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# War-Related Stress

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## *Addressing the Stress of War and Other Traumatic Events*

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*A task force on war-related stress was convened to develop strategies for prevention and treatment of psychological, psychosocial, and psychosomatic disorders associated with the Persian Gulf War and other extreme stressors facing communities in general. The task force focused on the return home, reunion, and reintegration of service personnel with their families and work. Although the Persian Gulf War was won with relative ease, negative psychological sequelae may develop in some individuals because of the stress of war, family disruption, financial difficulty, and changes in family routines. Typical stress reactions and modes of coping that are usually unsuccessful or destructive were outlined, and suggestions were made for monitoring these. In addition, guidelines for successful coping were developed. Special attention was given to children's reactions and needs. Recommendations were made for outreach and intervention on the policy, systems (e.g., schools, businesses, governmental agencies), family, and individual levels.*

During and after the recent war in the Persian Gulf, our attention was often riveted to the technological and military aspects of the war. New methods of warfare, computer-guided missiles, and high-tech fighter jets were presented daily in our newspapers and hourly on television. Perhaps reacting to the plight of the armed forces during the Vietnam War, TV and newspaper attention also focused on the service personnel in the desert, their families back home, and how we as a nation felt about the war. As mental health professionals, we have a clear responsibility to concern ourselves with the psychological welfare of the combatants, their loved ones, and the nation as a whole. There is much we can do to prevent psychological distress after war and many interventions that can limit

the negative psychological and psychosocial sequelae that often emerge from war.

In response to our concern for limiting the negative psychological and psychosocial ramifications of the Gulf crisis, a task force was formed consisting of leading experts on the stress of war and other extreme stressors. The charge of the task force was to develop guidelines for public policymakers, mental health professionals, and those persons directly affected by the stress of war. This article outlines the key formulations of the task force and relates them to these three groups. Key points about stress and coping that psychologists should know are given special consideration.

### **Who Is At Risk?**

Two elements emerged in the task force's discussion of risk: first, the greater the threat of loss or the actual loss to which individuals were exposed, the greater their level of risk (threat to life being a principle threat of loss; see also Dohrenwend & Dohrenwend, 1981; Green, in press; Hobfoll, 1989). Second, the fewer coping resources an individual had, the more likely that he or she would be overwhelmed by the losses or threats of losses encountered

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(see also Hobfoll, 1988; Holohan & Moos, 1991; Lazarus & Folkman, 1984). This two-axis model is straightforward, based, first and foremost, on objective stressors and actual resources at the individual's disposal.

According to this model, service personnel will be at risk to the extent that their duty was hazardous and to the extent that they believed they would confront chemical warfare. The more time they spent in the field of operations and the more they were exposed to the dead and wounded, the greater their risk will be. The feeling that they were deserting their families at a time of need will cause some service personnel additional stress. After the war, they will continue to be affected by the delayed return home, culture shock due to quick foxhole-to-front-porch transitions; pressures of reunion; pressures of meeting their own needs, as opposed to work and family needs; reorganizing financial and work responsibilities; and changed social relationships.

Families will have undergone similar disruptions in their routines. Many spouses and other family members were overburdened with multiple roles, financial pressures, fear for their service person's well-being, and disruption and negative reactions in children's lives. For families, reunions will also continue to be stressful. Some of the sources of stress for family members during and after reunions include being second-guessed on important decisions and being challenged in their new, more independent roles. Conflicts may arise over new relationships that emerged in the absence of the service persons. Family members may feel stress when idealized dreams of a glorious return are not realized. Families, employers, and others may have a mistaken expectation that the serviceman or woman returning from the Gulf conflict should not experience prolonged stress because the war was so brief and "antiseptic," compared with the Vietnam experience. This misperception may further exacerbate problems that do arise, because the individual may feel unjustified in having difficulty. Family conflicts from before the war will not have been magically resolved, even if the idealized notions about the family pushed them out of thought. Clearly, children will have been deeply affected by their parents' prolonged absence and may respond with a mixture of relief and anger that their parents may not understand.

In consideration of these issues, the task force developed a list of groups that are likely to be at risk for war-related stress and should be followed with a watchful eye by psychologists. We wish to emphasize that war-related events may piggyback on other recent stressors or may reawaken prior severe traumas; the course of treatment in these two situations will be quite different, as those with prior trauma are likely to have more severe difficulties and require more intensive treatment (see Green, Grace, Lindy, Gleser, & Leonard, 1990; Green, Lindy, & Grace, 1988; van der Kolk, 1987).

The risk groups recognized by the task force were as follows:

1. Troops who served in the danger zone, especially those whose duty placed them in particular danger and

who witnessed the death and injury of their comrades, civilians, refugees, or Iraqi soldiers.

2. Troops who served outside the danger zone, but who were at risk of entering the danger zone.

3. Reservists who could have been called up.

4. Families and loved ones of members of any of these groups.

5. Children of service personnel.

6. Children in general.

7. People who are potential targets of terrorism (those who must frequently fly overseas or those who are based in foreign countries with poor security).

8. People who have had previous exposure to war-related stress or to other traumas that may be associated with war (e.g., assault victims, refugees).

9. People who have a history of psychopathology.

10. People who have had other recent, major upheavals in their lives.

11. People who are socially isolated.

Risk factors, of course, do not necessarily lead to negative psychological or psychosomatic consequences. Indeed, a relatively low rate of serious problems was expected by the task force for even the highest risk group. There are many reasons for this interpretation. Service personnel were at risk without significant protection for only a short period of time, the ground war ended quickly and with few casualties for allied forces, and there was a large degree of support for soldiers and their families. However, it should also be emphasized that just because the war was won with relative ease, the peace may not be conquered so easily. Service personnel and their families spent significant periods of time apart, many servicemen and women saw horrible casualties inflicted on Iraqi soldiers and on Kuwaiti civilians, and fear of chemical warfare was significant. The rapidity of the news media brought the war into American homes. For many, the war was all but forgotten after the cease-fire, but for service personnel who were in the Gulf and their families, the conflict continued. Troops overseas continued to be at risk, financial problems and strains on relationships may have become worse, and the uncertainty of when reunions would actually occur weighed on those affected.

### **Stress Reactions to Be Monitored**

A number of common stress reactions were considered by the task force. Most are well-known to psychologists, but deserve mention, especially as such lists can be helpful when psychologists are communicating with allied professionals, support groups, the media, and other outreach mechanisms.

Some of the expected reactions include (a) guilt about actions; (b) shame over some failure; (c) excessive drinking or drug use; (d) uncontrolled or frequent crying and other extreme reactions to stressful events that would normally be handled more calmly; (e) sleep problems (too much and too little); (f) depression, anxiety, and anger; (g) stress-related physical illness (e.g., headaches, gastrointestinal disorders, upper and lower back pain, poor stamina or resistance); (h) inability to forget scenes

of horror from the war; (i) difficulty concentrating or excessive ruminating; (j) uncharacteristic social isolation; (k) blunting of emotions; and (l) suicidal thoughts and plans. In addition to these symptoms that will be common for individuals, a number of characteristic symptoms of family stress should be watched: (a) family conflict that does not come to resolution, (b) any signs of verbal or physical violence, (c) family members isolating themselves from one another, (d) extreme dependency and clinging, (e) making one or two family members (often children) scapegoats for the family's difficulties, and (f) children's discipline or academic problems.

Many of these symptoms will be experienced in mild forms and should not cause much concern if they are not prolonged. For example, (a) feeling blue would be quite normal for a few weeks and (b) families should not be expected to just snap into shape like a military unit coming to attention. The task force expected that individuals and families may well experience some rough times, but most concerns and problems should be able to be resolved with family and other social support and activation of personal resources. The problem becomes critical when symptoms are persistent or severe.

Some individuals will react in a more severe fashion, but they may be only a small percentage of those who were involved in the conflict. If the stress has become traumatic and individuals develop full-blown posttraumatic stress disorder (PTSD), they are likely to continue to react to current stimuli that are reminiscent of the original trauma with psychological and physiological reactions appropriate only to the traumatic event. If this occurs, one can expect to see (a) nightmares, (b) intrusive daytime images and bodily sensations related to the traumatic experience, (c) excessive physiological startle, (d) extreme anxiety states alternating with numbing and anhedonia, (e) difficulty modulating arousal in general and anger in particular, and (f) dissociative reactions (American Psychiatric Association, 1987; van der Kolk, 1987).

In the case of PTSD, professional help is required. The best treatment for PTSD has not been established, but most clinicians agree that traumatized individuals need to put their experience into words and go over the details of the events, including their own actions, their fantasies, and what they think they could have done to alter the outcome of events. Some form of desensitization of the traumatic experience appears to be essential. Depending on the theoretical orientation of the clinician and the exigencies of the situation, this may range from classical desensitization and flooding procedures to a psychodynamic working through the events and their subjective meaning. Group psychotherapy is generally considered to be very helpful to allow people to emotionally reconnect with the actuality of the experience and receive support from people who have gone through the same or similar experiences. Hyperarousal and sleep disturbances in PTSD may in many instances be best treated with psychotropic medications, in addition to individual or group intervention (see van der Kolk, 1987, for a detailed discussion on treatment). Others have had

success with mastery or efficacy enhancing intervention, such as teaching self-defense skills to women traumatized from rape or the threat of rape (Ozer & Bandura, 1990) or allowing soldiers with PTSD the opportunity to return to military boot camp or actual combat to prove to themselves (and perhaps others) that they can master military skills (Milgram & Hobfoll, 1986). These nontraditional treatments warrant further investigation and attention by clinicians.

### **Guidelines for Coping With War-Related and Traumatic Stress**

The task force developed a number of guidelines by which psychologists can guide individuals at risk for war-related stress or stress after other traumatic events. These guidelines can be loosely divided into individual and social coping efforts. However, it is important to understand that the individual and social spheres interact. Social support, for example, is not just delivered to those in need, but is based, in part, on both the recipients' social skills and the social skills of their potential supporters (Hansson, Jones, & Carpenter, 1984); how people perceive the social support they receive is also related to their own identity and their social view of themselves (B. R. Sarason, Sarason, & Pierce, 1990; I. G. Sarason, Sarason, & Shearin, 1986). Similarly, individual coping efforts are aided or impeded by the social milieu. Caplan (1974) envisaged social support principally as aiding individuals' perceptions of their ability to master their environment. Social ties have also been shown to boost self-esteem and forestall the onset of depression during periods of chronic stress (Pearlin, Lieberman, Menaghan, & Mullan, 1981). How effectively social support is used is also moderated by the presence or absence of personal resources—strong personality resources activating and enhancing support and weak resources diminishing the positive effect of support (Hobfoll & Leiberan, 1987).

One of the most effective coping strategies involves breaking down major problems into more manageable subcomponents. Many of the problems that follow major stressful events are not only large, they are also complex (Folkman et al., in press). A problem may concern a number of financial aspects, interpersonal difficulties with more than one other person, job problems, and leisure activities. It may affect both physical and psychological health, involve drinking and overeating, and produce short-term, mid-term, and long-term problems. Even the experienced psychologist may feel overwhelmed when clients so distressed enter therapy, and certainly they are overwhelming for the individual suffering them. To the extent that those affected can be aided in the direction of (a) disentangling the intertwined aspects of the problem; (b) setting small, accomplishable tasks and goals; and (c) rewarding one's self for small wins, they will usually function more effectively in their coping, and experience more positive outcomes. Small wins also lead to a greater sense of mastery and control over the environment, which in turn helps individuals feel and become more effective (Bandura, 1982; Meichenbaum, 1985).

A second method of effective coping is for one to become part of the solution for others' problems. By becoming involved in problem solving, individuals avoid the victim role and enter a mastery role. Becoming part of the solution can mean letter writing, helping others in need, and performing other volunteer tasks. There are many support groups that need a helping hand, single parents and acting parents (i.e., grandparents and others who have filled in for service personnel) who could use a break and demobilized personnel who need help locating jobs, among hundreds of other possible volunteer interventions. It is paradoxical that someone who needs help can be helped by aiding others, but many members of support groups find solace and a more positive sense of self when they see that they can be of assistance to others, even while in need themselves.

Another important step that individuals may take is to seek support. The social support literature has often mistakenly envisioned social support as a passive process. In fact, there is much individuals can do to develop, maintain, and mobilize social support (Milgram, 1989; B. R. Sarason et al., 1990). Social skills can be developed that make individuals more attractive to potential helpers; merely letting others know that one needs help is an important step in the right direction. The task force recommended that individuals identify the different players in their social support system and the kinds of help these individuals can offer. By matching social support with individual needs, those affected by major stressors can come to appreciate being selective in the kind of support they ask for and from whom they ask for it. This will minimize disappointments that follow inappropriate requests for help and maximize the chance that the support offered will be effective (Folkman et al., in press). Nor is this a one-step process; rather, individuals must keep in contact with their supporters and provide them with positive and continuing feedback on their needs. This reinforces our earlier point that part of receiving social support is giving social support. To the extent that people see themselves as helpless victims, they will be less likely to receive support (Dunkel-Schetter & Skokan, 1990).

Two levels of social support systems are important in the acquisition of actual support: intimate support and attachment to larger social groups. Research has clearly indicated that close attachments are the most critical (Brown & Harris, 1978; Hobfoll, 1985; B. R. Sarason, Shearin, Pierce, & Sarason, 1987). One or two intimate others may be sufficient for providing emotional support. Instrumental tasks, however, are often more manageable when people have a large support system available. A job search, for example, may be aided by friends and by friends of friends who help pass information, covering a wider net. In addition, the task force felt that individuals would benefit greatly from reforming their contacts with social and religious groups. S. B. Sarason (1974) termed this level *the psychological sense of community*. There is something important—even if amorphous—that relates to a sense of being esteemed and part of a broader community with which one claims membership. Perhaps it

relates to an early need to be popular among other children or perhaps to a primitive need to feel the safety of the tribe or clan, but whatever the source it has a positive effect. Support groups, church groups, even hobby groups can fill this need. Work also plays an important role as it involves people with others and provides a feeling of self-efficacy. Work that is socially isolating or degrading, however, may be resisted for these same reasons.

Seeking help should also be encouraged. Many psychologists' intervention efforts will be in the form of outreach in the community. Such interventions should contain the message that it is quite normal to experience some negative effects of stress. Seeking help, even from intimate others, may be feared by some because it places them in a one-down position (Fisher, Nadler, & Whitcher-Alagna, 1982). We have found that if individuals can see how willing they are to help others (and they usually are) and that they themselves do not place a stigma on friends or family who come to them for help, they can gain a perspective that enables them to seek help without a sense of stigma. People, however, also need to hear the message that sometimes the individual alone, or even with the support of loved ones, cannot successfully cope with stressful circumstances.

The most natural support resources for adults are clergy and primary care physicians, and for children, teachers and counselors at their schools. Although some individuals will turn directly to psychologists, it is more likely that psychologists will work with more natural contact people both as consultants and referral resources. Industry-based assistance has greatly increased, providing another source for psychologists to offer their consultation and to develop referral networks. Psychologists should share their expertise with these care providers, discussing with them risk factors, what interventions they can undertake, and when referral to a mental health professional is warranted.

Psychologists will also need to be sensitive about the meaning of help within a culture and about who in that culture are acceptable providers of help. Some groups or individuals may, for instance, find support groups to be stress engendering rather than beneficial (Turk, Meichenbaum, & Genest, 1983). Note also that many reservists and National Guard members who will return to communities with their comrades will have others around who understand and share their experiences. The experience for a member of the armed forces who is the only returning veteran in their locale may, in contrast, be much more isolating.

Individuals should be allowed great latitude in choosing how they cope with stressful events. The task force emphasized that there are no set "correct" stages of stress and coping (see also Silver & Wortman, 1980). Cultural, gender, and developmental differences are all critical dimensions that should be carefully considered. Early stress theory posited specific stages of coping, but coping is much more individualized in its paths. Emotion-focused coping may be very effective at first when one is combatting severe stress events and when some denial

can be very positive (Breznitz, 1983). Emotion-focused coping should, however, give way to problem-focused coping, and if this is delayed too long, problems can amass and multiply until they are almost unmanageable. Emotion-focused coping can be seen as a means of pausing, taking a different perspective, and planning, and psychologists can help people to allow themselves to take a step back for this important stage of refueling and developing strategy. With renewed strength, then, individuals can reenter the fray, employing more direct action, problem-solving routines.

Emotion-focused coping may be beneficial in situations that the individual can do nothing about (Folkman, 1984). In these circumstances, the individual should be helped to accept the situation and cope with its aftermath through emotion-focused coping techniques such as cognitive restructuring, relaxation or meditation, seeking appropriate social support, grief work, and diverting attention to other activities.

Whether on the individual or social level, an important understanding in coping is that the process of adjustment is not necessarily or even commonly a smooth one. Even those who achieve good adjustment should expect some setbacks. Where more difficult problems have emerged, overcoming stressors will have both high and low points. It is critical that individuals and families do not interpret these setbacks and low points as signs that they are not coping well or as reasons for pessimism; rather, they are to be expected as part and parcel of healthy functioning. Psychologists should help stressed individuals engage in relapse prevention—anticipating high-risk situations and viewing any setbacks or lapses as learning trials, rather than as occasions for “catastrophizing” (Meichenbaum, 1985).

### Negative Coping Pathways

The task force identified a number of methods of coping that in most cases lead to negative outcomes. Just as in the positive-coping pathways, these may be divided into individual and social efforts, with the recognition that the two domains overlap.

Some individuals affected by the war will respond with excessive self-blame. Inevitably, some bad decisions will have been made by people during the course of the war and the events surrounding it. Early views on stress saw poor copers as having a sense of helplessness (Abramson, Seligman, & Teasdale, 1978); however, this is at best only half true. As we discussed earlier, effective copers have a sense of personal mastery—a feeling that they can positively effect their environments. Those who do not successfully combat stress, in contrast, often feel that they are responsible for the negative outcomes in their lives, that they are responsible for all the bad things that occur. In a sense, this is expressing more power than individuals actually have in many stressful situations. Guilt and self-blame can demoralize individuals and paralyze them from coping adequately, as they feel that their intervention will only bring doom on themselves and on their loved ones. Beyond understanding one's mistakes

for purposes of not repeating them, there is little to be gained by guilt and self-blame.

Prolonged avoidance of problems is also a tactic that often leads to further difficulties. As we emphasized earlier, there is no harm and some good that can be derived from taking a step back from active problem solving, but eventually certain problems should be addressed. Hesitation feeds on itself in a negative cycle, and in the absence of action, individuals come to feel increasingly incapable of effectively addressing the problems that confront them. One way people may camouflage their avoidance is by concentrating on past problems. By dredging up stale concerns, they can give the appearance of coping with their difficulties, but there is little gain to be made. In the meantime they are able to avoid the current challenges, which may be compounding as time goes on.

In general, prolonged avoidance of problems has as its core the feeling of low mastery and limited control over the environment. We have already discussed the importance of a feeling of mastery over the environment, but many persons do not have this positive self-concept. When past circumstances have limited individuals' sense of control, inaction is seen as a reasonable course. This becomes especially clear when it is understood that coping demands high use of resources (Hobfoll, 1989; Schönplug, 1985). Given the cost of coping, if no gain is expected it is prudent to conserve resources through inaction. Of course, the solution to this negative cycle is to make some small efforts that will encourage risk taking in the hope of making larger gains.

Blaming and lashing out at others is another ineffective coping strategy and one that potentially harms not only individuals but their loved ones and their colleagues. This strategy may, at times, be the flip side of an underlying sense of guilt or, more simply, a way to avoid any responsibility for problems. It is usually related to a feeling that the level of difficulties is overwhelming. Many of the difficulties that service persons confront on their homecoming will inevitably be the fault of others or will follow from choices made by those at home. Many service personnel and their family members will fantasize that everything will be ideal when they return home, and when these idealized notions are not realized they will lead to frustration and, for some, aggression.

An easy way to find solace for problems is through drugs and alcohol use. Chemical use and abuse is a common avenue for coping. Small amounts of chemicals may aid individuals by limiting very intense emotions, especially during initial periods of distress. However, prolonged usage or use of large amounts of illicit or prescriptive drugs or alcohol can be very destructive. Illegal drugs are often the focus in this regard, but prescription drugs and alcohol are also often abused. Of course, some drugs of abuse are both dangerous and represent a warning sign even in small dosages.

Cynicism and excessive pessimism about the present and future are often used by some people in order to keep their expectations low. In a sense, with low expectations, people keep themselves from being disappointed. Re-

search has suggested, however, that there is some wisdom in Pollyana's rose-colored-glass approach (Goodhart, 1985). Depressed individuals may actually be more realistic than nondepressed individuals, but optimism, nevertheless, aids coping efforts (Carver & Scheier, 1983). Perhaps the major role of an optimistic outlook is to encourage continued efforts at coping. Pessimism, in contrast, leads people to believe that the worst is inevitable, no matter what they do. Pessimism also alienates potential supporters, who flee from the individual (Coyne, 1976). One common form of pessimism is catastrophizing, making every problem into an insurmountable crisis. Clearly, many of the problems that those affected by war-related stress will confront are significant in reality, and this tendency will create a sense that crisis lurks in every corner and is unavoidable. Support groups, friends, family, and therapists can help by lending perspective. Not being directly affected by a problem can give a significant other the distance necessary to see things for what they are and not elevate problems out of proportion.

Prolonged social isolation is another maladaptive avenue for coping. Often, talking about problems is painful and people may isolate themselves as they become increasingly depressed. Psychologists have a difficult task reaching these people. Suggestions for seeking them out include activating their family members, friends, and support groups. Sincere, persistent efforts to draw out isolated individuals can prove helpful. Remaining isolated prevents individuals from receiving social support, objective feedback, and the benefits of community attachments. It also removes individuals from the interpersonal arena, in which much problem-focused coping must occur in the domain of relationships.

Finally, given the very real social, financial, and vocational problems that returning soldiers are likely to experience, business and government agencies have a responsibility and an opportunity to play an active role in providing meaningful support. The burden of coping must not fall on the returning soldiers and their families alone. They fought for all of us. Psychologists need to carry this message, as well.

### **Children's Special Needs**

The task force gave a great deal of attention to the special needs of children. Many of the principles already outlined are relevant to children (Milgram, 1989; Milgram, Toubiana, Klingman, Raviv, & Goldstein, 1988), but children are not just small adults. A knowledge of developmental differences and the social world of children is paramount to successful prevention and early intervention work with children. Children are less likely than adults to speak directly about their problems or even to know they are having them. Their stress-related difficulties may instead emerge in their school work, in their relations with peers, or in their interactions with family members. Children are also vulnerable because they have less experience coping with stressful events. Lack of prior experience may lead them to exaggerate their problems and prevent them from seeing light at the end of the tunnel.

The specific coping patterns (good and bad) described earlier need to be adjusted for children at their age-appropriate level. The following suggestions specifically apply to children:

1. Parents and teachers should be encouraged to listen in a nonjudgmental fashion to children's thoughts, concerns, and ideas about the war and about reunions.

2. Adults should provide warmth and reassurance to children, without minimizing their concerns. Children need to feel that there is a safe haven provided by strong adults.

3. Adults should not impose their fears or burdens on children. Parental difficulties need to be worked out without burdening children. This does not mean that children should be entirely sheltered from family difficulties, but neither should they be made to feel that it is up to them to shoulder responsibilities that are beyond their developmental capability.

4. Just as we said that most adults will cope effectively, even if there are rough roads to travel in the process of adjustment, children too need to be given this positive expectation. Because of their limited experience and the length of stressors such as separation from parents, it is vital that children gain this perspective.

5. Children's reactions will often mirror the reactions of their parents. This is a double-edged sword, however. If their parents are combatting stressors effectively, the children will gain a sense that they too can overcome their difficulties. If, however, their parents are not adjusting successfully, children develop a sense that problems are insurmountable, and they lose their key support link. It is critical that parents see that seeking help for themselves when it is needed is the best therapy for their troubled children.

6. Children need accurate information about what has happened and why, but information that is appropriate to their developmental stage. This information should be provided before, during, and after stressful events. They also need to know why certain behaviors are required of them and usually need behavioral examples and sometimes rehearsal of behaviors that are not expected to be in their repertoire. It should not be assumed that children do not know the "dark side" of current events. Given that they have seen horrible events on television or have overheard serious discussions, it is incumbent on us to help them work through the meaning and significance of these events through discussion, support, and—in cases in which a child is traumatized—professional treatment.

7. As with adults, children should be involved in helpful behaviors. By being part of the solution in their own classrooms, families, and communities, children will develop an enhanced sense of mastery and control over their lives and cope more effectively with war and other severe stressful events.

### **Professional Intervention and Public Policy**

The watchword for both professional intervention and public policy after the Persian Gulf War and other trau-

matic events facing communities is *outreach*. Most intervention can be conducted through psychoeducational messages broadcast by the media and disseminated through schools, military organizations, community groups, businesses, and support groups. Information about reactions to expect, negative reactions to watch for, and desirable and problematic ways of coping should be disseminated through all of these sources.

In addition, schools, support groups, psychologists, and other primary care clinicians should be sensitive to those individuals who have extreme or prolonged reactions. The first step of intervention is to help individuals reverse loss cycles that emerge following failures to cope effectively. When indirect means to halt loss cycles are not effective, more direct interventions are called for, such as referral to counseling or therapy and enlisting the aid of family or friends. When professionals intervene among ethnic and minority populations, it is essential that they consult professionals from those groups or, at least, community leaders, if they themselves are not a member of that community or culture. Otherwise, intervention is likely to be misdirected and may even be received as offensive (Milgram & Toubiana, 1988).

Strong community leaders, support group leaders, and family leaders are another paradoxical group for outreach. Although basically strong, during extended period of crisis, these persons may become overburdened with the needs of others. In Israel, Hobfoll and London (1986) found that persons high in personal resources became drained by social contacts that constantly made demands on them, but which they did not feel they could go to for succorance. Psychologists need to reach out to these individuals, at times stand in for them, and give them the message that they must attend to their own needs as well.

For those in government and in the military, the task force felt that one of the most important strategies for prevention of psychological stress is the clear, accurate dissemination of information about reserve duty, demobilization, military support services to families, and other military benefits. It is essential that service personnel and their families obtain accurate, timely information so that they can be ready psychologically and practically for reunions and for a return to work and family routines. This will be a difficult task because reserve and guard units will be making a transition from military to civilian life that does not include the time for planning and preparation that active-duty personnel receive at the time of their demobilization.

The overall message must be conveyed to all that adjustment of families and service personnel is not a short-term process. Nor can the commitment to these individuals be short term. Although individuals should be well on the way to recovery three months after the combatant's return, some problems created or exacerbated during his or her absence may linger or become chronic. In these cases, it would be expected that the period of crisis will be prolonged. Financial hardship, job problems, and conflict in families may emerge that have a long-term effect. Because the war was won with such

relative ease, one should not assume that the peace will come as easily or quickly; unlike the war, it cannot be won from the air.

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