Post-traumatic stress disorder: The hidden epidemic and its effect on society

Donald Phelan Stewart

University of Nevada, Las Vegas

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POST TRAUMATIC STRESS DISORDER: THE HIDDEN EPIDEMIC
AND ITS EFFECT ON SOCIETY

by

Donald P. Stewart II
Bachelor of Arts
Florida State University
1969

A thesis submitted in partial fulfillment
of the requirements for the

Master of Arts Degree
Department of Sociology
College of Liberal Arts

Graduate College
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The Thesis prepared by

Donald P. Stewart II

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Post Traumatic Stress Disorder: The Hidden Epidemic and Its Effect on Society

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Dean of the Graduate College

Examination Committee Member

Examination Committee Member

Graduate College Faculty Representative
ABSTRACT

Post Traumatic Stress Disorder: The Hidden Epidemic and its Effect on Society

by

Donald P. Stewart II

Dr. Simon P. Gottschalk, Examination Committee Chair
Associate Professor of Sociology
University of Nevada, Las Vegas

Post Traumatic Stress Disorder, a debilitating and sometimes disabling mental disorder, is emerging as one that is costly to society from many perspectives. PTSD sufferers commonly experience an inability to function normally within the workplace or within their social and family relationships. The disorder triggers strong emotional responses, changes social interaction and precipitates primary and secondary deviant behavior. This work focuses on non war related civilian incidence of the disorder. It examines the causes, circumstances and processes leading to the onset of the disorder and explores societal reaction to PTSD sufferers. Central to the work are the individual case studies of PTSD sufferers which examine the individual circumstances leading to the onset of the disorder, the personal effects of the condition on the sufferers and those around them and their difficulty experienced in obtaining adequate treatment for their condition and in functioning normally within society.
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CHAPTER 1

INTRODUCTION

Research reveals that from 1968 to 1997 the professional journals of the medical and social sciences published approximately 1,200 articles of varying length on the subject of Post Traumatic Stress Disorder that are readily available for me to review. Most of these articles briefly describe the disorder from a psychiatric standpoint, as outlined in the Quick Reference to the Diagnostic and Statistical Manual IV, referenced herein. Most then pursue description of a case or cases relating to a specific event leading to the onset of the disorder. In list form below is a distribution of the type of potential Post Traumatic Stress Disorder (or PTSD as it will hereinafter be called) inducing incidents covered in the articles. They are, for simplicity, grouped to include 1) military or war related events, and 2) events involving the general public:

1) Military/War Events

Combat involving Military personnel
Combat involving Civilians as active participants or bystanders
Refugee movements with civilians fleeing actual combat, the threat of combat, or genocidal circumstances
Civil War, involving citizen combatants; citizens of Lebanon in particular
Peacekeeping Operations involving military forces
Refugees fleeing political and physical persecution

2. Public/Civil Events

Law enforcement activities involving Police officers experiencing violence in the line of duty
Auto accidents
Medical Treatment, particularly Anesthesia/Surgical patients
Within the literature there are articles of varying types dealing with the incidence of PTSD as a result of all the above.

There are other incidents described within the literature as being potential triggers for PTSD for which I have not located or reviewed any specific study or publication, including:

- Lifeguards involved in drowning and near drowning incidents
- Paramedics involved in critical victim care
- Athletes involved in repeated, stressful competitive activities
- Firemen involved in fires resulting in loss of life
- General public witnessing or being closely exposed to violent accidental death circumstances, such as automobile accidents
- General public subjected to mugging or armed assault or robbery
- General public associated with successful or attempted suicide

Focusing on the general population in the United States, statistics indicate that on an annual basis there is greater potential for exposure to some of the “unexplored” areas that are listed above. Despite that potential a review of the literature indicates that people who have experienced such exposure are receiving little or no acknowledgement of the potential for the problem to manifest itself, or assistance or support if the condition is actually present.
It is essential to clarify, in advance, that essential to my thesis is the notion that PTSD, by its very nature, precipitates deviant behavior. Much of the precipitated deviant behavior remains, as it began, at the primary level. There is, however, room for speculation and perhaps even interpretation of just when, how and with what frequency deviance precipitated through the manifestation of the disorder reaches the secondary level.

By definition, primary deviants "engage in deviant acts but continue to occupy a conventional status and role." Primary deviance remains such until such time as it emerges in a form that is subject to labeling, and subsequently, to stigmatization. More simply stated, much deviance, not readily recognizable as being deviant to those around the sufferer, goes undetected by the general population, or at least without public remark thereon. Without being detected, or marked, the deviance remains unlabelled. Or, does it?

In some instances, is the deviance, by its very nature, manifested in ways that are recognized and actually labeled, but not overtly labeled as being deviant? Does the escalation of deviance to the secondary level require specific labeling as such, as we typically assume, or is self definition and self recognition of the deviants' nonnormative behavior sufficient cause for reclassification? Is labeling essential or merely a tool for classification that is part of the empirical study process? (Clinard 1974:180-181)

Regardless, there seems to me to be little question that the issue of deviance must direct, in no small part, any sociological study of PTSD. As clearer clinical definition of PTSD itself, and its personal manifestations on its sufferers, is presented, that should also become clear to the reader. The notion that "the deviant individuals must react
symbolically to their own behavior aberrations and fix them in their sociopsychological patterns" seems clear enough. The larger issue is at what point does the person begin to employ his deviant behavior or a role based upon it as a means of defense, attack, or adjustment to the overt and covert problems created by the societal reaction to him? (Lemert, Edwin in Kelly 1951:194-195). And, frankly, at what point is there any real societal reaction to the PTSD sufferer? When suffering from PTSD when do such defensive or aggressive postures on the part of the sufferer become obvious? Typically, only when labeled by society, will the sufferer, now exposed and virtually naked, experience societal reactions. It is at that point, at that very moment of labeling that the private issue becomes a public concern and that the sociological imagination must begin to work. (Mills 1959:169-170)

But the real effect on society transcends the labeling process. While the resulting stigmatization that may follow the labeling process obviously affects the sufferer the self-perception of the deviant person may direct the person's behavior as much as does any public labeling or perception.

PTSD hides -- commonly from the actual sufferer, most probably from those in intimate contact with the sufferer, and, almost certainly, until secondary deviant behavior is revealed, from the general public. The fact that it does hide and that has been identified as a "hidden epidemic" (Zohar, et al 1998) makes it a problem that much more worthy of extensive sociological exploration and study. Sociological problems are difficult enough to deal with when, to the professional community, they are apparent, or transparent. When the problems themselves actually defy detection and discovery effective study to render working solutions becomes a challenge worthy of address.
A clear understanding of the nature of the disorder being essential to coherent presentation of much of this work, the clinical aspects of the disorder will be discussed at some length herein. In addition, I will examine some less unexplored, and possibly previously undocumented and unpublished, PTSD inducing incidents, seeking to determine:

1) How common is PTSD, or at least the experiencing of some of its key symptoms, among people experiencing traumatic incidents?

2) In the face of its elusive natures, is PTSD a condition that is recognized by the general public as a disorder that warrants attention and/or treatment at some level?

3) What treatment for PTSD is readily available, and if so, on what basis?

4) What methods are used to communicate to an actual or potential PTSD sufferer the methods and availability of treatment?

Finally, through narrative analysis of specific data gathered from patients, and presentation of histories of those patients, I will present coherent images of the impact of the disorder on its victims, on those closest to them, and on the society in which they live. Central to the overall thesis, these life histories provide direct connection between the private problems and public concerns Mills describes as being fundamental to sociological study.
CHAPTER 2

REVIEW OF RELATED LITERATURE AND THEORY

While not incorporated into the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders until the publication of its 3rd edition in 1980, Post Traumatic Stress Disorder has been present in society for a long time. The identification of PTSD by numerous scholars as an underlying character driving force in William Shakespeare's play Henry IV, (Trimble 1985) clearly links the disorder to the traumas experienced in war. In fact both Homer and Shakespeare, in character descriptions, describe the disorder's symptoms in almost clinical detail (The Harvard Mental Health Letter June 1996:1). And, while it was the Vietnam War that brought PTSD as a national illness to the attention of the American public, the disorder is certainly not limited to combat veterans, either ancient or modern.

Television, motion pictures, newspaper and news periodical photos and feature stories about displaced and disoriented Vietnam Veterans were, for at least a time, popular press. While reporting news is important, selling publications and gaining a larger market share drives the financial machines that provide the public with its information. There is, after all, a pathos present in disheveled military veterans searching among the public for some sense of resolution, acceptance or at least recognition of their plague of disorientation and dysfunctional lives and it is this public presentation of that pathos that draws viewers and readers.
There has also been lengthy study and analysis of the disorder among diverse populations around the world. Among those groups studied are survivors of the Holocaust, victims of natural disasters of various kinds, those who have experienced torture, civilians involved in civil war, and victims of sexual attack and abuse.

But, even today popular publications lead many Americans to associate PTSD almost exclusively with Vietnam War veterans. In fact before the American Psychiatric Association added the disorder to its diagnostic nomenclature it was often called "post-Vietnam Syndrome" (Learner 1997). There is, unfortunately, little recognition of the occurrence of the disorder among the general, non-military population. This closed view was pervasive enough to have caused the author some small discomfort during the presentation of a paper at a professional meeting.

During the customary question and answer period following presentation of a paper about PTSD at the annual meeting of the Pacific Sociological Association in Portland, Oregon in the spring of 1999, a member of the audience rose and indicated that: a) he was a Vietnam Veteran and due to combat experience he had, in fact, been suffering from PTSD for many years; and b) while he found my presentation interesting, and somewhat moving, he failed to see what it had to do with PTSD. In conclusion he chastised me by informing the rest of those in attendance that it was common knowledge that PTSD was to be found only among military veterans who had experienced repeated, continuing trauma in the course of combat. There were, he said, no non-combat related sufferers such as those I had described. It would appear that incidence of the disorder among the general public is, indeed, well hidden. And, significantly, within the aggressive, protective behavior exhibited by the well intentioned (?) veteran, is there
evidence of deviance? Is the assumption of a protective stance of claiming PTSD, and its painful manifestations, as the privileged territory of military veterans, a peculiarity, or a deviance, to be recognized and labeled as such?

A survey of publications on the disorder, particularly during the past 15 years, reveals an emerging position that this very real, painful, and debilitating disorder may in fact underlie numerous mental health complaints and disabilities Americans, and people in other societies, experience on a continuing basis. It is also easy, however, to conclude that much of the study leading to these publications may have been funded by government agencies directed specifically toward assisting military personnel and veterans in adjusting to the traumatic experiences of the various aspects of war and its aftermath. If incidence of reporting and publication is a valid indicator, the disorder as it occurs among the general public has been seriously understudied.

Nevertheless, whether military or civilian, all cases of Post Traumatic Stress Disorder present the same major symptoms as defined by the Diagnostic and Statistical Manual IV (Diagnostic Criteria from DSM IV 1994:209):

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experiences, 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 self or others

(2) the person’s response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

(2) recurrent distressing dreams of the event.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma.

(3) inability to recall an important aspect of the trauma.

(4) markedly diminished interest or participation in significant activities.

(5) feeling of detachment or estrangement from others.

(6) restricted range of affect (e.g., does not expect to have a career, marriage, children, or a normal life span).
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

As stated previously, a limited review of approximately 1,200 articles published on Post Traumatic Stress Disorder during the past 15 years reveals a preponderance of studies of its incidence in both active and retired military personnel. So lopsided is the reference material toward military personnel, and so common are the citations of professionals who have studied within military operated facilities, it becomes clear, as stated, that the funding for the bulk of these studies has originated from government
sources which are either directly involved with military funding, or at a minimum involved in providing mental health services to active or former military personnel.

In fact, of the 1,200 articles surveyed, approximately 90% were directed toward military personnel in one capacity or another. The articles were devoted predominantly to studies of veterans of combat, though with the changing world geo-political situation there is an emerging study of veterans of peacekeeping forces in various parts of the world.

Distribution of the remaining 10% of the articles was among subjects who were victims of or experienced one of the following traumatic incident circumstances, each of these categories discussed by more than one article:

(1) stalking
(2) sexual attack, abuse or harassment
(3) incest
(4) auto accidents
(5) AIDS
(6) urban youth violence, typically gang related
(7) child abuse, sexual or physical
(8) organ transplant recipients
(9) burn victims
(10) alcohol and other drug addicts
(11) jail and prison inmates
(12) medical patients experiencing general anesthesia
(13) war refugees
(14) political refugees

(15) police officers

In addition, there was one article on each of the following:

(1) civil war in Lebanon

(2) bombing of the Federal building in Oklahoma City

(3) targets of attempted assassination

The increase in and importance of study of Post Traumatic Stress Disorder on a global basis is evidenced, to at least some extent, by the emergence of a worldwide Internet database providing an electronic index to the worldwide literature devoted to exposure to traumatic events. That database, known as PILOTS, includes in most instances either a very complete abstract of documents involving PTSD or, in many cases, the entire text of the document. Unfortunately language is a problem in fully utilizing the database as the full text of the majority of documents, while available, has not been translated into English. Maintained by Dartmouth College, PILOTS maintains in excess of 12,000 documents of varying types and lengths dealing with the Disorder, and in addition maintains a User's Guide (last updated in 1994) that can be downloaded for printing and future reference and use.

Perceived at one time to be rare even among combat veterans (The Harvard Medical School Mental Health Letter 1988:1), growing public awareness and concern about incidence in the past 15 years, has encouraged an upsurge in study and responsible reporting. As previously stated, most of the study and reporting has revolved around military personnel, but there is a growing body of documents representing study of non-military incidence. Even so, the body of study is small and it is difficult to assess just
how common PTSD is among the general public. The fact that the disorder has only so recently been given official status by the DSM accounts for some of the reporting and documentation problems. But, another important and contributing factor, given the disorder's symptoms, is that people suffering from PTSD commonly do not want to think or talk about it. Avoidance is a key characteristic of the disorder, and those who seek treatment may thus be exceptional. There are surveys of the general population that do, however, provide some clues as to public incidence.

The National Institute of Mental Health's Epidemiologic Catchment Area survey found that more than 60% of men and 50% of women in the United States had undergone a potentially traumatic experience, most commonly seeing someone badly injured or killed or surviving a natural disaster or life-threatening accident themselves. It was estimated that 1% to 3% were suffering from PTSD at the time of the interview.

In addition, the National Co-morbidity Survey found that the lifetime rate of incidence of PTSD among the general population was 8%, with intrusive memories and hyper alertness being far more common symptoms than numbing and avoidance. In the National Co-morbidity Survey it was determined than on a lifetime basis 20% of women and 8% of men at some point developed (or admitted developing) PTSD after a traumatic experience, it being especially common after incidents involving rape and child abuse. But, among the general American population the most common single cause of PTSD may be a serious automobile accident — an event experienced by as many as 25% of all people at some time in their lives (Kessler et al 1996). Given the statistics on automobile accidents, the potential numbers for incidence of PTSD are staggering. If 25% of the population experiences a serious automobile accident at some time in their lives, in

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excess of 70 million people within the United States alone are exposed to trauma that may lead to PTSD.

The statistics developed through these studies indicate that most people who undergo a traumatic experience do not develop serious psychiatric symptoms, and even when symptoms are present they do not necessarily lead to PTSD. But among those who do develop PTSD, PTSD is rarely the person’s only psychiatric diagnosis. In fact, nearly half of people with PTSD also suffer from major depression, and more than one third of people diagnosed with PTSD suffer from phobias and alcoholism (Kulak et al 1990).

For the public, there are pitfalls in either a dearth or an abundance of research on any subject. Before PTSD became an accepted diagnosis, it was not uncommon for people exposed to severe traumatic stress to be belittled for their reactions, common feeling being that they were responsible for their own troubles and dysfunctions. Conversely, some critics now complain that PTSD is in danger of becoming a merely fashionable diagnosis, one that can be misused to obtain disability benefits, win personal injury law suits, or evade responsibility for crimes.

The controversy is likely to continue as long as there are subjective questions about what kinds of events are traumatic and how individuals’ responses to those events differ. Clearly, to resolve these issues, researchers need to know more about the lives of the victims before the traumatic events occurred. There is also a need for more longitudinal studies beginning immediately after the event and continuing for a prolonged time span, rather than studies that commence years after the event has occurred (The Harvard Mental Health Letter July 1996:4).
In fact, it is not so much the growing body of research in some areas that draws attention, but the conspicuous absence of research in other areas that causes concern and raises disturbing questions. Most study focuses on traumatic events that are already tracked statistically for specific groups (i.e. military personnel), or for specific events that require maintenance of statistics for commercial purposes (i.e. automobile accidents are carefully tracked by commercial insurance companies). As stated previously, statistics indicate that at some point in their lifetime in excess of 70 million Americans will experience a serious automobile accident. One recent study indicates that of those involved in a serious automobile accident, 14% suffer from moderate to severe post traumatic stress disorder as long as 15 weeks after the accident (DiGallo 1997:359). While statistical analysis was not pursued for purposes of this paper, other incidents for traumatic experience, not readily tracked or statistically quantified, must surely include:

1. parental loss of a child through death by accident or disease
2. exposure to workplace trauma, including fatal or permanently disfiguring injuries
3. accidents within the home leading to fatal or severely traumatic injury
4. public place occurrences, such as persons caught up in robbery (of business or individuals), street muggings and random acts of violence
5. public occurrences such as riots, civil insurrection or other disruptive crowd behavior
6. severely traumatic economic incidents, such as financial bankruptcy

While the implications of a large military population suffering from PTSD are significant, the implications of a huge portion of the general population suffering, at some level, from PTSD, are enormous. Given the number of people estimated to experience a
serious automobile accident during their lifetime, and the percentage of those that may develop PTSD (DiGallo 1997), automobile accidents alone may generate as many as 10 million PTSD cases during our lifetime. Of additional concern is the growing body of evidence that children and adolescents may be particularly vulnerable to the development of PTSD, but due to their age and abilities, are less able to comprehend the condition or seek assistance in its treatment. One study in particular found 29% of high school juniors indicated clinical levels of PTSD symptomatology. That study carefully compared incidence with regard to gender, ethnicity, family constellation, self-reported exposure to violence, self-reported exposure to trauma, and incidence of exposure to violent crime. The gender effect and response to violence, in particular, was revealing, indicating girls may respond to violence with more symptoms of PTSD than boys (Berton 1996:494).

Given the emerging evidence of the high incidence and debilitating effects of PTSD and attendant other mental disorders within the general population, military incidence notwithstanding, the potential for negative impact on both the mental health and functional status of a huge portion of the general population is enormous. And given that impact, the effect of PTSD on mental health in society in general warrants careful longitudinal study.

Various schools of thought regarding the emergence and manifestation of mental disorders should pay particular attention to the manifestation of PTSD within families. For example, those ascribing to the Palo Alto School, espousing the theory that most mental illness is a result of disturbed communication patterns within the family, should be initiating their own research on PTSD, carefully analyzing its diagnostic symptoms. When experienced at a level indicative of the presence of the disorder, particularly at a
chronic level, those symptoms would so deeply manifest themselves in the lives of sufferers that it would seem virtually impossible for disturbed communications patterns not to occur. A parent suffering even the more common symptoms, including sleeplessness and aggressive response mechanisms, seems likely to have difficulty performing in many parental roles. One subject to severe reactions including acting or feeling as if the traumatic event were recurring (including the reliving the experience, illusions, hallucinations, and dissociative flashback episodes) would, at times, be crippled in performing normal roles as a spouse or parent. And the symptoms of withdrawal, and avoidance of close contact, are especially problematic in relationships where clear communication is important. Given a high rate of occurrence of PTSD, and an apparent link between PTSD and mental disorders of other types, what other problems and impacts are there within the family and within society as a whole?

Does PTSD, or perhaps the better question is, when does PTSD affect an individual to the extent that other disorders emerge? Does PTSD precipitate “transgenerational traumatization” with the sufferer passing along signals and messages to progeny that may, in themselves, precipitate a second generation of sufferers? (Gallagher 1995:23). And, given the enormity of the previously recounted statistics of occurrence of traumatically stressful events among the general public, is it even sound to think that PTSD would not contribute to mental disorders ultimately diagnosed based on their own, freestanding symptoms? Given the similarities between PTSD symptoms and those characterizing other Anxiety disorders, is it unreasonable to assume there may, among sufferers within the general population, be a correlation and link to an earlier traumatic event?
If such a link does exist, treatment of PTSD may, in fact, reduce the emergence of other disorders at a later date, an ounce of prevention being worth a pound of cure. Longitudinal studies indicate varying rates of success from relatively simple therapies. But, treatment must be received if it is to have effect. Of interest, though not surprise, to me was the fact that among the case studies presented the sufferers indicated no treatment of any kind was recommended by any third party. But, it was later revealed in one of the cases that treatment had, in fact, been recommended to the sufferer by a third party. The diagnostic symptom of avoidance was, in fact, documented as being very real. The inability or unwillingness of a sufferer to acknowledge and confront the condition makes treatment very difficult.

In all cases, where treatment was ultimately provided, it was the sufferer who initiated the process. And within all case studies various reasons for lack of treatment, whether initially or presently, recur. While only case studies involving males are included in this work, similar responses to questions regarding treatment, or the failure to obtain treatment, were received from females in other cases. In the course of the interviews or conversations held in the process of developing the life studies included herein, as well as those others not included, common themes for not having obtained treatment, paraphrased here for simplicity, emerged:

I thought I could handle and deal with this on my own; it is a very private matter;

It (the event) still seems horrible, and unfair, but I didn’t want to drag other people into my problems;

If you’re used to taking care of yourself, you just do it;

No one suggested seeking help, and I didn’t really think about it until now;
Who would I see and where?

I talk with my husband/wife/significant other about it. We keep it between us and that's enough I guess; Together we're strong enough to bear the load without involving other people (this response from both male and female subjects).

Through each of the above stated reasons for not having obtained treatment there runs a common thread. Read them again and you will find within them the following common concern: Even a semi-public acknowledgment of the need for help carries with it an unexpressed fear of the potential of labeling and possible stigmatization. As a sociologist I have to work hard not to recognize an obvious fear of stigmatization.

Thomas Scheff (1964) and Erving Goffman (1961) both deal at length with this specific issue and the numerous other issues surrounding the social situation of mental patients. Scheff focuses on the issues of overt, public labeling and the response of the patient to the knowledge of having been labeled. While Goffman's work focuses on those housed within "total institutions" the parallels that he draws, and that others may easily draw themselves with or without reference to his specific findings, to those that are not institutionalized are clearly defined and easy to understand. "... any group of persons -- prisoners, primitives, pilots, or patients -- develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it." So it is with those suffering from PTSD.

At this point, though I need to direct your attention to the unspoken connections between the two perspectives and their relationship to sufferers of PTSD. Scheff concentrates on public identification of the deviant's behavior and the subsequent
labeling and stigmatization, making his case that the subsequent labeling and stigmatization drive the deviant even further into deviance. Goffman concentrates on the inpatient society in which the developing of an internal social order provides an environment in which behavior may come to be viewed as meaningful, reasonable, and normal once you get close to it.

The social circumstance of the PTSD sufferer lies between the scenarios of Scheff and Goffman. The PTSD sufferer, suffering a condition with universal symptoms of avoidance remains both conscious and cognizant of the world around him. The sufferer typically functions within a social framework that remains unchanged to those about him and in fact probably fills a role similar to one filled by any John Doe. He marries, has a family, works at his a job, and goes about his business in a manner he presumes to be unremarkable. Most commonly it is only his private world that is in chaos or turmoil. And, as part of the avoidance process, the sufferer fervently wishes the turmoil would not spread or become know to those around him.

But, despite efforts at avoidance the condition persists. And as it persists and despite his efforts to the contrary, behavioral changes occur. I could, as could Goffman or Scheff, have devoted endless time and energies to the gathering of additional statistical evidence on the tissue and fabric of the lives of those suffering from PTSD. But I chose, as did Goffman, the course of gathering ethnographic detail regarding selected aspects of sufferers’ lives, hoping through that process to provide them, and the world, with a better definition of their situation in society. Through that ethnographic exploration a better understanding of the social reasons for avoiding revelation of the condition and, as a result, failing to obtain treatment may be better understood.(Goffman 1961) The case
studies bring home, pointedly, the real fears, valid in foundation, of labeling and stigmatization. Yes, treatment is available. It is, unfortunately, not commonly sought.

The many therapeutic approaches available to PTSD patients are presented in detail in Williams and Sommer's comprehensive book on treatment (1994). Their work indicates results with patients who have developed chronic PTSD are often less than successful. There is strong indication that group therapy is the best therapeutic option for mild to moderately affected PTSD patients. For many severely affected patients options include intense psychotherapy, behavioral therapy and pharmacotherapy. A limited body of evidence indicates these approaches have provided mixed results. There have, unfortunately, been too few well-controlled therapeutic histories published to date (Friedman 1995).

On a brighter note, studies indicate that the most successful treatment for PTSD after a civilian disaster or war zone trauma is intervention implemented immediately after the event. This is referred to as a "critical incident stress debriefing" (CISD) or some variant of that term. Such interventions, commonly in the form of frequent, repeated debriefings, not only attenuate the acute response to the trauma, but often forestall the later development of PTSD. Such CISD debriefing opportunities commonly occur following mass, or group, traumatic events such as natural disasters or bombing or mass shootings in public places. It seems likely that comparable immediate intervention procedures among members of the general population experiencing individual traumatic stress (i.e. random automobile accidents, horrible deaths of close friends or family, etc) might provide similar benefit. But it seems likely such intervention cannot, and will not, occur until public demand forces service agency implementation of methods for referral
for treatment that are adequate to meet public needs. Among the following case studies you will find, sadly, no incidents of CISD, and even sadder, as previously stated, no acknowledged efforts at referral for counseling.

Research reveals that the present treatment referral system is better designed to take care of group victims and victims developing PTSD as a result of participation in an occupation in which exposure to traumatic incidents is part of the job, than of those suffering due to individualized experiences. In early August 1998, the Las Vegas Review-Journal reported the tragic group death of five children in the Salt Lake City area who accidentally locked themselves in the trunk of the car of the mother of one of the children. For approximately three-quarters of its length the article described the actual event and the circumstances leading up to it. The final lines of the article described the traumatized state of mind of the police officers who discovered the five children in the trunk. The officers had, upon discovery, hoped to resuscitate the young victims, but their efforts at resuscitation were unsuccessful (Las Vegas Review Journal 1998).

A telephone call to the Salt Lake City Police Department revealed that the department does provide counseling, through staff and contractual arrangements, to assist officers in coping with incidents involving traumatic stress. But what about the parents and families of the 5 children who died? In particular, what about the mother in whose care the 5 children were left?

Conversely, individuals involved in highly publicized, group incidents, such as the mass shootings and deaths at Columbine High School in Colorado in the spring of 1999, were, at least initially, inundated with various types of intervention therapy.
intended to minimize the trauma and hopefully defuse the onset of PTSD as well as other disorders.

Approached from a Sociological perspective, the subject of Post Traumatic Stress Disorder, requires careful examination of sufferers and the effect of the disorder on their ability to function within society in a manner reasonably consistent with their functioning prior to the event that triggered the onset of the PTSD. While statistical analyses, revealing the more common etiology of the disorder, and an understanding of its incidence and epidemiology are essential to a review of PTSD as a sociological problem, broad in-depth survey of the pre and post incident lives of sufferers is essential to an understanding of the overall impact of the disorder on society or on the sufferers and their social networks.

Gathering that data requires personal interviews conducted on a systematic basis seeking as much personal history as possible and exploring in as great a detail as possible the changes in the personal habits, life activities, and private and public social interactions of sufferers. Data for the included case studies was gathered using, as a guide, a standard questionnaire (Appendix 1). The questionnaire was utilized by the researcher not as a step by step guide, but as a reminder to him, in the interview process, of specific minimal questions that needed to be answered in the course of the overall data gathering process. All interviews were recorded, with the full knowledge and consent of the subjects, and the interview tapes varied in length from one to four hours. From those tapes and their transcription, as well as separate notes, the case studies are taken. Considering the length of most of the interviews there is obviously significantly more
revealing and deeply moving material. Due to time and space limitations everything gathered in the case studies is not presented herein.

The case studies included have in common the revelation of what seems at times to be an indifference on the part of members of the public, both individual and institutional, to individual people experiencing extreme traumatic stress on an individual, non-group related basis. The response to sufferers in other (not included), ongoing, case studies is generally similar in nature.
CHAPTER 3

METHODOLOGY AND APPLICATION OF THEORY

A difficult question in the formative process was that of what approach to take in developing this work? There are, in qualitative Sociology, numerous options that might be pursued. An attempt at actually understanding PTSD’s impact on its human sufferers, whether via something akin to Weber’s verstehen or another method, is essential. Included in the previous chapter there is, for a predominantly qualitative work, a significant amount of statistical data providing justification of the research, regardless of the method chosen. But description of the process of suffering from the disorder, on an individual basis, defies standard statistical classification and analysis.

As suggested by the D.S.M., there are within all the case studies certain common shared traits: A life history, in many cases unremarkable, leading up to a traumatic PTSD triggering event; then the event, or events, that set in motion the emotional forces that define the circumstances precipitating the onset of PTSD; and then there is the disorder itself with its ongoing, commonly daily, manifestations.

To some extent, the study is Weberian in nature, the history of the sufferer and his circumstances and surroundings being important to an understanding of the presence and problem of the disorder within both the individual and society. The significance of the roles now played, or to be played, by institutional forces in the discovery and treatment of PTSD should not be underestimated. But there is a significant departure from a
Weberian bent in that it is, with PTSD, within the individual that the understanding must begin, rather than within the society in which the individual lives.

The traumatic nature of PTSD inducing events crosses cultural and societal barriers. While within my study, no events experienced by PTSD sufferers would be considered normal, or precluded as being PTSD inducing stressors in any other Western society, some other societies might find some of the incidents to be within normal parameters. Conversely, incidents that might be considered tolerable and acceptable in the West might well be considered abnormal and PTSD inducing in other societies. But it seems clear there are events, in all societies, that are universal in that their nature is horrific, unpredictable and uncontrollable. The literature supports the global nature of both the problem of PTSD and its precipitators. What it does not adequately address is the presence of PTSD within individual lives and its impact on the lives of those in ongoing contact with those who are suffering the disorder.

Selection of Method

The methodology finally selected is based on the presentation of life studies. While, at inception, it was difficult to discern what specific sociologically significant data would emerge from such life studies it seemed clear, based on an understanding of the disorder, the studies would yield representations of lives lived in one way prior to the PTSD inducing incident(s), then being upset terribly by the onset of the disorder, and continuing under the influence of the disorder long after my narrative ends. Limited in length, the life studies touch on the impact of the disorder on the lives of the sufferers, and on the lives of those close to the sufferers. A broader study could, with further
research, reach, study, and present data relevant to the impact of the disorder on those related more distantly and with less social proximity to the sufferer. The potential for far reaching impact on the larger society cannot be underestimated.

Among the reasons for selection of the life study method are the fact that through life study there is opportunity for open ended exploration of the sociological experience of each participant, thus opening up pathways for future exploration and study of a larger sample. While the introductory section includes significant quantitative data, it is essential that the pursuit of knowledge of the problem through the presentation of the life studies not be obscured by obsessive interest in, or reference to, statistical verification. It is important to note, though, that two of the sufferers presented in the case studies have been clinically diagnosed as suffering from PTSD by mental health care professionals. The one not clinically diagnosed certainly exhibits sufficient symptoms to give credence to his suffering. So, the presence of the condition was not the question to be explored. The question to be explored, in each study, was how, in fact, did the condition affect, alter, and direct each sufferer’s social interaction? The life study technique, with its inherent opportunity for more open ended exploration, provides excellent method for gathering such broad data that might then direct further inquiry. As expanded upon later, the life study method also presents opportunity to utilize a professionally recognized framework through which data gathered can be presented in a format that is readable and coherent to not only those within academe, but to the general public as well.

Prior to the commencement of this work a respected professional questioned the wisdom of including herein any case studies relating to acts of suicide. Suicide is not, at present, specifically included within the DSM list of precipitators. Interestingly, in the
time frame required to develop the work a major study presented in a supplement to The International Journal of Neuropsychiatric Medicine (1998) has concluded that stressor events actually include any situations where “the person experienced, witnessed or was confronted with an event which involved actual or threatened death or serious injury or a threat to the physical integrity of self or others...” The extreme trauma of the event is central and when “coupled with the second component, namely, intense fear, helplessness, or horror, is sufficient to fulfill the criteria of trauma for PTSD.” Based on that criteria, close association with or involvement in an act of suicide is, indeed, a precipitator. While the prevailing authorities, having chosen to invest their budgets and energies in PTSD problems related to military veterans, cannot be ignored, neither may their military impetus be the sole directing force behind the study of PTSD. The public issues and private troubles of the disorder among all sufferers, military and civilian alike, require the attention of all scientists, social and other.

C. Wright Mills, in his great work “The Sociological Imagination” (1959) repeatedly reminds us of the importance of the aforementioned. He further reminds us of the necessity of social scientists to lead, rather than follow, to help rather than hinder the process of understanding society. There is, in effect, an obligation for the social scientist to lead the way, providing society and the general public with knowledge, reason and guidance not otherwise readily obtainable: “… ordinary men, when they are in trouble or when they sense that they are up against issues, cannot get clear targets for thought and for action; they cannot determine what it is that imperils what they vaguely discern as theirs.” (Mills 1959:169-170)
So, as stated and referenced from the literature, there is ample quantitative data regarding both the etiology and epidemiology of PTSD. What seems lacking is adequate presentation of the human agony it inflicts and the impact of that agony on the ability of the sufferer to function within society while caught in the disabling claws of the dominating condition.

Application of Method

It seemed clear, then, that the way to best present PTSD’s impact on sufferers, and on society, is to gather, on as personal a basis as is possible, individual case histories. Those case histories are, in fact, life studies (Cottle 1977). Through interview, sometimes lengthy, sometimes relatively brief, such stories can be gathered. But the life studies included herein differ significantly from those gathered and presented by Cottle, or by others. Typically the life study begins at a relatively random point in the subject’s life, the researcher entering the scene in most cases out of a sense of general curiosity about the subject to be studied. The study then continues over a period of days, weeks, or even months and years, until for whatever reason (time constraints being a common problem) the researcher has studied, and written, enough to present a coherent picture of the life being studied.

The life studies included herein differ. While the lives of those studied vary markedly prior to a specific point in time, they all have in common an experience, or experiences, specifically epiphanic in nature and effect, and causing marked, dramatic change in the life of the subject. Life after the experience will never again be as it was before. The stories all have in common the telling of how the lives were based and lived.
prior to the stressor trauma, the story of the trauma itself, and then a telling of a part of
the story of the life as it has been lived in the aftermath of the traumatic stressor event.
Through the presentation of those case histories, or life studies, in a very real and human
way, it is possible to bring to the reader, lay or professional, a better, more complete
understanding of both the individual experiences and the impact of those experiences on
the individual's social function. There is, then, within this work, a deviation from
standard life study work. Without that deviation the work itself would not have been
possible, and in fact, none of these studies would have been pursued, much less included
herein. The occurrence of the traumatic event and, as a result thereof, the onset of the
specific impact being studied, namely PTSD, is essential to each piece presented.

Having studied the PTSD condition at length, as revealed in the literature review
as well as the general bibliography, some of the stories confirmed notions about the
disorder I had entertained prior to commencing the life study works. Other stories
revealed aspects of the lives, and the condition, that surprised, or even confounded me.
In one life study in particular, the manner chosen by the subject for revelation of most of
the detail stunned me.

The research process itself needs to be explained. The process applies to all cases
studied, not just those chosen for presentation. PTSD, by its very nature, is a condition
that hides -- from its victims, from those close to them, and from the society in which
they live. Avoidance, manifested in several ways is a fundamental diagnostic symptom
of the condition. How then were subjects for study located and enlisted?
Procedure

The early case histories themselves were derived from two sources:

1) Personal referral to another person who had experienced something that seemed, to the referring individual, to be obviously traumatic;

2) personal knowledge on my part of an individual who had experienced something notably traumatic.

Later case studies would be derived from more diverse sources:

3) Publication, typically in a newspaper, of an incident or event involving one or more persons who, due to the nature of the incident or event, might have been exposed to a level of trauma or stress sufficient to precipitate the onset of PTSD. Having read about the incident, I then became a detective, tracking down the event participants, asking carefully for the opportunity for interview;

4) the development and ongoing maintenance of an Internet Web Site (www.unlv.edu/gradstudents/stewart) telling the visiting reader something of the nature and incidence of PTSD and inviting readers, who might be sufferers, to respond with their own stories.

All four of the above listed methods for acquiring case studies succeeded. Some produced case studies that were, in the stories told and in the impact of PTSD on the sufferer, more compelling than others. All produced case studies worthy of presentation herein, though only three are included, time and space constraints in a thesis, rather than a dissertation work, being an issue.

Of the four above described methods for gathering data, the first three presented opportunity for the use of identical methods of documentation and record keeping:
1) Initial contact was made, either in person or by telephone;

2) The contact was informed of the nature of the project and of the methodology to be used in the subsequent interview that was being sought. Disclaimers were also presented, and discussed, and the subject either agreed to participate or decided to sever contact, thus ending the opportunity for case study;

3) Agreement having been reached, an interview, or series of interviews, commenced. The interviews themselves were not clinical affairs. I did not conduct, in rank order, an interview as outlined in the appendix contained hereinafter. Instead, the interviews were, in effect, conversations between the subject and me. I knew where I wished the conversation to lead. And, having at least superficially examined the interview sheet, the subject knew the intended focus of our time together.

But the interviews themselves were not highly structured. They were, instead, a combination of "the focused interview, or the nonscheduled standardized interview." (Denzin 1978:172) With a list of questions constructed previously and now firmly embedded in my memory, and a clear purpose in mind in their asking, I proceeded through each conversation somewhat inductively.

Knowing full well the knowledge I hoped to develop from any given subject, I allowed the conversations to proceed on a casual, and for the most part fluid, basis. In so doing I had to think, plan, and adapt as the conversations proceeded. There were, of necessity, spontaneous inclusions, or exclusions, of questions that might otherwise have been interjected in specific sequence. Fluidity in the process became of paramount importance. (Denzin 1978:172)
All oral interviews, without exception, were to be tape recorded. The recording process itself, though, was flawed and subject to breakdown. Respondents were, in all cases, assured of the intent to maintain anonymity in future presentation of the contents of the interview. There arose, on occasion, a request by a respondent for total confidentiality of some detail or details conveyed in the interview process. In most such instances, after discussion of the importance of the detail, the respondent agreed that the revelation of the item was essential to an understanding of the story being told, and the request for absolute confidentiality was withdrawn.

It is important to note that while all interviews commenced, and in general continued, along a fluid track whose general direction was determined by the interview worksheet, in all cases digression, sometimes minor, sometimes extreme, occurred. It was in the digression, in many cases, that many of the more interesting details of the case studies emerged. It was, in most cases, in the fluid nature of our conversations, as opposed to a point by point interview, that the depth of the emotional suffering, and the inner anguish of the sufferer, was revealed.

4) Then, in summation, all the notes and tapes were organized, partially or wholly transcribed, digested, and ordered into coherent, presentable form. Specific life studies were selected for inclusion based on several criteria. First, it was my desire at the commencement of my research to develop cases involving diverse circumstances leading to the onset of PTSD. I was successful in that regard and cases were selected for their diverse representation. Secondly, cases were selected based on the coherence and readability of the study to be presented. There are, in all the studies, further questions that might be posed and additional answers that might broaden the knowledge gathered.
Within the case studies included, I believe there are fewer questions left partially or wholly unanswered. The stories presented, therefore, are more complete and flow from inception to conclusion in a more satisfactory manner.

Dealing with contacts made through the Internet took, of necessity, another course. With one exception, explored in the final life history, contact with the subjects was exclusively via email and there were no telephone conversations. Always tentative at first, some of these electronic contacts were terminated by withdrawal of the sufferer, some placed "on hold" as the sufferer privately sorted through the pros and cons of deciding whether to tell the story to a third party -- sometimes for the first time. Other contacts, surviving the initial exchange of pleasantries and information by email, continued through the somewhat clinical process (as described in step 2 above) of revealing the nature of what was to come. That having been completed, the email interview process commenced.

If not breaking new ground in the subject matter, I was at least breaking ground with reference to a methodology for procedure. The computer, and the electronic exchange process, became additional intermediary parties in themselves. Snail mail, as the normal paper driven mail service has come to be called by email users, would be too confining in both its lack of timeliness and potential for spontaneity. But email provided its own frustrations: Knowing the potential for almost instantaneous response, and the lack of ability to re-define or re-phrase, in situ, questions posed in search of specific answers, questions had to be phrased quickly and also extremely carefully. The content of answers received without benefit of personal observation of other discerning evidence of response (facial expressions, tone of voice), had to be evaluated somewhat blindly,
then other questions framed and submitted. With the final life history opportunity for more spontaneous, personal interviewing, in an Internet "chat" setting emerged. The chat kept in place the computer generated wall of anonymity, but facilitated quick, spontaneous interaction. But, as will be discussed later, Internet chatting has its own limitations and problems. There seems to be, in the intervening computer, a shield these respondents are reluctant to lay down; at least in most cases.

Regardless of the format of the actual contact or subsequent interview process, the stories that have emerged must compel. But compel whom? Returning again to Mills, and quoting him in almost perfect statement of my own feelings, "It is, I think, the political task of the social scientist who accepts the ideals of freedom and reason, to address his work to each of the other three types of men I have classified in terms of power and knowledge.

"To those with power and with awareness of it, he imputes varying measures of responsibility for such structural consequences as he finds by his work to be decisively influenced by their decisions and their lack of decisions.

"To those whose actions have such consequences, but who do not seem to be aware of them, he directs whatever he has found out about those consequences. He attempts to educate and then, again, he imputes responsibility.

"To those who are regularly without such power and whose awareness is confined to their everyday milieux, he reveals by his work the meaning of structural trends and decisions for these milieux, the ways in which personal troubles are connected with public issues; in the course of these efforts, he states what he has found out concerning
the actions of the more powerful. These are his major educational tasks, and they are his major public tasks when he speaks to any larger audience.” (Mills 1959:185-186)

Continuing, Mills describes, particularly in relation to the third role described above, the role of the social scientist as professor and teacher. The task of melding personal troubles and concerns and social issues is a formidable one. The interplay of both, always present, always affecting both cannot be denied. It is recognition, and acceptance of the interplay, on some level, however elevated (or not) it might be, that is essential in the advancement of the concept of good to be attained through the social sciences.

I find it important to convey, as well, that in undertaking these life studies, I had a specific goal in mind. As described by Cottle in his discussion of observant participation, “the interviewer cannot help but become immersed in the lives of those people whom he or she is interviewing.” (Cottle 1977: 8) And through such immersion there emerges, for the successful observant and writer, a study, or studies, that “convey small pieces of life as it is led and described by people with whom I have spoke,” those studies being presented to the reader in a manner intended to assure that “no one who listens to (the) recounting of these situations can possibly remain aloof, indifferent…” (Cottle 1977:8)

It is that knowledge and acceptance of the interplay that elevates the work of social science to relevancy. But, of the three roles of men described heretofore, those filling the first two are, with small exception, failing to respond at a significant level to the knowledge of PTSD presented to them. Therefore, in the face of that failure to respond, and in seeking greater understanding and acknowledgment of relevancy, it is then to the third role of man the social scientist must turn. The stories are told to at least
reduce, if not eliminate, the indifference to the problem amongst us. The general lack of public knowledge about and understanding of PTSD virtually assures a lack of public relevance. But, given the knowledge and understanding, the man in the third role may, within daily life, find relevancy. Given the knowledge and understanding, and grasping the relevancy, the third type of man may, with time, effect his own change.

"Good sociology is both historical and comparative in nature." So says Norman Denzin in his introduction to Part X, Life Histories and Comparative Methods: Uses and Problems, found in the second edition of his "Sociological Methods, A sourcebook." The life history method provides opportunity to "...narrate past experiences as these pertain to the current condition." (Denzin 1978:283) In a study of the effect of PTSD on the lives of individuals there seems to me to be no better method available. What these people were, they still are -- in some respects. The flesh, the blood, the bone remain unchanged. It is within the mind that the change takes place, that change manifesting itself in different actions, reactions, and responses to life as it proceeds, and the stimuli presented the sufferer on a regular basis. Knowledge of the interaction between the sufferer and his society is at the core of the study. Denzin discusses, at some length, and over 20 years ago, the lack of use of life history by contemporary sociologists, the genre losing favor. There has been, he says "...a shift in the methodological stance of the researcher. Rigorous, quantitative, and (frequently) experimental designs have become the accepted modes of investigation. This situation is unfortunate because the life history, when properly conceived and employed, can become one of the sociologist's most powerful observational and analytic tools. Through use of the life history the research may "record the objective events and elicit a subject's definition of those events as well as the
perspectives of other persons involved in those events (paraphrased). By fitting these
different perspectives together, the investigator develops a comprehensive and
comparative explanation of how the subject's experiences reflect variations in the social
situation." (Denzin 1978:285)

Continuing in Denzin's 1978 volume, Howard Becker brings further clarification
for the need for life history work in the study, and ultimate public presentation, of PTSD.
The numbers have been run, and not just once. They have been revealed repeatedly, and
with near startling similarity, in multiple studies, among them the National Institute of
Mental Health's Epidemiologic Catchment Area Survey, the National Co-morbidity
Survey and even through the cornerstone and ongoing General Social Survey. Discussed
previously, albeit briefly, the statistics provide evidence of a problem with profound
affect on society.

"The life history, by virtue again of its wealth of detail, can be important at those
times when an area of study has grown stagnant, has pursued the investigation of
variables with ever-increasing precision but has received dwindling increments of
knowledge from the pursuit." (Denzin 1978:293) And Becker, importantly, continues
along a similar line: "For the life history, if it is done well, will give us the details of that
process whose character we would otherwise only be able to speculate about, the process
to which our data must ultimately be referred if they are to have theoretical and not just
an operational and predictive significance. It will describe those crucial interactive
episodes in which new lines of individual and collective activity are forged, in which new
aspects of the self are brought into being. It is by thus giving a realistic basis to our
imagery of the underlying process that the life history serves the purposes of checking
assumptions, illuminating organization, and reorienting stagnant fields.” The life history, when properly researched, recorded, framed and presented, may then bring to life the statistical data that has failed to excite society to action. In considering the potential impact of PTSD on the lives of sufferers, as well as the lives of those with whom they interact, it seems, to me, almost remarkable there has been so little excitement, so little action.

The properly framed life history provides, I believe, a medium by which the story can be played out in a manner that ties together the previously gathered statistical data that elicited the initial interest, the theory that excited the sociological imagination, and the highly personal lived experience and combines all into a presentation with sociological relevance recognizable not only to sociologists, but to all potential readers.

Such presentation allows me to teach to the man in the third role as described by Mills and communicate in a manner that is both readily understandable and identifiable. I have attempted to design, then, a presentation of the stories in a manner easily understood by any reader with even modest reading skills. The stories must, in reading, compel even the most casual reader to seek a greater empathy with and understanding of the sociological relevance of the events that occurred. As described by Cottle “… no one can listen to the accounts of another person’s life and remain indifferent or objective, particularly when one is (or feels) a part of the situation or friendship that has created and perpetuated the conversation. Inevitably, something is evoked in us: our mind is turned to other subjects; or we feel moved, or a particular emotion comes over us that we either cannot identify or choose to ignore.” There is, according to Cottle, direct impact, in the end, on policy making and its affect on all of us. Writing policy is, too frequently, done
with inadequate knowledge of its effects. "Writing policy is much easier than looking into someone’s eyes as he or she reveals even the smallest morsel of himself or herself."

"While politically it may seem that policy is more beneficial than the enlightenment or evocation derived from still one more life study, the fact is that in the end, policies may not be better." (Cottle 1977:15)

Life studies, or histories, should instill a desire to seek greater knowledge of both the causes and commonality of PTSD. There has been, in my research, a general lack of either common causes or commonality in the manifestations of the disorder within the daily lives of the subject. Without exception, the subjects within the life studies have expressed:

1) their own lack of understanding of what has happened to them and their lives,

2) an inability to adequately confront past and ongoing events in a manner that provides any significant level of relief, and

3) an almost urgent desire to know that through telling their stories, sometimes for the first time, that they, through me, may reach others and possibly broaden understanding of PTSD.

There was a universal hope that through broader understanding suffering of others might be, to at least some extent, alleviated. Finally, as observed by Cottle, there was among all participants, a sense of isolation reinforced by a perception of general societal indifference, or perhaps hostility, to the original stressor event or the ongoing problems being faced. I commonly heard, as did Cottle: "I don't know what anyone would find so interesting about us?" (Cottle 1977:8) There was a universal and genuine feeling, and concern, that beyond the point of initial contact and data gathering, there would be no
further action. There was an almost certain conviction that within a short time interest in
the subject's problems would be abandoned, and the subject would be left, again, to his or
her own devices. There is, after all, a long history of political and social reality that
stands between the troubled participant and any effective intervention or assistance from
society. (Cottle 1977:9) And, sometimes plainly spoken, and sometimes tacitly
understood, there was concern about the possibility of being viewed as different, sick, or,
in sociological terms, deviant.

Theoretical Implications

If it is my job as the observant and writer to propel myself forward in a search for
better methods of raising societal consciousness and understanding of and sympathy with
the condition, then readers must feel compelled to broaden their own knowledge and
understanding. But, readers must be reached. And the third man, in particular, may be
best reached by writing in a more literary style, the style best suited to evoke both mental
images and emotional reactions with strength and verisimilitude. The life studies, the
stories, are intended to draw the third man in, make him feel himself to be a near
participant in the PTSD invoking event and its ongoing trauma, and leave him, at the end,
with some sense of resolution as to the role he might play in the ongoing public issues
precipitated by such private problems.

As a researcher I have, without exception, known when a story being told to me
was one of significance. While all the life studies developed contain material of interest,
the three life studies that were selected for inclusion are those of ordinary people who
have, on an unexpected and unwarranted basis, been caught up in traumatic
circumstances beyond their ability to direct or control. Readers of early drafts have been able to understand and recognize the everyday relevance of the stories told and so, I hope, will all future readers. As I have been enlightened and moved to seek greater understanding of the manifestations of PTSD by the life studies, so were early readers. I believe future readers will be similarly affected.

The process of telling the life stories involves a delicate balance. On the one hand privacy is an issue, and concern, for both author and subjects. But, on the other hand, there is no point to the research and study, to the life stories themselves if they are not to be told and presented in a public forum. The interviews, and the gathering of the stories, extended over a period of time that was, in most cases, lengthy enough so that agreements entered into at the commencement of the process might be forgotten by the time our conversations reached a point of conclusion. Despite mutual understanding and agreement on the purposes of the research and studies I have felt concern that “to describe in detail what transpired during these days is perhaps a violation of ethics and promises, a disclosure of materials presumably confidential. Without breaking a trust, some things, however, may be reported.” (Cottle 1977:144)

The process of ultimately going public does create, for me at least, a certain level of anxiety. I've been sued before; the process is not fun. In an increasingly litigious society, the possibility of overstepping the bounds and limits perceived to have been imposed, in advance, by agreement between parties poses a very real danger of, to put it simply, being sued for damages, both real and imagined as a result of revelation of private troubles to a very public audience.
And yet, simultaneously, and without exception, when subjects reviewed what I had written of them, both of their individual trauma and subsequent life experiences, they responded, inquiringly: "Why didn’t you write about this or why didn’t you tell more about that?" Or, even more strongly worded, were accusations of "stop protecting me. I’ve been protecting myself and hiding for too long. I told you these things because you said you wanted to know. Well, I didn’t want just you to know. I thought if you wrote about everything I told you maybe someone would listen, and understand, and maybe someone else wouldn’t suffer as I’ve suffered. God, I’d do anything to save someone else what I’ve been through." (quotes paraphrased from participant interviews).

So, I have written. I written some, but not all, of what I have learned and now know. There is, in each history, drama. In one there is ironic comedy. They all have the potential to move the reader. They all tell of "patients" who have, in effect, been subjected to involuntary admission to their own private asylums, the asylum being the isolation that comes with day to day living of life in a society that does not, in most cases, recognize their mental disorder. The PTSD itself is, in most cases, hidden from view. But, while unknown to the sufferers outward manifestations of the condition are obvious to those around him and are remarked upon. He has, without his knowledge, been labeled and stigmatized. Despite his fears and his efforts at avoidance and withdrawal, the process has occurred.

The parallels between Goffman’s (1961) descriptions of the involuntary admission of a patient to a mental hospital and the PTSD sufferer’s involuntary private battle are striking. The hospital inpatient is resistant to treatment and "is likely to feel that he has been railroaded into the hospital." (Goffman 1961:355) The PTSD sufferers I
interviewed similarly felt they had been railroaded into their own private hell. None asked to be where they found themselves and resented the nature and effect of what had been thrust upon them. And in both instances there is a strong sense of alienation. In describing the sense of alienation of the hospitalized patient, Goffman states that "while ordinarily an encounter with a server is likely to affirm the individual's belief in the rationality and good will of the society in which he lives, an encounter with hospital (or out patient) psychiatrists is likely to have an alienating effect." (1961:355) The PTSD sufferer experiences similar feelings of alienation, but they arise in a different manner. Among all the cases I studied the fear of, or concern over, discovery created a sense of a necessity for isolation, and resulted in self directed alienation. Such self directed alienation comes from the desire to avoid confrontation with the problem, specifically with memories of the stressor event in the past, and with public revelation that would identify and label him as being different. The word stigma need not be spoken by one who does not understand its meaning for the concept to exist and for the process to occur. Through such avoidance, and self directed alienation, the sufferer fights to decrease the probability of being labeled sick or different.

The process of alienation, for both types of "patients," arises from the fact that "the patient is not the only one, it seems, who declines to view his trouble as simply a type of sickness to be treated and then forgotten. Once he has a record of having been in a mental hospital, the public at large, both formally, in terms of employment restrictions, and informally, in terms of day-to-day social treatment, considers him to be set apart; they place a stigma on him. In response to his stigmatization and to the sensed deprivation that occurs when he enters the hospital (or with the PTSD sufferer publicly
acknowledges his PTSD) the inmate frequently develops some alienation from civil society, sometimes expressed by an unwillingness to leave the hospital.” (Goffman 1961:356) Similar alienation from society occurs in the case of the PTSD sufferer who refuses to abandon his cloistered and private suffering.

The onset of PTSD is involuntary, proven successful methods of treatment for it uncertain, the social manifestation difficult to directly identify. But within each of the three case studies that follow the elements of labeling, or the fear of labeling and of subsequent stigmatization, and of societal indifference or ineptitude in providing assistance are clearly and easily identified.

The issues of labeling, of fear of such and of fears of stigmatization by a person suffering a mental disorder, or the same fears on the part of those closest to the sufferer is covered at length in Michael Lynch’s excellent article “Accommodation to Madness.” (Lynch 1983) Therein he describes, in some detail, a “massive program of community care (which) exists independently of formally established programs of inpatient and outpatient treatment. Countless numbers of undiagnosed, but troublesome, individuals, as well as an increasing number of diagnosed outpatients, are consigned by default to the informal care of family and community.” This type of accommodation, also described by Lemert, describes, in effect, “attempts to ‘live with’ persistent and ineradicable troubles.” (Lemert 1962). The experience of two of the sufferers in particular, as recounted in their life histories, reflects, directly, this accommodating interaction with those surrounding them, with those who comprise the society with which they most frequently interact.

In fact, some studies have treated such accommodation practices as sources of delay in the recognition and treatment of mental illness. (Goffman 1961; Lemert, 1962)
Similarly, when mom, dad, spouse, child or sibling is suffering with PTSD and is, in fact, hiding from the disorder at the root of the anguish, and those closest interact with the sufferer and the symptoms in a fashion that encourages further avoidance, the problem, both personal and societal compounds itself. Such “accommodation practices integrate the troubled person into society, while requiring minimal initiative of him” in dealing with the problem. The individual is “given life through the conventional appearance of his overt actions.” The surface of the sufferer is, to a large extent, managed and shaped by communal activity, thus further alleviating any need for the sufferer to confront or alleviate the underlying condition.

As a result of this interaction with those closest to the sufferer in society, and the common effort at avoidance of confrontation with possible resultant labeling and stigmatization, the avoidance process becomes self sustaining, self perpetuating. The reaction and interaction between sufferer and society, between sufferer, society, and the labeling stigma associated with a mental disorder, exacerbates the problem.

In his book “Outsiders” Howard Becker (1963) deals specifically, and at length, with the issues of labeling and stigmatization, and the fear thereof, and of the deviance, and further deviant actions, thereby precipitated. Becker having done the work for me, I need not redefine deviance nor quote his work ad nauseam. Some reference to his work is essential, though, in as much as he also elaborates on the individualized nature of deviance. “Since deviance is, among other things, a consequence of the responses of others to a person’s act, students of deviance cannot assume that they are dealing with a homogeneous category when they study people who have been labeled deviant. That is, they cannot assume that these people have actually committed a deviant act or broken
some rule, because the process of labeling may not be infallible; some people may be labeled deviant who in fact have not broken a rule." "Insofar as the category lacks homogeneity and fails to include all the cases that belong in it, one cannot reasonably expect to find common factors of personality or life situation that will account for the supposed deviance." He then continues, discussing categories and labeling, concluding, "whether an act is deviant, then, depends on how other people react to it. You can commit clan incest and suffer no more than gossip as long as no one makes a public accusation; but you will be driven to your death if the accusation is made. The point is that the response of other people has to regarded as problematic." (Becker 1963:7-12)

Each culture is different, perception of deviance varies. And, within the varying cultures, variable definitions of deviance for the individual participants, as they perform their roles and are thereby perceived and evaluated by those with whom they have regular discourse, exist. Specific activities and actions are evaluated not only in terms of the acts themselves, but in terms of the actors who perform them. Activities, or lack of same, that might be viewed as deviant in a prairie town of 1,500, might not appear deviant in, for example, San Francisco.

The life histories which are, as previously stated, very diverse, reflect diversity in this final, central aspect as well: the aspect of individual deviance from norms, the deviance being precipitated by the onset of PTSD. Read each life history critically, reflect on the life history of each individual whose story is told, and learn more for yourself:
CHAPTER 4

CASE STUDY #1: JOHN

Introduction:

I can scarcely say it more plainly: I used to own a bar. I am proud of that fact because it wasn't just any bar. It was the best -- at least the best in the small Montana college town I'd decided was the ideal place to go through my own mid-life crisis. I spent a lot of hours in that bar, mostly having a great time. At age 47 I found myself invited into and part of a young, partying “Greek” college crowd, becoming friends with a lot of guys less than half my age. Their friendship was genuine -- they gave much to me and asked nothing in return.

We hunted ducks together in the cold autumn air of Montana, sharing smokes and beers as the sun broke through icy mist hanging over mist shrouded, silent rivers. My wife and I were invited to their formal parties. And on a regular, but casual, basis they bought me drinks in my own bar -- never once was I expected to pick up the tab; when I did so, the gesture was accepted with genuine gratitude and affection for my clear intent: To participate in the ritual without thought of needing to buy my way in. It wasn't necessary.

Many of those young friendships endure today. I talk, regularly, with many of these friends, sometimes as a social equal, sometimes as an elder mentor, always with affection. There is no false bravado now, nor was there then.
It is from connections made and friendships formed during those years that this particular life study emerges. I knew the "players" in the case study then, in that former life. I still know them. They are a part of my life and will be forever. The life study presented here, then, is not "pretentiously impersonal" (Mills 1959:221), nor is it presented in "'socspeak'" in an effort to make academic claims or establish academic credibility for myself. (Mills 1959:220) I identify myself as a voice, assume I am speaking to some general public audience, and am, therefore, trying to write readable prose. (Mills 1959:221)

The Case Study:

Subject Name: John

Sex, Age and Marital Status: Male, 28, married (age 24, single, at time of incident)

Occupation: Landscape Contractor/Supervisor

Personal Background: Upper middle class family, lost biological father in accident as toddler, mother remarried, mother and stepfather remain married, has stepbrothers and sisters. Raised in L.D.S. church but left church a number of years ago. There had, for a number of years, been no religious connection in John's life. Could such connection have influenced the course of events described herein? (Durkheim 1951: 27-29)

The Incident:

September 16, 1995, Salt Lake City, Utah.

John had known Allan Evans since boyhood, though being two years older than Allan they were not good friends in public school. John was a leader in High School,
president of the student body and an athlete. His younger life was marred by the tragic
death of his father in an explosion when he was a toddler, though his mother remarried
happily and ultimately relocated to the town where John grew up. His stepfather, whom
he considers his father, is a loving and sacrificing man, caring deeply for his family, and
his mother is described as a very loving person as well. Attending State University
John's life was, at times, a bit confused, his desire for what he viewed as social normalcy
conflicting with his Mormon upbringing. His desires for social normalcy prevailed at this
time, and neither he nor his wife are active in the LDS faith today. But, confusion brings
strife; he experienced arrest and penalty for MIP (minor in possession) as well as for
writing bad checks. Finally, in an effort to extricate himself from his problems and set
himself on a new track, he accepted a job, with his parents' blessing, with Club Med and
over a 2 year period worked in the Caribbean and Mexico. During his college years his
acquaintance with Allan Evans had blossomed into an all encompassing and truly great
friendship. The two were members of the same fraternity and became true bosom
buddies, doing everything together, going everywhere together, and sharing together the
burden of John's problems.

But, at no time did Allan share his burdens with John; Allan was, and had been
since childhood, subject to profound depression and had, at age 10, made his first attempt
at suicide. He was, unknown to John, seriously manic-depressive, had over the years
been in thus far unproductive psychotherapy and had predictably been prescribed various
anti-depressants, the final prescription being for Zoloft which he never took. At the time
John left his home town to work at Club Med he and Allan remained in close contact and
when John visited home in the fall of 1994, prior to transferring to a Club Med in
Mexico, Allan asked John to see if he could get him a job. When John arrived at the Club Med in Mexico and told the staff about Allan — his good looks, his charm, his athletic ability, his rock climbing skills which could be utilized in the resort's recreation program — they told John they'd hire Allan. Within a week Allan was in Mexico and at work.

During the ensuing months the friendship grew stronger and now included the friendship of John's then fiancée, and future wife, Karen. The three became inseparable, doing everything together. As described by John, his bond with Allan seems as strong a relationship of platonic love as I've ever encountered. But, life in paradise was to come to an end. In the spring of 1995 all three, John, Karen, and Allan, returned to the states to resume a life a bit less fantasy filled. After visiting at home, John and Karen settled in Salt Lake City, John working for a landscaping company, Karen for Nordstrom department stores. And, after a summer at home, working as a greens keeper at a local private golf club, Allan moved to Salt Lake City on Labor Day weekend, joining the same company John was working for and living with John and Karen as their roommate in their 2 bedroom apartment. The good life continued briefly, but it appeared to be a good healthy young adult life; partying but not to excess, evenings on the town having too much to drink sometimes, and working hard at their jobs during the day.

It all came to an end the night of September 15th. There was a bar-b-q at the home of John and Allan's boss; a good, fun time. Following that, there was a visit to a bar -- more drinks and a few games of pool. Everyone was having fun, Allan was playing host, but by about 2:00 a.m. John knew he needed to go home. He'd had too much to drink. So he and Karen left -- Allan said he'd catch a ride with someone else;
and he did. At home, John and Karen went to bed — they were out like lights. John said he slept incredibly soundly. Karen, awaking at some point to go to the bathroom, noticed Allan’s bedroom light was on; good, he made it home! She went back to bed. Morning: John and Karen awoke, shared a few thoughts, and John got up, followed by Karen. She headed to the kitchen to make coffee. John, seeing Allan’s light still on through his cracked door, went to peek in. He found Allan lying on the floor beyond the bed, ghostly white, blood pooled around his head; dead. Shock. He turned and went to the kitchen where Karen was working with the coffee. To Karen’s turned back John said: Allan is dead. Karen, not seeing John, responded: Don’t joke, this isn’t funny. But then she turned and saw him and knew things were bad and John was not joking. *The Dance* had ended (Arata/Brooks. 1989).

I interviewed John nearly three years after the event. His memories and emotions remained vivid and raw. His initial response was one of shock, disbelief, semi-hysterical feelings.

He had not been forewarned. Allan had not revealed to John or Karen his past private troubles that culminated in his suicide. John was overwhelmed by not just the act committed but also by his own lack of understanding of how it could have happened. There was, almost simultaneously, horror, shock, disbelief and fear. There was an overwhelming sense of loss coupled with a sense of abandonment. The act made no sense to him.

“If the observers cannot adequately determine whether the individual intended to commit the actions, or intended the consequences of the actions, then the actions (or words) are not seen as very ‘meaningful …’ ” (Douglas 1967:273).

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First there was a call to 911 and their question: Are you sure he’s dead? He returned to the bedroom, and for the first time comprehended that there was a gun in Allan’s lap. 911 dispatched help immediately upon hearing of the presence of a gun. The emergency crew arrived quickly. Coming from only four blocks away John heard their sirens as they approached. There were fears on John’s part they might blame him. What if they thought he shot Allan? They were a good, compassionate crew, though. The body was removed within about 30 minutes, John and Karen were questioned, and told what little they knew. The authorities asked them not to contact anyone until they could contact Allan’s family. John remembers telling the emergency crew he wanted to be with his mommy and called his sister anyway. He needed to talk to someone.

Conversations with a coroner’s assistant ensued. John also made a call to a cleaning company and received a matter of fact $800 quote to clean up the blood and brains. Next step: Get home to be near Allan’s family and his own. What if Allan’s family blamed him? What if they held him responsible for Allan’s death?

They made a mostly wordless drive home (6.5 hours), during which there was some clarity of thought -- “I can handle this.” Stopping, John had a brief telephone conversation with an uncle as they passed through an Idaho town. They arrived in the home town on Saturday evening. His parents came out to greet them.

“John, you look good,” his father said as he embraced him. John said he was internally outraged, thinking: “Don’t tell me you’re glad to see me and I look good. Tell me how sorry you are for me. Make me feel something other than the horror I feel about my best friend, a man I loved as much or more than any brother, blowing his brains out and leaving me behind to find him and deal with this.”
Then, there was no further avoiding the necessary visit to Allan’s parents’ home. He feared accusation of blame, but Allan’s father greeted John with love and concern: “John, I want you to know we don’t blame you for any of this.” That brought relief, but then enormous emotional chaos when Allan’s father told John he wants him to be the one to contact the boys’ mutual friends, fraternity brothers, etc. John consented and spent several hours on the phone, then spent several hours meeting and talking to friends and acquaintances.

Response to Event and Subsequent Impact on Social Function:

As described in our conversations, John experiences constant reminders on a daily basis, even now three years later (at the time of our conversations). The responses as described are taken, as best as possible, from John’s words. While I can empathize with John’s anguish, I know little his agonies. “Each of us senses the private inner sphere of human reality and what influences it, and the exterior sphere and what seems to affect it. Everyone senses the ways in which these two spheres shift so that their boundaries are at times indistinguishable, and how this shifting may result from changes in either sphere or in the interplay between spheres. Essentially, this interplay lies at the core of the subjective inquiry. I mention this notion of spheres so that no one will think I am arguing that nothing existing in the mind of one person can ever be known by another.” (Cottle 1977:35)

I do know, from both his descriptions and his ragged emotionally charged revelations that John does suffer strong responses. Triggered by sounds, songs, and exposure to situations of familiarity the responses are strongly emotional and result in
feelings of detachment as well as providing him an outlet through crying. He indicates that no day passes without an incident of some sort.

Nightmares, frequent and vivid at first, now come only occasionally. But dreams of Allan that are not unpleasant also occur with some regularity. Initially there were frequent and intense sleep disturbances. They are fewer now, though still exist. When John cannot sleep he suffers even more. At times his work is physically demanding. When sound, rewarding, sleep fails him, he, and those around him, suffer. When he is tired, and becomes irritable, his responses to minor inconveniences may be explosive in nature. Mental images are incredibly strong and fear of disaster lurks behind every event. Cues easily set traumatic memories in motion.

There is previous reference to response and flashbacks triggered by songs. Music provides a cue for the onset of flashbacks and John shared the detail of one flashback episode with me. (Diagnostic Criteria from DSM IV 1994:209) The process of sharing the specific flashback triggered an additional, extremely emotional flashback. A summary of this specific flashback episode follows:

It is just after 5 o’clock in the afternoon. The L.A. freeway is jammed. A handsome young man, 25 years old, is on the freeway. John is heading home from work, feeling carefree, listening, as is his common practice, to a “mix” station, one that plays oldies, a bit of hard rock, some country. And then, at a time crucial to being a good driver, navigator and decision-maker, music emerges from the radio that sets off a cascade of emotions that disables him. Unexpectedly, Garth Brooks, singing “The Dance,” (Arata/Brooks. 1989) brings down on him more than he can bear. The song was an important part of the shared experiences of John, Karen and Allan. The words shut
down his senses and bring to life visions and memories. Haunting in their beauty and
pain, the memories of a best friend, gone now and never to return are stirred by a
mutually loved song. Garth Brooks delivers the lyrics, rich with meaning, hammering
him, killing consciousness, flooding his senses:

Looking back on the memory of
The dance we shared 'neath the stars above
For a moment all the world was right
How could I have known that you'd ever say good-bye

Images flashing before his eyes first triggered soft tears, followed quickly by choking
sobs. Reactions that verged on panic emerged: “I’ve got to get this truck off the road; I
can’t see, I can’t think, I can’t hear. What the hell am I doing in the left lane? God, I’m
going to have a wreck. Jesus, I’ve got to get over, got to get into the emergency lane, got
to stop, got to have some time.”

And, he did manage to pull over and stop. He sat there, consumed by his
emotions, and cried uncontrollably for 15 minutes. Not one single vehicle stopped to see
if he needed help. Alone, he took the time he needed to get himself and his overburdened
emotions back under control. Reflecting on the episode, John figures everyone else on
the freeway thought a damned idiot was at the wheel of his truck. He said other drivers
honked at him, gave him the finger, rolled down their windows and called him a mother­
father, and just generally added to his personal hell. It seemed clear to him that no one
cared about him. No one was interested in him. He felt he was as alone in a crowd as you
could get.

Following that particularly strong flashback episode there was some temporary
loss of appetite, though normalcy returned. Today, current medical research not
withstanding, John feels strongly he has a significant stomach ulcer as a result of the
ongoing traumatic stress. There is a strong sense of wanting to be done with this, and a fear of consequences, including thoughts of suicide, if he doesn’t get over this, and he welcomed the opportunity to talk with me. (DSM IV 1994:210) While he has no desire to return to the location of the event, his memories are vivid and include exceptional detail.

Among the residual emotions are a strong sense of feelings of estrangement from people who won’t recognize the severity of his emotions or the magnitude of the event. But he feels stronger than ever feelings of love and closeness to his wife, Karen, who shared the actual event and shared, for a time, some of the friendship with Allan. Within Karen’s life there is response to the trauma I have not explored. John, however, related one incident, filled with humor, and a bitter sweetness, revealing some of Karen’s own continuing reactions.

Allan, John and Karen were best friends. They were friends who could, and did, share, unreservedly, many intimacies of life and living. Despite Allan’s self denial of his own problems and his failure to share them with his friends, there was other sharing.

I knew Allan. He was, without question, blessed with exceptional physical beauty. John has described the absolute sense of exultation he felt when he and John would walk down the street together. Heads would turn, both male and female, as normally disinterested passersby stared openly at this incredibly handsome young man. John, handsome in his own right, was encompassed by Allan’s aura of beauty. He felt proud of himself in Allan’s company; proud to be close friends with such an exceptional person. During their time at Club Med as the friendship between the three grew and common interests emerged, Allan and Karen began sunbathing together -- in the nude.
There was no eroticism in the act; just a simple sharing in the luxuriating sense of soaking up the warm tropical sun. False modesty was lost in the process.

But Allan's beauty was erotic to many around him. He was, in John's words: "A babe magnet." The three shared a two bedroom / one bath apartment at Club Med. Late one night, or in the wee hours of the morning, Karen rose to use the bathroom. She moved carefully through the room she and John shared, quietly opening the door to the bath they shared with Allan. Quietly closing the door to the darkened room she reached for the light switch, flicked it on, and there was Allan! He was stark naked -- except for the used condom hanging from his now flaccid penis. In an effort not to disturb his own guest, Allan had quietly entered the bathroom and not bothered to turn on the light.

Both were startled, and then, almost simultaneously, amused by the ridiculous scene presented. They laughed -- together, silently, uncontrollably. Allan finished his business, departed, Karen did her business and went back to bed. Today the sight of a condom, in a box, or as part of a shelf display, throws Karen's own memories and responses into motion.

John's feelings and responses include a real, and repeatedly vocalized, fear of taking his own life in response to being unable to get past this. Persistent sleep problems aggravate his emotions, and his temperament which is by nature solid and easy-going drifts to volatility without great self control. He hints at drinking more than he should. He talks frankly of loss of self control, without revealing specific details or incidents.

John remains close with his parents even though his immediate response was that his parents didn't exhibit proper response to him at the immediate time of the event. They said he looked good and were glad he was all right, which was nice but, in his
opinion, inappropriate considering what he had just experienced. There is no real change in his relationship with his parents; he loves them very much though appears confused a bit. John is closer now than ever to his wife Karen and discusses how they rely on each other for ongoing support.

His friends were open about the incident at the time; curious and loving. But John had already left college and many of the old relationships were dwindling at that time so there was no real change with most of those friends. There were feelings of anger, which persists to the present, at some who John feels failed to respond appropriately to the incident and his feelings.

Allan's parents told John they were going to sort of “adopt” him in Allan's absence. John said it seemed strange to have them say that, but he now talks with them as he never did when Allan was alive. When Allan was alive they were Allan's parents and he viewed them as such and had no closeness with them at all.

Summary:

John is a strong, intelligent, clear thinking and well spoken young man who has experienced a personal horror. He appears to be suffering chronic PTSD. He indicates his love for his wife provides sustenance for him. He describes a relationship with Karen that includes significant dependence on her, and her possible reciprocal dependence, and wonders aloud if there may be more burden than either of them is equipped to bear. They seem to need the intervention of a third party on whom they can unload, but he indicates he hasn't sought help and that my conversations with him provided the first thorough
emotional debriefing he has had since the suicide. He was specific in his desire to
disclose through me, but not with others.

He stated that no one had actively encouraged him to seek professional help. But,
subsequent communications with Allan's father who is a mental health professional,
contradict that statement. Allan's father indicated that immediately subsequent to Allan's
suicide he actively encouraged John and Karen to seek therapy at a PTSD inpatient center
with which he is familiar. In fact he offered to underwrite the entire expense of such
inpatient therapy, recognizing the probability of its need. He said that at the time John
simply, but firmly, declined the offer. Avoidance is a key diagnostic criteria of PTSD.
(Diagnostic Criteria from DSM IV 1994:210)
CHAPTER 5

CASE STUDY #2: MARK

Introduction:

I have a 19 year old son. He is a marvelously intelligent and astute young man, aware of both himself and his position in life, and is also interested in and enthusiastic about my work. As college student he has worked part time jobs of various types, among them several different positions with Dominos, the large pizza chain. Well aware of my ongoing study of the impact of PTSD on the general population he informed me, one evening, that the Dominos store he was currently working in had been robbed — at gunpoint — that morning. He had not been present, but a young man he knew fairly well had been the victim of the crime. Did I think it would be worth my time to talk to him? Was an experience of this type one that might trigger PTSD? Was I interested in talking to his friend Mark? If so, he'd put me in touch.

Obviously I was interested and he gave me Mark's home telephone number. The next day I made initial contact. In the initial telephone contact there was an easy going and comfortable conversation. Yes, Mark acknowledged, he had been robbed — at gunpoint. Yes, he'd be glad to talk to me. But, he was curious. Why did I want to talk? My response, somewhat clinical in nature, satisfied him. Where would we meet? I had no University office at the time, he had no privacy at home. We agreed he would meet with me in my home. We would meet during a time when it would be quiet
and no one else would be around. We could have an uninterrupted conversation for as long as we cared to talk.

The appointed day and hour arrived, the doorbell rang, I responded and -- I was initially shocked. Mark, standing at my door, appeared impossibly young. Physical appearances can be deceiving, but this young man appeared to be nearly a child. Quickly and without hesitating, I moved through the initial handshake and greeting and invited him into my home.

Following my suggestion of possible places to sit, we agreed to sit at a breakfast table that has comfortable chairs. Sipping soft drinks we began our conversation. I described, in more detail than I had on the telephone, the nature of my work and my interest in his experience. After little discussion he consented to the process by which I would gather and record my data and nodding agreement with my indication that the interview would be conversational in nature, we began.

The Case Study:

Subject Name: Mark

Sex, Age and Marital Status: Male, 18, married (wife, age 16)

Occupation: Domino’s customer service representative

Personal Background: Middle class family with problems that would reveal themselves in our conversations. He and his wife live with his mother at present.
The Incident:

September 5, 1998, Las Vegas, Nevada

It was early in the morning. So early, in fact, that no orders for pizza had been taken yet. Mark was working in the front of the store, alone, when the door opened. A lone man entered. His appearance struck Mark as odd. At the time he didn't identify what was wrong. Later he did: The man was wearing a long, ski type jacket. The outside temperature had already reached 90 degrees. He approached the counter and Mark greeted him and asked how he could help him. The response was the swift revelation, from within the coat, of a sawed off rifle. Lifting it quickly, the man placed the muzzle directly against Mark's forehead and said, simply: "I want the money in your drawer." Nearly simultaneously another customer entered the store. This one was a legitimate customer. He had stumbled into the crime scene. The robber turned his head to the entrant but said nothing. The customer, stunned, responded on his own. He pulled his wallet from his pocket and offered his own money to the robber. The response from the robber: "I don't want your money. Get out!" He did.

He again turned his full attention to Mark, repeating "I want the money in your drawer. All of it." Mark complied. There was not even twenty dollars in the drawer. Only the minimal amount of bills and small change from the preceding night remained in the drawer. As was common practice at Dominos little more was ever kept in a till. Operating procedures directed that money was always to be dropped into the time safe as it came in and during the preceding shift procedures were properly followed.

The robber was incredulous. "Is that all there is?" The muzzle, withdrawn slightly from Mark's forehead, was now replaced, this time with more force. The
pressure of its impact caused discomfort. That was all, Mark had replied. There was no more. Then, having second thoughts, he too reached for his wallet. The robber, disgusted, said forget it, he didn’t want what little he might have. He grabbed the few bills from the till that Mark had placed on the counter, turned and fled.

There was silence. Then, from the back of the store, where he had been working unaware and unseen, the only other worker in the store at the time emerged. He indicated to Mark that the scene he observed had struck him as odd -- Mark standing quietly at the counter, the till sitting in front of him. Mark turned and said, simply: “We’ve just been robbed.”

Response to Event:

Mark’s description of the events filled roughly an hour of our time together that first day. He is very bright, but also very shy. He is, he said, unaccustomed to talking about himself, unfamiliar with the process of describing happenings such as he had experienced. He would hint at how things happened, I would pursue the detail. Questions, when properly framed, drew complete responses, painting a clear picture of the event as it had unfolded. For the most part this gentle probing process continued, successfully, throughout our interviews.

There was, though, in all the answers given, both direct and narrative, a curious absence of any emotion and I found myself feeling that a discussion of the price of canned goods at the local market might have drawn more animated responses. I was frankly puzzled. While not attempting a diagnosis of PTSD I nevertheless inquired about symptoms that might be present in the aftermath of the robbery: Were there nightmares?
No, he didn’t dream -- ever. Had he worried about being robbed again? No, not really. Did he think about what had happened? Did he worry about what might have happened? No. No. He appeared, frankly, to have taken this incident in stride, being no more affected than he would have been had someone approached him on the street, panhandling for loose change.

Pausing, seeking some grounds for further pursuit of knowledge of the incident and its after effects (if there were any, which at that point I doubted) I said, fairly simply and directly: “I’m surprised. You seem totally undisturbed by the robbery. I’ve never had a gun put to my forehead, but I think if I did, it would upset me a lot.”

In response he was silent for a long time, lost in thought. It was obvious to me that he was, for the first time in our meeting, searching inside himself. I am familiar with the pregnant pause. The few seconds that pass seem, in most instances, to stretch to a much longer time than they really are. But in this case the silence was truly lengthy. I could, from where I sat, see a clock on the wall. Nearly three minutes passed before Mark spoke.

Finally he looked up, directly into my eyes, which he had not done before and said: “Would you mind turning off your tape recorder?” I said no, and complied.

Then he began again. To summarize, he said, “Look, I’ve had a lot of things happen to me in my life. Some I didn’t even know about, some I probably still don’t know about, some I’ve only just started learning about. This robbery, the gun, all of that, well, it was no big deal. I’ve had a lot of stuff happen to me. Do you really want to talk to me?”
I felt, in honesty, a sense of confusion. I'd sought this young man out to explore a specific event in his life. He was now apparently responding with an offer to discuss and explore much more. My work was academic and documentation was important to me. He had asked me to turn my tape recorder off. I kept my own silence for a few moments, then responded.

Yes, I said, I'd like to really talk, but about what? His response was simple and forthright: About what's gone on in my life; at least all I know about. I've never talked with anyone about it -- at least not most of it. Never, to no one. Ever. But I'd like to talk if you have time.

I felt more confusion. In carefully chosen words I told him: It's important you understand, Mark, that I'm not a counselor, not a therapist. I don't have skills or training in that area. I'm a sociologist and I'm building my knowledge of how PTSD affects peoples' daily lives and how they get along with themselves and others. If you want counseling, therapy, I can put you in touch with someone I'm sure. But I can't provide it. I do want to hear what you want to tell me, but I don't want you to expect things from me that I cannot deliver in return.

At that point he pulled from his wallet a card that had been given to him by one of the police officers who had responded to the robbery call. On the back were telephone numbers an officer had suggested he could call if he felt a need for help in dealing with emotional problems that might result from the robbery event. He said he'd called two of the numbers. He didn't like what he was told during his brief conversations with the persons handling his calls. He'd decided there was no point in calling any other numbers, or of pursuing further contact with those at the two numbers he had called. He just didn't
feel like bothering with the process. He said he understood who I was, what I was doing, the nature of my study. He wanted to talk — to me. Why I asked? Because I think you’ll listen. That’s all I want, he said. I just want for you to listen. OK?

OK, I said, I’ll listen, but only with my tape recorder on. I need to record our conversations for my work. I have a good memory, but I’m not a human computer. I need to have a good record, good reference upon which to rely in the future.

Now he paused again, sitting silently. Finally, raising his head, he said: OK, record me. It’s OK. I want to talk and if you need to record me, that’s OK. Go ahead.

And, as we talked for several hours spread through numerous meetings Mark’s life history unfolded.

The earlier incidents:

Mark and his wife live with his mother who, it turns out, manages her own Dominos store. Her life is stable now. It wasn’t for many years.

Mark told me he never dreams. That wasn’t quite true. Now he told me that for a number of years he hadn’t had dreams. During those years there had been neither good dreams, nor nightmares. Nothing, just sleep. Then, about 6 months ago he’d had a dream.

He saw himself (he said he knew it was himself because he said he’d felt fear and helplessness in the dream and after awaking) as a very small child, lying on a bed. In the room with him were two adults, his mother and a man he did not recognize. They were fighting. He watched helplessly as they struggled. The fight was violent, the man struck his mother repeatedly. There were loud words, most unintelligible to him. The fight
continued. Suddenly, in the midst of the fight a knife appeared. The man struck his mother with the knife, repeatedly. She screamed, begging him to stop, but he continued his assault. The dream ended.

It was, he said, a dream that began to come to him regularly. Not every night, but regularly. He had not dreamed before and now this one terrible dream was beginning to dominate his nights. He wasn’t sleeping well.

Finally he decided he needed to talk to someone about the dream and since his mother was such an incredibly real part of the dream he decided he’d share the dream with her. One morning, he didn’t recall just which morning, as he and his mother prepared to start their respective work days and were both grabbing a quick bite and cup of coffee in the kitchen, he told her he’d had a dream that was bothering him. Did she have a minute; could he tell her about it?

She said yes, she’d be glad to take a minute and listen. So they sat down at the table and he told her. And, he said, as he told her she began to respond. As he described, as best he could, the vivid images that had come to him, she at first became nervous. Her hands shook, she grasped her coffee cup tightly with both of them, seeking to stop the shaking. Then, as he continued, her eyes filled with tears. And as he finished, her tears flowed, followed by sobs.

Having revealed his dream to his mother, it then became her turn to reveal some of their common history to Mark. She told him the dream was not fantasy. It was real. Her presence in the scene, and his, were part of their shared personal history. So was the man. He had been her husband and was Mark’s father. Mark had no other recollection of his father.
There had, she said, been many such fights. This particularly terrible fight and struggle had culminated in her being stabbed by Mark’s father. She wasn’t sure if Mark had witnessed other fights. She said he probably had, though he had only attempted to kill her the one time. Maybe that’s why that incident stuck with him. Who knew?

This final fight, and all those preceding it, had been over drugs. She had, prior to the marriage, prior to her pregnancy and Mark’s birth, been educated and had been a registered nurse. In fact, she’d been more than just a nurse. She had been a charge nurse, the head of a unit at a large hospital in the Los Angeles metro area.

Her marriage to Mark’s father had, at first, been one of infatuation and physical love. The marriage had rapidly become abusive when, a year or two into the marriage, his drug habits, dependencies and trafficking had revealed themselves. As a charge nurse, she had access to the controlled substances available at her hospital. She was expected to supply him. And she did.

Being his supplier was, at least at first, fairly easy for her. Controls were lax, her access broad. Her hospital became his supplier. She became the middleman. But the system did have controls. As time passed she grew fearful of being caught and of the consequences. She was well educated, well trained, and had a career to worry about. Now she also had a child who was dependent upon her. She was needed in more ways than one. She felt her child’s needs for her as a mother took precedence over her husband’s need for drugs.

He disagreed with her priorities. His needs, he insisted, should, and would, come first. The fighting commenced and continued, escalating along the way. Finally, in one last desperate fight, he attempted to kill her. Now the authorities intervened. He was
arrested. Ultimately he was released. For reasons unrevealed to Mark, the charges didn’t stick. But the marriage was over.

However, ending the marriage didn’t end the problem. Now there was blackmail. Mark’s father had escaped the legal charges resulting from beating and stabbing his mother, but he would not let her escape him. She was still in a position to be a supplier and supply him she would. If she didn’t what would happen? It was simple: He would turn her in and tell all. His revelation of her “dealing” drugs from the hospital pharmacy would cost her dearly. She would, in short and at the very least, lose her job. In all probability she would lose her nursing license and with that, her ability to care for her children. She might even end up in jail.

In their marriage dissolution she had gladly released him from all support responsibilities in return for his agreement to have no contact with Mark. He had willingly agreed -- she said he was relieved at not being burdened and simply didn’t care about his child. But now a specter emerged. He painted a picture that was, to her, horrifying. If she was unemployed, possibly even in jail, she could not support Mark. He, on the other hand, having cooperated with the police would not go to jail. He would petition the court for visitation. In fact, he’d go further. He would seek full custody of Mark. And, especially if she were jailed for her drug theft and dealing, he would almost certainly gain custody.

The prospective scenario was more than she could face. She agreed to continue to be his supplier, and she was for a number of years. During those years he kept his distance, honoring his pledge to have no contact with Mark. He didn’t care. Mark never
knew his father. But there were controls at the hospital and ultimately they were both caught.

The consequences for her were, essentially, those her husband had threatened if he turned her in. She lost her license, lost her job, was tried and convicted on various criminal charges and was jailed. The consequences for Mark’s father were worse. He’d woven an incredibly tangled web of involvement in the drug underworld. He was, prior to trial and probable conviction, murdered.

Now an adolescent, Mark knew only of the parts of the scenario of his life unraveling that affected him directly. According to his mother, legal ties to his father had been severed in the divorce action. There was no other family upon whom she could depend. Mark became a ward of the State of California and was placed in a foster home.

There was emotional trauma for Mark in all the events that had taken place. Though unremembered at that time he had witnessed his father’s assault on his mother. The separation from her following her arrest and temporary placement in a juvenile facility had been bad. Settling in to the foster home environment he felt, he said, some sense of loss and loneliness, but he also felt a sense of security. There were several other boys in the home, most his age. The foster parents themselves seemed good and caring. They weren’t sweet, or loving, but they were nice to him. And the social worker from the state seemed interested in his well being, though he always seemed to be in a hurry to be on his way.

Mark indicated that his monthly interviews with the social worker went something like this:

“Well, it’s been a month since we last visited.”
"Yeah."

"Well, everything's alright, isn't it?"

"Yeah."

"No problems?"

"No."

"Nothing you need to tell me? Anything you want to ask me?"

"No."

"Well, that's good. I'll see you next month."

And that was about the extent of the conversations with the social worker. Mark said that was OK. He didn't like to talk much and didn't really have much to say anyway. Things were OK with the foster parents and he felt more and more at ease with his life. He had been told it was nearly certain his mother would be out of jail in less than two years and that when she was released, and could support him, he'd be going back to live with her. He wanted that.

Life was OK for now. At least it was until Jeff, the son of the foster parents, entered his life. Jeff son did not live with the parents. He had his own place, a mobile home, a few miles away. When he first showed up he was nice. He talked easily with the boys, brought them things, took them on excursions to the store and generally made them feel comfortable around him. Then, one day, he asked Mark if he'd like to come to his place -- spend the day, and night, with him at his trailer? Mark said that would be fine; it would be fun and a nice break. He wouldn't have to do his share of the household duties.
So he went. But the events that took place at the trailer were not at all what he expected. The day and evening had been fine, but then, when it came time to go to bed things took a turn for the worse. Jeff said Mark needed to take a bath. OK. Then he said he'd help Mark bathe. Mark was 13; he said he didn't need help. He repeated himself when Jeff said, again, that he'd help Mark. Jeff insisted, and accompanied Mark to the bathroom.

Mark's description of the events in his life to this point had not come easily. The conversations we had took place in the course of several meetings. He had told me that he did not like to talk about himself. But yes, he did want to talk. He would tell me things. Then he would stop. I'd ask questions. Typically he would respond with brief answers, and then ultimately return to a halting narrative. I never lead the conversation but I prodded to keep it going. But at this point all communications came to a dead end.

I knew Mark was now intensely uncomfortable. He had told me before that he didn't like to talk much, didn't like to talk about himself, and that he had rejected talking with counseling professionals after the robbery. But, despite all of that, he'd indicated he wanted to talk to someone, and had identified me as being the someone with whom he felt he could talk. And he had talked to me -- up to this point.

I was, in honesty, too wrapped up in the events unfolding at this particular time to pay as much attention as I should have to my recorder. I did not notice my tape had come to an end. And the roughly 20 minutes we spent together in a predominantly mute truce went unrecorded. During that time I got us fresh soft drinks. I would ask simple questions to regenerate conversation. He would either not respond at all or would give short answers with no meaning.

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Finally, I suggested that maybe we had reached the end of his story. Maybe we should let this rest. Clearly there were some things in his life he didn’t want to share and I understood that. It was his right to maintain his privacy. I was not hurt, or offended. I respected his rights.

And, after a few guarded words on his part, he agreed and we ended our meeting. In so doing, I thanked him for all his time. He thanked me for listening. I wished him well, and told him I was sure I’d be seeing him from time to time through his contact with my son Miles. He smiled at that and said, yes, he was sure we’d see each other. And then he left.

About a week later Mark called. He wanted to talk again. He’d said he’d thought about it and wanted to tell me some of what he could. He didn’t think he could tell me everything, because he wasn’t sure he remembered everything, but he wanted to try. So we agreed upon a time to meet and he kept the appointment.

He was very business like when he arrived. It was clear he was a man on a mission and had thought some about how he wanted to handle himself. We sat in our usual seats, around the breakfast table, sharing a diet Coke or Pepsi. Nodding at him, seeking confirmation that it was OK, I turned on my tape recorder and began to say something. He stopped me and said, “Just let me talk. It will be better. OK? I’m not going to talk long because I don’t want to. I don’t want to say a lot. Just some.”

And he began abruptly by saying: “He abused me.” I sat silently. “He abused me,” he repeated.

Impulsively I responded, “What do you mean he abused you?”
Mark snapped his eyes at me and said, “I told you, I'll talk. You just listen. Please. He abused me... sexually. Now you know.” I lifted my hand in a gesture of intervention. His own gesture in response cut me off. Just listen, he said.

And then, over the next 30 minutes he told me of abuse without telling me detail. I do not know exactly what the son of the foster parents did to him but I do know this: It hurt, a lot. He did it repeatedly. There were many nights at the trailer and all of them involved sexual abuse. Most of the other boys were abused, though they were all afraid to tell each other about the abuse. He (Mark), they all, were threatened and warned not to tell anyone. If they told it would be very bad for them, and maybe even for Mark’s mother as well. They all knew what was happening to them. Theirs was a shared experience. They all were given the same warnings: Don’t tell. They all kept silent, believing they were protecting each other in the process. They accepted the circumstances into which they had been placed, and were held. They had to survive. (Goffman 1959:36)

And so now, when the social worker would come to the foster home the questions directed to Mark were the same, and so, for the most part were his answers. Any revelation of the truth would invite even worse experiences. (Goffman 1959:36) He had much to tell, but couldn’t, or wouldn’t, his self enforced silence borne of fears, some of which remain undefined to this day.

And, at that point in our meeting, my own thoughts raced ahead to noble pursuits. How could this have happened? How can it be allowed to continue? How can I not run screaming for help for Mark, for those who had been at the foster home with him, for
those were there even today? Was there not, in my research, in this work, an implicit desire to create a call to action? (Cottle 1977:181)

But, I was drawn back to Mark’s story as it unfolded. He said it was at this point in his life that he stopped dreaming. He said he had dreamed prior to the onset of the abuse, and even for a short time after it began. Those dreams, immediately after the abuse began, had been horrible. But then all dreams had stopped. There were no good dreams in which he was with his mother again, there were no nameless dreams of others, or even bad dreams of his separation from his mother. And there were no dreams of the sexual abuse. There were simply no dreams at all. None. Ever. At least there had been none until just a few months ago when the dream of his father attacking his mother had emerged to haunt him and ruin his rest.

He said he had, for a long time, feared contact with all young men. He was, he stated clearly as if to remind me, a boy at the time all this had gone on. And contact with young men, even the social worker, made him feel panicky and ill at ease. In fact, when he was with the social worker what he wanted most was to not be there; to get the meeting over and just get away from him. There was, he said, a lot of danger in being with the social worker. Did I understand that?

It was at this point he volunteered information on a subject at which I’d gently probed previously: Who was his young wife; what circumstances had brought him to marriage, so young himself, and her even younger. I knew there had been no pregnancy. I’d gained that knowledge previously through a rather directly framed question. But, in his response to that earlier question there had been no further information volunteered. It
was one of those dead ends I had encountered periodically along the way. Now he was ready to talk about her and his marriage.

I met her when I was still in high school, he said. I saved her. Her life was awful. She had no where to go. We got permission to marry so she could escape.

Escape from what, I inquired? In response he simply looked at me.

I’d hit another dead end. There was no verbal response, either direct, or indirect. He just repeated that he’d marry her to help her escape. The door to that part of his life history had been closed.

And so, for a while, we talked about other things. We discussed his work at Dominos, his thoughts of getting his GED since he’d dropped out of high school. Maybe college? Who knew. He was smart, he knew that. He just didn’t know what he would do.

I decided to back track just a little, and asked about his reunion with his mother, his departure from the foster home. What had happened?

There was, he said, nothing unusual about what happened. His mother had been released. It had taken her about four months, mostly spent in a half-way house, to get herself back on her feet. She would never have a nursing license again. She had found work with Dominos in southern California. Then, with a job in hand, she had petitioned to have him returned to her and the petition had been granted. They were back together. She was, of course, very smart, she progressed quickly at Dominos, and in a relatively short time was offered the store manager’s position in Las Vegas she holds to this day.

Had he ever seen the foster parents again? No.

What about the other boys at the home? Had he had any contact with them?
Some.

Like what kind of contact?

Well, I’ve stayed in touch with some of them. I know it went on with them after I left and I know they are still keeping boys at their home and I know the son is still abusing the boys. We tried to help each other, take care of each other, but we really couldn’t do much. You know? We tried. (Goffinan 1959:64) And we’ve talked. I know.

But how do you know?

I told you. I’ve talked to some of them, and they’ve talked to others. I know. I know.

Don’t you want to punish him, I asked? Don’t you want it stopped?

Yes, he said, I do want to punish them, and him. But I can’t. I just can’t. I couldn’t talk about it with the social worker when I was there and I can’t do anything about it now. I had to get along; I still do. (Goffinan 1959:66) I can’t do anything about it. Not now. Not ever. I just can’t. And, I don’t want to talk about it anymore now, OK? It was, is, something I can’t help with. (Goffinan 1959:67) I really don’t want to talk about it anymore.

And, after a few minutes of lame, drifting small talk our last meeting and our last real conversation about his life came to an end.

Response to Event and Subsequent Impact on Social Function:

The subjects of the life study presented prior to Mark’s, and the one presented subsequent to his, both offered much more detail of their ongoing problems with PTSD.
Despite their problems they were more willing, and able, to share their knowledge of their experiences. It is also significant to note that in both of those studies the subjects had been previously diagnosed by credible professionals as suffering from PTSD.

Mark has not been so diagnosed. Nor, in my study, have I attempted a diagnosis. I am not qualified to do so. I will, however, venture the opinion that formal diagnosis seems, in the course of this particular case study, to be almost superfluous.

The events in Mark's life have been traumatic and he has suffered various symptoms of PTSD at various times. His life is, today, one of confusion. To wit:

1) He knows the level of his own intelligence. He was, as a child, a good student. His performance as a student was, in fact, exceptional. Through casual contact at the high school he attended I confirmed his self assertions of high intelligence and strong academic capabilities. But he has lost his capacity to focus and concentrate.

    His sudden, unexplained decision to drop out puzzled many of his teachers. Inquiry brought them no explanation. I was told that when pressed for some explanation he withdrew. But, based on even elementary knowledge of labeling theory and the process of stigmatization, the avoidance of explanatory conversation is no mystery. Telling people about being subjected to repeated homosexual abuse would invite labeling and stigmatization. Questions, unspoken or vocalized, would arise: Was he gay now? Had he invited the advances when they occurred? The withdrawal from school and the avoidance explanatory conversation aren't difficult to explain given the proper context for understanding.
But, through the deviant act of dropping out of high school he has imposed on himself a penalty that will, if statistics are to be believed, haunt him financially and socially the rest of his life;

2) He is haunted by knowledge upon which, for various reasons, he cannot bring himself to act. He has indicated he knows, with certainty, that the sexual abuse he experienced in foster care continues to be enforced on others. But he cannot confront the situation, he cannot revisit the scene and effect any action that might bring change and improvement for others. He said, repeatedly, that he does not like to talk about himself. In fact, rather than talk about some aspects of his past, he withdraw and temporarily severed contact with me. Upon return to contact he told his story in a manner reminiscent of a child hinting at a surprise he hopes will be discovered: Something happened to me; can you guess what? I don’t want to talk about it, but I need to talk about it. In effect: I don’t want to be labeled, and stigmatized, but I need to reveal myself.

3) Dreams of past events have returned to haunt him. When deprived of proper rest, irritability emerges and dominates his normally docile demeanor. This otherwise shy, reticent young man, becomes explosive in his responses.

In summary, his social functioning seems seriously impaired. (Diagnostic Criteria from DSM IV 1994:210)

And from a Durkheimian perspective, he is gripped by a strong sense of anomie. His life history being as it is, what are his norms? His work at Dominos provides a paycheck with no sense of fulfillment. He recognizes the need to utilize his previously proven intelligence but is unable to clearly identify how to do so. He’s thought of
college, but how would he do that? You have to graduate from high school first. He knew he could get a GED, but why? It would be tiresome and boring. It seemed like such a waste of time. I know, he said, all that I need to know to get a GED. Undertaking the GED process in addition to working at Dominos seemed like such a futile effort.

And there was, underlying all the conversations about his mother, her conflict with his father, his forced abandonment to foster care and the agonies of abuse suffered therein, a clear presentation of his feeling that the system has, to this point and at best, consistently failed to properly provide for and protect him. At worst, the social system has in fact at times actually condemned and committed him to circumstances resulting in his suffering undeserved agonies. Normlessness, anomie, has dominated his past life and the dominance continues at present.
CHAPTER 6
CASE STUDY #3: TOM

Introduction:

By its very nature, PTSD is a disease that defies identification and study. Sufferers, for the most part choose to deny their disorder, hoping to avoid the experiencing of more symptoms. I spent uncounted hours on the Internet seeking clinical references to broaden my knowledge and also to quote. I discovered various web sites, hosted by various individuals and agencies, both private and government, devoted to PTSD. I had also learned, though, there was very little published material concerning non-military, non-war or civil conflict, onset of PTSD. Yet many references discussed the potential for such onset.

The statistics, compiled in numerous studies by various agencies, all of which reached remarkably similar conclusions, compelled my interest in the prospect of several million American civilians being afflicted with PTSD. But, in all my searching I could find little real discussion or description of civilian case studies. I obtained a URL from UNLV Computing Services (www.unlv.edu/gradstudents/stewart), designed my own web site to assist in my research, and went on line myself. I would see if there were, out there in cyberspace, PTSD sufferers who had hidden longer than they cared to, and who might now be interested in telling their stories. My efforts were rewarded and I was not disappointed in the responses I received.
The Process:

March 14, 1999

I received my first response from my web site. I had asked any visitor to the site who suffered from PTSD to relate some, or all, of their experience to me if they so desired. This first response was short.

"You wouldn’t believe it if I told you. It’s worse than any soap opera you’ve ever seen.” That was all. I’d hoped for more but was pleased to have received any response at all. When I first developed the site I knew that in order to have even a hope of eliciting responses the site needed to be listed on as many search engines as possible. I had decided I’d seek listing on the two I most frequently use: Infoseek and Yahoo. The listing process is tedious, the results of enduring the process are difficult to gauge. For example, at the time I did my listing Infoseek displayed, upon search, site addresses for over 7,000 PTSD related sites. Yikes!

But I did pursue the listing process and approximately 10 days after I began the process I was delighted to discover that upon entering PTSD in the Infoseek search box, my site was there. It was, in fact, the first URL to appear. Success! But, success and easy access, I have learned, are fleeting in the world of Internet search engines. On September 27, 1999 a similar Infoseek search yielded links to 8,015 PTSD related sites and that same day I could not even locate my site within the 8,015 sites produced by an Infoseek search. There are so many sites!

I honestly cannot say what are the statistical probability of a PTSD sufferer finding my site. Given the number of sites it would seem the odds must be enormous
against such a hit. I was, and am, therefore, extremely pleased when through whatever chance or circumstance an interested person hits on the site.

So, when the first response came in I was happy — elated actually. I decided not to pursue the reluctant respondent initially and tucked the brief message away. Then, a few days later, as I reviewed my email files, I decided to respond. I sent a simple message: “I’m sorry for what you are feeling and will be glad to listen if you’re willing to share. There is so much that goes on in the world there is little of which I would not want to learn more. Share with me if you are comfortable doing so.”

There was, for the next two weeks, no response. Then the email responses began to come. Initially they were brief; just a few sentences.

The Incident:

Slowly the story began to unfold. My respondent, Tom, was a male, beyond middle age, but, as self-described, not old either. He and his wife had been married 50 years more or less and had, for the most part, been happy. As far as he knew she had never strayed. He acknowledged that he had, but only in a physical way. He loved his wife deeply and had for the duration of their marriage.

They had three sons, one living near where they lived, the other two in other parts of the country. His problems had begun with the oldest of the boys. Tom, through good planning and good luck, had become wealthy. He’d had some resources given him in his youth, but nothing approaching the current value of his assets. Early in the marriage of his oldest son he’d tried to bring him into his business life. They’d made a diligent effort at the process for over a year but the effort had failed. There were too many personal
problems. The son’s wife did not like the business, did not like where they had to live to work the business and felt her father-in-law dominated her husband. There was a lot of conflict. The business portion of the relationship was severed, the son and daughter-in-law moved to an area she preferred, and while some tension remained as a result of the failed effort at working together, the family relationship was at least cordial, if not warm.

In the course of their marriage the son and his wife had two children of their own; first a daughter, followed shortly by a son. Their lives progressed. Over the years the young family visited the parents and the visits were reciprocated periodically with the parents, who had plenty of money, traveling to the son’s home, spending time with them, participating some in the family’s life. There was friction; it was tolerable.

The son did well in his own business efforts and was successful, though not enormously so. Knowing of his father’s wealth he, and his wife, approached Tom with a request: Would he give them $80,000 with which to buy a cottage on a lake near where they lived? Tom and his wife said they’d think about it. They did and after much consideration responded negatively. They didn’t feel they could make a gift of that magnitude to one son without sharing equally with the others. While their resources were ample, they weren’t comfortable with the impact of making gifts of the magnitude envisioned.

The son and daughter-in-law were angry. They accused the parents of being stingy. Harsh words were exchanged but as time passed the relationship again took on somewhat comfortable dimensions. Tom said there always was, with the daughter-in-law, an underlying tension; he could feel it. It was not displayed overtly, no words of anger or disagreement were spoken, but he felt there was, beneath the surface, a
resentment. And the resentment appeared to be affecting the relationship Tom and his 
wife had with the two grandchildren. They were alternately open and loving, and then 
withdrawn. On occasion they seemed to open up and communicate, at other times they 
too seemed to shut out Tom and his wife, seeming to almost intentionally exclude them 
from their lives.

As time passed the granddaughter began to experience problems of her own. She 
had, as Tom described it, a bit of a wild time as she went off to college. Her mother 
didn’t approve of her social life, of the numerous boys with whom she became involved, 
and worried for her future. Despite her mother’s concerns, she continued to live her life 
as she chose. Her parents did not choose to enforce their values by tightening the purse 
strings.

Then, in a single evening, all the problems building over the years exploded in a 
single incident. In the course of visiting and staying with his son and daughter-in-law 
Tom and his granddaughter were sitting together, on the couch in the family room late 
one evening, watching television. They visited some, the granddaughter talked of being 
tired; she slumped in the corner of the couch. Tom said she was welcome to lie down if 
she wanted; he put a throw pillow in his lap and said she was welcome to rest her head 
there -- jokingly he said he didn’t bite. She did lie down and they continued watching 
television. The program ended, the hour was late, they were both tired and now 
agreed it was time for bed. And so they went to bed -- Tom to the guest room he shared 
with his wife, the granddaughter to her own room.

To this point, the story had come to me in bits and pieces via email. Now the 
method of communication changed. Tom indicated, in his last, more lengthy, email, that
this process wasn’t working for him. He didn’t want to talk in person but did want to chat on line. Would I agree to that? Yes, of course, I responded in my own email. When and where? He gave me his Instant Messenger screen name and suggested I put him on my buddy list. He said he’d be on line at a certain time and I should watch for him to “pop up.” I did as he suggested and sure enough, there he was. I initiated the contact:

“Hi, this is Don. Do you want to talk now?”

“Yes, sure. Let’s go.”

And so we went, or rather mostly he went. I felt, and still feel, as though I was having a real conversation. He was, and is, a good typist. It seemed to me at the time, and still does, that he was well organized. He acknowledged later that he had, in fact, thought and considered for hours, just how to tell his story; what words to use, which to avoid. How to make, or help, me understand what had happened to him and what he was suffering as a result. With an adequate ISP (Internet service provider) and peripheral services, e-mails can be preserved, catalogued, and maintained as readily as can paper letters. On line chatting does not provide similar opportunity for preservation. Unlike a personal, or telephone, conversation, they cannot be recorded on tape. The words flow from one to the other, and back, appearing on your screen in disembodied boxes. As they flow, and your screen fills with messages received, and sent, your screen scrolls. And, as the chat continues, you can scroll back to earlier portions of the conversation to refresh your memory as to what has been said, or not said. But I know of no method for saving to memory the content of the chat. I have, subsequent to that time, learned that I can, with at least some success, print to paper portions of the on screen chat. The process is not altogether satisfactory, gaps occurring in the printed record. It is, however, better
than having no record at all. But, at the time of our chat, I just didn’t know enough. So, I scribbled notes as we chatted; that was tough and caused delays when I needed to respond. I’d be scribbling away, and then would have to put down pencil and take to the keyboard, to tap away my responses and acknowledgements. Nevertheless, despite, the shortcomings of the recording process, the story was told and continues here:

Upon awakening the following morning, Tom went to the kitchen for coffee. The horror began.

“She told me what you did to her last night.” It was a statement and accusation from his daughter-in-law.

Caught off guard, Tom’s reply was vague. “What? What are you talking about?”

“You know, you bastard. She told me you raped her. Kim told me you raped her last night!”

He said he was, initially, stunned and speechless. He actually recalled seeing spots floating before his eyes, remembers vague buzzing, ringing noises in his ears. It was almost as if his mind left his body, floated around, and observed the scene from a distant viewpoint. Time passed; probably moments. He wasn’t sure.

He responded: “What? What are you talking about? Where’s Kim? What the hell is going on here?”

“She’s locked in her room. She’s terrified. She’s staying there; I told her to keep the door locked. She doesn’t want to see you -- now or ever. I don’t know what we’re going to do.”
"I need to see her. This is crazy. Nothing like that went on here. She needs to come out here so we can talk, find out what's going on. There's something really wrong going on here."

"You are disgusting," she responded. "I don't know what we're going to do, but you need to get out -- now."

Where, Tom asked, was his son?

He had, she responded, left very early for work. He knew nothing yet, but, she assured him, he would.

Tom was incredulous. Let's call him and get him home, he pleaded. We need to get this straightened out.

No, she had responded, they couldn't call him -- he was out in the field and she didn't even know how to reach him. He needed to leave, she repeated -- now! After several minutes of futile efforts to communicate the daughter-in-law became more shrill. If they didn't leave, she would call the police. They probably would be called anyway, but she would call them now and have him arrested.

At that threat Tom and his wife did leave. They packed, called a cab, went to the airport and got on a plane and flew home. They were, in his words, "devastated" by the events that had unfolded. They could make no sense of all that had happened. They both cried. His wife continually assured him she was certain of his innocence. At the time, neither could make sense of the situation.

That night, their telephone rang. It was their son. He wanted to talk but he did not want to have a conversation. He would talk and his father was to listen. So he talked. He restated the earlier accusation of rape, he described his daughter's devastation, his
wife's horror and anger. He talked of his disgust with the knowledge that his own father would come into his home and take advantage of his daughter. He told his father he was sick and needed help. And then, finally, he said he had, in fact, begun the process of turning the matter over to the police. No, they hadn't called the police to the house; they didn't want a spectacle. But he had called, had made an appointment with the appropriate person, and was going to keep the appointment -- tomorrow afternoon.

Now Tom pleaded with his son. They would fly back, they could all sit down and talk. None of this was true, it needed to be stopped now before more damage was done and not just to him; what about his granddaughter? She needed to open up, tell what was really going on. The son’s response was stony. There would be no further conversation. There would be no family meeting. There would be a meeting with the police and then they’d see what would happen. He restated that his father was “sick, and needed help,” but that he couldn’t do anything about that. He was done talking. He hung up.

The horror of the reality now began to sink in. Tom stood, essentially alone, about to be accused of incestuous rape and it was clear there would be no possibility of intervention to defuse the bomb that was ticking. With the police involved it seemed likely things would get even worse.

And they did. In an order still not clear to me, several events occurred (or didn’t):

1) a police report was filed;

2) the daughter was placed under hypnosis and in a hypnotic state confirmed the accusations she had made to her mother;

3) no gynecological examination of the daughter ever took place;
4) ultimately charges emerged from the State prosecutor's office: Tom was charged with sex crimes. He did not specify the exact nature of the charges.

As, over a period of weeks, the scenario unfolded, Tom's life became a living hell. He could not eat. Sleep, when it came, was restless and interrupted with nightmarish dreams of the confrontation with his daughter-in-law, the telephone conversation with his son. And, within the dreams, there were snippets of his last time spent with his granddaughter, with her laughing at him, and pointing at him. He began to feel multiple fears: He was innocent, but the accusations were horrendous. What would others think of him? And what about the legal ramifications?

He hired an attorney; a good attorney. After carefully investigating and evaluating the charges, and the overall circumstances, the attorney indicated it was clear that 1) the son, daughter-in-law, and granddaughter were standing by their story, 2) the charges filed were all too real, 3) the nature of the charges were such that the State would not seek to extradite Tom to prosecute him, but would, if he returned to the state, arrest, formally charge, and then prosecute him. He was, therefore, permanently exiled from the state unless he wanted to become embroiled in a nasty, highly publicized proceeding that would resemble something from a soap opera or the Enquirer. His attorney's advice: Have no contact with the son or his family ever again and stay the hell out of the state. Period.

And, he said, for the most part he had followed his attorney's advice. He had not, and would not, return to the state. He had not attempted further contact or communications with the son or the family.
But he was living in hell. His health declined. He lost weight, lost interest in activities that had previously stimulated him. His thought stream, when moving in normal directions, was continually interrupted by ugly, flashing images and fears. And, there was a continuing, ongoing fear of public ridicule and social expulsion, if the incident became public. He sought professional help.

He thought the psychiatrist he found was good. He had had numerous sessions which had, to at least some extent, helped him unburden himself and gain some focus. He decided he would now tell his other two sons of the events. He did. They were horrified. But not at him. They believed him, suffered with him, attempted to intervene with their brother on his behalf. They were repeatedly rebuffed in their efforts and ultimately ceased. There was no point. It was as if there was an impenetrable stone wall they could not breach

One of the sons had a suggestion: Perhaps their long time, much loved, family physician, could reason with the family. He had, after all, known all the boys since birth, had, in fact, delivered the granddaughter in question. Was it worth a try?

Tom and his wife considered the possibilities for a long time and finally decided to make the effort. They went, together, to visit their physician and friend. He listened carefully, thoughtfully, asked some questions and at the end agreed to attempt to help. He was not optimistic, but he would try. And he did. He flew, unannounced, to the son's city and arrived, unannounced at the home in the early evening. The son was clearly surprised when he answered the door. What was the doctor doing there? Was he OK? Was he in town for a meeting? What a surprise!
Invited in, the family friend sat with the son and his wife and, with little hesitation, explained the purpose of his visit. They were stunned. They had, they told him, nothing to say to him. The event, the acts committed by Tom, had been horrible, the State had been clear: They were not to discuss this outside of legal proceedings. That was all. There would be no discussion. They turned cold then and suggested that it would probably be best for the doctor to leave. They did not want to compromise themselves, or him. The son's only noteworthy comment came as they parted. Perhaps the doctor could get help for their father? He needed help. The family physician replied that his father had gotten professional help -- that was one reason he was there this evening. They said good-bye then.

As Tom's story unfolded I lost track of the time. We were, I believe, on line together for approximately three hours. There is, I think, detail that was lost due to the problems with making a record. The intervention of time, the event having occurred five years ago, may have clouded and affected Tom's telling of his own story. The distance of cyberspace made the telling of the story easier in some ways, more difficult in others. But, it became clear at this point that the story having been told our chat was coming to an end.

Then, to my surprise, as we ran out of words, came the inquiry: "Could I talk to you, in person, now?" Now it was my turn to see spots, feel dizzy, actually feel perspiration rise on my brow. I had, during the preceding hours, "listened" to a long, convoluted, gut wrenching story of personal agony. He had, in the course of the chat indicated that his psychiatrist had indicated he was certainly suffering from PTSD. And, coping with the PTSD and living with it would not be easy for him. Even though he had
conquered the avoidance problem, or symptom, he could not confront the stressor event head on, even though he wanted to, and the problem was ongoing. He said his psychiatrist had used an analogy in one of their meetings: It was sort of like a Vietnam vet being placed in a position in which not only would he never be able to revisit the site of his horrors in an attempt to exorcise them, but the Viet Cong with whom he had fought would, in fact, be perpetually tracking him, waiting for an opportunity to exact personal revenge on him.

I am not a counselor. I am very clear on that point with all subjects. I am a sociologist gathering histories that might, through their telling, help others. I tapped that message back to Tom. He responded: “I know that, but now I want to talk to you. What’s your phone number?” I paused. I was, in honesty, afraid. Of what I’m not sure, but I was afraid.

I tapped my number onto the screen. Within ten seconds the telephone on my desk rang. Unsure of who might be there I answered as I always do: “Hello.” And through the ear piece came a voice I knew. I recognized it immediately.

Epilogue:

As stated earlier, I had, in the spring of 1999 established a web site for my study of PTSD. And, as described above, the sit has yielded worthwhile responses. I had, as a graduate student, an interest in sharing with others in my life, some of the process and product of my discipline. To that end, I had, in our Christmas 1998 newsletter to friends, described my enrollment in the UNLV Master’s program, and touched briefly on some aspects of my professional life. I had also included my email address in the newsletter,
hoping to elicit some more regular, and ongoing, communications with some of its intended recipients. My stated intention was, in fact, rewarded with numerous contacts, via email, from various friends. One of those responding was a truly old family friend. He was, in all probability, my father’s closest friend at the time of my father’s death in 1968. Their friendship had endured much. Through my father’s alcoholism, through my family’s move away from our native area, through my father’s death at age 51, and even through my mother’s subsequent, wretched remarriage three years later, Jim’s friendship had endured. He had, during those years, chastised my father’s siblings for their failure to provide proper emotional support for us at the time of my father’s death. He had always been ready, and available, for discussion as a mentor (though I hadn’t relied on him as my older brother had). He’d come to our rescue when my wife’s father died unexpectedly, leaving us with broken plans for a vacation. He had been a stalwart, first to my father and then to me.

In our first e-mails after his response to my Christmas letter, we had chatted about various simple things. We talked mostly in generalities, telling each other what we were doing with our lives. He had, I was surprised to learn, become a student himself, having gotten involved in computer science and becoming a bit of a cyber-whiz. He had developed his own simple web page which I visited and on which I commented. He asked about my work and I told him of the web site I was developing, its subject and intent. When I first published the site I e-mailed him to let him know the URL so that he could check it out. He did visit the site and sent me a response. Despite my ongoing aggravation with some aspects of the service provided by America Online I continue to use their service because it provides, with ease, a durable filing system for use offline as
well as online. I thank and praise them for that. From that filing system I include here, 
via cut and paste technology, his response after his initial visit to my own web site:

"Came in just fine with that address Don, will read through it. As for the web
page of mine yes it's old, but prefer to think of the kid's (sic) at that age, rather than now
after they have grown. I have my reasons, maybe can get some help from your Page or
some input. thanks Don---Jim"

I was pleased he had visited my site. I had previously chided him for out of date
pictures and information on the simple site he maintained (again courtesy of AOL). At
the time his somewhat cryptic message in response to his visit to my site had puzzled me
but I was moving along and quickly forgot it. But the message had been filed away.
Now, his message has meaning for me. I understand his words.

Returning to my reaction upon answering the telephone: I was stunned at my
recognition of the voice I heard. I had, through all the e-mails and through the entire on­
line chat, never imagined that the subject was someone I knew. Tom was Jim. Now I
needed to respond to this very personal contact. And I did.

Jim and I talked for about 30 minutes. I regret I did not record the conversation. I
believe he would not have objected had I asked for permission. I was, quite simply,
overwhelmed by the circumstances and forgot to follow my normal procedures.

Jim asked, initially, if he had been right? Was his story more than you might
expect from the worst soap opera? I responded that, yes, it truly was. But, I added, there
was a distinct difference, wasn't there? The old axiom of truth being stranger than
fiction is, in fact, true.
During the conversation he told me more of the events, though none that require inclusion herein to complete the story. I, in turn, made inquiries of him. Again, most responses added detail without providing new insights. I did, though, ask him about his visit to my web site and was intrigued, and gratified, at his response. He had, he said, visited the site more than once before actually really digging into it. And, when he dug into it some of it had been of simple passing interest. The clinical portions were, he said, somewhat old hat. He'd done a huge amount of reading on PTSD as part of and subsequent to his receiving treatment. But, he said what appreciated most, and for which he was extremely grateful, was the effort I was making to shift the focus of the study and understanding of PTSD from military personnel and events to people like him -- the civilian fighting a war in his own private trench.

He said the portion of the site that had helped him, and on which he had focused most directly, was one of the papers included in the site, the piece entitled "Circle of Friends." The title had initially drawn him to the piece. He said, he felt, some need for friends these days. His withdrawal from contact and friendship will be discussed in the final summary which follows.

I had presented the "Circle of Friends" piece at the Couch-Stone Symposium in February of 1999. It had been quietly, but not particularly enthusiastically, received. It was my "first time out" and while I'd hoped for a more enthusiastic response, I felt I'd done OK with my work and my presentation.

But I had liked the work and was proud of it. My feelings haven't changed. "Circle of Friends" had spoken of PTSD in a very real and human way. It had addressed the problems of others, as well as my own. It provides, I think, a story evidencing a real
bridge, or need for such, between private problems and public concerns. I had hoped it would provide some listener, or future reader, with a means for focusing on the problems with which they were confronted: "... ordinary men, when they are in trouble or when they sense that they are up against issues, cannot get clear targets for thought and for action; they cannot determine what it is that imperils what they vaguely discern as theirs." (Mills 1959:169-170) The "Circle of Friends" piece, not included here because of its length, addresses, in its due course, problems with drinking too much alcohol, with feelings of estrangement and alienation and with issues of avoidance and withdrawal. It describes, in fact, in non-clinical terms, the emergence of deviant behavior in response to the onset of PTSD.

In format the piece is not clinical or academic. It is not footnoted, contains no references, and certainly does not meet standards requisite for selection and publication in any professional journal. But there is, within the piece, a message that had reached someone and that, I believe, is most important.

Jim continued and related his experience in reading the piece. He paused periodically as he described his reactions, and emotions, to the stories I had told to him on his computer screen. He said when he read the "Circle of Friends" piece his attention was drawn to a small entry at the end of the paper, which, at that time, provided a link to a related piece called "Piano Man." That link is no longer in place. I removed it because I was concerned that my web site had become too large and convoluted and might intimidate, or overwhelm, some visitors. Now I question my decision. Perhaps I should restore it?
He said, he had returned to, and re-read, both of the pieces several times, finally printing hard copy of them. He said he still had the copies; that they'd gotten a bit dog eared from handling and re-reading. Reading them had, he said, given him some sense of sharing his problems. As he read them, he said they had brought tears, but these tears were for someone else, someone other than himself. That had helped him, he said.

And, he went on to say, the unburdening he had done through his e-mails, and through our on-line chat, and in our final culminating telephone conversation had helped him as well. They had provided him with a bridge which, when utilized, allowed him a better means of understanding and expression.

I was moved, and felt gratified, that my work had reached, and possibly helped someone.
CHAPTER 7

SUMMARY AND CONCLUSIONS

One learns best, I believe, by doing. When, after much consideration, I chose PTSD and its hidden (and revealed) effects on society as my thesis topic I thought I knew much about the topic. In retrospect it is clear to me that while I knew much of the disorder on a clinical level, I knew little of its impact on its human victims.

Each of the three life histories presented is unique. Within them, there are no similarities between the stressor events that triggered the onset of PTSD. There is enormous diversity in the life histories of all three subjects. The age span, from youngest to oldest subject, is nearly 60 years. The subjects themselves have, in reality, only two things in common: They are all males and they are all suffering from PTSD. Two have been professionally diagnosed as suffering from the disorder. Based on his history I presume that the third subject is suffering from PTSD as well. There seems little purpose in arguing about my diagnostic abilities or my professional credentials to that end. All three subjects have suffered greatly, and continue to suffer, the after effects of experiencing serious emotional trauma. It is the job of the psychologist or psychiatrist to provide clinical diagnosis of, and attach proper names to, mental disorders. That is not my job.

"It is the political task of the social scientist -- as of any liberal educator -- continually to translate personal troubles into public issues, and public issues into the terms of their human meaning for a variety of individuals. It is his task to display in his
work -- and, as an educator, in his life as well -- this kind of sociological imagination.
And it is his purpose to cultivate such habits of mind among the men and women who are
publicly exposed to him. To secure these ends is to secure reason and individuality, and
to make these the predominant values of a democratic society.” (Mills 1959:189-190)

So, as I have done my research and my writing I have, to at least some extent,
performed the service envisioned by Mills. I have also gained insight into the parallels
that might be drawn between the PTSD victim, suffering in silence and commonly alone,
and the mental patient who has been confined in the course of controlling or treating his
disease. Asylums, such as those described by Goffman, (1961) come in many forms;
some do not have walls. Within the life studies developed for this work reside new
possibilities for future sociological research. Goffman, in “Asylums,” describes the
career of the mental patient. The three life studies included herein describe the career of
the PTSD sufferer, and that career is based upon not only the DSM-IV diagnostic
characteristics of the disorder, but upon the social interaction processes all three sufferers
experience. The prior study, writing and theoretical development of sociologists such as
Goffman, Lemert, and Becker all provide sound basis for the initiation of these life
studies. The life studies themselves provide basis for further development of their
theoretical findings, particularly in the expansion of aspects of labeling theory.

In proceeding with the summary, it is important to note, and acknowledge, the
limitations of this study. Within such sociological study there is always the desire to
develop findings that may provide a basis for generalization of the knowledge developed
to the general population. This work, which includes three case studies drawn from a
total of eleven developed in the course of research, does not provide such generalizable

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knowledge. The size of the sample is simply too small to permit such generalization. The findings are significant, though, in as much as all the case studies developed reveal common ties to aspects of labeling theory not adequately considered in the past. Those aspects include an overt or implicit acknowledgement of a fear of labeling and its consequences. And, that fear of labeling pushes the sufferers in these case studies to a self labeling process that has not previously been explored.

Among those suffering one of the DSM-IV defined anxiety disorders, the PTSD sufferer, due to the nature of the disorder’s characteristics, suffers the most privately. The PTSD sufferer specifically avoids confrontation with his stressor. From a perspective of deviance theory, the purpose in avoidance seems multi-faceted. The avoidance reduces the potential for onset of unpleasant manifestations of the disorder. But, beyond that, the sufferer, at least in these three case studies, is aware he is a part of a subjective, judgmental society and does not wish to be publicly labeled as one who is having mental problems. There is, within the interview notes, clear evidence that consciously, or unconsciously, all of the sufferers are aware that labels, while easily affixed, are difficult to remove. Therapy, particularly if insurance is involved, requires at least some degree of public exposure. Once exposed, and labeled, how difficult is delabeling? Acknowledged mental illness, at almost any level, carries stigma. Could the sufferer’s history and his stigma follow him as he works to develop his life and career? Will the label harm him in his aspirations? Agency is powerful in our society. Labeled as deviant, he might be excluded from processes that would further his career and precluded from personal opportunities.
So, the sufferer hopes, believes, consciously or unconsciously, that if he ignores the problem it will at least grow smaller or perhaps, even better, it will go away and leave him alone. He is, however, on a daily basis, exposed to stimuli that may, in one way or another, trigger memories and emotions that tear away at and destroy him. He cannot avoid them. Serendipitous circumstances may place him in harm's way. "Learning to live under conditions of imminent exposure and wide fluctuation in regard, with little control over the granting or withholding of this regard, is an important step in the socialization of the patient, a step that tells something important about what it is like to be an inmate in a mental hospital." (Goffman 1959:164) Being confined to a mental institution and living under the oppression of PTSD are both tyrannical experiences. Both careers involve the development of techniques for adaptation and accommodation. All the case studies have in common the development of such adaptive techniques. All the techniques have in common a deviance from prior social behavior.

For example, in the third life history, in which fear of public accusation of engaging in secondary deviant behavior is specifically identifiable as being part of the stressor, there is, in every day living, the fear of loss of status, or regard. There is a persistent, morbid, gnawing fear of exposure that would lead to ridicule or ostracism based on unproven accusations. That fear forces his withdrawal from contact. To paraphrase Jim's words: "I don't go as much as I used to. I just don't want to be around people as much as I used to. And I don't want to be around situations where somehow, in some way, someone might suspect or learn what has gone on and goes on in my life. I used to do a lot more. I was active in the community, on the board of the hospital. Now I just want to stay away from people."
Significantly, not only is he being damaged by the withdrawal, so is his society. The small town that was previously able to depend on him for assistance and input in civic and public affairs has lost a captain.

In the first case there is a continuing, and ongoing, concern for emotional exposure and vulnerability at inopportune times. Losing control of self in the middle of a Los Angeles freeway rush hour is a dangerous business, and not to be taken lightly. There was, in my initial conversation with John, an emotional statement and plea: “God, I’d do anything to save someone else what I’ve been through.” If, in accordance with Parsons, normative structure is the heart of the social system, John feels he has been removed from the normal.

While not part of the actual research process other aspects of John’s life have changed as well. He always enjoyed social drinking. Now when he drinks, particularly in the company of old friends and fraternity brothers, he quickly drinks too much. And when he drinks too much he becomes abnormally and unexplainably aggressive. He provokes confrontation, picks fights with strangers, engages in public displays of irrational behavior. He suffers, and in suffering, recognizes and yearns for opportunity to assist in the process of sparing others his anomic state.

And the second history, that of Mark, involves an ongoing life bereft of most established norms. Mark’s work habits, and ethic, are among the few normal aspects of his life. As previously stated, and confirmed, he is extremely intelligent. He is, nevertheless, a high school drop out. He has, in a protective effort, married a young woman in an attempt to save her from potential terrors, imagined and real, similar to
those he suffered. He sleeps strangely; for years there were no memories of dreams, now the memories and dreams haunt him.

All three subjects, as described by Mills, "act with and against one another (other men). Each takes into account what others expect." Struggling with PTSD, and its primary symptoms creates anomie. Given the following, how could their lives, and social integration (or lack thereof) be otherwise: recurrent and intrusive distressing recollections of the event, recurrent distressing dreams of the event, flashback episodes, intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event, avoidance of stimuli associated with the trauma, and numbing of general responsiveness (not present before the trauma), efforts to avoid thoughts, feelings, or conversations associated with the trauma. Add to those problems difficulty falling or staying asleep, irritability or outbursts of anger and difficulty concentrating. The emotional baggage overloads the individuals' ability to function normally.

Specific parallels may be drawn between Goffman's described phases of the mental patient and the experience of the PTSD sufferer:
The Mental Patient

Prepatient - disintegrative re-evaluation of self; unwillingness to face evidence of loss of control; concealment from others of fundamental facts about self and condition

Voluntary Inpatient - sense of desertion by society and avoidance of others in attempt to deny reality of problem; adaptation to ward living processes imposed by institution

The PTSD Sufferer

Initial Onset - decline in function and ability to cope based on sleep dysfunction and other characteristic symptoms; unwillingness to acknowledge manifestations privately or publicly; avoidance manifested in withdrawal from family and social groups

Self-recognition - response by others may force confrontation over issues of family/societal compatibility and function; self imposed adaptation to life processes based on partial recognition of dysfunction

There are other parallels. The mental patient, the voluntary one in particular, may, upon self acknowledgement of a problem and voluntary admission in an effort to obtain help, regret the disclosures, voluntary committal and subsequent conditions attached thereto. The confinement, positively anticipated, may, in fact, become nightmarish in its manifestations.

The PTSD sufferer, upon self recognition of the problem, and seeking help, may regret his self recognition, fearing the consequences of going public and dealing with the treatment and the possible exposure to stigmatization. In addition, the PTSD sufferer may have difficulty locating suitable sources for treatment on an easily accessible and affordable basis. The mental patient suffers from too much intervention, the PTSD patient not enough.

"In a psychiatric hospital, failure to be an easily manageable patient -- failure, for example, to work or to be polite to staff -- tends to be taken as evidence that one is not 'ready' for liberty and that one has a need to submit to further treatment." (Goffman

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1959:385) For the PTSD patient, suffering silently and most commonly alone, the emotional outbursts, flashbacks, social avoidance, and other symptoms may publicly identify the individual as having problems or being in need of help of some sort. But most commonly neither the sufferer nor society can, or will, identify the source of the problem or the methods for any treatment. It is, in fact, the "maladaptive mechanisms used by patients with anxiety disorders" that creates the hidden problem for society. (Zohar, et al 1998:13) The attempts to "avoid thoughts, feelings, conversation, activity, places, or people associated with the trauma, ... suffer(ing) from emotional anesthesia, show(ing) markedly diminished interest in significant activities, (having) feelings of detachment and the sense of a foreshortened future" all stress social function and result in a persistent, ongoing anomic state. "PTSD is a disorder in which, by definition, an external traumatic event is associated with its onset. Thus, PTSD may demonstrate a clear example of the interplay of environmental (societal) and internal factors that contribute to the development of a severe, disturbing, and disabling mental illness.” (Zohar, et al 1998:13) A good example of all these aspects of the disorder, as well as of deviance precipitated by the disorder can be found by returning, briefly, to the life history of John.

Finding John had involved a significant amount of sleuth work. He had, it seemed, vanished. I contacted his fraternity house. No one there knew where he was or what he was doing. No one had had contact with him since shortly after Allan’s death. My initial thoughts were that he had, as is not unusual, simply gone about his life, not paying much attention to the faces and voices from his past. But, I did want to find him and so began making inquiries about his whereabouts to the fraternity brothers who had
been his contemporaries in the house. I knew many of them very well. Finally, through one of those contacts, I found a fraternity brother who did not know where John was, but did know the name and whereabouts of his parents. Through contact with the step-father, who would not initially reveal where John was living, I finally made contact with John and he told me his story. He acknowledged, as described at the end of the story, a strong sense of estrangement from many of those from his past.

I was surprised, then, when roughly two months after my first contact, John unexpectedly telephoned me. I had told him, when I first contacted him, of the search process I had gone through to locate him, and of the fraternity brother who had put me in contact with his family, that contact ultimately leading to him. He had indicated, at the time, that he was glad to talk to me but expressed no interest in being in touch with his fraternity brother despite the fact that the fraternity brother lived, surprisingly, within an hour of John. Now, however, he'd had a change of heart; he wanted to contact Bob. The old college football team was playing a game in the area and he thought it would be fun to see Bob, share the event and maybe some memories. Did I have Bob's phone number? Could he have the number? I gave him the telephone number and heard no more from him for a long time.

But, roughly a month after John obtained Bob's telephone number from me I did have a telephone conversation with Bob that revealed much to me. He did not volunteer the information. I had to inquire: Had John called him? Had they gone to the football game?

The response was quick and initially somewhat short tempered in nature. Yes, John had called. Yes, they had gone to the game.
I inquired further: Had they had a good time? It had been a long time since
they’d seen each other. How had it been?

The response caught me by surprise: “That crazy mother fucker almost got us
killed. Let me tell you what he did. We met at the stadium, found our seats, and then,
since we were early we headed down to the concourse to grab a beer. At least I grabbed a
beer. John grabbed several -- too many. After downing about four or five in short order
he began to change and get sort of belligerent, boisterous. Then he noticed some gang-
bangers hanging out in the area and started making loud comments about them. He said
he thought he’d go over and kick their ass. I tried to calm him down; told him this didn’t
make sense. They weren’t bothering us. We weren’t even really close to them. But he
was hell bent on it and the next thing I knew he was over there, in the middle of it with
them, calling them names, telling them he was going to kick the shit out of them -- and on
and on. I got in the middle of it, trying to pull him off, break it up. Then security came
and they did break it up; and they kicked the gang-bangers out. They let us stay but it
was bad. He’s turned into a fucking lunatic. Even after that he kept on drinking beers,
drank way too much and the whole thing sucked. He used to be a great guy -- he was
always fun to be around. I used to love hanging out with him, with Allan, with all the
guys. But now ...... I don’t know. I know I don’t want to be around him again like that;
maybe not at all.”

A college educated, bright, popular (formerly?) young man, now turned
belligerent street fighter? The whole process made no sense to Bob. Since then, despite
two efforts by John, Bob has avoided further contact. Was this secondary deviant
behavior precipitated by the onset of PTSD? Probably. Further discreet inquiry of other
fraternity brothers confirmed what Bob had told me. John had never been a drunk, never been a fighter. His problems in college had been small in their estimation; some bad checks, minor in possession charges. Those things were considered pretty routine among the college crowd. But, when among that crowd he’d always been fun, always been in control. He clearly had changed.

Edwin Lemert, in his own words as well as in quoting the words of others, says much that addresses the issue of PTSD as a social problem. “It must be taken into consideration that traumatic experiences often speed up changes in personality. Nor can the “trauma” in these experiences universally be attributed to the unique way in which the person conceives of the experience subjectively. Cases exist to show that personality modifications can be telescoped or that there can be an acceleration of such changes caused largely by the intensity and variety of the social stimulation. The importance of the person’s conscious symbolic reactions to his or her own behavior cannot be overstressed in explaining the shift from normal to abnormal behavior or from one type of pathological behavior to another, particularly where behavior variations become systematized or structured into pathological roles. This is not to say that conscious choice is a determining factor in the differentiating process. It is granted that original causes or antecedents of deviant behaviors are many and diversified. This holds especially for the psychological processes leading to similar pathological behavior, but it also holds for the situational concomitants of the aberrant conduct.” (Kelly 1993:192-193)

Lemert continues, at length on the topic in his “Primary and Secondary Deviation” discussing the onset of excessive use of alcohol in response to PTSD inducing
stressors. The onset of primary deviance is clearly, in Lemert's work, linked to PTSD. And, given time and the opportunity for the development of defense and adjustment mechanisms secondary deviance follows. "In the process of group formation, crises and interactional amplification are vital requisites to forging true, role-oriented group behavior out of individual behavior. (Allport, 1947:57) Society consists of the collective behavior of its component individuals. Deviance from the norm impacts the society." Lemert links the onset of secondary deviance to societal reaction. For the PTSD sufferer the secondary level may be reached despite a lack of initial societal reaction.

And the norms, from a societal perspective vary from individual to individual. Tom, in describing his own deviance from his normal position in society, had said he no longer went out much and really didn't want to be around people anymore. The significance of the words was lost on me until, in casual conversation with another friend in Tom's home town, his name came up. She asked, totally innocently, if I had any contact with Tom and his wife. Yes, I said, I did. I told her we talked regularly. Obviously I did not reveal the nature of much of our discourse. I was saddened, but not surprised at what she told me.

Tom, she said, had really withdrawn -- from everything and everyone. He had, without much explanation, walked away from everything he had taken great interest in for many years. He had, she said, been instrumental in maintaining the financial integrity of their small local hospital. His resignation from the hospital Board, and withdrawal from involvement in their ongoing financial concerns, had hurt the hospital and the community terribly. And he'd done the same thing with other prior interests and civic involvements as well. People were shocked and hurt. They had counted on him for so
much and he had simply turned his back on everyone and everything. He had recently, she told me, experienced some heart problems and his health wasn’t too good (which I knew about and acknowledged to her). But his withdrawal, all of this, had happened long before his health turned bad. It was hard to figure -- what did I think, she wondered? I puzzled about it with her but offered nothing in response. The confidence invested in me by Tom was too great a gift to violate. As stated earlier, omitted or committed acts viewed as deviant in one context would not be viewed as deviant in another. Had Tom lived in San Francisco his deviance from the norm as a stalwart civic leader would have been little noted or remarked upon. In a small prairie town it upset the social order.

These overtly described incidents of deviance are easy to recognize and identify. In re-reading my own notes, and in further studying my own writing of the life histories included herein, other incidents of deviance jump out at me. I puzzle, though, in considering which deviance poses the greater threat to society, to the values, ideals and norms that underlie social structure.

Is the greater threat or loss through deviance to be found in Tom, the older civic statesman, expressing his deviance through the quiet act of total withdrawal from community and responsibility as he continues to live in his own private hell? He has, through withdrawal, damaged the society within which he lives. With the loss of his input, experience, and guidance, the community is suffering. Its health care system has taken a financial nosedive, and other civic agencies have suffered for his absence as well. Surely that loss portends greater damage to society than does the explosive, easily labeled deviant behavior of John as he challenges random gang bangers to fight him in public places. And what of the deviance exhibited by Mike? Acknowledged by his peers and
teachers to be not only smart, but almost brilliant, his deviance has manifested itself through, among other things, his withdrawal from school and his marriage to a sixteen year old for protective purposes. How destructive might that deviance, and its potential impact on his future children and subsequent generations, be in the long term?

The statistics compiled by others, cited earlier in this work, provide impressive evidence of incidence of trauma that may precipitate the onset of PTSD in a large segment of society. PTSD, an anxiety disorder, precipitates deviance, both primary and secondary. Lack of public awareness of, or response to, the problem, and individual inability to cope with and obtain treatment for the disorder, as evidenced in the three life histories presented is problematic.

As I neared the end of the process of writing this paper I was intrigued to find, in the local newspaper, a story that described a murder and the subsequent sentencing of the murderer to prison for 40 years. The Las Vegas Review-Journal presented the story in a boxed format, drawing some attention to it even though it was well inside the second section of the paper. The coverage and information provided was limited, but described the defense position taken in the case: The murderer “said he was experiencing a flashback to the Vietnam War when he shot a police officer in the face.” (Las Vegas Review Journal, 1999:7B) A search for more details on the case via the Associated Press web site yielded information that the overall defense was, in fact, based on the defendant’s claim that he was suffering from Post Traumatic Stress Disorder. Was it, in reality, a fashionable defense? (p. 12) And, does the aspect of the defense being fashionable matter? The more important issue is that the defendant was, in fact, clinically diagnosed as suffering from PTSD. What is unclear is whether the PTSD actually
precipitated the act of murder. And, beyond that lies the issue of tolerance of deviant acts, particularly those of a secondary nature that threaten societal integrity and stability, regardless of their origin.

Deviance and deviant behavior are, at some levels, tolerated by society. At other levels, and regardless of its causes, the deviance is punished. In the above referenced sentencing, the deviant act was punished, regardless of the circumstances surrounding its origins. The secondary nature of the deviance and the violence of the act precluded public tolerance.

The life studies previously presented describe PTSD and its impact on three specific individuals. For the most part the studies do not explore the impact of the disorder on those closely associated with the individuals studied. The interview process and time constraints did not allow for that. This is, after all, a thesis and not a dissertation. The primary deviant behaviors developed in response to the disorder and described herein directly affect the subjects but the affect on society is difficult to measure. In the newspaper case described above the influence of the disorder, or the claimed influence, had a direct and significant impact on individuals and on the public. Secondary deviance emerged at an intolerable level and was punished. However, sensational murder cases aside, it appears the disorder, in potentially epidemic proportions, and the deviance it may precipitate may, for the present, remain hidden.

As previously acknowledged, this work has not developed generalizable knowledge. However, through inquiry in the form of life study, it does provide a sound basis for further inquiry that might lead to such generalizable knowledge. Future development of a larger sample may produce similar findings relative to previously
unexplored variances for applications of theories of labeling and deviance. There is, today, concern that the hidden epidemic of PTSD within the general population may emerge as a threat to social order. Today we can only speculate on the real effect of PTSD on that general population. Further study may provide generalizable knowledge that would lead to implementation of diagnostic and treatment techniques aimed at minimizing such effect.
APPENDIX

INTERVIEW GUIDELINES
AND
DISCOVERY QUESTIONS

POST TRAUMATIC STRESS DISORDER STUDY

Date: _____________

Subject Name: ________________________________________________

Subject Date of Birth: __________

Subject Address: ________________________________________________

Subject Telephone: __________________________

Subject Religious Affiliation and Level of Involvement: _____________

Standard Oral Questions:

1. Description and date of Incident?

2. Location of Incident?

3. Subject's Memories of Incident, including immediate emotional response?

4. Subject Long Term Responses and Reactions:

   a. Event reexperienced?
      1. day - mental images, thoughts, perceptions?
      2. night - dreams?
      3. other sleep disturbances?
      4. sense of recurrence, i.e. flashbacks, illusions, hallucinations?
      5. cue response?
b. Physiological changes?
   1. appetite or food preference changes?
   2. abnormal indigestion?
   3. unexplained stomach ache or nausea?

c. Changes in cognition and stimuli responsiveness?
   1. avoid thoughts, feelings, conversations about event?
   2. desire to avoid locale of event?
   3. inability to recall details of event?
   4. diminished interest in other activities?
   5. feelings of detachment or estrangement from others; Unable to have loving feelings for others?
   6. sense of foreshortened future or sense of failure or doom?

d. Increased arousal?
   1. difficulty sleeping or falling asleep?
   2. irritability or outbursts of anger?
   3. difficulty concentrating?
   4. hyper vigilance and hyper responsiveness?

5. Family of Subject Reactions:

   a. Change in relationship with spouse / parents?
      1. new sense of distance?
      2. new sense of closeness?

   b. Changes in family communication patterns?
      1. new sense of openness?
      2. new sense of closeness?

6. Friends of Subject Reactions:

   a. Change in relationship with close friends or romantic partner?
      1. new sense of distance?
      2. new sense of closeness?

   b. Changes in communication patterns?
      1. new sense of openness?
      2. new sense of closeness?

7. Victim and Family of Victim Reactions:

   a. Change in personal relationship?
      1. new sense of distance?
      2. new sense of closeness?

   b. Changes in family of victim relationships
      1. new sense of distance?
      2. new sense of closeness?
8. Workplace Reactions:

Co-workers

a. New sense of distance?
b. New sense of closeness?
c. Ongoing discussion, questions?

Employer (if workplace related incident)

a. New sense of distance?
b. New sense of closeness?
c. Ongoing open discussion?
d. Workplace changes?
e. Attempt to assist with adjustment to trauma?

9. Personal Adjustment

a. Counseling? If yes,

   1. Type?
   2. Provider (Personal, or if employment related incident, employer)?
   3. Feelings about counseling process?

      a. Helpful?
      b. Not helpful?
      c. Bullshit?

10. Overall personal feelings and comments?
BIBLIOGRAPHY


VITA

Graduate College
University of Nevada, Las Vegas

Donald P. Stewart II

Local Address:
Department of Sociology
University of Nevada, Las Vegas
4505 Maryland Parkway, Box 455033
Las Vegas NV 89154
(702) 895-0269

Home Address:
5137 Crimson Ridge Drive
Las Vegas NV 89130
(702) 658-4195

Degrees:
Bachelor of Arts, Anthropology, 1969
Florida State University

Master of Arts, Sociology, 1999
University of Nevada, Las Vegas

Thesis Title: Post Traumatic Stress Disorder: The Hidden Epidemic and Its Effect on Society

Thesis Examination Committee:
Chairperson, Simon Gottschalk, Ph.D.
Committee Member, Andrea Fontana, Ph.D.
Committee Member, Zachary Zimmer, Ph.D.
Graduate Faculty Representative, Jeffery Kern, Ph.D.