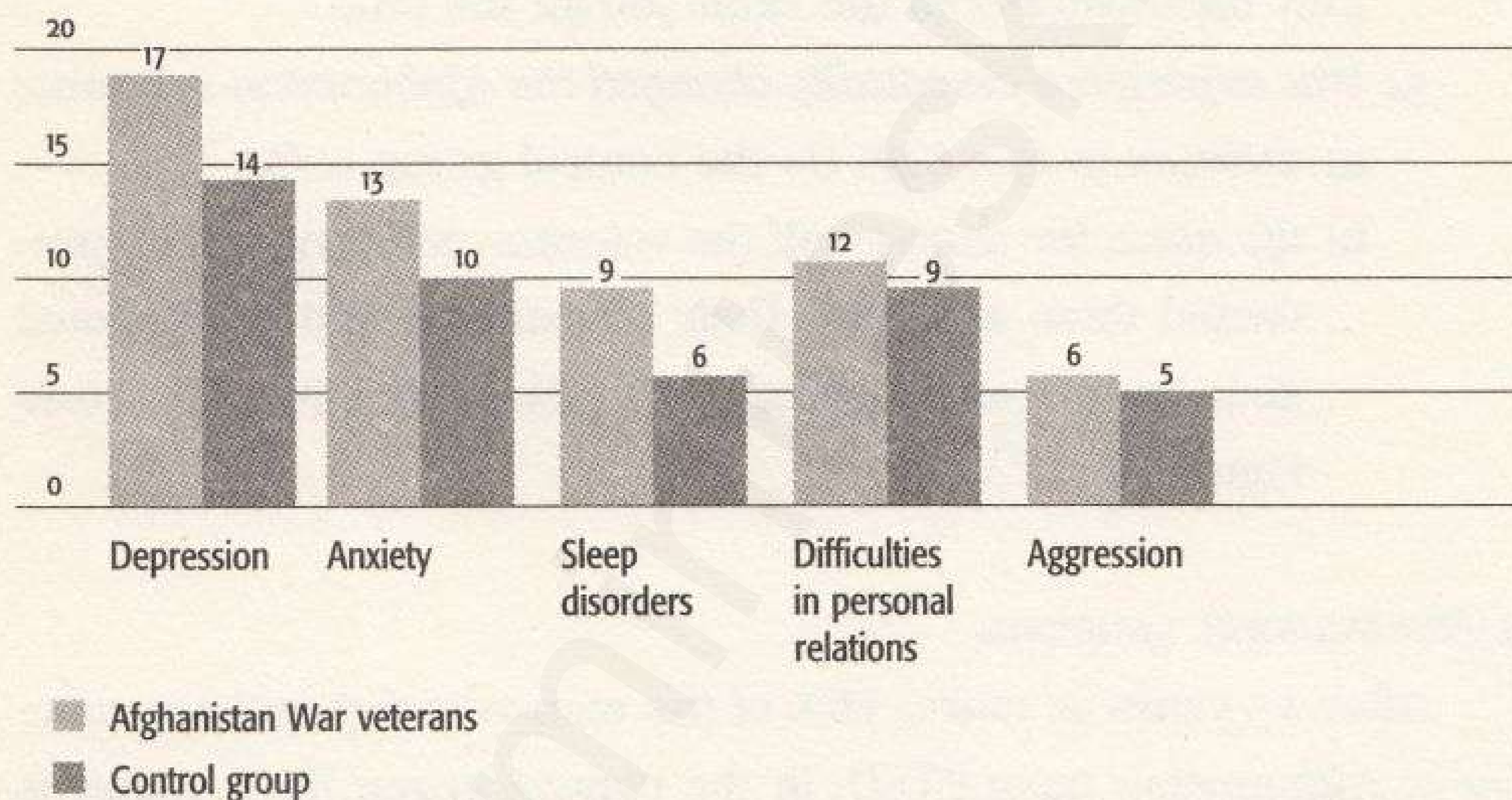
Thus, 30% of the veterans suffer from PTSD, while in the control group the number is as low as 2%. Having reviewed various studies, Mehlum and Weisæth (2002) determined that in 5% to 20% of soldiers on peace missions, PTSD starts manifesting itself after five months to seven years after they return from service. PTSD is more prevalent among veterans of the Vietnam War: from 30% to 67% if they were wounded during the war (Goodwin, 1987; Weiss et al, 1992). Yet a comparison of the results obtained from different studies is complex, either because different PTSD assessment

Table 2. **Distribution of PTSD among the Lithuanian Afghanistan War veterans and the control group**

	Military service In Afghanistan N=154		In the USSR (control) N=90		
	N	%	N	%	χ^2
No PTSD	108	70.1	88	97.8	27.87***
Subclinical level PTSD	21	13.6	2	2.2	
PTSD	25	16.2	0	0	

Note: ***p < 0,001

Figure 5. **Post-traumatic symptoms experienced by Afghanistan War veterans and the control group (in %)**



methods are applied, or because these methods have not been clearly documented.

Post-traumatic symptoms shown in Figure 5 are characteristic of the veterans more than of the control group.

They suffer more frequently from depression and anxiety. They experience communication difficulties more often, sleep disorders (eg nightmares) and aggression. These symptoms commonly accompany PTSD and are characteristic of those who have experienced the trauma of war.

The increased intensity of the post-traumatic symptoms in the

veterans as compared to the control group is related to the fact that these men had very different experience both during service and after it. They went through more traumatising events and experiences during their service. When they returned home, they had to endure the indifference of the public, their experience was kept secret, and they did not receive any help.

4. Psychological Support

The veterans do not receive suitable psychological support. "Thank God, you've returned home safe and sound," many a mother and father sighed with relief when their sons returned home. Months and years of troubled waiting had finished. Yet is their son really sound? In most cases no, because the man who returned from the army is wounded, and in need of support and understanding from the people closest to him. But were – or are – these people always able to help? It goes without saying that the intentions of friends and relatives are good, but they are not easy to carry out, especially when life is not too easy for them, either. So is the support received by the veterans a factor reducing the symptoms of their post-traumatic stress?

The men who served in Afghanistan received and still receive less psychosocial support than the men in the control group. Respondents from both groups are moderately satisfied with the support they have received. The men in the control group are more satisfied with it, although, as is well known, the veterans had harsher experiences. Studies of veterans of the Vietnam War reveal identical tendencies (Keane et al, 1985). The soldiers who have had a harsher experience of war and suffer from worse symptoms receive less psychosocial support, and this support is gradually diminishing. The same tendency has been observed in our study: the amount of support to the veterans has been diminishing since the end of their service, while the support given to the men in the control group has remained stable. Extremely traumatising events/situations have a negative impact on social relations (Buunk, Hoorens,

Table 3. **The correlation between PTSD, post-traumatic symptoms (results of the HTQ and TSC scales) and social support received in the family and from friends in the veterans group and the control group**

Afghanistan War veterans N=174	2	3	4	5	6	7	8	9	10	11
PTSS	.76**	.67**	.58**	.31**	.24**	–.19**	–.29**	–.27**	–.31**	–.36**
HTQ overall	1	.83**	.60**	.24**	.23**	–.24**	–.30**	–.28**	–.33**	–.31**
TSC overall		1	.77**	.26**	.20**	–.23**	–.28**	–.26**	–.30**	–.31**
Sleep disorders		1	.32**	.27**	si	–.18**	–.17**	–.23**	–.30**	
Met with service friends as				1	.64**	.13*	si	si	si	si
Meet with service friends cr					1	si	si	si	si	si
Talking about thoughts and feelings in family as					1	.47**	.34**	.25**	.30**	
Talking about thoughts and feelings in family cr						1	.47**	.28**	.38**	
Support and sympathy in the family cr								1	.37**	.49**
Satisfaction with support received as									1	.54**
Satisfaction with support received cr										1

Abbreviations: as – immediately after service; cr – currently; si – statistically insignificant.
$*p < 0.05$; $**p < 0.01$

1992). People who have had extraordinary experiences, exceeding the bounds of normal experience, find it difficult to talk about it, they are depressed and tend to withdraw into themselves, and even reject the support offered. On the other hand, those who can help are also inclined to avoid what is unusual or hard to understand. Put simply, each has the feeling that what they might hear will not be easy. All this aggravates the provision of emotional support to the victims and the reception of the support by the victims.

Further research into the impact of social support has shown *that immediately after the service and to this day the family has been more supportive than friends*. The veterans find it easier to share their feelings and thoughts with the family. Members of the family comfort and help, and therefore they are more satisfied with that support.

A comparison of the veterans with the control group has shown that *friends from military service play a very important part in the lives of the former*. Afghanistan War veterans communicate among themselves much more often. For many, the friendship with their army friends is the best thing that they experienced in the war. There, during the war, and now, in normal life, these men are people who have experienced the atrocities of a meaningless war. Good relations with friends during their military service and at present usually reduce the level of post-traumatic symptoms and instil a feeling of being understood. It has turned out, however, that the relationship between the interpersonal relations of the veterans and their post-traumatic symptoms is not unambiguous. *Post-traumatic symptoms depend on the support of others* (see Table 3). Stronger emotional support is related to a weaker degree of psychological traumatism in both groups (see Table 3). We have found that:

- The more emotional support the veterans receive in the family and the more satisfied they are with it, after the service and now, the less their post-traumatic symptoms and PTSD.

We have also discovered one paradoxical correlation:

- The more frequently the veterans met with their service friends after the war, the stronger their post-traumatic symptoms and PTSD were; and the more often they interact now, the more sleep disorders they experience.

Such a relation was not observed in the control group. It very likely points to specific relations among Afghanistan War veterans. Although they meet and feel that they understand each other because they have gone through an identical experience, they find it hard to share their thoughts and talk about their feelings. Being together and not sharing problems does not provide support; rather, the other way round, it brings back memories and thus makes them feel worse.

Thus, most of the veterans are still in need of help/support. We think that they need not only professional support but also political and social support. It is necessary:

- *to recognise* men who experienced the atrocities of the Afghanistan War *as victims*. Recognition is a strong support to victims. Research has shown that social and political recognition of trauma is a very important factor in overcoming the traumas of the past. Research into the veterans of the Vietnam and other wars, as well as research into political prisoners, point to this. Unfortunately, as we have mentioned, it has not yet been done in Lithuania. A veil of oblivion and secrecy envelops the veterans of the Afghanistan War and their experience;
- *to provide professional support* to the veterans of the Afghanistan War and their families.

Conclusions

1) Seventeen years after the war, almost one-third of the men who served in Afghanistan and only 2% of the control group suffer from PTSD.
2) The war experience has essentially changed the aims of life and attitudes to life of the veterans.
3) At present, the adaptation by the veterans and their life situations are considerably worse than those of the men in the control group (for example, as many as 28% of the veterans and just 2% of the men in the control group are unemployed).
4) Afghanistan War veterans receive less psychosocial support than those who served in the USSR.
5) The men who served in Afghanistan need political and social recognition; many of them are in need of professional support, too.

References

Buunk, B.P., Hoorens, V. (1992). Social Comparison and Stress: The Role of Social Comparison and Social Exchange Processes. *British Journal of Clinical Psychology*, 31:445-457.

Classen, C., Koopman, C. (1993). Trauma and Dissociation. *Bulletin of Menninger Clinic*, 57:178-195.

Domanskaitė, V., Gailienė, D., Elklit, A. (1998). Studentų psichologinio traumatizmo ypatumai. *Bakalauro darbas.* Vilniaus universitetas, Aarhuso universitetas.

Domanskaitė-Gota, V. (2002). Dalyvavimo karo veiksmuose padarinių įvertinimo metodologiniai ir metodiniai aspektai. *Genocidas ir rezistencija*, 12:127-130.

Gailienė, D. (2002). Politinių represijų psichologiniai padariniai. *Genocidas ir rezistencija*, 12:121-126.

Gailienė, D. (2001). Vienos diagnozės istorija. *Naujasis židinys*, 12:675-683.

Ена, А. И. (Ena, A. I.), Маслюк, В. В., Нерода, В. И., Селина, О. Г., Скалецкий, Ю. Н., Фартушный, Е. Н. (2000). Психосоматические расстройства у участников боевых действий. *Проблемы реабилитации*, 1:60-64.

Goodwin, J. (1987). The Etiology of Combat-related Post-Traumatic Stress Disorder. Williams T. (ed). *Post-Traumatic Stress Disorders: a Handbook for Clinicians* (pp. 1-18). Cincinnati: DAV National Headquarters.

Joseph, S., Yule, W., Williams, R., Bernice A. (1993). Crisis Support in the Aftermath of Disaster: A Longitudinal Perspective. *British Journal of Clinical Psychology*, 32:177-185.

Keane, T.M., Owen Scott, W., Chavoya, G.A., Lamparski, D.M., Fairbank, J.A. (1985). Social Support in Vietnam Veterans With Posttraumatic Stress Disorder: A Comparative Analysis. *Journal of Consulting and Clinical Psychology*, 95-102.

Lietuvos Respublikos asmenų, nukentėjusių nuo 1939–1990 metų okupacijų, teisinio statuso įstatymas Nr. VIII-342 (1997). *Valstybės žinios*, Nr. 66-160.

Mehlum, L., Weisæth, L. (2002). Predictors of Posttraumatic Stress Reactions in Norwegian U.N. Peacekeepers 7 Years After Service. *Journal of Traumatic Stress*, 15:17-26.

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., Lavelle, J. (1992). The Harvard Trauma Questionnaire. *The Journal of Nervous and Mental Disease*, 180:111-116.

Weiss, D.S., Marmar, C.R., Schlenger, W.E., Fairbank, J.A., Jordan, B.K., Hough, R.L., Kulka, R.A. (1992). The prevalence of lifetime and partial post-traumatic stress disorder in Vietnam theater veterans. *Journal of Traumatic Stress*, 5:365-376.

Trauma and Suicide among Aboriginal People: Stories from the Arctic and Australia[*]

(with Particular Reference to the Situation in Lithuania)

ANTOON A. LEENAARS
Private Practice, Windsor, Canada

They lived here since the world began. They are the indigenous people, or more accurately, just people of the world. They lived in the north, the south and all corners of the world. They were a prosperous, active, adaptive people, attuned to the land. The land was sacred; until, as told in prophecies, the white invaders came. The occupiers, or colonialists as they called themselves, came to take the land and to destroy the people as a race. Dire consequences occurred from what may well have been some of the heaviest traumatisation that the world has ever witnessed. High rates of suicide and suicidal behaviour among indigenous people are one expression, but also a most revealing one. The World Health Organization (WHO, 2002) has, in fact, concluded the following: "Among the proposed underlying causes [of the high rate of suicide and suicidal behaviour] are the enormous social and cultural turmoil created by policies of colonialism and the difficulties faced ever since by indigenous peoples in adjusting and integrating into the modern-day societies" (p. 190).

The indigenous people were then, and even now, treated as primitive, passive and dependent people, a race with no contribution to the world (see the opposite view, for example, in Jennes,

* Parts of this text were published in Leenaars, A., Anawak, J., Brown, C., Hill-Keddie, T., Taparti, L. (1999). Genocide and suicide among indigenous people: The north meets the south. *The Canadian Journal of Native Studies*, 19:337-363.

1922). This view was paradoxical because the world was not only sacred to them, but their ancestor. The invaders saw the "natives" as needing to be assimilated into their superior race. The occupiers' real intent was for these people not to exist because they wanted to take the land and wealth. But such policies are not rare in the world, as, for example, the atrocities in Lithuania that occurred after 23 August 1939, when the Soviet Union and Germany signed the Molotov-Ribbentrop Pact. Lithuania was occupied from 15 June 1940 and later taken – or annexed – and Sovietised (Anušauskas, 1999), no different than the colonialists. The Soviets attempted to assimilate the Lithuanians, just like all other nations dominated by the communist empire, and to turn them into the so-called "Soviet people". One paradoxical, but also revealing, piece of Soviet propaganda reads: "The equal among the equal and free." Heavy traumatisation occurred in the Arctic, Australia and Lithuania, but let me return to the stories of the people in the Arctic and Australia. They will shed some new light on the psychology of heavy traumatisation: the long-lasting effects of political repression.

With the long-lasting effects of colonisation, the indigenous people suffered unbearable pain, many dying by their own hand from the traumatic aftershocks. This is a not unusual psychological effect of heavy traumatisation. Suicide, in fact, became an escape, the only solution for some. Yet, of late, these proud indigenous people are giving voice to their pain. It was, in fact, prophesised that this time of healing would come (Connors, 1995). It is within this socio-historical context that I tell the story of the north, the Arctic, and the south, Australia. My intent is to remind all of us that we are all just people, whether in the Arctic, Australia or Lithuania.

A personal frame

Suicide is a common problem among indigenous people across the world (WHO, 2002). Historically it was much less common. This is true in the Arctic and Australia (the same, of course, is true in

Lithuania [the country now with the world's highest rate of suicide (Gailienė, Domanskienė, & Keturakis, 1995; Gailienė, 2004)]). Lucien Taparti (1998), a deceased Elder, from the Arctic stated:

> In the past we hardly used to hear of suicides in our communities and would hear of them every so often only. Only once in a blue moon you'd hear of suicides in one of the communities. But nowadays, in one year there would be quite a few suicides (p. xi).

The same is true in Australia. Suicide was, in fact, rarely known in traditional Aboriginal society, but suicide and suicidal behaviour are now at epidemic levels. How do we understand this psychological effect of the policies of colonialism? How do we understand the impact of heavy traumatisation, whether in Lithuania or the Arctic or Australia? The incidence of suicide, I believe, reveals a landscape to unhealed wounds.

Suicides are complex. No one person, especially a non-native, can know all about suicide among indigenous people in the Arctic and Australia. Native people are credible informants about the event, however (Hunter, 1991 a; Leenaars, 1995), and therefore, this paper is written with informants from two groups of people, the Inuit in the Arctic and the Aborigines in Australia, each of whom has been able to reflect on the issues in their own people. One can witness this approach also in Lithuania of late (Anušauskas, 1999; Dulkinienė & Keys, 2003; Grinkevičiūtė, 2002). The people's voice of heavy traumatisation is the best recording of what happened. I recognise, of course, that we do not represent all indigenous people or even the Inuit and Aborigines. Yet, I hope that our perspectives will cast a wider net over the shared issues than one view in isolation. The wider perspective will allow all to be less myopic, lest we forget.

I hope, with at least two perspectives on the topic, from two different groups of indigenous people, one from the north and the other from the south, that we can come to a closer approximation of understanding the complexities of heavy traumatisation, including suicide risk among indigenous people. We hope that it will aid not

only in the understanding of these people but also in providing a larger perspective on the atrocities that have occurred of late in the Baltic, during the Soviet years.

Epidemiology is the study of the incidence, distribution and determinants of a disease or an event, such as suicide (see Durkheim, 1897). There are few early observations about suicide in both the north and south, although it appears that the reports on the rates of suicide in these two regions differed. Early records on suicide suggest epidemic levels in the Arctic, whereas in Australia, very low rates were recorded at the turn of the century. Older records from the people themselves indicate that suicide was very rare in the south and the north.

Weyer (1932/1962) was one of the first to suggest that suicide was a cultural trait of the Inuit (although he called them "Eskimos", a word that means "eater of blubber"). Boas (1964) concurred, but Weyer and Boas exaggerated their reports, loosely collecting data from diverse events, not only self-inflicted death (Kirmayer, Fletcher & Boothroyd, 1998). Even more so, youth suicide was very scarce in the old ways, but not so today (Kirmayer, 1994; Kirmayer, Fletcher & Boothroyd, 1998; Leenaars, Wenckstern, Sakinofsky, Dyck, Kral & Bland, 1998).

The records report a different scene in Australia. In Australia, early commentators noted that suicide was quite scarce among indigenous groups (Moodie, 1973). Cawte (1964) concluded, in fact, that suicide was "almost unheard of". Moodie (1973) cites a rate of three per 100,000, compared to around 12 per 100,000 in the general population of Australia. As in the north, despite limitations (eg events being recorded in specific communities only), suicide in the young was rarely recorded (Hunter, 1991 a & b; Reser, 1989 a & b).

Today, the rates are quite different. Suicide rates in the north and south have increased strikingly in the last 30 years among indigenous people (WHO, 2002). In Australia, reports of rates as high as 60 per 100,000, which is six times the general population, have

been reported, with rates of 112.5 per 100,000 in men aged 15 to 24 years. Yet, the rates are not uniform: some Aborigine communities have rates much lower than the Australian rate. This is also true in the Arctic.

Canada's north has equally high rates of suicide, however, in many communities. Abbey, Hood, Young and Malcolmson (1993) have, for example, reported rates of 59.5 to 74.3 per 100,000 in some communities in the Arctic, compared to around 13.5 per 100,000 in the general Canadian population. The highest risk group is young males (15–24); Wotton (1985), for example, reported a rate as high as 295 per 100,000. Regrettably, there is evidence that the rates of suicide are increasing in indigenous people in the Arctic and Australia (WHO, 2002).

Stories from the people

Understanding suicide is complex, more complex than early commentators in both the north and south suggested. Suicide has increasingly been understood as multifarious. As in all suicides, there is pain, mental constriction, frustration of needs, and so on (Leenaars, 1996; Shneidman, 1985). Suicide is, however, not simply a psychological event. Suicide is equally an event with socio-cultural aspects (Hunter, 1991 b; Leenaars, 1996). As is well known, indigenous people have experienced profound cultural change in their lives, and this rapid change has had a major impact on the Inuit and Aboriginal people (Royal Commission on Aboriginal People, 1995; Read, undated; WHO, 2002). Thus, it is easy to conclude that a socio-historical account is crucial for understanding contemporary suicide in Australia (Hunter, 1991 b) and the Arctic (Leenaars, 1995; Leenaars, Anawak & Taparti, 1998).

Let me turn to the recent insights of the World Health Organization (WHO, 2002) on the known facts, followed by the people's stories of the Arctic and Australia.

In Australia, aboriginal groups were the object of stringent ra-

cial laws and discrimination as late as the 1960s. When these laws, including the restrictions on alcohol sales, were lifted within a short period in the 1970s, the rapid social changes in the previously oppressed indigenous peoples gave rise to instability in community and family life. This instability has continued ever since, with high rates of crime, delinquency and imprisonment, violence and accidents, alcohol dependence and substance abuse, and a homicide rate that is tenfold that among the general population.

In the Canadian Arctic in the early 19th century, epidemics swept the region as the first outsiders, whalers and fur traders, arrived, taking tens of thousands of lives and leaving the population reduced in size by two-thirds by 1900. By the 1930s the fur trade had collapsed, and Canada introduced a welfare state in the Arctic. In the 1940s and 1950s missionaries came to the Arctic and there was an attempt to assimilate the Inuit. Feverish exploration for oil, starting in 1959, further added to the social disintegration.

Research on suicide among the Canadian Inuit has identified several factors as likely indirect causes of suicide, including:

a) poverty;
b) childhood separation and loss;
c) accessibility to firearms;
d) alcohol abuse and dependence;
e) a history of personal or familial health problems;
f) past sexual or physical abuse (WHO, 2002, p. 190).

To understand the heavy traumatisation, and suicide risk, however, I believe that we have to go beyond the general, nomothetic findings and give voice to the people. Narrative accounts have, in fact, a long history in people's pasts (Hunter, 1991 a; Leenaars, 1995). They have been *the* way to knowledge among indigenous people since the world began. In Western culture, science has included not only statistical nomothetic approaches but also narra-

tive, idiographic approaches (Benjafield, 2000; Windelband, 1904). Although there may be shortcomings in the use of idiographic approaches (eg unrepresentativeness of sample, self-deception, blindness to motives, errors in memory), Allport, in 1942, argued for the use of such documentation, showing the importance of personal documents in human sciences. He argued that letters, logs, memoirs, diaries, autobiographies, personal accounts, and so on, have a place in understanding people and to aid in the aims of science in general: understanding, prediction and control. This has been true in suicidology (eg the study of suicide notes) (Shneidman, 1980). The tabular, statistical, demographic, quantitative, nomothetic approach has a place in understanding the generalisations about suicide among the indigenous people. Yet, the idiographic approach, which involves the intense qualitative study of individuals, equally has a place. Informants can be most credible, whether told in writing (such as notes, diaries, memoirs) or orally. It is, in fact, the personal accounts that allow us to "do justice to the fascinating individuality" of people (Allport, 1942).

Storytelling or narrative knowing is the tradition of people across the world. No statistics can capture the pain of the people, and thus, we report some personal documents about the events. I do not wish to imply that the nomothetic avenue has no place, only that both avenues are needed to comprehend suicide among the Inuit and Aborigines (and suicide in Lithuania, again the country with the world's highest rate of suicide), a view supported by a report of the International Academy for Suicide Research (Leenaars, De Leo, Diekstra, Goldney, Kelleher, Lester & Nordstrom, 1997). The documents will be the actual words from Jack Anawak, Colleen Brown, Trish Hill-Keddie and Lucien Taparti. Each of these individuals was asked to reflect on the issues of suicide and to share some of their thoughts and reflections on the topic (Anawak, 1995; Brown, 1991, 1992; Hill-Keddie, 1997; Leenaars, Anawak, Brown, Hill-Keddie, & Taparti, 1999; Taparti, 1998).

The problem

Epidemiology does not provide a full reflection on the pain in the north nor in the south. To illustrate, let me share with you a trip on the land in the Arctic. I (Leenaars, 1995) went out for a *kamatiq* (sled) ride with two Inuit guides on Baffin Island. We went over the ice of Frobisher Bay and went inland over the small lakes and land, while it was snowing. We travelled and travelled. The caribou were passing us; it was like what one sees on a National Geographic special. The land is not only beautiful but also healing. On the trip, we stopped at a camp for tea, after all it was 2 pm, and as we sat, one Inuk (singular for Inuit) told about his sister and brother who had killed themselves. He had wanted to tell his traumatic story. Everywhere there is pain. Regardless of where you go, one becomes aware of the vast number of suicides. All of the community is experiencing aftershock. The official statistics of the Arctic are likely unreliable, according to the people themselves. Subsequently, travel to Australia suggested a similar problem. Suicide is so vast in both regions. Not only do the epidemiological studies underreport the problem, but also the people themselves had become silent. There was such silence (and this was also true in Lithuania).

Jack Anawak stated the following about the silence and what the people need to do:

> It is a sad fact that the Arctic leads the country in many respects when it comes to suicide. I say this because we cannot sit back and pretend this problem will go away or just solve itself. We cannot assume that other people will address the problem or take action on our behalf. It is our problem and we have to deal with it. Often we have heard people say they are scared to talk about it because if they do, it will cause more people to consider doing it. This kind of fear and the silence that results from it keeps the subject of suicide under the table instead of being put squarely on the table to be looked at and dealt with. I believe that when we learn to really listen to each other and care deeply about keeping the lines of communication going with each other that people are going to feel better about themselves and their work.

It is especially the young who are affected in the Arctic. The same is true in Australia. And there are many young people in Lithuania who commit suicide. Trish Hill-Keddie noted:

> The majority of suicides within the community have been by Aboriginal youth, aged between 14 and 18 years. Tragically, these young people have never been reintegrated back into the family unit or their community. Suicide attempts within the community are hidden from police and welfare agencies, simply because of the shame attached to the attempt.
> There are young people who choose suicide because of the psychological traumatisation that the historical impact has on them, their parents, their ancestors.

The association of the rise in suicide to the policies of colonialisation is obvious to the indigenous people, much like the rise in suicide associated to policies of the Soviets in Lithuania. Hill-Keddie's own memories are as follows:

> Mum remembers being dragged away kicking and screaming, Nanna was collecting the eggs when the welfare car came up and a policeman grabbed them. They were trying to get out of the car window and nanna was trying to grab their hands and get them out (abridged from an article in The Bulletin, 27 June 1995. Used with permission).

This scenario is one to which I can relate. I am a "stolen child"; this extract is from an article written by my sister. I am a survivor of what has been described as attempted genocide, but there are many Aboriginal people who have, past and present, mutilated, self-harmed, and attempted suicide in an effort to erase the separation pain they endured during this experiment. The successful suicide attempts are at present growing, and are exacerbated by existing government policy, ill health, unemployment dislocation and family breakdown. The majority of these attempts are youth. Most attempts are made within the communities, they are hidden from the public.

Of course, the secrecy and denial are not only about suicide but about many aspects of life and death; but then, of course, if one gave voice during the colonial years, one was arrested, deported, killed and so on, something equally witnessed in Lithuania.

Genocide

There is no question that the high rates of suicide in the north and south are largely due to genocide. By genocide, I will here take the United Nations' definition approved on 9 December 1948, that took force on 21 January 1951, in the Convention on the Prevention and Punishment of the Crime of Genocide. In that document we read articles 1, 2 and 3:

> Article 1. The Contracting Parties confirm that genocide, whether committed in time of peace or in time of war, is a crime under international law, which they undertake to prevent and to punish.
>
> Article 2. In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:
>
> a) killing members of the group;
>
> b) causing serious bodily or mental harm to members of the group;
>
> c) deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
>
> d) imposing measures intended to prevent births within the group;
>
> e) forcibly transferring children of the group to another group.
>
> Article 3. The following acts shall be punishable:
>
> a) genocide;
>
> b) conspiracy to commit genocide;
>
> c) direct and public incitement to commit genocide;
>
> d) attempt to commit genocide;
>
> e) complicity in genocide.

The implications and applications to the Arctic, Australia and Lithuania are obvious.

As an example of the genocide, Australia's people were taken away as children from their families and were raised as white children in white homes. Historically, the official perspective on why children were taken from their families and raised by the non-Aboriginal people in the last decades can be gleaned from the doctrine of the Aborigines Protection Board in 1909. The abduction of children was to be a solution to the "aimless, useless life of idleness and vice" of the indigenous people in Australia. The adults were written

off as lost generations, but the children of the Aborigines, the Congress decided, required the "gravest consideration". The *only* solution (somewhat consistent with the Soviet mind) was the following:

> ... the removal of the children and their complete isolation from the influences of the camps. Under no circumstances whatever should the boys and girls be allowed to return to the camps, except on a short visit in an emergency and then only by consent of the department ... In the course of a few years there will be no need for the camps and stations; the old people will have passed away, and their progeny will be absorbed in the industrial classes of the country (Aborigines Protection Board, 1909).

The Aborigines Protection Act was amended in 1916. It read: "The Board may assume full custody and control of the child of any Aborigine, if after due inquiry it is satisfied that such a course is in the interest of the moral and physical welfare of the child." (One can associate this to a line attributed to a Soviet: "Lithuanians are animals: and they must be treated as such.") Often there were no inquiries; the children were simply "taken". They were deported. The government had the power to forcibly transfer any child of any Aborigine family to another group, much like the aim of the residential schools in Canada, as we will see. Stories are rife about the unbearable pain that occurred, because of the government's solution. Post-traumatic stress effects were common. In Australia there are endless stories about the stolen generations (Morgan, 1987; Read, undated). Pauline McLeod, an Aboriginal poet, is a well-known public case example of the "taken". She writes:

> Separated
> Fretting, sad
> Given into other hands.
> Parents, sisters, brothers
> gone
> Wondering what did
> I do wrong

McLeod was separated from her family at a young age and lived in various homes until she was four. She was told that her natural parents had abused, neglected and rejected her. At 12, she was sexually abused by her foster father, an event that occurred frequently among the "taken". Yet, she writes, "I've lost one family, I don't want to lose another, so I'd always do whatever they'd say. Even things that were quite hurtful or annoying I'd tolerate." Pauline struggled during adolescence. One day when threatened to be sent away for stealing, she attempted suicide with a gun. To return to the family, she was required to say, "Rosy red, everything was alright, nothing was wrong." Later, Pauline discovered her Aboriginality and survives today because of this ownership. She writes: "Please! No more, the hurt, the pain."

As an observation, the stories in Lithuania of the "taken" or "deportees" to Siberia are no different. Dalia Grinkevičiūtė, in her moving memoir, *A Stolen Youth, a Stolen Homeland*, tells her story. Dalia, a 14-year-old girl, was deported by the Soviets in June of 1941 from Lithuania to Siberia. Neither Dalia nor Pauline had to invent images of pain; both testify about the crimes of genocide, condemned by the civilised world. Allow me a few lines of Dalia's "flashes of light in a great darkness". She writes:

> My mother lost consciousness. For the first time in all those nightmarish months I started praying.
>
> "God, let my mother stay with me. Let Mother live," I implored, hugging her numb body, her ribs, and her red, swollen, formless, terrible face.
>
> Somebody was trying to dig into our hole. He crawled in and shouted that the trial had already started, and they were waiting for me. I crawled out together with Žukienė, who was coming with me as a witness.
>
> "Goodbye, Mother; goodbye, my dear Mother," I started kissing her unfeeling body, the face, the hands and the feet (Grinkevičiūtė, 2002, p. 60-61).

Later, Dalia reflects:

> Mother, you will recover. I know you will. Mother, they have not got me yet. Love is stronger than death. We shall live, do you hear? We may even return home. Mother, forgive us for not taking proper care of you, for allowing you to commit suicide (p. 71).

Of course, in Canada, atrocities also occurred. In Canada, including the Arctic, the native children were taken to residential schools. We shall not expand here the events in detail, as it would repeat the accounts from Australia; however, let us quote Roland Chrisjohn (1994), a native psychologist in Canada. He stated:

> Residential schools were one of many attempts at the genocide of the Aboriginal Peoples inhabiting the area now commonly called Canada. Initially, the goal of obliterating these peoples was connected with stealing what they owned (the land, the sky, the waters, and their lives, and all that these encompassed); and although this connection persists, present-day acts and policies of genocide are also connected with the hypocritical, legal and self-delusional need on the part of the perpetrators to conceal what they did and what they continued to do (Chrisjohn, Young, 1996, p. 2).

Genocide was widespread. It was layer of genocide upon layer of genocide. The native people were subjected to genocide (Government of Canada, 1998; Hunter, 1991 a; Leenaars, 1995), actions that were intended to remove the people from earth as a people. It was one generation after the next, since John Cabot landed in Canada and James Cook in Australia. The foster homes in Australia and residential schools in Canada were only the latest attempts at genocide. (The same attempt at genocide can be seen during Soviet times in Lithuania.) Even the people themselves, however, denied these atrocities. In the north and south, people are only since the 1990s beginning to remember and accept the problems. (I wonder if there is a reason, beyond reason, that the liberalisation in the Arctic, Australia and Lithuania, all occurred at the same time.) Jack Anawak stated:

> We must never give away this responsibility for this problem ever again! Nothing ever got any better when we tried to give it over to others – in fact things just got worse! It's time to admit this problem isn't going to noticeably decrease until we look at how we are reacting to it, take the steps now to make the changes in our own homes, in our own lives and in the level of interest, sincerity and understanding we show to our young people. If we don't set an example on how we deal with our own frustrations, anger, fear and uncertainty, then how can we expect someone younger, and perhaps more vulnerable, to handle their issues any better?

People from around the world need to understand the malaise in both regions. Lucien Taparti reflected:

> … when it comes to us, the people in the communities, I wonder if we are going to be silent about this or are we going to try to do something about this before our elders die off?
>
> A person's life is precious and it seems like the elders knew this. Even though the people were capable once, later they forgot these things. For example, they have forgotten the hunting of the animals and the heavy labours of survival on the land. Even though these people know they need help, they don't really ask for help, so it becomes a burden for them in their mind.

The same is true in Australia. Trish Hill-Keddie stated:

> The assimilation policy from past years is still prevalent in today's society, and although these young people have never been "stolen" from their families, they experience the pain that their parents are enduring. Many young people have unwanted pregnancies at 14 years, and cannot cope with the hardship they must endure at such a tender age. There are many factors attributing to attempts, but one of the most alarming, is glue sniffing. When you have been dispossessed it is a feeling of absolute isolation and exile, it is a feeling of having your very heart ripped from your body. You no longer have your extended family for support, for they are lost in their own despair. Aboriginal people dispossessed feed off those with the same loss, this alienates our people from mainstream resources that would enable them to heal.

Colleen Brown has also noted that we must listen to the people. Only then will the people share the pain and heal "in return for our willingness to listen and to try to understand". Generations had suffered, but the people are now a healing people … and the same must be true now in Lithuania. Vytautas Landsbergis, in his foreword to Dalia's memoir, writes:

> Prisoners returning from the gulag used to quote a Russian proverb, adding an amendment: "Pluck out the eye of he who remembers the past … and both eyes of he who forgets it."
>
> To continue the metaphor, plucking out is senseless. By blotting out the past, a person becomes blind to the present and the future. All the idle talk about what should be done in order for things "never to be repeated" remains empty unless there is knowledge of what kind of evil it is that should not be allowed to repeat itself.

> Without knowledge there cannot be evaluation. When the borderline between good and evil is blurred, both become just two "points of view". In that way evil becomes justified and legitmised, and therefore malum vincit.
>
> The testimony of Dalia Grinkevičiūtė stands guard lest such a thing should happen. It reminds us of what we should know and never forget, so that even those who greatly desire to be fools should find it difficult to remain fools (Grinkevičiūtė, 2002, p. 11).

Giving voice

The people had been silent in the Arctic and Australia. They were stolen. They were deported. They were lost. Yet, there is now a voice crying in the wilderness in both the desert of the south and the tundra of the north (and the land of Lithuania).

During a visit in the early 1990s to Rankin Inlet, a beautiful community on the very north shore of Hudson Bay, the author and Jack Anawak MP met with Senator Willie Adams and the mayor of a hamlet, Chesterfield (Leenaars, 1995). At a recent school reunion in Chesterfield, there had been many tales of abuse and sexual abuse by the white men. The abuse, like elsewhere, was often by the Catholic priests and Anglican ministers. The silence was broken. Since the events in Chesterfield were learned, it has become well documented that they were not unusual in residential schools (Government of Canada, 1998). Since the first landings, the churches were not only the promoters of genocide for the occupiers, but also carried out the atrocities. An Inuk woman, for example, shared the following about abuse by a priest in a residential school. She said sexual abuse occurred to everyone. It happened for years; yet, she believes that "it never bothered" her. Although at the same time, she reports years of depression, asking why she might feel that way. She was alienated not only from the past but from herself. These events had been shared over and over by many in the Arctic.

Sexual abuse, an example of heavy traumatisation, is also now discussed in Australia. Pauline McLeod, the poet discussed earlier, was sexually abused. Sexual abuse was not rare in the "taken", but

it was only in the early 1990s that a voice to the abuse was spoken. Sexual abuse, rape, and so on, often of children, occurred to the indigenous people from the first days that the conquerors landed. Even the stories of Christopher Columbus attest to the rapes and subsequent mass suicides that occurred in the Caribbean. The sexual abuse was only one abuse. As an aftershock, the memories were subsequently buried, to use a metaphor, in the sand and the snow. (Dalia discusses the same in the Russian Arctic.) There was loss. There was a loss of identity. There was no respect. There was no dignity. To heal, the people must now reclaim what is buried (repressed), including the unbearable PAIN.

Jack Anawak stated:

> In our tightly knit communities we too have developed some gaping holes that we must not ignore. We cannot pretend that we are all happy and are all safe within ourselves. Our traditional beliefs remind us that we are interdependent, we affect each other. We are taught that there is a collective benefit only when we work together, value each other and ensure that people have a sense of belonging. We have to take a long look at ourselves to see if we live our own lives honouring these principles in our daily interaction with our families and within our communities.

Trish Hill-Keddie stated the same:

> Each suicide or attempt within the community is an irreplaceable loss, which makes Aboriginal people feel that they are under constant threat of genocide again. The loss of Aboriginal identity and the destruction of Aboriginal culture have contributed to a tremendous sense of loss within indigenous communities. Children are urbanized to a point where they are accepting the "white man's" way of living; drugs and alcohol are an indiscriminate part of life; this paves the way for our children to lose themselves and their identity. They are being assimilated into the lowest classes of the culture imposed upon them. They are not learning about the importance of their culture, and current education systems treat the culture as stories and myths. The system we live in now does not tolerate discipline; white structures have now penetrated traditional ways; our children have no longer the respect for our old people, who once held great esteem within the community. They do not understand how actions of the past impact on their lives, they just feel empty. A healing is needed.

Lucien Taparti has stated the same in the Arctic:

> Many of us have experienced losing someone. That's why I really want to talk about it. If I were silent, I know it wouldn't be of help. We have to be visible, and if we are visible then that's how the problem will become visible.

Culture

The pain of the people is "deep in the psyche". Traditional ways among the people had been forgotten. Acculturation was the norm. People don't know who they are, where they came from, and where they are going. The abuse at Chesterfield, for example, is only the surface of the problem. How the people think, how they talk ... has been affected deep in their psyche. The people in both the north and the south had their cultures stolen. Culture is the collective meaning and value of a people. The Royal Commission on Aboriginal Peoples (1995) in Canada wrote:

> Culture is the whole complex of relationships, knowledge, languages, social institutions, beliefs, values and ethical rules that bind a people together and give a collective and its individual members a sense of who they are and where they belong (p. 25).

Culture is rooted in one's land. It is a vast heritage. The cultural genocide was initiated to destroy that meaning, and this deeply affected the mind and spirit of the people. The best analogy that I can offer from the north is the iceberg. In the Arctic, icebergs are large, and what people are beginning to struggle with in the north is likely the tip of the iceberg. Analogically, what people are beginning to struggle with in the south is only a few grains of sand from the desert, and in Australia the outbacks are very large.

Colleen Brown stated:

> I would dearly love to be able to get with the older people, too, that were taken away and get their feelings and thoughts on it, you know, but the trouble is that they have kept it for so many years inside that I don't think they would ever part with why, or explain or talk about why and their life being taken away from their family. I think what they have done is suppress it so far down that they won't let it come to the surface.

Only by re-learning the traditional ways and meanings with the new is healing possible. We do not believe that people can only heal by going back to the old; there is a need for growth and development in culture. To go back to only the old ways is much too simplistic a solution. This is as true for the north as it is in the south.

Healing is possible. Many people in the Arctic and Australia believe healing is now occurring. People need to give voice to the heavy traumatisation. Suicide must be discussed. Jack Anawak once said: "I have no questions about who I am. I'm an Inuk, but I can adapt to other ways." The Aborigines in Australia have said the same: "I am Koorie – I survive" (Koorie is a group of Aborigines living in New South Wales). (I have heard the same in Lithuania. A priest, who spent years in Siberia, said to me: "I am Lithuanian. We Lithuanians will survive").

In the north and the south, the people speak about assimilation, acculturation, and being "totally lost". Accepting the acculturation is hard; yet others and I encourage progress, a "waking up". The Inuit and Aborigines are beginning to talk. Yet, healing will take a long time, because the indigenous people have not only lost their way of life, but some, their spirit. The occupiers stripped them of their dignity. There was no respect for people. Their children were taken from them. They were imprisoned for speaking their languages. They were deported for practising what the Western world calls "religion". They were raped. They were abused. It was a *cultural genocide* and, as the example of Tasmania will show, it was genocide.

Many doubt that genocide occurred among indigenous people, even if these same people accept what is called cultural genocide occurred. The attempt to kill indigenous people across the world can, however, be tragically illustrated by the events in Tasmania (Commonwealth of Australia, 1990).

In 1788, Governor Arthur Phillip arrived in Sydney, Australia. Settlers, many of them convicts, came to settle the land. The native

people fought for their land, but the British soldiers attacked and killed the people. They destroyed the lifestyle. There was resistance; some, like Pemulway, a warrior, fought but were killed (New South Wales Aboriginal Land Council, undated). Within 50 years, the colonists hunted down and killed the people by the hundreds. The Arctic did not see these large-scale massacres, likely because there was no value to the land in the north initially. Of course, other atrocities, such as the introduction of the great diseases (eg measles, tuberculosis, influenza) by the white people contributed heavily to the people's demise in the north. But, in Australia, the land had immediate value and was taken away from the native people. If the natives were in the way of these conquests, like in Tasmania, they were killed.

The Tasmanians lived on the land, the island, since the world began. They were a sharing people: sharing food, holding sacred and secret ceremonies, arranging marriages. Men hunted. Women gathered small animals, collected shellfish and prepared food. They were a spiritual people. They had totems and taboos. Then, the invaders came.

In 1642, the Dutch navigator Abel Tasman landed. This signalled the end of the Aboriginal isolation and lifestyle. From the 1770s on, the English and French visited the island, and in 1803 the first "settlers" came, and tragedy prevailed.

Aboriginal society is based on sharing and exchange. In return for gifts, Aborigines expected fairness and respect, which was their way as it is in the north. The settlers, however, saw the Aborigines as taking the land, because primitive ownership of the land was not understood. They set up land claims, built fences, and so on. The Aborigines' land and sacred places were taken. Hostilities arose. In 1804, the first massacre in Tasmania occurred. Women and children were ordered to be killed. By 1806, massacres were common: children were abducted; women were raped, even the young; people were tortured; and all native people were enslaved.

By 1820, the white settlers poured into the land in greater numbers, taking more and more land that did not belong to them. Then in 1824, Governor Phillip proclaimed martial law. He ordered every Aborigine man, woman and child to be killed. A reward was offered for their heads and a massacre occurred. The Aborigine people fought back. In 1830, a military operation was introduced to kill all remaining Aborigines. Between 1829 and 1834, it was believed that the genocide was completed. The last Tasmanian, Fanny Cochrane Smith, died in 1876. Yet, the people prevailed. There were survivors of Tasmania, who had fled to the mainland. These people today have returned to Tasmania and continue to live on their land.

Tasmania is, unfortunately, only an illustration. We shall not report other atrocities in the south or the north. We will only cite, as an example from Canada, that Jacques Cartier, the French conqueror, exterminated the Stadaconans on the St Lawrence River in the same fashion in Canada (Ray, 1996). Tasmania is not unique; rather, it illustrates the intentional genocide against indigenous people all over the globe ... and all people over the globe.

There is hope, however, from the abyss. Lucien Taparti stated: "People have been crying inside for a long time." Yet, he sees hope in culture:

> We all have different lives, different cultures, and we can't say that the Qablunaat have a strong culture. All of us came from our ancestors, and if we could grasp that back then there were less suicides, perhaps we could start utilising our culture for prevention. We'll have to know more about the cultures of our ancestors, and try to follow them and try to help each other more. We can use many peoples' cultures, whether they may be the Qablunaats, the Denes, or even the Inuits. If we can be more aware of people's cultures, I'm sure we would be able to come up with something that would be of benefit.

Culture, the way of the people, is a solution. Colleen Brown quotes the following from one of the "taken" when asked what she would say to the white people:

> What would I say to them? Oh, what would I say to them. I suppose just try to understand. I mean, you've gotta been there, done that situation to know what's going on. Just listen to them, try to understand. Because what's happened to them, what's happened to me, has really knocked me around. Even today it knocks me about. Just try to understand that ... listen to them, you know. Being brought up by white people, it's hard, but it's even more harder when you get out, out into the real world, real society, when you run into your own people. I used to just walk past my people, you know, just look at them, just keep walking.

There is hope. The culture in the north and south (and in Lithuania), despite the attempt at genocide, is alive. The cultural genocide failed in the Arctic, Australia (and Lithuania). It is culture, the people's heritage, that now offers hope.

Taparti gives snow as a method to the solution in the north and, we believe, the south. He stated:

> We really have to start thinking of ways to rectify things. I'm sure this can be achieved somehow, but I don't know the answer to it. If solutions came from a larger community it could be a starting point, and even if they think they couldn't come up with solutions, they would be able to do so. Just as long as they have appropriate laws (rules) that they'd use. As long as the rules are capable of being followed. I'll use snow as an example: it is worked on by different people – some are very good with snow and some are able to work with it but not as well. That's why we use different types of snow to work with. Snow was our means of survival, even when we were young and even when we became adults. I wasn't worried at all, knowing that we'll get an iglu, even when there was going to be a blizzard. That was one of the laws and I followed it; so that was our life and the iglus were where our lives were. That's how we used to live in the wintertime.

And Jack Anawak stated:

> As Inuit people we have survived in what is considered to be the most challenging climate in the world. We have coped for hundreds, even thousands, of years and developed attitudes, behaviours, values and beliefs that allowed us to face whatever had to be dealt with and to overcome great difficulties. We must call upon those same values that brought us to this day. We need to own this problem. We cannot give it over to the governments, authorities, specialists, professionals, scholars, organizations or consultants. We own this problem. Say it ...

> Believe it! We are part of the problem if we do not acknowledge this fact and take both individual and collective action to address it. We have finally come to realise that:
>
> We are the experts on our stories;
>
> We know the strengths and weaknesses of our own communities;
>
> We have a pretty good idea about how things got this way;
>
> We have a value system that is worth honouring …
>
> and we do have the brains to figure out what to do about it.

"Long times", as indigenous people would say, are needed for healing. Perhaps it describes the resilience of the people of the Arctic and Australia, like in Lithuania, as by right they should all have fallen by the wayside. The long-lasting effects of the political oppression should have terminated the people, and this is surely true in Lithuania. To repeat Jack Anawak's words: "As Inuit people, we have survived in what is considered to be the most challenging climate in the world." The people will survive. It is, in fact, believed by many native people that the white men may not survive, if they continue their atrocities to people and to the Mother, Earth.

Lucien Taparti has made the same observation in the north. He stated:

> If we started tackling different things that we were capable of doing on our own, we couldn't really think of other things to get into. Soon as we were able to do things that we had to follow, we didn't have much to be concerned with, not like our young people I see today. That's how it is with our culture from the harsh region; our cultures are all different and we need to keep our culture visible. If we ignore the issue, it is obvious that it won't get rectified.

The solution, according to Taparti, is "to teach our young people their own culture, whether it be Inuit culture, Qablunaat culture ..." In the Arctic, Australia and Lithuania, culture, the collective meaning and value of a people, is seen as the means for healing. The indigenous people have survived since the beginning of time. They still know how.

And in Lithuania it is no different. The Lithuanians have survived long-lasting repression. The anti-Soviet resistance fighters are examples (Anušauskas, 1999; Kuodytė, 1999). (I have had an opportunity to visit the old KGB jail in Vilnius, now, appropriately, the Museum of Genocide Victims. One is left with such heavy feelings, visiting there. Feelings that I have felt before in the Arctic and Australia.)

The Lithuanians survived. Dalia writes the following:

> Golgotha! It was the Golgotha ["a graveyard"] of the spring of my life. With short breaks, I became convinced I would have to carry its cross throughout all my life. That Calvary formed my character. It gave birth to my persistence. I learned to suffer quietly, and step by step and painfully to approach the top. After reaching it, I learned to feel joy and to trust my own strength. That Calvary was the first teacher in my life. It was a very cruel and merciless teacher. It taught me to fight and survive ... (Grinkevičiūtė, 2002, p. 120)

Maybe all victims of genocide can become survivors. They are, in fact, the experts in their healing.

A final story

One marvels at the people in the north and the south. They have endured and survived genocide. They are a strong people; their visions, in fact, will be essential to all, if we are to survive the 21st century.

I am struck by the similarities between the north and the south and Lithuania. As a final illustration, I share a story from the north. In Pangnirtung, I heard an Elder speak. She told about the old ways, and then the whalers came. People hunted. People cleaned the whale... "and then the white man would take the catch, leaving only blubber for us. In our way," she said, "we share the labour and the catch."

In Wreck Bay in Australia, I heard another Elder speak. He told about the old ways and then the sailors came. Sealskins were desired. People had always hunted the seal for food, skin, and so on, this was the law of the land. Yet, when the sailors came they violated the law, taking only the skin. The people were forced to help

in the hunt. Not only Nature but also people were abused. The people were treated cruelly, leaving nothing for the Aborigine ways. The Elder said that the Aborigine way is one of sharing, caring, living, and so on, and then we will survive.

And, in Lithuania, I heard another Elder speak. She had been deported to Siberia for ten years and, as she held her dog close to her chest, she said ...

References

Abbey, S., Hood, E., Young, L., Malcolmson, S. (1993). Psychiatric consultation in the Eastern Canadian Arctic: III. Mental health issues in Inuit women in the Eastern Arctic. *Canadian Journal of Psychiatry*, 38:32-35.

Aborigine Protection Board (1909). Text stated to Australasian Catholic Congress in 1909. In: Kendall, C. *Link-Up*, undated. Lawson, NSW: Link-Up.

Allport, G. (1942). *The use of personal documents in psychological science*. New York: Social Science Research Council.

Anawak, J. (1994, May). Suicide and the community. Keynote address presented at the conference of the Canadian Association for Suicide Prevention, Iqaluit, Nunavut.

Anušauskas, A. (ed) (1999). *The Anti-Soviet Resistance in the Baltic States.* Vilnius: Akreta.

Benjafield, J. (2000). Research methods: A history of some important strands. *Archives of Suicide Research*, 6:5-14.

Brown, C. (1991, Jan). Stories of Wreck Bay. A plenary address presented at the 11th Australian Family Therapy Conference, Adelaide, Australia.

Brown, C., Larner, G. (1992, July). Every dot has a meaning. Workshop presented at the 2nd Australian and New Zealand Family Therapy Conference, Melbourne, Australia.

Boas, F. (1964). *The central Eskimo*. Lincoln: University of Nebraska Press.

Cawte, J. (1964). Australian ethnopsychiatry in the field: A sampling in North Kimberley. *Medical Journal of Australia*, 1:467-472.

Chrisjohn, R., Young, S. (1996). *The circle game: Shadows and substance in the Indian residential school experience in Canada*. A report to the Royal Commission on Aboriginal Peoples, submitted 1 October 1994.

Commonwealth of Australia (1990). *Aboriginal people of Tasmania.* Canberra.

Connors, E. (1995). The healing path: Suicide and self-destructive behavior in North American native people. In: Leenaars, A. & Lester, D. (eds). *Suicide and the unconscious* (p. 257-269), Northvale, N.J.: Jason Aronson Inc.

Dulkinienė, R., Keys, K. (eds). (2003). *With a needle in the heart.* Vilnius: Garnelis.

Durkheim, E. (1897). *Le suicide.* Paris: Felix Alcan.

Gailienė, D., Domanskienė, V., Keturakis, V. (1995). Suicide in Lithuania. *Archives of Suicide Research*, 1:149-158.

Gailienė, D. (2004). Suicide in Lithuania During the Years of 1990 to 2002. *Archives of Suicide Research*, 8:389-395.

Government of Canada (1998, January 7). *Gathering strength – Canada's Aboriginal action plan*. Ottawa.

Grinkevičiūtė, D. (2002). *A Stolen Youth, a Stolen Homeland*. Vilnius: Lithuanian Writers' Union Publishers.

Hill-Keddie, T. (1997, March). Footprints in time. Paper presented at the 19th congress of the International Association for Suicide Prevention, Adelaide, Australia.

Hunter, E. (1991 a). Out of sight, out of mind-1. Emergent patterns of self-harm among Aborigines of remote Australia. *Social Science and Medicine*, 33:655-659.

Hunter, E. (1991 b). Out of sight, out of mind-2. Social and historical contexts of self-harmful behaviour among Aborigines of remote Australia. *Social Science and Medicine*, 33:661-671.

Jennes, D. (1922). *The life of the Copper Eskimo: Report of the Canadian arctic expedition, 1913–1918*, Vol. 12. Ottawa: Dept. of Naval Services.

Kirmayer, L. (1994). Suicide among Canadian Aboriginal Peoples. *Transcultural Psychiatric Research Review*, 31:3-58.

Kirmayer, L., Fletcher, C., Boothroyd, L. (1998). Suicide among the Inuit of Canada. In: Leenaars, A. et al (eds), *Suicide in Canada* (pp. 189-211). Toronto: University of Toronto Press.

Kuodytė, D. (1999). The Contacts between the Lithuanian Resistance and the West. In: Anušauskas, A. (ed). *The Anti-Soviet Resistance in the Baltic States* (pp. 71-83). Vilnius: Akreta.

Leenaars, A. (1995). Suicide in the Arctic: A few stories. *Archives of Suicide Research*, 1:131-140.

Leenaars, A. (1996). Suicide: A multidimensional malaise. *Suicide & Life-Threatening Behavior*, 19:249-263.

Leenaars, A., Anawak, J., Brown, C., Hill-Keddie, T., Taparti, L. (1999). Genocide and suicide among indigenous people: The north meets the south. *The Canadian Journal of Native Studies*, 19:337-363.

Leenaars, A., Anawak, J., Taparti, L. (1998). Suicide among the Canadian Inuit. In: Kosky, R. et al (eds). *Suicide prevention: The global context* (pp. 111-120). London: Plenum.

Leenaars, A., De Leo, D., Diekstra, R., Goldney, R., Kelleher, M., Lester, P., Nordstrom, P. (1997). Consultations for research in suicidology. *Archives of Suicide Research*, 3:139-151.

Leenaars, A., Wenckstern, S., Sakinofsky, I., Dyck, R., Kral, M., Bland, R. (eds) (1998). *Suicide in Canada.* Toronto: University of Toronto Press.

Moodie, P. (1973). *Aboriginal health*. Canberra: Australian National University Press.

Morgan, S. (1987). *My place*. South Fremantle, W.A.: Fremantle Art Centre Press.

New South Wales Aboriginal Land Council (undated). *Our land, our people*. Liverpool, NSW.

Ray, A. (1996). *I have lived here since the world began*. Toronto: Lester Publishing Ltd.

Read, P. (undated). *The stolen generations.* NSW: Ministry of Aboriginal Affairs.

Reser, J. (1989 a). Aboriginal deaths in custody and social construction: A response to the view that there is no such thing as Aboriginal suicide. *Australian Aboriginal Studies*, 2:43-50.

Reser, J. (1989 b). Australian aboriginal suicide deaths in custody: Cultural context and cluster evidence. *Australian Psychologist*, 24:325-341.

Royal Commission on Aboriginal Peoples (1995). *Choosing life: Special report on suicide among aboriginal people*. Ottawa: Ministry of Supply & Service, Canada.

Shneidman, E. (1980). *Voices of death*. New York: McGraw-Hill.

Shneidman, E. (1985). *Definition of suicide*. New York: Wiley.

Taparti, L. (1998). Suicide. Recording of his words; synopses for foreword. In: Leenaars, A. et al (eds), *Suicide in Canada* (pp. XI-XVII). Toronto: University of Toronto Press.

United Nations (1951). *Convention of the Prevention and Punishment of the Crime of Genocide*. New York.

Weyers, E. (1962). *The Eskimos: Their environment and folkways*. Hamden CN: Archan Books (original published 1932).

Windelband, W. (1904). *Geschichte und Naturwissenschaft* (3rd ed). Strasburg: Heitz.

World Health Organization (WHO, 2002). *World health report on violence and health*. Geneva.

Wotton, K. (1985). Labrador mortality. In: Fontaine, R. (ed), *Circumpolar health*, 1984 (pp. 139-142). Seattle: University of Washington Press.

Psychological Injury: Disability Compensation in Military and Civilian Veterans and War Victims. A Norwegian Perspective

LARS WEISÆTH
Norwegian Centre for Violence and Traumatic Stress Studies
Department of Psychiatry, Medical Faculty, University of Oslo, Norway
Joint Armed Forces Medical Services

Financial compensation: Important, but difficult and controversial

The purpose of this article is to describe the present Norwegian practice and the historical development of the principles applied when evaluating a possible relationship between war stressors and health failure, particularly when the latter is of a psychiatric nature.

Documented causal relationship between a war stressor and a subsequent psychiatric disorder in the person applying for a war pension. This was the sole principle applied from 1945 in the wake of the Second World War.

Presumed causal relationship: When excessive war stress exposure can be documented, any (somatic or) psychiatric disorder with significant disability (more than 50% loss of work capacity) will be accepted. This principle was introduced in 1967.

Presumed causal relationship: Based upon the statistical relationship between a group's exposure to war stressors above a *defined threshold*, and the prevalence of subsequent disorders within the *post-traumatic stress syndrome*, a disorder of this kind will be presumed to have been caused by the war stressors unless other obvious reasons can explain it. This principle was introduced in 1989.

Financial compensation for mental injury is a complex problem, whose medical and legal solutions vary from country to country. Establishing formal principles and practices tends to cause con-

troversy and often medical, legal and political disputes. Norway has had its fair share of these problems and seems to have developed original solutions to some of them, reflected in the present legislation mainly in relation to mental injury suffered during the Second World War. During the postwar years, there has been a dynamic interaction between researchers at the University of Oslo Medical Faculty, the war veterans in the Association for War Disabled, and the Ministry for Social Affairs/the Norwegian Parliament. Back in 1945, however, it was unthinkable that a 50-year perspective would be necessary to fully evaluate the long-term and delayed effects of traumatic war stress as they are known today.

The result of the collaboration was original and timely legislation which solved pressing problems for the government, the National Health Insurance Administration and the war veterans and victims. One ideal was to have laws for war disability compensation based on sound medical evidence.

With regard to the possible adverse health consequences of severely stressful war experiences, the outcomes studied have been: increased mortality, increased general physical morbidity and psychosomatic and psychiatric morbidity. Some of the findings will be reported in the following pages.

The nature of war

Until recently, standard psychiatric textbooks (Kaplan et al, 1980) limited their coverage of war psychiatry to syndromes related to combat or prisoner-of-war (POW) experiences. This limitation was a reflection of the recent national history of some Western nations, such as the United States and Canada, which had made their people regard war primarily as a cluster of events affecting military personnel on foreign soil, and their next of kin at home. Citizens of other countries, such as the United Kingdom, have experienced additional war-related traumas, such as having homes destroyed by enemy bombs. Still other nations have endured inva-

sions, followed by partial (France, the Soviet Union) or full occupation, such as many European countries, or Kuwait during the Gulf War, which have varied in severity for the average citizen along a stressor continuum from what may be termed moderate, to the most extreme. Some of these nations were not actually liberated in 1945: a communist occupation followed the Nazi occupation.

The many stressful experiences of war can be placed in a time-phase model: threat, attack, invasion, occupation, liberation, post-war legal action against collaborators and war criminals, and finally peace, with the reestablishment of national institutions. Each of these phases brings characteristic stressors (Eitinger, 1990; Weisæth, 1997).

The relationship between war and mental health is not a simple one. There is a general association between the severity and duration of exposure and the risk of psychiatric consequences. But not all war stressors increase the incidence of mental health problems, and some may even have positive effects: during the Nazi occupation of Norway, for example, the prevalence of certain types of psychoses decreased by 15% (Ødegård, 1954). A reduction in social isolation may have a preventative effect among civilians, much the same as the strong group cohesion of a tight, close-knit military unit has among soldiers. Strong leadership and motivation, a perception of suffering as more meaningful during wartime than during peace, and the stronger sense of importance and control individuals may also experience during war, are likely mediating factors that improve coping during such stressful times.

Norway during the Second World War

Due to its geographical location on the outskirts of the main Second World War theatres, Norway acquired experiences from war and occupation which include many typical aspects. During the initial phase, a neutral country with a population of only 3.3 million, it was overrun by superior German forces. Towns and cities were

bombed and burned. Small groups of poorly organised army, navy and air force units mustered considerable resistance with Allied support during the campaign in Norway. They were even victorious in northern Norway, until surrender was inevitable after two months when the breakdown on the continental front in early June 1940 made it necessary for the Allies to pull out of Norway.

With the royal head of state and the government established in exile in London, various types of forces were organised in the country and outside. While the country was formally occupied by overwhelming German forces for five years, Norway entered a role as one of the Allied nations fighting actively against the Nazi aggression.

The three main "fronts" during the occupation were the outer (exile) front, the home front, and the prison front.

1) The outer front comprised the merchant navy, the navy, the army and the air force. The most significant contribution to the Allied war effort was undoubtedly delivered by the Norwegian merchant navy, managed by the government in exile, with 40,000 men on 1,022 ships, of which 520 were eventually sunk. (Studies of the long-term effects of war sailor stress were to have important consequences for legislation on war disability compensation; see below.) The Royal Norwegian Navy operated as part of the British Royal Navy, a small air force was operative, and a few army brigades underwent training in Allied Scotland and neutral Sweden.
2) The home front was slowly built up to a clandestine partisan army of 40,000 part-time soldiers, in addition to numerous civilian resistance groups. The resistance on the home front ranged from civil disobedience on the one hand to armed combat on the other, with a great variety of resistance roles with many types of stress exposures: border pilots, illegal press workers, civilian hostages, clandestine army soldiers, guerrilla fighters, spies, undercover agents, double agents,

saboteurs, radio operators and many others. Common to most of these was that their stress exposure was long-lasting and severe, and arrest nearly always implied torture and often deportation to concentration camps or the death penalty. Of the approximately 150,000 who took an active part in the organised home front, 41,000 were arrested. According to Keegan, the resistance in Norway was the only resistance movement during the Second World War organised under one leadership, that is probably why it was effective.

3) The political prisoner population in Nazi camps in Norway and on the continent, called the "prisoner front", included military and civilian resistance fighters and ethnic minorities, primarily Jews. Captured merchant sailors were interned in Nazi or Japanese prison camps, but also murdered immediately after the torpedoing, as happened in the Pacific.

The concept of the "prison front" was valuable also from a psychological point of view in that it emphasised the role which the prisoners kept on playing in the resistance movement.

In 1945 very little scientific knowledge was available on the severity, types and course of stress-related illnesses likely to occur in these groups from the three fronts.

The line between military and civilian roles had become less distinct during the occupation as regular military combat after defeat was followed by a broad spectrum of "civilian resistance" activities. Different groups of people who had not been pre-selected and pre-trained were exposed to unique stressors, hardly any of which had been well studied.

It inevitably had to have consequences for the war disability compensation scheme that a large proportion of the entire national population actively or passively had been exposed to war stress, and not only military personnel.

Many questions had to be answered for a just and adequate com-

pensation scheme to be formed. The exact definition of who had been an active war participant was an open question. What about civilian resistance fighters? How can we define a resistance fighter? How organised should the resistance activity have been? How can we document the stress of highly secret operations? What about civilians in jobs that carried a great risk, such as sailors, railway personnel, etc? And what about accidental victims of war traumas?

Should all disabled war veterans be entitled to the same amount, or should the compensation reflect the previous income?

The variations in stress experiences on the three fronts contributed to unprecedented complexity for the authorities when trying to establish criteria for awarding war disability compensation after the Second World War.

In general, postwar compensation controversies have focused on various definitions of "active participation" in war, the nature and degree of war stressors, and the criteria for war disability compensation.

No doubt, a major difficulty was the problem involved in proving causal relationships between the stressful war experience and the ensuing health failure, be it somatic or psychiatric in nature. This problem increased with time as the distance from the war as a possible cause of illness increased.

Several nations faced similar challenges in the wake of the Second World War. Since then, internationally accepted definitions put forward by the World Veterans Federation (WVF, 1997) of who is to be granted the status of war veteran, victim of war and dependents may serve as guidelines.

The objectives and principles of disability compensation

The purpose of awarding disability compensation is primarily to reestablish a person's economic security, ie to repair an economic loss. It may also be necessary for covering expenses caused by the disability and costs of medical treatment and rehabilitation, and for

improving the disabled person's quality of life. There has never been a military or war veteran pension scheme for ex-soldiers in Norway, as these are included in the general basic social security system. This reflects a thousand-year history of "citizen conscript soldiers", ie military service for all males, and the modern concept of "total defence", which diminishes the difference between the military and the civilian communities. In 1945 it was decided that only loss of earning capacity due to war-induced illness or injury and loss of income in bereaved families should be compensated for.

Two important implications stem from this principle.

First, loss of quality of life would only be financially compensated for in a symbolic and minimal way. Traditionally, there has been a marked reluctance in most European countries to pretend that human suffering can be measured and alleviated by money. This attitude has changed somewhat in recent years.

Secondly, a war-related illness is in itself not sufficient to give compensation. It should cause some degree of functional impairment.

Since the whole population in fact had been exposed to some of the many consequences of war and had their lives and careers affected by it, the priority of disability was expressed as follows: those who have been involved in or hit by the war without having been inflicted permanent injury or illness, are not entitled to compensation after these laws.

War disabled were not social clients; thus, providing for basic economic needs only was seen as unacceptable. Neither should the war effort of the disabled be rewarded, as the war participant with maintained health got nothing. (As we shall see, the introduction of objective stressor criteria from 1967 to some degree was experienced by the applicants as a reward for particularly tough war service, and this created some psychological problems when applications were rejected.) Nor could full compensation be justified or afforded, since the nation itself and virtually all its citizens had suffered substantial economic losses that would not be compensated

for from any source. (For this reason, all compensation for material damage was reduced by 14% of the lost value.) In 1945 the war-ravaged nation was poor and the welfare state in its infancy.

Some nations, particularly those with professional armies, have their own health-care systems for military veterans. Some countries applied positive discrimination, such as subsidised loans, entrance into universities, reserved seats on public transport, free medical services for life for all veterans, and other benefits. There are no benefits for veterans in general in Norway. One reason why positive discrimination was not recommended as a principle was that the Nazis had used that practice for their party members during the war.

As in most other countries, the discussion about what principles should be followed in establishing the amount of compensation ended in a compromise. In 1945 it had been decided that the compensation to some extent should reflect the previous income.

There has, however, been a marked trend over the years for the difference between the highest and lowest war disability pension to diminish, from 37.3% in 1946 to 6.85% in 1995, and from 1 January 1999 the difference finally disappeared. Compared to the wages of the average industrial worker in Norway, the amount has varied over the years: from 1945 to 1959 there was a relative reduction of the war disability pension; while in 1968 the comparison was most favourable, the lowest war disability then corresponded to 86.3% of the industrial worker's pay, the highest 138%. Since 1987, regulating mechanisms have been applied so that the pension automatically follows the general wage level. Since 1990 the medical injury part of the pension has been tax-free, so that the first 20% of the pension is not subject to taxation.

It is obviously important to reestablish a disabled person's sense of value, power, dignity and self-esteem. The war pension scheme has contributed much to the identity, honour and pride of the disabled war veterans. These feelings are influenced by the status assigned to victims and military and resistance veterans by society as

a whole, and the reparation process may be dependent upon compensation, both real and symbolic, restitution, rehabilitation and commemoration (Danieli et al, 1996).

Although our focus is financial compensation, a matter in which fairness, equality and justice are very sensitive issues, we have to remember that this is only one aspect within the much wider scope of justice for the war disabled: a very thorough postwar legal process against renegades, collaborators and war criminals was carried out. This prosecution encompassed proportionally more than other Nazi-occupied countries. Documentation on the war events, and making them public, contributed to stabilising public opinion. The result of this very thorough legal process, lasting several years, was that very few complaints from war victims concerning retribution have been heard, much in contrast to the anger and insult of many present victims of violence who often hear no apology, and many experience no prosecution or punishment of the perpetrator. The situation for the war victims in Kuwait has been less satisfactory in this matter, as no Iraqi has yet been sentenced or punished for war crimes (Al-Hammadi et al, 1994; Weisæth, 1997).

The situation in 1945

In 1945 the prevailing view on the prognoses of the traumatised war participants and victims was very optimistic. This attitude was certainly not based upon any reliable empirical evidence, but rather on the dominating optimistic attitudes at the time, both in the population and among ex-prisoners. The collective relief that the war was over, and particularly the relief, even euphoria, among the most severely exposed for having survived, but also the tiredness of war, the wish to put the war behind them and concentrate on a promising future, all played a part.

In 1945 it was expected that the total compensation scheme could be finalised by 1948, when it was expected that the war injury/illness would be either cured or its final prognoses could be

determined. To some extent this prediction was borne out: approximately 80% of those who received disability compensation had been cured by the end of 1951. The course of somatic illnesses, and to some extent somatic injuries, explained this trend. Of the 26,605 who applied, 24,538 had been accepted. From 1946 to 1967, when the Amendment Act was implemented, the number of war disability pensions was reduced by more than 50%.

After the Second World War, traumatic stress disorders were conceptualised in diagnostic manuals as acute and time-limited phenomena. Symptoms would presumably disappear within a few months of the cessation of the stress, unless some pre-existing character pathology was present which could contribute to symptom maintenance.

In the Scandinavian countries, psychiatry traditionally had put more emphasis on environmental factors, such as psycho-social conditions, than was generally the case on the European continent. The impressive demonstration on the battlefield during the First World War, however, of the importance of intrapsychic conflicts, primary and secondary gain, escape into illness etc, had more enduring effects than the demonstration that extreme external stress could break most men.

Early in the 20th century, research findings had created an expectation of a good prognosis in stress-induced psychiatric illnesses. One example was Bonhoeffer's findings (1907) in Germany that a significant proportion of prison psychoses proved to be of a transitory type, with symptoms disappearing when the stress exposure ended. The "Jaspers' five criteria for psychogenic reactions" (Jaspers, 1913) were introduced and acquired an axiomatic character over the years: given a significant stressor, a time relationship between event and response, symptoms mirroring the stressor and an unremarkable premorbid personality, the psychiatric condition was expected to have a good prognosis. Many patients with chronic ailments were to have their compensation claims turned down with arguments derived from Jaspers' criteria: the delayed debut and

the poor prognosis of the disorder did not fit with Jaspers' criteria. (But neither did the robust premorbid psyche that many of the chronic cases would be proven to have had.)

In postwar Germany, however, a decision was reached in 1926 by the psychiatric community to the effect that traumatic neurosis was not accepted as a genuine illness. Traumatic neurosis was seen as a social problem. By "blaming the victim" for his illness psychiatrists relieved the state of their responsibility at a time of severe economic problems.

Bonhoeffer and his colleagues argued that the real cause of traumatic neurosis among their patients was the availability of compensation (*Das Gesetz ist die Ursache der Unfallsneurosen*, "The law is the cause of traumatic neurosis"). Traumatic neurosis was not an illness, but an artefact of the insurance system, a "Rentenneurose", a compensation neurosis caused by the availability of compensation. In Bonhoeffer's study (1926) he concluded that practically all of his 142 cases of traumatic neurosis had hereditary predispositions.

Since Jaspers' stress criteria for psychogenic disorders only included patients without premorbid personality problems, the conclusion was that a poor outcome must be the result of premorbid vulnerabilities. The German Reichversicherungs Ordnung (RVO, the National Health Insurance Act) of 1926 was based on the philosophy that traumatic neurosis was incurable if and as long as patients were rewarded by pensions or other forms of compensation. Only the immediate and brief shock reaction was accepted as an illness.

The connection between service and condition attracting compensation

Documented causal relationship

After the Second World War the requirement for a war disability pension in Norway was the demonstration of a direct causal connection between the actual disease/injury and the war stressors. A

more than 50% probability was considered causal. As no general pension scheme existed before the war, two bills were passed in 1946 introducing provisions for war pensioning, one for military personnel and one for civilians. The latter comprised Norwegian citizens in general, regardless of where they had been exposed to the stressors, as long as they had not been in the service of the enemy, and included resistance activities and "war accidents". The only exception to the strict requirement of causality was the "24-hour rule", which implied that military personel qualified as long as the injury or disease, regardless of its nature, had been contracted during war service. For everybody else, including children, the war experience had to be a direct exposure to a real threat; indirect experiences were not enough. In the case of premorbid vulnerability, the person was "accepted as he was"; no reduction was made in the compensation.

There were few problems involved in compensating for physical disability, such as sequels from having been wounded in action. In these cases, the documentation was reliable from the time it was inflicted; the disability was often a continuous process, could be objectively characterised, and was easy to grasp.

Based upon prewar perspectives, adequate war stressors, "war accidents", were limited to sudden and intense impacts, such as torpedo attacks, mine explosions, air attacks, clandestine resistance, imprisonment and escape.

This reasoning was consistent with the definition of an occupational injury in civilian life; it had to result from an unexpected, sudden, violent event. Exposure to severe risk in itself was not accepted as sufficient stress; a concrete potentially traumatising event had to be demonstrated.

The late psychic sequels

The prevailing view during the late 1940s and early 1950s was that stress casualties among war veterans who resumed civilian status

would either adjust without difficulty or recover during the immediate postwar years (Op den Velde, 1988; Ørner, 1992).

In Norway nearly all the survivors from the concentration camps had gone back to work and their prospects looked good. When, however, many ex-prisoners after some years of work reported that they were incapable of keeping up with their job's demands, their problems were not immediately connected with their exposure to war stress. The exceptions were the few cases in whom so-called "bridge symptoms" could be demonstrated: ex-prisoners who had sought help for their symptoms. In such cases a likely causal connection could be seen.

In 1957 the Association for War Disabled in Norway contacted the Military Medical Corps and the Medical Faculty at the University of Oslo and a research group called the 1957 Board of Doctors started an extensive research project which examined concentration camp survivors from a neurological, psychiatric, psychological, social and medical point of view. Detailed health registers had been developed for a homogeneous population as part of a National Health Service, established in 1931, thereby creating good opportunities for retrospective longitudinal research, with rigid methodology, long-term follow-up, high response rates in representative samples and adequate control groups (Eitinger, 1964; Strøm, 1968; Eitinger and Strøm, 1973).

A particular focus was put upon the surviving NN prisoners (Nacht und Nebel = Night and Fog) whose intended fate was to be death and total extermination and obliteration. The fates of 4,574, or 96%, of those who survived imprisonment were known in 1966. The mortality study was based on 719 (94%) of the 763 deaths during the 1945–1966 observation period. Compared with the mortality of the Norwegian population, which appeared to be the most suitable basis for comparison since the ex-prisoners came from all parts of Norway, that of the ex-prisoners was much higher.

The duration of imprisonment did not seem to have an effect on

Table 1. **Observed (D) and expected (En) numbers of deaths for "ordinary" prisoners, NN prisoners, and all prisoners in relation to age, 1945–1966**

Age	"Ordinary" prisoners			NN prisoners			All prisoners		
	D	En	D/En	D	En	D/En	D	En	D/En
<30	52	22.6	2.30	6	1.4	(4.29)*	58	24.1	2.41
30–39	55	53.6	1.03	13	4.2	(3.10)	68	58.0	1.17
40–49	112	102.7	1.09	12	7.4	1.62	124	110.4	1.12
50–59	170	147.3	1.15	12	8.4	1.43	182	156.0	1.17
60–69	179	154.2	1.16	8	7.9	1.01	187	162.4	1.15
>70	94	89.1	1.05	6	8.8	0.68	100	98.1	1.02
Total	662	569.5	1.16	57	38.0	1.50	719	608.9	1.18

the mortality rate during the observation period. As expected, the death rate was much higher among NN prisoners.

The most important causes of the excess mortality among ex-prisoners were: tuberculosis, other infectious diseases, other and unknown causes of death, coronary heart disease, lung cancer and violent death (accident and homicide). The three last causes were especially marked during the later periods. Many of the causes of death that showed a higher death rate than expected among ex-prisoners are those for which towns generally have a higher mortality than rural areas. The possibility that the higher mortality was partly caused by ex-prisoners having adopted a more urbanised way of living was considered.

The case-control morbidity study was carried out on a random sample of 498 people selected from the register and still alive at the end of 1966. Information about sick leave, the number of days of sick leave, the number of hospital admissions, the number of days spent in hospital and medical diagnoses was gathered from the local health insurance offices to which the ex-prisoners had belonged during the observation period. Matched control material was selected from the health insurance files by choosing the card nearest that of each selected ex-prisoner belonging to a person of the same age, sex and occupational group.

The ex-prisoners had constituted a positive sample in terms of their pre-Second World War health. After the war, the ex-prisoners led less stable working lives than the controls, with more frequent changes of job, occupation and domicile. Among as many as 25.4% there was a transition to less qualified and less well-paid work during the observation period, as compared to 4.3% for the controls. At the end of the observation period, 17% of the ex-prisoners were receiving invalidity pensions because of illness and failing work capacity. The ex-prisoners from the lower socio-economic classes seemed less able to compensate for their failing health than those from the higher occupational groups, and therefore more of them had to be pensioned.

The ex-prisoners had more sick leave, longer sick leave and more frequent and longer hospitalisation periods than the controls. Only 10% of the ex-prisoners had not been registered as sick during the observation period, as compared to 21% of the controls. Thirty per cent of the ex-prisoners had more than 365 registered sick days during the observation period, as against 8% of the controls. The higher morbidity among ex-prisoners was not connected with any particular diagnosis. The frequency and variety of illness appeared to involve almost all organ systems. As many as 51 of the ex-prisoners had more than ten different diagnoses during the observation period, as against only six controls.

In all 14 diagnostic groups there were more registered sick persons among the ex-prisoners than among the controls.

The difference was statistically highly significant (p values < 0.001 or < 0.01) for the diagnostic groups listed in Table 2.

For psychoses, the difference was statistically significant at the level of 5%, but for cardiovascular diseases and diseases of the skin and subcutis there was no clear statistically significant difference (Table 2).

Tuberculosis had the largest excess mortality and morbidity (45 ex-prisoners as compared with nine controls). The ex-prisoners'

Table 2. **Diagnostic groups**

Diagnostic groups	Ex-prisoners (N=498)		Controls (N=498)		
	No of patients	%	No of patients	%	P
1. Tuberculosis	45	9.0	9	1.8	<0.001
2. Neurosis, nervousness	121	24.2	47	9.4	<0.001
3. Alcohol and drug abuse	35	7.0	8	1.6	<0.001
4. Psychosis	15	3.0	5	1.0	<0.05
5. Cardiovascular diseases	58	11.6	40	8.0	<0.1
6. Peripheral varicose diseases	37	7.4	18	3.6	<0.01
7. Diseases of the upper respiratory tract	195	39.1	49	29.9	<0.01
8. Diseases of the bronchi, lungs etc	104	20.8	71	14.2	<0.01
9. Diseases of the stomach and duodenum	101	20.2	43	8.6	<0.001
10. Other diseases of the digestive organs	127	25.5	91	18.2	<0.01
11. Diseases of the skin and subcutis	64	12.8	52	10.4	<0.1
12. Diseases of the bones, joints and muscles	237	47.5	172	34.5	<0.001
13. Injuries and other external causes	219	43.9	174	34.9	<0.1
14. Other diagnoses	194	38.9	127	25.5	<0.001

sick periods and hospitalisation periods were about three times as long as the controls'.

Neurosis and nervousness were diagnosed in almost a quarter of the ex-prisoners, as compared with one tenth of the controls. The ex-prisoners' nervous diseases were more serious than those of the controls, with longer sick periods and more frequent hospitalisation.

Abuse of alcohol and drugs was registered in 35 ex-prisoners and eight controls. These figures must be regarded as representing a minimum, a hypothesis which was confirmed during the course of the investigation. The authors consider that the higher morbidity registered for all diagnostic groups among the ex-prisoners was not due to the greater number of alcohol abusers, since the difference between the ex-prisoners' and the controls' general morbidity is the same if the alcohol abusers are excluded from the calculations.

None of the findings suggest that the ex-prisoners constitute a group with a greater pre-war morbidity or a negative sample, or that this is the reason for the greater incidence of nervous diseases, alcohol and drug abuse, and (modest) crime to be found among them. The only explanation the authors could find for this high incidence was that it was connected with their imprisonment.

Psychoses were registered in 15 ex-prisoners and five controls. In two of the ex-prisoners the psychosis almost certainly had nothing to do with the concentration camp imprisonment, in four the connection was doubtful, and in three it was highly probable. The remaining six had a diagnosis of dementia, and it seems reasonable to assume the existence of an organic dementia resulting from organic brain damage during imprisonment.

Cardiovascular diseases were registered in 58 ex-prisoners and 40 controls. The difference is statistically significant only at the level of 10%, but the average number of sick leaves per person, sick days per person, and sick days per sick leave were greater for the ex-prisoners than for the controls.

The findings indicate that the ex-prisoners' resistance was lower than that of the controls: their diseases recurred more often and lasted longer. Figures for the subdiagnoses (coronary heart disease and vascular lesions of the central nervous system plus hypertension) showed the same tendency.

Both diseases of the upper respiratory tract and those of the bronchi, lungs etc, were significantly more frequent among ex-prisoners than among the controls, but there was little difference in the degree of seriousness of the diseases.

Diseases of the stomach and duodenum (especially peptic ulcers) were diagnosed in 20% of the ex-prisoners and 8.6% of the controls. The ex-prisoners' diseases were also more serious, with more and longer sick periods per person and more hospital admissions. Other diseases of the digestive organs showed fewer quantitative differences: 25.5% as compared with 18.2%. The tendency

towards a greater degree of seriousness was more pronounced, however, with, for example, twice as many sick days per sick leave among the ex-prisoners than among the controls.

Diseases of the bones, joints and muscles were registered in about half of the ex-prisoners, and in about one-third of the controls. This diagnostic group was responsible for 24.5% of the ex-prisoners' sick days and 16.7% of those of the controls. Lumbago-sciatica was the most common condition within this group.

Forty-four per cent of the ex-prisoners and 35% of the controls received injuries and other external traumas which necessitated sick leave during the observation period. The number of hospital admissions and the number of days spent in hospital was greater for the ex-prisoners than for the controls.

The "other diseases" group showed a greater morbidity among ex-prisoners than the controls, and a greater degree of seriousness.

It is the authors' opinion that the most natural explanation for the ex-prisoners' higher mortality and morbidity is that the excessive stress they experienced during imprisonment lowered their resistance to infection and lessened their ability to adjust to environmental changes. Even small additional stress situations could upset their labile equilibrium and result in a manifest illness. Such additional stress situations could arise at any time during a person's life, and this explains why there was no accumulation of diseases in any particular period, apart from the high incidence of tuberculosis and other infectious diseases shortly after liberation. This weakened resistance and ability to adjust did not seem to have altered during the observation period; the changes were so profound that recovery did not appear to be possible. This increased vulnerability to all kinds of stress made the ex-prisoners a group of people who ever since the war have been more frequently and more seriously ill and who have consequently had a lower working capacity, lower incomes, and fewer possibilities for self-realisation than a corresponding group of the population who had not experienced the same stressors.

War sailor studies

As mentioned above, out of 1,022 ships in the Norwegian Merchant Navy, 520 were lost, mainly to German torpedoes, but also to mines or aerial bombing. The ships were engaged in the worldwide transportation of war supplies, including ammunition and airplane fuel for the Allied forces. War sailor service was characterised by constant lethal danger, continuous uncertainty about when an attack might occur, and relative helplessness in the event of an attack since convoys were poorly protected. Thousands of merchant sailors took part in the Battle of the North Atlantic lasting from March 1941 to the end of 1943, making it the longest continuous battle in the Second World War. The objective of the German submarines was to sink merchant ships in order to block the transportation of US military personnel and material to the war theatres in North Africa and Europe. In the Pacific, Japanese submarines played a similar role. At the battle's worst, one Norwegian ship was torpedoed every other day. Approximately 4,000 Norwegian sailors out of a total of 40,000 lost their lives. The survival rate among Norwegian sailors was considerably higher than among British and US ones. Between 1942 and 1943, the mortality rate of a torpedo attack was 20%, 40% and 70% respectively. Their survival seems to have been based on their professional seamanship. Merchant sailors were not seen as active war participants by the Norwegian authorities in 1945 (they had not worn military uniforms and had "just continued doing their ordinary work as sailors") and thus were not eligible for either military or civilian war disability pensions, unless their ship had been attacked, which satisfied the criterion of a "war accident". One can imagine how it felt to be conscripted for military service after the war after five years of convoy service! During the 1960s, however, systematic research documented that a torpedo attack in itself was not a necessary stressor; the constant anticipation of a possible attack and the conditions of unpredictability and relative defencelessness on ships with highly explosive cargo were

sufficient (Askevold, 1976–77; Egede-Nissen, 1978). War sailor syndrome was in part a form of delayed PTSD and/or enduring personality change after catastrophic stress and strikingly similar to concentration camp syndrome.

The acceptance of findings on late psychic sequels represented a breakthrough in the compensation scheme also for war sailors who had constituted an "invisible" and "silent" sector of the population (most of them went back to their jobs at sea after the war and none of them wrote books about their wartime experiences, in contrast to many of the heroic resistance fighters and concentration camp survivors). Not defined as war participants, neither their stress-exposure nor their mental health problems were understood until late. The traumatising effect of a threat experience had not been recognised, in contrast to the easily understood psychological effect of the invasive experience of a concrete traumatic event likely to produce specific post-traumatic stress syndrome. As a result of the research, the definition of a war accident was modified to include prolonged high risk exposure. In retrospect, it was considered a national disgrace that war sailors had been treated so badly after the war. Social degradation and health failures led many to premature deaths; alcoholism frequently added to their nervous problems. The situation of Allied war sailors was probably unsatisfactory in many countries: in spite of the heavier losses than among the US Marines, US merchant sailors were not accepted as war veterans until 1989.

The positive psychological effects of the introduction into Norwegian diagnostic nomenclature of the terms concentration camp syndrome and war sailor syndrome in the 1960s can hardly be overestimated. In contrast to nearly all diagnoses in psychiatry, these were etiological diagnoses, pointing at what was considered the main cause of the disorder.

The lack of a unifying clinical and diagnostic concept until then had many negative consequences. It hindered both the public and

the professional understanding of the post-traumatic suffering. Focusing on the causal role of such a psychic trauma by introducing the mentioned diagnoses had similar effects as the 1980 introduction of a diagnosis of PTSD. The new diagnoses helped to see the true relationship between the trauma and the sequelae, a *sine qua non* for correct treatment. The previous practice of applying an ordinary psychiatric diagnosis to a trauma patient, termed after the response such as anxiety neurosis or depression and not the exposure, because of the apparent similarity, was unfortunate. Most importantly, the diagnoses helped war veterans and victims to a fuller understanding and acceptance of themselves. The suggestion that the forthcoming DSM-V definition of PTSD will do away with the stressor criterion altogether is not good news. If PTSD in the future is to be a syndrome diagnosis only, the risk is that the veteran population with war-related disorders will again merely be seen as yet another psychiatric patient group.

Presumed causal relationship: Excessive war stressors/all disabilities

With findings such as those reported above, the research led to a radical change in the understanding of the long-term effects of war stress: the findings had shown that an increased postwar mortality and increased general morbidity could be related to what was defined as an excessive war stress experience in individuals without any prewar vulnerability. Based upon this new insight, the Norwegian Parliament adopted the Amendment Act in 1967, stating that such an "exceptionally severe" war experience, clearly beyond the "average expected war experience" for anyone taking part in war activities, was a sufficient basis for awarding war disability compensation as long as his health problem caused more than a 50% reduction of his earning capacity. The new regulation meant that the onus of proof was reversed. Whereas earlier the applicant was required to present evidence of a causal relationship, the bur-

den of proof was shifted on to the authorities. The individual was entitled to compensation, unless the authorities could rule out such a cause-effect relationship. With the increased prevalence of practically every illness in the studied groups, it could hardly in a single case be argued that the illness had another causation. In fact, all ordinary illnesses (heart disease, backache, cancer, etc) which these individuals contracted during the postwar period until retirement age are recognised as "war-related" under this act. Only well-defined occupational diseases, traffic injuries and certain ailments which are obviously due to old age are actually rejected.

Initially, the international research community was very sceptical towards these findings, as medicine knew of no other examples of such a time relationship between exposure and effect, implying a latency period of long duration. Since then, these findings have repeatedly been replicated in international studies.

The evaluation of the war stressor in a single case is made by an advisory group consisting of military and resistance war veterans and legal experts. In the main, the concept of "exceptionally severe war experience" or excessive war stressors covered extreme and prolonged stress exposure. In cases of concentration camp incarceration and war sailor service, an approximate threshold of a duration of at least six months was estimated. When it came to time-limited extreme exposures, some army and navy combat experiences were accepted when the losses had been extreme. Severe torture would also be accepted. A great advantage with the Amendment Act was that the stress exposure was based on objective criteria that could usually be verified from independent sources.

Whereas the causality demand was thus lessened in the Amendment Act, the requirement of the disability to have caused work incapacity was raised: from 20% as a minimum in cases where an individual cause-effect had to be proven, to 50% loss of earning capacity. (In the first postwar years the disability had been judged from the degree of permanent medical injury, as it corresponded

reasonably well with the loss of income. Over the years this relationship was weakened, particularly for the non-manually employed who could often carry on some employment in spite of war injuries. Accordingly, an evaluation of loss of work capacity became the main principle, and from 1951 the lower threshold was 8.3%.) Because minor reductions in work capacity due to psychiatric problems cannot reliably be scaled like somatic injuries, psychiatric cases are never given less than 20% disability.

The definition of the stressor criterion made matters much simpler for the patients, the doctors and the authorities. In a way, this principle of presuming an etiological link for an entire exposed group anticipated the definition of the stressor criterion in the PTSD diagnosis of the DSM III of 1980. The principle was also applied by the UN Compensation Commission for the victims of Iraqi aggression before and during the Gulf War (UN, 1991). This was the first time that the UN could force an aggressor to pay compensation to victims.

Effects of the Amendment Act of 1967

The 1967 introduction of the Amendment Act dramatically reversed the trend in disability compensation: between 1965 and 1975 there was a threefold increase of military veterans and civilian resistance fighters/prisoners who received a war disability pension and a 14-fold increase (!) in the war sailor population. During the 15 years from 1967 to 1982, the National Health Insurance Administration received nearly 20,000 new applications. As recently as 1994, 250 new applications were received. It must be stated that this is a relatively high figure considering that the "time of the injury" is about 50 years ago. By 1995 a total of 58,696 applications had been processed. While the percentage of applications that were approved was as high as 90% in the 1950s, by 1994 approximately 50% of applications were approved.

It is a common experience that the laws in practice may have other effects than what the legislators assumed when the law was

formulated. Partly through its own dynamics and partly through administrative practice, the law may have unexpected effects. Often overlooked is the effect of war disability compensation upon a person's self-esteem, dignity and socio-economic status. What is the relationship between the primary economic purpose of war disability compensation and its additional psychological and social effects? There is not much specific research carried out that may shed light on this issue, but we will quote findings from one study (Strøm, 1978).

A sample of 936 applications for disability compensation by the Amendment Act was studied, half of which had been rejected, half approved. Every other applicant was randomly sampled for a personal examination. Every third applicant was found to have undergone more than one type of war stress exposure. For the majority, stress exposure had been long-lasting. During the war, 65% had had one or more somatic illness and 27% a psychiatric disorder. At the time of investigation in 1975, about half had suffered from considerable health failure for more than ten years.

A positive correlation was found between approval of a war disability pension and the severity and duration of the war exposure, and the degree of morbidity during the war and the duration of the health failure after the war and the reduction in social status.

Only 15% of those who had their applications rejected accepted the decision. The reasons for rejection in 63% of the cases were that the applicant was not 50% work disabled. At a follow-up, less than 30% of these managed relatively well in spite of their failing work capacity; they belonged to liberal professions and were in control of their situations, or had understanding employers/workmates. The remaining 70% had severe problems. The rejection had been interpreted to mean that they should work themselves to death. They had entered a vicious circle: for economic reasons and out of fear of losing their jobs they did not dare to give up their work before they got a disability pension, and they could not get a disability pension as long as they were employed. It was concluded

Table 3. **Changes in life situation in war veterans (N = 890) after being awarded or rejected for a war disability pension**

	Awarded (N=445)			Percentages	Rejected (N=445)	
	Improved	Worsened	Unchanged	Improved	Worsened	Unchanged
Situation in general	64	19	17	5	48	47
Family situation	13	12	75	3	13	84
Housing	31	3	66	18	6	76
Work capacity	5	16	79	0.5	40	59.5
Income	95	3	2	13	20	67
Social contact	13	38	49	0.5	42.5	54

that there had been a severe failure in information from the National Health Insurance Administration.

Many of the 30% who had had their applications rejected because their war experience did not reach the threshold of "excessive stress exposure" interpreted this as a degrading of their war effort; bitterness and feelings of humiliation were often the consequences.

The follow-up demonstrated a marked difference between those who had their applications approved and those who were rejected (Table 3). Improvements were far more frequent in the first group: life situation in general, family situation, housing standard, work capacity, financial situation, social contact.

Presumed causal relationship: War stressors/post-traumatic psychopathology

Three decades after the war, the causal relationship between service and psychological injury naturally became harder to assess. In particular, this applied to the so-called psychological late sequels which affected many veterans and ex-prisoners decades after the end of the war and who had not been exposed to a severity of war stress that could be characterised as excessive, in which case the Amendment Act would apply.

An appointed group of experts, termed the Eitinger Commission, wrote a proposal which aimed at simplifying and speeding up the application procedure.

Based upon the comprehensive traumatic stress research carried out internationally over the last two decades, the proposal set out defined stressor criteria for every kind of war stress experienced by Norwegian military personnel or civilians during the Second World War that had the potential to produce a disorder within the post-traumatic stress spectrum and with a risk of chronicity (Eitinger et al, 1988, 1995).

Dose-response relationship: Stressor-stress response

Most psychiatric disorders have multifactorial causation; so has PTSD. It is usually a question of a combination of risk factors classified, for example, as predisposing, pathogenic, pathoplastic, precipitating and perpetuating factors ("the five Ps"). In PTSD the stressful event must be severe enough to be the primary and overriding causal factor. We therefore favour a strict definition of the stressor: it should be a stressful event with the potential of producing acute PTSD in at least about 20% of an average population, while in a resilient group the risk may be considerably lower. We are sceptical about the subjective response to the threat, which is a prerequisite part of the critical event criterion in the DSM-IV. Although in most studies of shock traumas the immediate response is found to be characterised by a deep fear, helplessness or horror, we find that prolonged stress exposure that allows or even demands a mobilisation of psychological defences may lead to the use of coping techniques that totally suppress such responses. The emotional anaesthesia of the concentration camp inmate, is one example: in Major's study, only 40% of the survivors of a death camp reported that they had experienced fear (Major, 1996). It would be a paradox if a PTSD stressor definition which aims to exclude the more trivial life events also excludes the adaptive response to overwhelming threat.

Danger to life in military combat has been the classic stress exposure studied by generations of stress researchers. The severity

of combat exposure may be scaled by various objective measures, the intensity and duration often being used.

The intensity of combat is traditionally scaled by numbers of soldiers killed per day (KIA), and wounded (WIA) or missing in action (MIA). The ratio of combat stress reaction (CSR, "battle shock", likely to be a form of acute stress reaction as defined by the ICD-10) to KIA and WIA is expected to be 1:1:4 in an "average" battle fought with conventional weapons. The risk of developing PTSD has been shown to be associated with the rate of CSR (Solomon et al, 1987). In a number of recent studies of combat-related PTSD, a relationship has been found between the severity of exposure and the risk of PTSD (Foy et al, 1984; Laufer et al, 1985; Friedman et al, 1986; Solkoff et al, 1986; Solomon et al, 1987 a, b; Snow et al, 1988; Green et al, 1989; Kulka et al, 1990; O'Brien and Hughes, 1991).

Our research group has carried out a number of studies, and the main finding is the rather strong association between stressor severity and risk of PTSD: resistance fighters (Major, 1996), UN peacekeepers (Weisæth et al, 1993), victims of terrorism (Weisæth, 1989; Lie et al, 1994) and civilian disasters (Weisæth, 1989; Weisæth and Eitinger, 1992).

If exposure to a sufficient stressor could be reliably documented and the clinical condition was found to be within the post-traumatic stress spectrum, a causal relationship was automatically presumed. Only if alternative explanations were obviously more likely would the application not be granted. Thus, the principle of presumption based on group statistics applied in the Amendment Act was now also applied to traumatic stress response disorders.

A follow-up study 58 years after the Battle of Narvik in 1940 of veterans from one Norwegian battalion supported the hypothesis of the Eitinger Commission: the battalion had taken part in continuous operations for 48 days, and although losses were moderate the physical hardships were extreme. While about 30% of the combat veterans still alive suffered from post-traumatic stress, none in the

control group did; the latter was a twin battalion which had been kept in reserve in 1940 (Weisæth and Kristiansen, 1998). However, the postwar mortality of the combat battalion did not differ from the military controls, nor civilian controls matched for age, sex and local residency. Thus, in spite of severe combat stress in 1940 and family exposure to the scorched earth policy in 1944, the combat veterans had not developed postwar health problems that indicated that the war exposure had approached the "excessive stress" as defined by the Amendment Act. Few of the veterans suffering from post-traumatic stress had full-blown PTSD, and few had had a significant reduction in their work capacity. It was found that hardly any of the cases could have been caused by other than the war-related stress. Finally, the symptoms had in general been present since June 1940; hardly any case was identified which could be characterised as delayed. A number of veterans who had applied for disability compensation previously had been turned down for lack of evidence of a causal relationship. At this great age, close to 80 years, and after retirement, the disability pension is for medical invalidity and limited to 20%, the equivalent of 500 US dollars per month; but tax-free it is still a significant handshake.

Finland, the only other Nordic country severely affected by the Second World War, had 700,000 front-line soldiers out of a population of four million (90,000 were killed in action or died as POWs, 90,000 were physically disabled) and seems to have had a stricter procedure than Norway, not surprisingly considering the extreme postwar situation Finland went through. Long-lasting psychic disturbances, diagnosed as "reactio psychopathica" and "constitution psychopathica", were not eligible for compensation, and in the 1960s there were still very few cases; a psychosis was more readily compensated for. In the 1970s, "nervous sensitivity connected with (Russian) captivity" was to be compensated for, while "nervousness connected with battle experience" has never been a reason for compensation. The country could not afford it (Achte et al, 1998)! Up to

the year 1991, only 146 front-line soldiers had received any partial compensation for a mental health disorder connected with wartime military service.

During the 1990s, however, the Finnish Supreme Court set down some new principles, such as:

1) A logical and reliable description of the stressful incident is sufficient to prove the fulfilment of the etiological criterion;
2) Psychiatric care during the war is not necessary to prove that late PTSD is caused by the war;
3) Specific PTSD is characterised by the continuance, content and harmfulness of the symptoms;
4) Success in professional and social life after the war does not exclude war-induced PTSD;
5) A profound psychiatric examination by an expert on PTSD is needed for a decision for compensation; also the expert's estimation of the anamnesis;
6) Another possible psychic disturbance in connection with age does not exclude the possibility of PTSD.

In accordance with these principles, it seems that the compensation procedure is approaching the wishes of Finnish veterans and their medical carers.

As mentioned above, we would like to see that the stressor criterion for PTSD is retained at a high level of severity. In order to avoid inflation of the PTSD-diagnosis, it is also important to demand that the post-traumatic stress symptoms should cause a clinically significant impairment or disability.

Sometimes the diagnosis seems to be made on the basis of demonstrating post-traumatic stress reactions rather than symptoms. Painful memories are not enough to qualify as intrusive phenomena; the memory of the stressful event should be accompanied by an arousal response, with a disruptive effect on the person's functions.

Psychological injury/disability scale

Whereas a disability pension is based on the principle of compensating for loss of earning capacity, the compensation for an injury of a permanent character is based upon the medical invalidity. The latter, however, does not aim at compensating for tort. The introduction of compensation for injuries of a permanent character around 1970 was an innovation in Norwegian legislation. Until then, the need for compensation for non-economic loss related to personal injuries had not been recognised. Thus, the general compensation law is now a two-track system: rules for compensation for economic loss, and rules which, independently of the former, compensate for the non-economic loss suffered by the infliction of a permanent and severe injury of a medical nature. The latter comprises both psychic and somatic disorders and is included in all occupational injury compensation and in accident insurance. The basic philosophy is that money can to a certain extent compensate for the deprivation caused by a permanent injury. When physical or psychological self-realisation is limited or precluded, other positive experiences may be bought, which compensation based only on the economic loss would not have made possible. This compensation aims to help the person lead a meaningful life and reflects the present political goal of individual self-realisation, and not only to secure a certain living standard, but also to improve the individual's total life quality. With regard to psychological symptoms, traumatically induced insomnia is, for example, a condition which is likely to weaken one's initiative and happiness.

The psychological injury scale is divided into eight levels. Each group level gives a certain percentage of a nationally established basic annual amount regulated in accordance with the cost of living.

Until 1997 the degree of injury represented by trauma-related psychiatric disorders was typically established by clinical evaluation. The new injury scale from 1997 introduced specified criteria

for the degree of injury in post-traumatic stress disorder and in chronic or frequently recurring psychosis.

When evaluating post-traumatic stress disorder, the following is taken into consideration when assessing the extent to which the disorder leads to a reduction: daily activities, social function and interaction, concentration ability, memory function, general problem-solving capacity, endurance and speed, and the ability to cope with new situations and demands. The disorder must be verified by a psychiatrist.

1) Symptoms such as intrusion, avoidance, irritability and behaviour disturbance in daily life, but without significant loss of personal and social self-realisation: 0% to 14%. This means that symptoms only and no impairment after occupational injury will not qualify for compensation, since the threshold is 15%. War injuries, however, are compensated down to 8.3%.
2) As above, but more pronounced and accompanied by impaired functions, so that daily life is significantly inhibited: 15% to 34%.
3) More severe complaints, including permanent regression, psychogenic pain or vegetative symptoms: 35% to 54%.

Chronic or frequently recurring psychoses are graded in the following manner:

1) Lesser disturbance of cognitive, emotional, orienting or judgmental ability with small effects on daily activities. This group is also used for patients who over time have been well compensated on medication: 0% to 14%.
2) Obvious disturbances of cognitive, emotional, orientation or judgement capacity without severe behavioural disturbance. This group is also used for patients who need steady medication: 15% to 34%.
3) Severe disturbances of cognitive, emotional, orientation or

judgement capacity with such severe behavioural disturbance that it implies disadvantage for the patient as well as his surroundings: 35% to 54%.

4) Severe disturbances of cognitive, emotional, orientation or judgement capacity with behavioural problems that necessitate long stays in hospital: 55% to 84%.
5) Severe disturbances of cognitive, emotional, orientation or judgement capacity with such severe behavioural disturbances that it necessitates permanent hospitalisation with protective measures: 85% to 100%.

In preparing the law, it was stated that the development over time had been to focus more on subjectively experienced symptoms and functional impairments in health problems, and also health awareness. Compared to the time when the first injury tables were introduced, the new injury table puts more emphasis on the effect that traumas and illnesses have on mental health and social function. It was stated that these conditions have made it more complicated to establish the degree of permanent medical injury. To a certain extent, psychiatric judgement and the patient's subjective experience and concern about the injury's consequences and their importance to his self-image and social function will today play a greater role than previously, even if the objective practice should serve as a starting point. In fact, such functional injury consequences as mentioned above are seen as more encompassing and disruptive, and often more difficult to live with than well-defined organ injuries that the individual can be trained to cope with and that do not stigmatise personally and socially. With their emphasis on physical defects, the previous injury scales had been based more on the importance of physical fitness to manual workers. All in all, the greater demands on cognitive functions that accompany modern life were to be taken more into consideration.

References

Achte, K., Jarho, L., Ponteva, M. (1998). *The compensation of enduring PTSD after war in Finland – principles and practice.* Paper presented at World Veterans Federation 1st International Conference on Psycho-Social Consequences of War, Dubrovnik, April 26-30.

Al-Hammadi, A., Staerh, A., Staerh, M., Aref, M., Al-Turkait, F., Al-Asfour, A. (1994). *The Traumatic Events and Mental Health Consequences Resulting from the Iraqi Invasion and Occupation of Kuwait.* Kuwait: Al-Riggae Specialised Centre.

Askevold, F. (1976–77). War sailor syndrome. *Psychother Psychosom*, 27:133-138.

Bonhoeffer, K. (1907). *Klinische Beitraege zur Lehre von den Degenerationspsychosen.* Halle: Marhold.

Bonhoeffer, K. (1926). Beurteilung, Begutachtung und Rechtsprechung bei den sogenannten Unfallsneurosen. *Deutsche Med. Wochenschrift*, 52:179-182.

Danieli, Y., Rodley, N.S., Weisæth, L. (1996). Introduction. In: Danieli, Y., Rodley, N.S., Weisęth, L. (eds). *International Responses to Traumatic Stress* (pp 1-14). New York: Baywood.

Egede-Nissen, A. (1978). *Krigsseilersyndromet (War sailor syndrome).* Tidsskrift for Den norske lægeforening, 98:469 (English summary).

Eitinger, L. (1964). *Concentration Camp Survivors in Norway and Israel.* Oslo: Universitetsforlaget.

Eitinger, L., Strøm, A. (1973). *Mortality and morbidity after excessive stress: A follow-up investigation of Norwegian concentration camp survivors.* Oslo: The University Press. New York: Humanities Press.

Eitinger, L. (1990). World War II in Norwegian psychiatric literature. In: Lundeberg, S.E., Otto, U., Rybeck, B. (eds). *Wartime Medical Services* (pp 413-425). Stockholm: FOA.

Eitinger, L., Vold, O., Weisæth, L. (1988). *Eitingerutvalgets rapport.* Oslo: Sosialdepartementet.

Eitinger, L., Vold, O., Weisæth, L. (1995). *Krigsskader og senvirkninger – krigspensjoneringen gjennom 50 år.* Oslo: Rikstrygdeverket.

Foy, D.W., Rueger, D.B., Sipprelle, R.C., Carroll, E.M. (1984). Etiology of posttraumatic stress disorder in Vietnam veterans: analysis of premilitary, military and combat exposure influences. *Journal of Consulting and Clinical Psychology*, 52:79-87.

Friedman, M., Schneiderman, C., West, A. (1986). Measurement of combat exposure, posttraumatic stress disorder, and life stress among Vietnam combat veterans. *American Journal of Psychiatry*, 143:537-539.

Green, B.L., Lindy, J., Grace, M. et al (1989). Multiple diagnosis in posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 177:329-335.

Jaspers, K. (1913). *Allgemeine Psychopathologie.* Berlin: Springer-Verlag.

Kaplan, H.I., Freedman, A.M., Sadock, B.J. (eds) (1980). *Comprehensive textbook of psychiatry* (2 vols). Baltimore: Williams & Wilkins.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K. & Marmar, C.R. (1990). *Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans' Readjustment Study.* New York: Brunner/Mazel.

Laufer, R., Brett, E., Gallops, M. (1985). Dimensions of posttraumatic stress disorder among Vietnam veterans. *Journal of Nervous and Mental Disease*, 173:538-545.

Lie, T., Mehlum, L., Weisæth, L. (1994). *Gulfundersøkelsen. Helsemessige følger for besetningen på norske skip etter seiling i den persiske gulf i perioden 1984–1988.* Oslo: Norwegian Maritime Directorate.

Major, E.F. (1996). *War stress in a transgenerational perspective. Norwegian concentration camp survivors and two other resistance groups and their children.* Division of Disaster Psychiatry, University of Oslo.

O'Brien, L.S., Hughes, S.J. (1991). Symptoms of post-traumatic stress disorder in Falklands veterans five years after the conflict. *British Journal of Psychiatry*, 159:135-141.

Ødegård, Ų. (1954). The incidence of mental disease in Norway during the World War II. *Acta Psychiat. Neurol.*, 29:333-353.

Op den Velde (1988). Specific psychiatric disorders. In: Hers, J.F.P., Terpstra, J. (eds). *Stress, Medical and Legal Analysis of Late Effects of World War II Suffering in the Netherlands.* Alphen aan den Rijn: Samson Sijthoff.

Ørner, R.J. (1992). Post-traumatic stress disorders and European war veterans. *British Journal of Clinical Psychology*, 31:387-403.

Snow, B., Stellman, J., Stellman, S. et al (1988). Post-traumatic stress disorder among American Legionnaires in relation to combat experience in Vietnam. *Environmental Research*, 47:175-195.

Solkoff, N., Gray, P., Keill, S. (1986). Which Vietnam veterans develop posttraumatic stress disorders? *Journal of Clinical Psychology*, 42:687-698.

Solomon, Z., Garb, R., Bleich, A., Grupper, D. (1987 a). Reactivation of combat-related posttraumatic stress disorder. *American Journal of Psychiatry*, 144:51-55.

Solomon, Z., Weisenberg, M., Schwarzwald, J., Mikulincer, M. (1987 b). Posttraumatic stress disorder amongst front line soldiers with combat stress reactions: the 1982 Israeli experience. *American Journal of Psychiatry*, 144:448-454.

Strøm, A. (ed) (1968). *Norwegian concentration camp survivors.* Oslo: University Press.

Strøm, A. (ed) (1978). *Krigspensjoneringen. Hvordan har tilleggsloven av 22. mars 1968 virket? En analyse av en trygdelov.* Oslo: Universitetsforlaget.

Weisæth, L. (1997). War related psychopathology in Kuwait: An assessment of war-related mental health problems. In: Fullerton, C.S., Ursano, R.J. (eds). *Post-Traumatic Stress Disorder. Acute and Long-Term Response to Trauma and Disaster* (pp 91-121). Washington, DC: American Psychiatric Press.

Weisæth, L., Eitinger, L. (1993). Posttraumatic stress phenomena. Common themes across wars, disasters, and traumatic events. In: Wilson, J.P., Raphael, B. (eds). *International Handbook of Traumatic Stress Syndromes* (pp 69-77). New York: Plenum Press.

Weisæth, L., Kristiansen, H. (1998). *Combat War Veterans 58 years after.* Paper presented at World Veterans Federation 1st International Conference on Psycho-Social Consequences of War. Dubrovnik, April 26-30, 1998.

World Veterans Federation (1997). Guidelines to basic rights for war veterans and victims of war. Paris: World Veterans Federation Doc/2090.

www.atmintieskny gos.lt