SOCIAL PERCEPTION OF PERSONS WITH PTSD SYMPTOMS
A test of some predictions of attribution theory*

VERA ĆUBELA
Filozofski fakultet u Zadru
Faculty of Philosophy in Zadar

UDK/UDC: 159.923.5:316.6
Izvorni znanstveni članak
Original scientific paper

Primljeno
: 1997-11-05
Received

A broad research of the impact of PTSD diagnosis and presenting symptoms of this disorder on social reactions to persons with PTSD has been undertaken to test the prediction that the relative absence of fairly recognizable symptoms of this disorder promotes less positive social evaluation. This paper presents the effects of manipulating with the PTSD label and the recognizability of presented symptom pattern on ratings of the target person responsibility and elicited affective reactions and support giving intention in subjects.

Three vignettes, differing in recognizability of presented symptoms of PTSD, were given to the subjects (228 students at the University of Mostar), and about a half of the subjects in each of these symptom pattern conditions was told that the target is a PTSD casualty. Subjects responded to the vignettes by rating target’s responsibility and their own reactions to him (pity, anger and willingness to give him support) on a five-point scale.

The results showed significant effect of the symptom pattern manipulation, which was most pervasive in responsibility judgments and reported support intentions. The pattern of differences in judgments of responsibility suggests that the prevalence of less recognizable symptoms of PTSD might result in ascription of some responsibility to a target person for causing actual conditions. The relative absence of these

* Some parts of this paper have been presented at the "Ramiro Bujas's days" 1997.
symptoms appears to reduce, in particular, the variability in the subject's willingness to give support to the person, which is generally reported as being very high. Unlike these responsibility and support ratings, the effects of the symptom pattern on reported affective experiences of pity and anger do not match the pattern predicted from the attribution model of B. Weiner and an extension of this model made by Lopez and Wolkenstein. The absence of the predicted Label x Symptom pattern interaction was explained in terms of some drawbacks in the construction of the stimulus material.

KEY WORDS: PTSD, attribution, responsibility

Introduction

The important role of the social environment in the posttraumatic recovery process is a common notion in the literature of posttraumatic stress disorder (PTSD). It is also often noticed, however, that there is a lack of empirical work on identification of factors determining social reactions to traumatized persons and, especially, of processes underlying these reactions (e.g. Figley, 1986, 1995; Stretch, 1986).

An attributional perspective is frequently used to explain the negative social reactions toward traumatized persons in the first place, including the tendency to “blame the victim”. As noted by Weiner (1995), the very expression is somewhat misleading because people do not blame the victim but the person who is ascribed responsibility for causing the circumstances of traumatization. The issue of personal impediments (behavioral and/or characterological) in traumatized persons is often addressed while considering victims of rape, crime and even concentration camp survivors. This process of secondary victimization was also evidenced in studies of society’s reactions to Vietnam veterans, and it was suggested that negative attitudes towards the traumatic event itself could result in a tendency to hold a person with prolonged symptoms of trauma responsible for his/her plights (Epstein, 1989; Figley, 1995). Some authors argued that the very presence of prolonged effects of trauma is, in fact, threatening to the western concept of the individual who should be in control over the effects of trauma, if not over its causes (van der Kolk et al., 1996). Janoff-Bulman (1992) stated that the blaming-the-victim phenomenon could be conceived as an unfortunate generalization from this expected responsibility for resolving post-trauma problems to the responsibility for causing them. Such a victim-blaming perspective might be promoted by the negative attitudes toward traumatic event and/or prejudices about persons who have been traumatized (Sampson, 1991).
The attributional perspective is also often used to describe the differences in clinical and theoretical conceptualizations of posttraumatic stress syndromes during the last century. Although various terms that have been used to describe prolonged effects of trauma usually refer to the nature of the traumatic event (e.g. railroad spine, shell-shock, war syndrome, concentration camp syndrome, rape trauma syndrome, battered woman syndrome etc.), they were nevertheless linked to different beliefs about the locus, controllability and/or stability of perceived cause(s) of problems in actual functioning of a person (for example, organic damage, moral weakness, secondary gain, premorbid personality etc.). De Vries (1996) suggests that the very introduction of PTSD in the psychiatric taxonomic system could be seen as a definite recognition of the external causality of a psychopathological disorder. This external causality should not be reduced to the exogenous event by which the pathological process was set in motion. Beside this primary distant cause of actual psychopathology, there are some other external factors influencing person’s functioning at different stages of this process, including reactions of the social environment that can be detrimental as well as beneficial to a person (Figley, 1985; Foy, 1994).

Bernard Weiner (1995) recently suggested that judgments of responsibility could play an important role primarily in social reactions that are of hedonistic value for a target person. In his attribution model a sequence underlying these reactions is proposed which begins with a “need for help” situation, such as negative condition of a person that can be conveyed by medical diagnosis applying to the target person. Such a situation arises in others a tendency to find its cause(s) that could differ on several dimensions, such as locus or controllability, for example. Causal controllability is conceived as main factor determining judgments of person’s responsibility, which influence affective reactions toward person and, indirectly, the behavioural tendencies (e.g. helping vs. not helping). For instance, if a person’s condition is attributed to the uncontrollable cause, he/she is expected to be held not responsible and, therefore, to elicit in others positive affective reactions (e.g. pity) rather than negative ones (e.g. anger), and help giving intentions. Such a pattern of reactions has been found for the targets labeled (Vietnam) war syndrome and PTSD (Weiner et al., 1988; Lin, 1993, in Weiner, 1995; Čubela, 1996b).

It should be noted, however, that in these studies the label was actually the only information about the target’s actual condition, while in the real life settings of social interaction much more information about a person with PTSD could be available. Namely, the symptoms of this disorder could be expressed in various degrees of recognizability. Even when a person is identified as a
PTSD casualty, his/her individual actions might not be identified as symptoms of this disorder. Therefore they probably would not be attributed to the "disorder", but rather to some other factors, including personal characteristics that are considered controllable. Indeed, the findings of some studies, in which an effort has been made to test the predictions of Weiner's model in the clinical area, indicate that, for example, those psychotic patients who elicit hostility and criticism in their relatives are in fact held by them somewhat responsible for enacting the problems in actual functioning. Lopez and Wolkenstein (1990) proposed that these problems (mainly so-called negative symptoms) are not recognized as symptoms and, therefore, are attributed to more controllable causes such as lack of motivation or some personality traits.

Symptoms of PTSD are usually reported as forming three distinct categories: symptoms of reenactment and reliving trauma, symptoms of avoidance of stimuli associated with trauma or numbing of general responsiveness, and persistent symptoms of increased arousal. This syndrome can also be seen as reflecting a dynamic process by which a person attempts to integrate a traumatic event into his/her existing schemata. According to Horowitz (1992), two groups of symptoms could be distinguished from the perspective of psychological control mechanisms: reactions of intrusion that indicate failures of control over trauma impact on all levels of functioning, and reactions of avoidance that suggest, in contrast, an excessive control which prevent a person of reenactment of trauma. This defensive function of avoidance reactions might not be easily recognized by lay persons and, therefore, attributed to the factors other than disorder. Moreover, the professionals seem to have a problem when dealing with these symptoms, that is manifested in the tendency to consider some other diagnostic categories when these symptoms prevail in the symptom profile of a person. The main alternatives that are considered in these cases appear to be personality disorders and schizophrenia (Epstein, 1989). Moreover, the pattern in which the avoidance reactions prevail (primarily numbing and denial) is sometimes explicitly referred as being similar to the negative symptoms of schizophrenia (Epstein, 1989; van der Kolk et al., 1996). An analysis of the recognizability of PTSD symptoms showed that, unlike intrusive reactions, these symptoms have been rarely identified as PTSD symptoms by students at the University of Mostar, and the manipulation with the PTSD label generally did not influence the perception of their controllability (Čubela, 1996b).

Heedful of these observations and Weiner's assumption about the relationship between the causal controllability and judgments of responsibility and related affective and behavioral reactions, a study was carried out that was aimed to examine if manipulation with the recognizability of presented
symptoms of PTSD would influence the perception of a person's responsibility and the affective reactions and support giving intentions he/she elicits in others. In a previous study the pattern of these reactions was obtained that suggested a tendency of students to evaluate a person with PTSD positively (not responsible - high pity and low antipathy - high tendency to give support) (Čubela, 1996a). In this study the hypothesis was that this tendency of positive evaluation would be less pronounced in the relative absence of recognizable symptoms, but the contrast effect could also occur, i.e. the tendency to evaluate a person with predominantly unrecognizable symptom pattern more positively if information about the diagnosis is not provided in comparison with a situation when his/her condition is identified as PTSD. Specifically, it was predicted that the target person with predominantly less recognizable symptoms of PTSD would be judged more responsible for causing his actual condition compared to the targets manifesting mainly recognizable symptom pattern and complete symptom profile of PTSD. Correspondingly, the target in the unrecognizable symptom pattern condition would elicit relatively more anger, less pity and less support giving intentions than targets in two other conditions. Finally, the target in this condition was expected to be rated more responsible, and to elicit more anger and less pity and support intentions when he is labeled “a person with PTSD” than in no-label condition.

Thus, the main purpose of this study was to examine usefulness of PTSD concept in verification of predictions of B. Weiner's attribution theory and its extension made by Lopez and Wolkenstein.

Method

A 3 x 2 factorial design was used with presented PTSD symptom pattern (complete/recognizable/unrecognizable) as one variable and PTSD label (provided vs. not provided) as the other variable.

A vignette has been constructed that describes a PTSD symptom profile in the form of an excerpt from the interview with a male person who talks about the problems in his actual functioning. This description of the PTSD symptom profile was done in such a way that it could be easily divided in two parts representing mainly recognizable and mainly unrecognizable symptom patterns of PTSD on the basis of the previous study results. The form of the excerpt from the interview has been chosen to ensure the context in which the target’s self-disclosure would seem legitimate and credible to the subjects. Furthermore, it was important to define a situation that could be interpreted in terms of the beginning stage (“need for help”) in the Weiner’s Attribution - Affect - Behavior sequence. The vignettes are provided in the Appendix.
The three vignettes (Complete, Recognizable or Unrecognizable) were presented to 228 students (163 females and 65 males) at the University of Mostar. They were asked to try to form an impression about the target. In order to express their impression about him, enclosed with the excerpt was a set of rating scales on which they rated: a) the target’s responsibility for causing his actual condition, b) the intensity of their affective experience for the two emotions (pity and anger) that were typically used in the investigations of predictions derived from Weiner’s model, and c) their willingness to give him support. Ratings were made on the five-point scale on which higher ratings signify higher degree of responsibility, pity, anger or support.

The study was done during regular lectures in psychology on existing groups of students. The students’ attendance of the lectures was hard to predict because of frequent “incidents” in the town during the period in which this study was carried out. Therefore it was difficult to achieve an equal number of subjects in all experimental conditions. In the instructions one group of subjects (N=99) was told that the vignette concerns a person with the PTSD diagnosis, while the rest of the subjects (N=129) did not get this information. In each of these two main groups of subjects one of three vignettes was given to the individual subjects in random order.

Results and Discussion

The mean ratings of target’s responsibility, and of subjects’ pity, anger and willingness to give him support are shown in Table 1.

As can be seen from the table, the target was, in general, rated mainly not responsible for causing his actual condition, and elicited pity rather than anger, as well as a strong tendency to give him support. This pattern of ratings is in accordance with the findings of some previous studies (Weiner et al., 1988; Ćubela, 1996a).

In this study, however, it was our primary concern to see if the manipulation with PTSD label and presented symptom pattern of this disorder would produce significant effect on these ratings. To test these effects, four separate two-way analyses of variance of obtained ratings were performed. The results of ANOVA procedures are provided in Table 2.
Table 1. Mean values of the ratings of target's responsibility and related subjects' own reactions in the conditions defined by the symptom pattern and label variables

<table>
<thead>
<tr>
<th>Symptom pattern</th>
<th>Responsibility</th>
<th>Pity</th>
<th>Anger</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>2.26</td>
<td>4.00</td>
<td>1.23</td>
<td>4.27</td>
</tr>
<tr>
<td>N=74</td>
<td>(1.061)</td>
<td>(1.085)</td>
<td>(.562)</td>
<td>(.896)</td>
</tr>
<tr>
<td>Recognizable</td>
<td>1.94</td>
<td>3.78</td>
<td>1.62</td>
<td>4.63</td>
</tr>
<tr>
<td>N=79</td>
<td>(.965)</td>
<td>(1.140)</td>
<td>(.978)</td>
<td>(.664)</td>
</tr>
<tr>
<td>Unrecognizable</td>
<td>2.95</td>
<td>3.43</td>
<td>1.44</td>
<td>4.11</td>
</tr>
<tr>
<td>N=75</td>
<td>(1.077)</td>
<td>(1.327)</td>
<td>(.919)</td>
<td>(1.060)</td>
</tr>
<tr>
<td>PTSD label</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provided</td>
<td>2.28</td>
<td>3.85</td>
<td>1.39</td>
<td>4.44</td>
</tr>
<tr>
<td>N=99</td>
<td>(1.069)</td>
<td>(1.256)</td>
<td>(.855)</td>
<td>(.745)</td>
</tr>
<tr>
<td>Not provided</td>
<td>2.44</td>
<td>3.65</td>
<td>1.46</td>
<td>4.26</td>
</tr>
<tr>
<td>N=129</td>
<td>(1.145)</td>
<td>(1.164)</td>
<td>(.857)</td>
<td>(1.012)</td>
</tr>
<tr>
<td>Total</td>
<td>2.37</td>
<td>3.74</td>
<td>1.43</td>
<td>4.34</td>
</tr>
<tr>
<td>N=228</td>
<td>(1.061)</td>
<td>(1.206)</td>
<td>(.855)</td>
<td>(.908)</td>
</tr>
</tbody>
</table>

Note: Standard deviations are in parentheses.

Table 2. Effects of the PTSD symptom pattern and label on students' ratings of target's responsibility and of elicited pity, anger and willingness to give him support

<table>
<thead>
<tr>
<th>Variable</th>
<th>Effects</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility</td>
<td>Symptom pattern</td>
<td>2/222</td>
<td>18.67</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>Label</td>
<td>1/222</td>
<td>2.03</td>
<td>.15</td>
</tr>
<tr>
<td></td>
<td>Symptom pattern X Label</td>
<td>2/222</td>
<td>2.31</td>
<td>.10</td>
</tr>
<tr>
<td>Pity</td>
<td>Symptom pattern</td>
<td>2/222</td>
<td>4.04</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td>Label</td>
<td>1/222</td>
<td>2.01</td>
<td>.15</td>
</tr>
<tr>
<td></td>
<td>Symptom pattern X Label</td>
<td>2/222</td>
<td>1.78</td>
<td>.17</td>
</tr>
<tr>
<td>Anger</td>
<td>Symptom pattern</td>
<td>2/222</td>
<td>3.69</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td>Label</td>
<td>1/222</td>
<td>.51</td>
<td>.47</td>
</tr>
<tr>
<td></td>
<td>Symptom pattern X Label</td>
<td>2/222</td>
<td>1.61</td>
<td>.20</td>
</tr>
<tr>
<td>Support</td>
<td>Symptom pattern</td>
<td>2/222</td>
<td>7.11</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>Label</td>
<td>1/222</td>
<td>2.34</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td>Symptom pattern X Label</td>
<td>2/222</td>
<td>1.43</td>
<td>.24</td>
</tr>
</tbody>
</table>
The symptom pattern manipulation produced significant effect on all dependent measures in this study.

Results of Scheffé’s procedure showed that this main effect on responsibility ratings in fact applies to the unrecognizable symptom pattern condition (vignette U): the target in this condition was rated more responsible than targets in the complete and recognizable symptom pattern conditions (vignettes C and R, respectively). This finding suggests that the tendency to hold a person with PTSD more or less responsible for causing the actual condition could be primarily linked to the presence/absence of the highly recognizable symptoms, such as sleep disturbances, hyperalertness, intrusive images while awake etc. As long as these problems are conveyed to others, it could be expected that a person with PTSD would be held not responsible for causing the actual condition. Relative prevalence of less recognizable symptoms (trouble concentrating, emotional constriction, pessimism, detachment etc) could reduce the impression that the person is not responsible. According to Weiner’s assumption about the determinants of responsibility judgments, it could be argued that the prevalence of less recognizable symptoms might result in a tendency to attribute a person’s actual problems (symptoms) to the more controllable and, probably, internal cause(s).

Symptom pattern manipulation produced a somewhat different effect on the reported williness to give support to the target. Specifically, Scheffé’s procedure revealed two significant differences in these ratings, both applying to the recognizable symptom pattern condition (vignette R): mean support rating in this condition was higher than in the complete and unrecognizable symptom pattern conditions (vignettes C and U). In other words, the reported tendency to give support to the target - although generally high - was more prominent in the absence of the unrecognizable symptoms. However, this finding should be interpreted with caution because the variances of support ratings in these three conditions differ significantly (p<.05). Specifically, the variance of support ratings in the recognizable pattern condition was lower than in the complete and unrecognizable pattern conditions (F=2.548 and F=1.820, respectively). That is, the absence of unrecognizable symptoms in the target’s presenting problems actually results in the reduced variability of the self-reported willingness to give him personal assistance. The same effect was obtained for the label variable: variance of the support ratings was significantly lower in the group of subjects who were given the information about the PTSD diagnosis than in no-label group (F=1.845, p<.05). These effects of the label and symptom pattern manipulation on the variance of support ratings perhaps suggest some conditions under which people might be expected to reach a
consensus about the person’s need for other people’s personal assistance or about the efficacy of their own personal assistance to the needy person.

The ratings of affective reactions (pity and anger) were also influenced by the presented symptom pattern. Scheffé’s procedures showed that the subjects who were presented complete symptom profile of the PTSD (vignette C) reported more pity toward the target than the subjects in the unrecognizable pattern condition (vignette U), and they also reported less anger toward the target than the subjects in the recognizable pattern condition (vignette R).

This pattern of differences does not confirm the hypothesis that the symptom pattern manipulation would produce an effect on affective reactions that is consistent with its effect on responsibility judgments. It could be argued that the stimulus situation in this study might not be emotionally involving enough to elicit in subjects neither pity nor anger. Subjects’ ratings of these reactions could simply reflect a general tendency to evaluate positively persons with PTSD symptoms rather than actually experienced emotions, and the obtained variability of these ratings could be due to the level of attention individual subjects have paid to the content of the vignette. This issue of experimental realism is in fact often addressed with studies, which use a description of target person as stimulus, rather than studying the problem of interest in the situation of actual social interaction. The objection for the artificiality of stimulus material also applies here. The use of vignette technique in further research in this domain would require at least some procedure that will ensure subjects’ emotional involvement so the conveyed “need for help” could actually be of hedonistic value for subjects. Furthermore, some refinements in descriptions of Weiner’s construct of negative affect might be also needed. In a subsequent examination, which was aimed to ascertain what are possible affective reactions toward person described in vignettes, a group of students (N=52) was asked to assume that the target is talking to themselves and to describe what they would feel in such a situation. None of subjects reported anger, while pity and compassion were most frequently reported. Thus, these free-response affects suggest that - at least for the students - “anger” would not be an adequate description of the negative affect that could be elicited by these vignettes.

The manipulation with the PTSD label failed to produce significant effects even in the unrecognizable symptom pattern condition that, in fact, was predicted. This finding suggests that presented symptom patterns were generally recognized as PTSD symptom patterns, including the one identified as “unrecognizable”. It was already mentioned that recognizability of these patterns was only supposed on the basis of the results of a previous study in which individual symptoms’ recognizability has been analyzed. In this study
the symptoms were presented to the subjects in the context of other symptoms, but the recognizability of these patterns was not checked. However, another possible explanation for the ineffectiveness of the label manipulation arises from the content analysis of the vignettes. In all of them the information about the primary cause of actual condition (traumatic event) was omitted, but subjects could get some idea about it from the target’s statement that he “feels nice with fellow soldiers”. Actually, in a discussion after the study even the subjects in no-label condition pointed out the similarity of target’s problems with those of soldiers who had traumatic experiences in combat and for whom they knew or suspected to be PTSD casualties. Supposing that the information about PTSD diagnosis primarily conveys information about the original cause of the actual condition, the failure of the label manipulation could be due to the fact that this information has actually been indirectly communicated. It should be noticed, however, that PTSD diagnosis cannot yet be dismissed as a potential factor influencing reactions toward a person since PTSD information actually resulted in reduced variance of support ratings. This effect demonstrates, in fact, that presentation of PTSD information was strong enough to exert even more positive effects on what was already a very positive reaction. A definitive conclusion about the effect of this diagnosis needs more evidence. Similarly, the recognizability of symptom pattern variable could be confounded with some other attributes of the symptom patterns as it is related to the very nature of symptoms, so alternative explanations for its effects in this study cannot be ruled out.

Although the issue of social reactions toward persons with PTSD is of practical importance, it should be noted in conclusion that the use of the PTSD concept in this study was primarily aimed to test some predictions derived from B. Weiner’s attribution theory and an extension of it made by Lopez and Wolkenstein. The standard procedure of research in this area was used, including written stimulus material and self-report measures of responsibility and its hypothetical correlates that are typically used in the investigations derived from the Weiner’s model. We have discussed some problems with the used definition of PTSD and some dependent variable measures, but they do not necessarily imply that the very concept of PTSD is not useful for testing predictions of attribution theory. As mentioned in the introductory part of this paper, in the literature about PTSD the role of attribution processes is more or less explicitly considered in explaining social reactions to persons with this disorder. Yet, few attempts have been made so far to empirically examine these observations using some attribution model as a conceptual framework. It should be noticed that in this study, even with an artificial stimulus situation, the hypothesized symptom pattern effect on responsibility judgments was
obtained which attests to the usefulness of attribution analysis of social perception of persons with symptoms of PTSD, as well as to the usefulness of the PTSD concept in investigations of attribution theory predictions.

References

ČUBELA, V. (1996a): Uloga nekih atribucijskih procesa u socijalnoj percepciji PTSP-a, Rad prezentiran na skupu X. dani psihologije u Zadru.


**Appendix**

**Vignette “C” (complete symptom profile)**

I'm constantly tense and on my guard. For example, while I'm sitting in a café I don't hear the music but sounds that mean that someone is coming, getting up... While I am in company I can't follow well the conversation because it seems as if I'm continually expecting something to happen... I don't know what... And usually I'm not concentrated; sometimes I can't even concentrate on reading the newspaper or watching TV. I'm tense. To calm down ... I take a pill or drink something.

I'm especially disturbed by sounds, even when children throw firecrackers. I'm startled even when someone suddenly touches me... I cannot relax in any way or enjoy anything, not even in what I once liked very much.

I continually think of what happened. Those scenes come back to me constantly... I am already, ahead of time, afraid of going to sleep because those awful dreams, for which I wake up, keep repeating... Those scenes appear to me even before sleep, and sometimes even during the day. They appear suddenly and in any kind of situation: when I'm at home, in company, with friends... Then I feel a strong uneasiness, anxiety, fear; I sweat; I feel as if something was flowing through my body, I tremble... The same as when I'm reminded by something. And almost everything reminds me, if on television I hear that that place is being mentioned or I see pictures of a similar region. Or at the time of the anniversary - then I felt it again. That is why I do not like
being reminded. Actually, I do not quite remember everything... But when something reminds me... That is why I avoid ... I do not like it when it is mentioned, especially when people gather and retell it, as if they were competing who had gone through more and through worse. I become irritable; I begin to feel anxious, an anger in me... Some people assume an air of importance; they had been living comfortably and I had risked my life...

Fellow soldiers? I feel nice with them. I think that they understand me. Other people cannot understand this.

It is very difficult for me to express what I feel... At home I’m expected to act “normal”, as before, to take delight in the everyday things and to talk about them, but I have no interest for that... We have become estranged. I feel as if they are not that close and dear to me as they had been before ... Even with my girlfriend it is not as it used to be. It is as if I am not capable of loving any more, neither to show it nor to feel it as before... I do not know what is to become of us, of me... I am worried about the future, I do not see any perspective.

I would like to forget and really talk, act as I once used to, but I cannot, I don’t know if I will ever be able to... I would like to sit with friends and talk in a normal way. But I do not like to do this; I cannot talk about what happened. It is very difficult to express... feelings... People do not understand that. If I talked about it I’m afraid that I would lose control of myself. That is why I don’t like it when people talk, retell. I become nervous. I feel like striking them ...

That is how I hit that young man...

\textit{Vignette “R” (recognizable pattern)}

I’m constantly tense and on my guard. For example, while I’m sitting in a café I don’t hear the music but sounds that mean that someone is coming, getting up... While I’m in company I can’t follow well the conversation because it seems as if I’m continually expecting something to happen, I don’t know what...

I’m especially disturbed by sounds, even when children throw firecrackers. I’m startled even when someone suddenly touches me... I cannot relax in any way and enjoy something, not even in what I liked once very much...

I continually think of what happened. Those scenes come back to me constantly... I’m already, ahead of time, afraid of going to sleep because those awful dreams, for which I wake up, keep repeating themselves... Those scenes appear to me even before sleep, and sometimes even during the day. They appear suddenly and in any kind of situation: at home, in company, with friends... Then I feel a strong uneasiness, anxiety, fear; I sweat; I feel as if something is flowing through my body, I tremble... The same as when something reminds me of it. And almost everything reminds me: if on the
television I hear that that place is being mentioned or I see pictures of similar regions. Or at the time of the anniversary - than I felt it again. That is why I don’t like being reminded. Actually, I don’t quite remember everything... But when something reminds me... That is why I avoid... I don’t like it when it is mentioned, especially when people gather and retell it, as if they were competing who had gone through more and through worse. I become irritable: I begin to feel anxious, an anger in me... Some people assume an air of importance; they had been living comfortably and I had risked my life...

Fellow soldiers? I feel nice with them. I think they understand me. Other people cannot understand this...

Vignette “U” (unrecognizable pattern)

I’m constantly tense and on my guard. For example, while I’m sitting in a café I don’t hear the music but sounds that mean that someone is coming, getting up... While I’m in company I can’t follow the conversation because it seems as if I continually expecting something to happen, I don’t know what... And usually I’m not concentrated, sometimes I can’t even concentrate on reading the newspaper or watching TV. I’m tense. To calm down... I take a pill or drink something.

I’m especially disturbed by sounds, even when children throw firecrackers. I’m startled even when someone suddenly touches me... I cannot relax in any way or enjoy anything, not even what I once liked very much.

It is very difficult for me to express what I feel... At home I’m expected to act “normal”, as before, to take delight in the everyday things and to talk about them, but I have no interest for that... We have become estranged. I feel as if they are not that close and dear to me as they had been before... Even with my girlfriend it is not as it used to be. It is as if I’m not capable of loving any more, neither to show it nor to feel it as before... I don’t know what is to become of us, of me... I’m worried about the future; I don’t see any perspective.

I would like to forget and really talk, act as I once used to, but I cannot, I don’t know if I will ever be able to... I would like to sit with friends and talk in a normal way. But I don’t like to do this; I cannot talk about what happened. It is very difficult to express... feelings... People do not understand that.

Fellow soldiers? I feel nice with them. I think that they understand me. Other people cannot understand this.

Actually, I don’t quite remember everything... but when something reminds me... If I talked about it I’m afraid that I could lose my control. That is why I don’t like people retelling. I become nervous, irritable, a kind of anxiety comes over me, an anger. I feel like striking them... That is how I hit that young man...
Vera Ćubela: SOCIJALNA PERCEPCIJA OSOBA SA SIMPTOMIMA PTSP-a
Provjera nekih predikcija atribucijske teorije

Sažetak

U ovom radu prikazani su rezultati jedne studije u okviru šireg istraživanja utjecaja etikete "PTSP" i simptomatske slike ovog poremećaja na socijalne reakcije prema osobama s PTSP-em, kojemu je cilj provjeriti pretpostavku da relativna odsutnost jasno prepoznatljivih simptoma ovog poremećaja u simptomatskoj slici rezultira manje pozitivnom socijalnom evaluacijom. Čudno su opisani efekti manipuliranja etiketom PTSP i prepoznatljivošću prezentiranih simptoma na procjenjivanje odgovornosti osobe, te na afektivne reakcije i tendenciju pomaganja.

Ispitanicima (228 studenata Sveučilišta u Mostaru) prezentirana su tri prikaza osobe sa simptomima PTSP-a različite prepoznatljivosti, te je približno polovici ispitanika u svakoj od ove tri grupe rečeno da se radi o osobi kod koje je dijagnosticiran PTSP. Ispitanici su nakon toga procjenjivali odgovornost osobe iz prikaza i svoje reakcije na nju (sažaljenje, srdžba, spremnost da joj pruže potporu) na skali od pet stupnjeva.

Rezultati su pokazali značajan efekt manipuliranja prezentiranom simptomatskom slicom koji je najizraženiji u procjenjivanju odgovornosti i tendencije pomaganja. Dobiveni obrazac razlika u procjenama odgovornosti sugerira da prevalentnost manje prepoznatljivih simptoma PTSP-a u simptomatskoj slici može rezultirati tendencijom da se osobi atribuiru određena odgovornost za uzrokovanje aktualnog stanja. Relativna odsutnost ovih simptoma u simptomatskoj slici izgleda da prvenstveno reducira variabilitet referirane spremnosti ispitanika da osobi pruže potporu. Za razliku od procjena odgovornosti i potpore, efekti simptomatske slike na procijenjeni stupanj sažaljenja i srdžbe nisu u skladu s obrazcem koji je predviđen na osnovi atribucijskog modela B. Weiner. Relativna odsutnost ovih simptoma u simptomatskoj slici izgleda da prvenstveno reducira variabilitet referirane spremnosti ispitanika da osobi pruže potporu. Za razliku od procjena odgovornosti i potpore, efekti simptomatske slike na procijenjeni stupanj sažaljenja i srdžbe nisu u skladu s obrazcem koji je predviđen na osnovi atribucijskog modela B. Weiner.

KLJUČNE RIJEČI: PTSP, atribucija, odgovornost