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An investigation of post-traumatic stress disorder in Central American refugees living in Tucson

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The University of Arizona, 1988

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AN INVESTIGATION OF POST-TRAUMATIC STRESS DISORDER IN CENTRAL AMERICAN REFUGEES LIVING IN TUCSON

by

Sharon A. Hendrickson-Pfeil

A Thesis Submitted to the Faculty of the

SCHOOL OF FAMILY AND CONSUMER RESOURCES

WITH A MAJOR IN COUNSELING AND GUIDANCE

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF ARTS

In the Graduate College

THE UNIVERSITY OF ARIZONA

1988

STATEMENT BY AUTHOR

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APPROVAL BY THESIS DIRECTOR

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Date

ACKNOWLEDGEMENTS

I would like to thank Dr. Phil Lauver, my Commitee Chairperson, without whose consistent encouragement and valuable insights, this study could not have been completed. My committee members, Drs. Betty Newlon and Oscar Christensen, have helped me greatly by providing additional feedback and encouragement.

My husband, Cliff Pfeil, shared the experience of thesis preparation with me, providing unflagging love, validation, and day-to-day support. Jim Corbett, helped me to learn about new treatment centers in Minneapolis and Toronto and shared relevant sources from Argentina. Pam Vossler, who typed this thesis, did so with humor, flexibility, and, at once, concern that this information be made available to helping professionals.

Most of all, I would like to thank the courageous Central American men and women who trusted me with their stories. I hope that the information presented in this thesis may help other refugees and, in this way, convey a small measure of my gratitude.

DEDICATION

This thesis is dedicated to Cándida

In love and courage,

she was a teacher.

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ABSTRACT

The purpose of this study was to investigate post-traumatic stress disorder among Guatemalan and Salvadoran refugees living in Tucson, Arizona. The questions that guided the study were:

1. Does post-traumatic stress disorder exist among Central American refugees living in Tucson?

2. If so, how does it manifest itself in this population?

3. What counseling or other therapeutic interventions may be helpful for Central Americans experiencing post-traumatic stress disorder?

Six Guatemalan and Salvadoran refugees who had reportedly experienced major stressors participated in a semi-structured interview and responded to a health questionnaire based upon post-traumatic stress disorder symptoms.

Findings indicate that five out of six participants were experiencing patterns of stress-induced symptoms which were consistent with a DSM III diagnosis of "Post-Traumatic Stress Disorder".

Recommendations for intervention with Central American individuals experiencing post-traumatic stress disorder are presented.

CHAPTER I

INTRODUCTION

In 1982, a small but growing number of Guatemalan and Salvadoran individuals and families began arriving in the Tucson area. Many stated that they were fleeing from political repression. Some bore scars which appeared to support their tales of brutality and torture. They were aided in their journeys by religious workers affiliated with the Sanctuary movement, which had been initiated as a renewal of the Biblical tradition of providing sanctuary in holy places for those fleeing from legal prosecution.

While facilitating medical referrals for some of these individuals, their frequent rapid deteriation in health following arrival in the United States was noted. Other common problems reported by Central American refugees recently arrived in Tucson included severe nightmares and other sleep disturbances. Many men and young boys engaged in excessive alcohol consumption.

The exascerbation of symptomatology observed in recent arrivals was paradoxical in view of the extreme courage and human endurance which these same people had demonstrated over long periods of imprisonment, hiding, repeated loss of family members and difficult travel across two or more national borders during the journey to the United States. In some cases, letters from Central American clergy, newspaper clippings or reports from reliable sources such

as medical personnel, clergy and international relief workers corroborated much of the information supplied by refugees.

New arrivals appeared to fall within one of the following groups:

1. Persons who had been placed on death lists and who were fleeing for their lives. Some of these individuals displayed symmetrical scars which, they reported, were the results of electroshock torture or other physical abuse during imprisonment. Others had a variety of visible scars which were said to be the results of gunshot wounds and other sources. Although some of these persons had themselves been imprisoned, others had had family members tortured and killed and, upon receiving threats to their own lives, had fled.

This group also included spouses and other family members of imprisoned, missing or dead persons who had themselves been threatened, tortured or imprisoned.

2. Persons who, although not themselves personally singled out for torture, murder or imprisonment, feared for their lives because of the fates of family members. Representative of this group was a fifteen year old boy who was injured by a train while "riding the rails" through Tucson in order to reach a sister living in Los Angeles. He repeated over and over again that he did not know how to tell his sister that he had watched their

parents and brothers die as the small city shuttle bus they were riding in exploded into flames. He said that people at the scene were afraid to touch the charred bodies of the dead, many of whom had been considered sympathetic to anti-government forces.

3. Family members of individuals described within groups one and two. These persons had not directly witnessed violence to a close friend or family member, although some had lost friends or relatives to political violence. Almost all of these individuals expressed fear about the political situation in their countries of origin and all expressed fear of returning. However, this group also included persons such as the young wife of a government employee who had been told by her husband that flight was necessary but had not been told by him that both sides in the conflict had threatened his life.

Members of this group expressed ambivalence about their refugee status and often complained of nostalgia for home. Some expressed frustration, concern and bewilderment about behavioral problems exhibited by family members whose experiences placed them in one of the first two groups.

4. This group consisted of single men who were looking for work in the United States. While economic motives were their stated reasons for coming to this country, they frequently added that it was difficult or impossible to avoid conscription by

government or anti-government forces and that their families were experiencing severe economic hardship brought on by the conflict in the country of origin.

5. Young military deserters who had, by personal report, fled in order to avoid the guilt of committing atrocities under orders.

Only a few individuals corresponded to this category and those complained of insomnia, nightmares, and flashbacks and engaged in alcohol abuse.

Purpose:

The purpose of this study was to examine stressful experiences of Central American refugees living in Tucson within the larger context of similar experiences across several cultural and historical contexts. The following research questions were addressed:

1. Does post-traumatic stress disorder exist among Central American refugees living in Tucson?

2. If so, how does it manifest itself in this population?

3. What counseling or other therapeutic interventions may be helpful for Central Americans experiencing post-traumatic stress disorder?

Assumptions:

It is assumed that participants in this study have experienced a major stressor outside the common range of human experience during peacetime.

It is further assumed that participants have remembered these experiences well enough to describe them and that, while some details may be omitted in their narratives, they have responded honestly to the author's questions.

Finally, based upon abbreviated informal interviews with an additional 14 refugees and upon the author's social services and medical experience with the refugee population, it is assumed that the participants are representative of other refugees from Guatemala and El Salvador now living in Tucson.

Definition of terms:

For purposes of this study, the definition of "Post-traumatic stress disorder" is based upon the diagnostic criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, 1980, American Psychiatric Association, (DSM III). According to this definition, a psychologically traumatic event outside the realm of ordinary human experience provokes characteristic symptoms which may include reexperiencing the precipitating trauma, ("flashbacks"); reduced participation in the external world (e.g., "numbing of affect"); and other somatic or cognitive symptoms. (Appendix F).

For purposes of this study, somaticization is defined as the conversion of stress-induced anxiety into physical pain or discomfort.

Several culture-specific terms were used in the semi-structured interview through which participants shared information. The

Spanish term "susto" refers to a loss of appetite, sleep disturbance, listnessness and pallor which may be brought on by a frightening experience (da Silva, 1984). The term "nervios", refers to generalized anxiety and, in some cases, agitation which is brought on by a stressful situation.

The possibility that post-traumatic stress disorder may be affecting some Guatemalan and Salvadoran refugees living in Tucson implies the need for appropriate interventions. Stress-related symptoms and adjustment difficulties experienced by many of these individuals may require interventions which are to some extent specific to this population. This study addresses post-traumatic stress disorder in Central Americans within the context of cultural considerations and intervention issues.

CHAPTER II

REVIEW OF THE LITERATURE

In this literature review, information regarding post-traumatic stress disorder as a diagnostic entity, is presented and the experiences of other survivors of massive trauma are described. A considerable literature has developed based upon studies conducted with Holocaust survivors and Vietnam veterans. Further studies based upon the experiences of Southeast Asian refugees have been published during this decade. Finally, several authors have addressed treatment issues for Central Americans, whose symptoms and prognoses must be viewed in a historical perspective.

Historical background:

The historical and political background from which the Central American refugee crisis has emerged is a bleak one.

In No Promised Land: American Refugee Policies and the Rule of Law, Gary MacEoin and Nivita Riley reported results of research supported in part by OXFAM, America (a relief organization.) Some of their 1982 findings are summarized below:

El Salvador has a population of approximately five million people in an area of 8, 260 square miles, about the same size as Pima and Santa Cruz Counties combined. Despite the unsuitability for intensive agriculture of half the land in use, 50% of the economically active population is absorbed in agricultural

activities. Only 2% of the population control 60% of the best land and production of most of the agricultural exports. A small feudal oligarchy, the "fourteen families", dominates the economy and the political structure of this nation. In contrast, most Salvadorans now live in poverty. Approximately 60% of the rural workers have no land and most others rent or own plots of land inadequate for their families' subsistence needs.

A small feudal oligarchy, the "fourteen families", dominate the economy and political structure of this nation. In contrast, most Salvadorans live in poverty.

In 1932, a peasant uprising led by Faribundo Marti was put down through the killing of 30,000 people and the forced exile in Honduras of another 100,000 refugees. Over the succeeding years, economic reforms have been mostly cosmetic. By 1980, tortures, mutilations, disappearances and murders or persons identified as popular leaders were common. By the first half of 1980, killing of unarmed civilians had risen to a thousand a month. Detailed studies by religious and human rights groups in El Salvador and by international groups such as Amnesty International and Pax Christi attributed 80% of these killings to the military and to right wing paramilitary groups. The murder that year of Archbishop Romero as he said Mass in the cathedral of San Salvador has been described in detail in the international media. As a religious leader, he

had pled for an end to both economic injustice and the murders perpetrated by these death squads.

Conditions of civil war now exist in El Salvador. In an urgent bulletin dated June 10, 1986, the Religious Task Force on Central America reported 11 kidnappings of human rights activists during the past month. Among them were three members of COMADRES, (a group of relatives of persons who have been killed, "disappeared" or imprisoned and tortured by the military or by paramilitary death squads), six members of the Human Rights Commission of El Salvador, and one member of the Commission for the Displaced.

MacEoin and Riley (1982) also reviewed the historical and political context in Guatemala, whose seven million inhabitants populate an area of 40,000 square miles, a little over 1/3 the size of Arizona. According to the authors, 80% of all U.S. investment in Central America is focused here in the areas of agriculture, manufacturing, and increasingly significant petroleum exploration and development.

In 1954, a government which had initiated major land reform was overthrown through a military coup. Subsequently, rightist military regimes have brought suffering to the Guatemalan people, 11,000 of whom were killed in 1981. In this country, 10% of the population control more than 81% of the land. In rural areas, 90% of the population are illiterate and 80% of the children suffer from malnutrition.

may exceed a million. This upheaval is especially difficult for the indigenous peoples of the mountain regions, whose cultural traditions and language set them apart from the mainstream of Spanish-speaking ladino society in the urban areas of Guatemala and in neighboring countries.

The problems of El Salvador and Guatemala are fast becoming problems for the United States. State Department estimates of the number of Salvadorans in the United States have run as high as 500,000, with Los Angeles the biggest center for immigration, with a Salvadoran population of as many as 200,000. San Francisco is now home to 70,000 - 100,000 persons from El Salvador.

While the Immigration and Naturalization Service has consistently maintained the position that the great majority of Salvadorans and Guatemalans living in this country are economic migrants rather than political refugees, this position is problematic. The United Nations Convention of 1951 states that refugees claiming political asylum must have a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Certainly, most Guatemalan indigenous peoples have experienced genocidal raids perpetrated by military or paramilitary groups. To be young in either of these Central American countries is to be recruited to one side of the political conflict or the other. To be a Catholic health worker or religious

worker serving the poor is a role sometimes accepted at the risk of one's life. To be a relative or a friend of a "disappeared" one may bring great danger.

Uncertainty is always with one. A couple interviewed by this author reported that they were not granted political asylum, even though the death squads came for the neighbors in the next apartment, because they themselves were not "political". Even so, they live in a state of constant fear. Many refugees insist that the socioeconomic and political suffering which exist in these countries are interrelated and that it is therefore not possible to clearly distinguish between economic and political reasons for leaving the nation of origin.

POST-TRAUMATIC STRESS DISORDER

While Post-Traumatic Stress Disorder has only been included as a diagnostic category since publication of Diagnostic and Statistical Manual of Mental Disorders, (1980), this condition was not previously well defined and was subsumed under other categories, the choice of which tended to vary according to the manifestations of post-traumatic stress in different individuals.

Over time, diagnostic labels which referred to specific etiologies were offered. For example, Holocaust victims were said to manifest "survivor syndrome" and military physicians discussed treatment of "battle stress". As a review of the literature shows,

these constellations of symptoms were descriptive of more universal human responses to extreme stress.

Henry Krystal performed much of the pioneering work regarding post-traumatic stress disorder. In Massive Psychic Trauma, (1968), Krystal and Niederland described a disorder they call "survivors syndrome" whose symptoms are summarized below:

1. Anxiety with three relevant clinical characteristics:

a. Fear of impending danger to family members.

b. Fears related to current situations which remind the individual of past terrors.

c. Fears of persons who remind the individual of past persecutors.

2. Disturbances of cognition and memory.

3. Sleep disturbances.

4. Chronic depression.

5. Impoverished relationships with others (reacting to current situations using protective patterns which were no longer useful).

6. Psychosomatic disorders. (327-348)

Horowitz, (1980), has performed landmark research on stress induced disorders. In an extensive study upon symptoms in 66 patients who were evaluated at a stress reduction clinic at the University of California Medical Center, three instruments were used: the Impact of Events Scale, a 90-item checklist, and the Stress Response Rating Scale. Said Horowitz: "The most frequent signs and symptoms of stress

response disorders. . .are intrusive ideas and feelings that tend to repeat aspects of the experience of the inciting event and reactions to it". (91)

Horowitz suggests that "important other experiences, episodes of numbing and ideational avoidance, are the results of control efforts aimed at preventing intrusive episodes." (91)

Horowitz sees precipitating events as extremes of normal everyday experiences. In such normal experiences, a process ensues which permits previous inner models, now recognized as discrepant with new realities, to be revised so that they (are) in accord with the current event." (91) This is a process of examination, of assimilation and accomodation to new meanings. When trauma precipitates a stress disorder, the event is serious, precipitous and often unexpectedly intense.

Reactive ideation reflects the discrepancy between the traumatic event and the individual's inner model of "how it was" (or was remembered). Says Horowitz:

"When the repetition of coded perceptions and reactive thoughts occurs despite controls, the episodes will be experienced as intrusive. (92)

However, when the converse occurs, the individual experiences constrictions of the ideational range and emotional numbing ensues.

Offering a neuropsychological perspective, Brende (1982) reports findings of his pilot study of post-traumatic stress disorder in Vietnam veterans, and advances the following hypotheses:

a. Post-traumatic symptoms are associated with poorly controlled or poorly integrated cerebral hemispheric functioning.

b. Psychic numbing, nightmares, and flashbacks are associated with abnormal right hemispheric function in relationship to the left hemisphere.

c. Aggressive behaviors, hypervigilance and character pathology result from abnormal activity, suppression or integration of left hemisphere function in relation to the right hemisphere.

In any case, post-traumatic stress disorder appears to be problematic with regard to chronicity. Nichols and Czirr (1986) describe patterns of deferred onset or reemergence of symptoms in geriatric patients many years after the precipitating stressor. These authors suggest that chronic post-traumatic stress disorder may be incorrectly diagnosed as primary alcoholsim or depression in individuals who, respectively, may be attempting to self medicate using alcohol or who may simply be experiencing deferred onset or recurrence of symptoms. Reports of chronicity have also been widely documented in the literature of psychiatric treatment of Vietnam veterans. (Kolb, 1987, Saw et al, 1987, Parson, 1986)

An analysis of post-traumatic stress disorder as it occurs across populations will show that, despite commonalities which do exist, its specific manifestations may vary based upon socio-cultural factors and pre-trauma personality and experiences.

Post-Traumatic Stress Disorder Across Cultures

The Holocaust

The Holocaust literature provides the most extensive information upon the long-term effects of stress disorders which has yet become available. While survivors have been interviewed on an ongoing basis, there seem to be three major waves of literature: that developed in the 1950's, much of it based upon psychoanalysis of survivors; that developed in the 1970's, which focused upon long-term effects of the concentration camp experience upon such individuals; and the most recent research conducted in the 1980's, which has focused upon the effects of the Holocaust experience upon children and grandchildren of survivors. This, it should be noted, is the primary source of available information regarding transgenerational effects of post-traumatic stress disorder.

Kestenberg (1985) cites Poltawka (1978), who, before the inclusion of the diagnostic category in DSM III, reported that Holocaust survivors experience periodic attacks of "hypermnesia" or "ecmnesie paraxystique" in which sudden waves of vivid recollections of camp experiences engulf them, lasting for minutes,

hours or days. These are elicited by olfactory, visual or auditory stimuli and, says Poltawka, are often concealed by survivors, who use avoidance as a coping strategy.

The long-term effects of traumatic stressors on concentration camp victims have been well documented. In Canada, Eaten (et al, 1982) compared the psychiatric status of 135 Holocaust survivors with that of a like number of control subjects. Recent increases in anti-semitism in Montreal were positively correlated with levels of mild psychiatric symptoms experienced by survivors. Surviving women had a higher level of symptoms than did controls. This was significant at the .001 level. Similarly, 36.7% of surviving males had four or more psychiatric symptoms compared with 22% of controls.

The authors conclude that a situation of perceived potential ethnic persecution brought about by a surge of anti-semitism in connection with heightened nationalism appeared to bring with it psychiatric consequences. Fears of ethnic persecution were determined to be associated with the psychiatric consequences of the Holocaust.

This finding has implications for the psychological status of Central American refugees who have fled from persecution in their countries of origin, and yet have found only an uncertain haven in the United States. It also implies considerable chronicity for post-traumatic stress disorder.

Further support for the long-term effects of this severe

psychic trauma is found in a study by Lomanz et. al (1985). These authors studied 44 concentration camp survivors 40 years post-trauma. All were immigrants to Israel. The authors used a time orientation questionnaire in which subjects listed 10 important life events and also used a Life Line technique in which survivors located significant life events along a linear continuum. They found that, when compared with a control population, concentration camp survivors tended to be more past-oriented with regard to predominance, extension and density of life events. They were more pessimistic about life than were controls.

Transgenerational effects of severe trauma have also been documented. Link (1985) found that psychotic material of children and grandchildren of Holocaust victims sometimes contains persecutory delusions reminescent of those survivors' experiences. In two case studies, schizophrenic patients who had been unsuccessfully treated with neuroleptic medications had come from families in which the Holocaust was a forbidden topic. Nevertheless, these young adults' delusions were based upon their imaginings of family members' horrific experiences as they reconstructed them using information obtained regarding Nazi Germany. The authors suggested that unresolved survivor guilt on the part of both parents and children may have interacted with the parents' "conspiracy of silence" to mystify offspring and thus to contribute to the contents of their schizophrenia, perhaps impeding recovery.

Krell (1979) has identified two common patterns of coping in families of Holocaust survivors. In one, the child is reared by a "silent family" and may indeed feel responsible for parents' outbursts of grief. In such families, the children are seen as removed from the precipitating trauma and therefore unaffected by it. Krell cites other instances in which parents go to the other extreme and tell their children every available detail regarding their sufferings, often indicating that they have survived against all odds. Children of such parents must logically infer that their own existence is against all odds and that they, too, are survivors.

Nadler et al., (1985) hypothesize that survivors perceive their children as a source of new hope and meaning, thus forming unrealistic expectations regarding their offspring. The child, whose psychological survival is dependent upon fulfilling these expectations, avoids guilt by repressing aggressive feelings. As compared to subjects in a control group, survivors' children studied by these authors tended to respond to projective measures in ways suggesting "more guilt, depression, (and) unexpressed anger" than controls. With response to general anxiety, their responses suggested a greater sense of approaching disaster than did those of controls. The authors suggested further studies of the prevalence of such intergenerational patterns among other groups of survivors of massive traumas.

The above studies imply the need for family education as one means of ameliorating potential transgenerational effects of major trauma. Unfortunately, there is a paucity of available information regarding educational and therapeutic interventions with families of Holocaust survivors and other individuals who have survived major stressors outside everyday experience.

Southeast Asian Refugees

In discussing the etiology of psychosocial adjustment difficulties in Southeast Asian refugees immigrating to the United States, Nicassio (1985) utilizes the construct of learned helplessness. Coming from a society in which nothing one attempted succeeded in improving one's wellbeing and, perhaps, that of one's family, it may be difficult to initiate adjustments to a new environment such as learning a new language or acquiring job skills and social behaviors.

Nicassio points out that in the case of Southeast Asians the refugee's experience is different from that of other immigrants in that the move from one country to another is based upon fear rather than upon "a rational desire to resettle elsewhere."

Obviously, in the case of some refugee families, both motivations may coexist. For example, many individuals experience both a fear of persecution and a desire to be reunited with family members.

Precipitous separation from family members and uncertainty regarding the eventuality of reunion with loved ones are common experiences in the lives of Southeast Asian refugees. Nicassio also stresses the deep sense of loss which refugees experience. Such loss may be material, cultural or political as well as that of significant personal relationships.

It is important to observe that the public's attitudes toward refugees in the receiving country may also profoundly affect the adjustment process. Another potential stressor for the refugees is the degree of disparity between cultural norms in the country of origin and those in the receiving country.

Nicassio cites depression as the most common psychiatric disorder found among Southeast Asian refugees who have sought professional counseling. In the Portland, Oregon area, the incidence of major depression in Southeast Asian patients seen at an outpatient mental health clinic has been high, 49% to 263 refugee patients as compared to 23% of nonrefugee patients (1985).

Southeast Asian patients experience somatization as a frequent symptom of emotional distress. In his study, Nicassio found that headache and insomnia were the most common features. He cites Nguyen (1982), who has suggested that, because mental health problems are highly stigmatized in Southeast Asia, the presentation of somatic symptoms rather than frank statements of psychic distress may be more socially approved.

Westermeyer et al., (1983) analyzed premigratory and postmigratory characteristics of Hmong refugees from Laos who did and did not seek psychiatric treatment. The authors studied 97 subjects aged 16 or older. A weekly Hmong clinic was intiated at the University of Minnesota at the request of tribal elders. During its first year of operation, 19 of the original 97 subjects sought care there. The authors followed 17 individuals for treatment. The most requent diagnosis made in 15 of 17 cases, was major depression. Only one of these episodes was a recurrence.

The authors investigated 60 premigration and post-migration factors in comparing these patients with the remaining 80 subjects who had agreed to complete oral interviews. They found that the patient group contained an excess of persons in their 30's, with typically major family responsibilities and a deficit of those in their 20's, who tended to have fewer such responsibilities and more literacy and foreign language skills. Farmers and others who had little hope of pursuing their vocational roles in this country (e.g., midwifes, blacksmiths) were judged to be at risk. Refugees whose sponsors were fundamentalistic rural church groups whose members actively interfered with Hmong cultural practices were also frequently seen for treatment.

Vietnam Veterans

Much of the recent literature on treatment of post-traumatic stress disorder focuses upon clinical studies with Vietnam veterans.

This is of importance to counselors working with Central American clients, as many young people reaching the United States have served in the military or in the guerrilla forces in either El Salvador or Guatemala. Some of those who have served in government forces report post-traumatic stress disorder symptomatology connected with atrocities which they themselves committed.

Referring to Kohlberg's work on moral development, Glover (1984) suggests that most young Vietnam veterans lacked the opportunity to establish their value systems, whose absence impeded their ability to cope with war experiences and readjustment to civilian life. In Glover's words, "adolescents are the most sensitive to disillusionment and loss of faith in their cherished ideals and the institutions which purport to represent them." (448) Consequently, mistrust often complicates efforts at treatment of facilitation of social/vocational readjustment for this population.

Glover hypothesizes that the Vietnam veterans' alienation and mistrust result from the war experience, society's negative responses toward men upon their return from combat, and the individual's stage of psychosocial development at the time at which the precipitating trauma is experienced. Soldiers in the Vietnam war often found themselves in paradoxical "Catch-22" situations in which even civilian children might prove to be sources of danger. Soldiers became increasingly hardened to feelings of compassion.

Glover notes that, recalling wartime experiences, many veterans in treatment referred to themselves as having become "animals".

Along with estrangement from civilians came estrangement from the social values which they had previously been taught. Glover points out that this was compounded by the families' reluctance to discuss war experiences with them. He states that veterans belonging to uncommunicative families "were more vulnerable to later-developing stress-related symptoms." (446)

Central American Refugees

The experience of rejection encountered by many returning Vietnam veterans may have some parallels among Central American refugees who have arrived in this country. Portes (1985) reports the case of a young man from El Salvador who was mistrustful following initial counseling provided by bilingual but "culturally alien, unsympathetic mental health professionals." (3) This man had also previously experienced rejection and condescension on the part of Sanctuary workers who were repulsed by his physical abuse of his common wife and who successfully persuaded her to leave him.

This client was counseled successfully regarding problematic behavior patterns. The foundation for intervention, however, was unconditional positive regard. As Portes observes, removal from one's culture may deprive the individual of stress-reducing mechanisms and thus increase the possibility of social dysfunction.

A critical transition in the counseling process, says Portes, is helping the client to realize that the goal of intervention is the maximization of one's own social competencies and internal resources rather than the necessary resolution of external problems.

Interventions

How should the clinician perceive the individual experiencing post-traumatic stress disorder? There appear to be proponents on both sides of the following issue: Is the individual to be perceived as a patient to be medically/psychiatrically treated or is he/she to be treated as Glover says, as a normal person who has simply reacted to "unthinkable experiences"?

Information on intervention has been developed through extensive work with Vietnam veterans experiencing post-traumatic stress disorder and, increasingly, through work with refugee populations as well.

Glover (1985) has worked extensively with returned veterans. He has the following suggestion for intervention:

> "I have found it helpful in working with veterans to encourage whatever expressions of skepticism they have toward persons in authority, when this suggests an effort on their part to think independently and to find their own solutions." (450)

Pervasive cynicism, however, is seen as a sign that the veteran continues to covertly seek a return to a state of innocence, thereby

denying full responsibility for his life. Glover believes that experiences with peer groups may help to increase social relatedness. The psychiatrist, he remarks, must also be seen as an "autonomous and independent thinking individual" in order to facilitate the veteran's individuation. (405)

During wartime, treatment of "combat stress" or "battle stress" has been aimed at promptly returning the soldier to active combat as a functioning participant. (Schneider and Luscomb, 1984). These authors developed a questionnaire regarding perception of battle stress casualties, which they subsequently administered to 261 randomly chosen U.S. Army soldiers. Results indicated that few respondents had an accurate idea of how to recognize or treat "battle stress response". The authors advance the concept of "battle buddies" or peers paired with one another in providing mutual emotional support and short-term, special consideration such as temporary rest, provision of a hot meal, and allowing the distressed individual to talk about his feelings. Essentially education regarding stress reactions is directed at teaching soldiers what to expect as "normal" combat reactions.

Parson (1986) has found that somatic disorders such as autonomic nervous system disturbances, and sensory, proprioceptive, enteroceptive and kinesthetic disturbances are major components of what he labels "postcombat stress pathology." Commonly reported

somatic complaints include body tension states, migraine headaches, dizziness and gastroinestinal disorders. Sleep disturbances are also quite common and problematic. A powerful "conditioned response", (39), (Kolb and Mutalopassi, 1982 in Parson) comes into play and may be a contributing agent in the intensification and increase in frequency of symptoms over time.

Parson hypothesizes that severe battle stress produces "irreversible regressions in the body-ego which, in turn, affect the proprioceptive and enteroceptive processes. The traumatized psyche depends on somatic-level defenses and thus mental defenses are "relatively ineffective in integrating thought, memory, perception and sensation." (40)

Parson takes a very detailed, highly structured approach to therapy. In the first stage, therapy focuses upon stabilizing the veteran's state of inner chaos and in reducing acute anxiety. This, in turn, reinforces the veteran's decision to stay in therapy. "Moment-to-moment" problematic behaviors are the focus of intervention. Strategies which are used during this phase include concrete educational information regarding his/her symptomatology, behavioral bibliotherapy focusing on veterans' experiences, and cognitive restructuring.

Parson states that empathy and warmth on the part of the therapist are critical to the success of therapy. He advocates reattribution techniques and "deresponsibilitizing" or

reinterpretation of veterans' actions in terms of the need to survive and pressures which were brought to bear upon him. At the same time, emphasis upon self-awareness, self-responsibility and self-control in the here and now is introduced. Progressive relaxation, systematic self-desensitization, biofeedback and mild doses of psychopharmacological agents are also suggested as possible interventions.

In the second phases of therapy, the therapist becomes somewhat less active than in the initial phases. He/she models stable behavior in order to provide the patient with a frame of reference for change. Here once more, unconditional acceptance is crucial, although information shared by the patient may be uncomfortable and even abhorrent for the therapist. Parsons emphasizes that during this phase of information sharing, the therapist must be at once "securely anchored in a cohesive self-organization" and must be willing to go "all out" for the patient, experiencing the veteran's "endopsychic, interpersonal and experiential climates." (42)

The third phase, says Parson, is characterized by an empathic, noninterpretative attitude joined with some activity performed by the therapist. The veteran is encouraged to reexperience and recall traumatic events in the present, with much of the immediacy of recapitualated emotions. Parson says that the goal of this therapy phase is the fostering of a "controlled, regressive pathway to the

original traumatic experience," thus accomplishing abreactive regression which "may later help in the integration of the war experience into the patient's psychic structure." (43)

The final phase of therapy focuses upon reintegration of estranged parts of the veteran's personality. The patient is then brought from total reliance upon the therapist as an "archaic self-object" to reliance upon him/her as a whole object upon which transference displacements may be projected.

Parson's model appears important in that it is based upon his observation that the psychological needs of the individual who has experienced psychic trauma change from time to time over the course of therapy. He also emphasizes the uniqueness of the individual and of the meaning of combat for that individual as factors which must affect the nature of the treatment process and the course of therapist-patient interactions.

Something which may be of prognostic importance for many refugees in Parson's recommendation for a "containing, facilitating and holding environment" upon returning home. (50) For the refugee, there is no going home. Cessation of acute trauma brings with it an uncertain future and, for many, enduring loss of family, friends, and all that is familiar. Even residents of the host country who want to help these individuals may not have the information needed to establish a healing environment.

Kinzie (1978) is hopeful regarding the possibility of providing successful cross-cultural therapy. He believes that the elements of such intervention include appropriate use of the medical model in the sense of its function as a form of treatment of the ill, with no blame assigned. Noting the almost universal authority of physicians and healers across cultures, he uses this as a way of mobilizing hope and then facilitating psychic healing. Kinzie advocates a subjective phenomological approach in relating to clients whose value systems or cultures may differ from one's own. He also points out that nonverbal behaviors such as facial expression may have some universality of meaning and may thus facilitate understanding of the client's emotional experience during the therapy session.

Taking a radically different approach toward the study and treatment of post-traumatic stress disorder in veterans, Birkheimer et al., (1985) explored both the symptomatology and response to pharmacological treatment of 15 veterans. The symptom profile of these patients was much more complex than the presentd in DSM III. For example, a number of patients cited more than one major recognizable stressor preceding onset of symptoms. These patients had an average of 3.2 hospital admissions before assignment of the diagnostic label of post-traumatic stress disorder, which was formally accepted by the American Psychiatric Association in 1980.

Depressive symptoms were present in all patients and were applied to 60% of previous admissions. Other diagnoses previously applied to 30% of the group's members included anxiety, alcoholism, drug abuse, borderline personality and antisocial personality. Anxiety-related symptoms experienced by subjects included tachycardia, tremor, hyperalertness, and dizziness. Poor social function was also reported. Combat-related nightmares were reported by 60% of the patients surveyed and 80% experienced flashbacks. These symptoms tended to serve as crisis interventions. Approximately half of these veterans reported hyperalertness and almost all complained of sleep disturbances. Pre-combat factors may have placed some of these persons at risk, as 50% had reportedly experienced dysfunctional families or had had "a troubled childhood or adolescence". The authors reported misuse of alcohol by 80% of the subjects, which, they suggested, might have been attempts at self-medication.

As subjects had received intermittent group or individual psychotherapy, an average of 12 psychoactive medications had been prescribed for each. However, over the course of their hospitalizations, none had proven completely effective in achieving remission of symptoms. For these patients, tricyclic antidepressents such as imipramine and amitriptyline had proven ineffective in treating symptoms of depression. Although amitriptyline improved sleep for some patients, it did not reduce flashbacks, nightmares or

depression. Imipramine had some effect on nightmares and sleep but patients experienced no improvement in frequency of flashbacks or depressive symptoms. Only one out of three patients who had received phenelzine showed transitory improvement.

However, alprazolam, a newer benzodiazapine, was given to two patients in this study and, respectively, complete and partial control of anxiety symptoms were reported. Hypnotic agents such as Fluorazepam were used effectively for all of the 14 patients who complained of sleep disturbances and a variety of antipsychotic medications appeared to facilitate improvement in psychomotor agitation and impulsivity. However, the problems of flashbacks and nightmares never fully resolved. One patient was successfully treated with lithium carbonate for episodic, explosive outbursts which he had experienced since the Vietnam war. Long term efficacy was unknown at the time of this study. Overall, the authors felt that the outcome of pharmacotherapy was generally inadequate with regard to combat-related post-traumatic stress disorder.

Behavioral strategies have also been utilized in treatment of post-traumatic stress disorder. Keane and Kaloupek (1982) reported a single-case study in which imaginal flooding was used to treating combat-related stress disorder in an alcohol-abusing patient who experienced chronic anxiety with acute panic attacks two to three times per week, along with nightmares, flashbacks, insomnia and

concomitant social and vocational problems. Therapy was based on the implosive therapy model of psychopathology, according to which prolonged and repeated imaginal exposures to the precipitating traumatic events may lead to extinction of anxiety.

The authors readily acknowledge that it is difficult to assess the efficacy of imaginal flooding in treatment of this individual, as each session included a review of symptoms and their frequency in order to identify environmental events contributing to problematic stress levels, guided practice in using appropriate problem-solving strategies for stress reduction, and a 10 minute relaxation period preceding imaginal flooding. Nevertheless, it is interesting to note that a year following termination of therapy, the patient was reportedly alcohol free, was in a "satisfactory relationship with a woman" and was still gainfully employed and attending school.

Finally, one is brought to consider the existential approach to psychotherapy. One of its original proponents, was Victor Frankl, whose three years in the Auschwitz concentration camp along with his expertise as a psychiatrist certainly gave him a profound understanding of human behavior under extreme stress. In Man's Search for Meaning, (1959) he describes two instances of intervention for suicide prevention in which he participated while a prisoner. In each, the key factor determining success in the intervention was the provision of hope--in one case, that of eventual reunion with a child who was safe in Switzerland, in the other, the possibility of finishing

scientific writings which represented years of work and which could be completed by no one else.

Frankl founded the school of logotherapy, which is based upon his assertion that the search for meaning is the primary motivational force in one's life. For Frankl, even the experience of suffering may carry great meaning, depending upon the way in which one confronts it.

This emphasis on imbuing suffering with meaning as a healing intervention is congruent with the approach to psychotherapy with victims Chilean political repression which has been reported by Cienfuegos and Monelli (1983). These authors, who are associated with a mental health center which has provided treatment for victims of stress-induced disorders since 1973, report the use of testimony aimed at both facilitating reintegration of the precipitating trauma and restoring self-esteem.

Many of the Chilean subjects studied by these authors have experienced forms of trauma which closely parallel those reported by many of the Central American refugees who have arrived in Tucson. Among the forms of torture experienced by the Chilean individuals. were:

"application of electricity to the most sensitive parts of the body . . . ; blows; burns; . . . suspension of the person in the air in various positions, sexual harassment; and immersion in water . . . to cause asphyxia." (46)

The authors note that hunger, isolation and pain together alter the basic affective and cognitive functions so profoundly that implementation of traditional psychotherapy may be problematic.

The 39 subjects of the Chilean study included prisoners who had been tortured or who survived execution attempts, relatives of prisoners both living and dead, and returning political exiles. Their presenting symptoms included helplessness, anxiety, sleeplessness, feelings of disintegration, impaired concentration and memory, specific or generalized fears, social withdrawal, loss of appetite, irritability and diverse somatic complaints.

Treatment began with one or two sessions aimed at gathering data on the individual's life history and experiences of political repression and at establishing a therapeutic relationship. Patients were then encouraged to tape record their stories using their own words. They were told that this would help them to understand their emotions associated with the precipitating trauma and would also permit them to denounce in writing the violence and injustice which had been inflicted upon them.

During the dictation of testimony, the therapist sometimes requested clarification or greater detail. The taped testimony was subsequently transcribed and the test was reviewed by the patient in conjunction with the therapist. The authors report that written testimonies have ranged from 15-120 pages in length.

The authors reported that the highest success rate was achieved with those patients whose traumas had been precipitated by torture. In 12 of 15 cases, the use of testimony as a therapy strategy was followed by alleviation of anxiety and other acute symptoms. An additional two cases were judged to be partial successes. The sole failure was attributed to serious pathology in the patient's premorbid personality. Of the two individuals who survived execution, one achieved success and one partial success through use of this intervention protocol.

Although partial success was achieved among the 15 relatives of executed prisoners treated furing this study, unresolved grief was still present in most individuals following testimony. Rather than expressing outrage, bereaved family groups tended to display guilt, depression and anxiety. One wonders to what degree this response may have been related to Chile's climate of ongoing political repression and authoritarian government, in which overt expressions of anger at political killings may endanger bereaved relatives.

The five patients returning from political exile had varying reasons for both that exile and the conditions of exile and success was mixed for this group. Testimony was not determined to be a successful treatment modality for the two relatives of missing persons. This may reflect the unresolved grief or arrested mourning process which these unfortunate people were unable to complete due to the uncertainty surrounding the fates of their loved ones.

In reviewing the literature, it is apparent that, while etiological theories vary, post-traumatic stress disorder has been well established as a diagnostic entity with well defined symptoms which do, indeed, appear to occur across cultures. However, the stress-induced symptoms experienced by individuals appear to vary. Vietnam veterans frequently report flashbacks, while many Southeast Asian refugees frequently diagnosed as suffering from major depression. The Holocaust literature indicates the strong possibility of transgenerational effects and suggests a need for prevention programs with first generation refugees.

The literature suggests that considerable chronicity exists with regard to post-traumatic stress disorder and also indicates that it frequently coexists with other behavioral patterns, such as alcohol abuse, which complicate both diagnosis and treatment. Finally, it appears that no clear consensus exists with regard to optimal intervention strategies. Psychoanalytic, behavioral, phramacological and existential interventions have been utilized. Results appear to be mixed and further research is indicated in order to better match the treatment to the individual seeking relief from the symptoms of this disorder.

CHAPTER III

METHODS

The purpose of this study was to ascertain the existence of post-traumatic stress disorder among Guatemalan and Salvadoran refugees living in Tucson and to explore culturally based variations in its manifestations. The methods and procedures which were used for this purpose are described under the following headings: (a) Subjects, (b) Instrumentation, (c) Collection of Data, and (d) Methods of Analysis.

Participants

Subject selection: Subject selection was nonrandomized. It was necessary to interview individuals who had experienced extreme trauma and who had minimal neuropsychological dysfunction based upon organicity (e.g., closed head trauma following beatings). Further, as many Tucson refugees are living here with many members of their extended families, it was necessary to minimize the possibility of artificially skewing results based upon premorbid dysfunction within a few large family units. Finally, it was considered imperative that interviewing not disrupt the sequence of the counseling or therapy process for individuals presently receiving mental health services. All potential participants were either known to the researcher through social service work in the refugee community or were referred by other medical or legal personnel.

With these factors in mind, the examiner approached Guatemalan or Salvadoran refugees who met the following criteria:

1. The subject reported experiencing severe stressors prior to the journey to the United States from the country of origin.

2. The subject did not report head injuries followed by loss of consciousness.

3. The subject was not currently receiving ongoing counseling or psychotherapy.

4. The subject was at least 21 years of age.

5. The subject was not related to any other individual selected for interviewing.

All subjects were told that the examiner was conducting a study of emotional adjustment following severe trauma and of subsequent adjustment to the experience of living in a new country. They were informed that information about the nature of their difficulties and their strategies for successful coping successes would be summarized for use in a study whose results would be shared by the interviewer with other health practitioners and social service workers in an effort to better assist future refugees.

Subjects were told that all information would be provided anonymously and that no information regarding their names, relatives' names, or other identifying information would be recorded or shared in any way. They were also informed that they could discontinue

the interview at any time and that, even after completion of the interview, any subject might withdraw from the study.

Instrumentation

A semi-structured interview format was developed based upon a review of the literature regarding etiology and course of post-traumatic stress disorder and upon cultural factors (e.g., commonly experienced somatic disorders) which might affect responses of Central American participants. It was the researcher's impression that this would yield more valid data than would use of one of the previously developed questionnaires which have been used for research based upon Vietnam veterans (Friedman, 1986). The interview (Appendix A) consisted of a biographical study of the participant based upon experiences both preceding and subsequent to the precipitating trauma and of a culturally adapted questionnaire regarding post-traumatic stress disorder symptoms which was orally administered to participants.

Due to ongoing concerns regarding the safety of refugees living in Tucson and that of relatives remaining in countries of origin, extreme care was taken to preserve anonymity. Accordingly, all volunteers were given code numbers and pseudonyms for use in the study. The only individual collecting and compiling the data was the researcher. In transcription of the interviews, place names were altered and details of the precipitating trauma and

flight from the country of origin were deleted from the transcription whenever it appeared that these might lead to identification of the refugee or to that of significant others. Nevertheless, even descriptions of certain family constellations recorded by the examiner were considered sufficient for identification of subjects by persons familiar with the refugee community in Tucson. For this reason, personal data was summarized in the form of a biographical sketch and only English translations of the coded health questionnaires were directly included in the study. Copies of the original Spanish questionnaires with subject responses will be kept in the researcher's files until May, 1988. At that time, they will be destroyed.

Collection of Data

After preliminary discussions and, in some cases, partial interviews with approximately 18 individuals, six persons who agreed to participate in the study were identified as appropriate subjects. These individuals were interviewed either in their homes, at a local church, or in therapy offices in the community. After a review of subject rights, individuals were interviewed over a single session, lasting approximately two hours. At the conclusion of the semi-structured interview, the questionnaire was administered. In addition to reported frequency of symptoms, any participant comments regarding severity or course of recovery were recorded.

Method of Analysis

In order to address the research questions posed in this unstructured interview and responses to questions contained in the health questionnaire were analyzed with respect to the following:

a. Number of post-traumatic stress disorder symptoms reported by participants, based upon criteria found in the Diagnostic and Statistical Manual of Mental Disorders, (1980).

b. Responses by female as compared to male participants.

c. "Objective" severity of stressors in comparison to severity of post-traumatic stress disorder symptoms experienced by individual participants.

d. Types of somatic symptoms reported by participants.

e. Pre-trauma family environment and lifestyle (in those cases for which this information was available).

f. Current status with regard to social relationships, health and employment.

Finally, the information about post-traumatic stress disorder symptoms in this population was compared with that presented in the review of the literature. It was hoped that a cross-cultural comparison of symptoms and the possible identification of culturally based variations in symptomatology would facilitate formulation of interventions addressing the needs of Central American refugees.

CHAPTER 4

Findings

Participant Profiles

Six participants are described in this study. They ranged in ages from 20 to 45 years. Two men and two women had fled to the United States from Guatemala, while the remaining man and woman had come from El Salvador.

Educational status was limited but was not unusually low with respect to societal norms within the countries of origin. All three men had completed primary school and one had also finished three years of commercial school. All of the women had attended primary school for one or more years but non had completed the sixth grade. As all explained during interviews, economic hardships experienced by their families did not permit all children to finish school. Since men are expected to become heads of families, boys are more likely than girls to receive additional formal education.

Vocational histories were obtained from all participants. This research population represented a range of working class occupations. All the female participants were housewives prior to flight from their countries of origin. One had had a small general store next to the family home and another had worked very successfully as a cook. One of the male participants had been trained as an artisan, one was a soldier, and another was a white-collar employee in a factory.

Birth order was also ascertained. Interestingly, three eldest children were represented in the sample: Maria del Carmen, Maria de la Luz, and Felipe. Of the remaining three participants, two were middle children and the third was an only child who was raised in a reform school after reaching age five years.

All subjects were interviewed over single sessions lasting from one and a half to two hours. All expressed strong interest in sharing their experiences and perceptions with the author. Summaries of information shared by each informant follow:

CASE SUMMARIES

Participant Number 1: María de Carmen

Precipitating trauma:

María is the eldest of eight children of a rural family from Guatemala. She came to Tucson in the Spring of 1984 following the torture and murder of her husband, who was being questioned about her whereabouts. He had had several bones broken and, when the body was found, the face was horribly burned. An uncle had previously been tortured and murdered for organizing campesino and María's daughter was fighting in the hills with anti-government forces. María has two sons, ages four and six years, and also brought her two year old granddaughter with her on her flight to this country.

Family atmosphere during childhood: María's parents were hard workers. Her parents were married in religious and civil ceremonies. Her mother reportedly showed affection to the children on an inconsistent basis and preferred the boys. She was her father's favorite child. Both parents spoke of her being sent to the city to study, as she did well in school, but she completed only the second grade, fearing separation from her brothers and sisters. As the eldest child, she was responsible for much child care and remembered tearfully that she was seldom praised or acknowledged for her hard work. She described her family atmosphere as being a harsh one, with enforcement of strict values through the frequent use of corporal punishment. María commented that one good thing

about this environment was that she had learned to work hard.

Family atmosphere prior to trauma: María reported that she was very proud of her three children and that she had managed to provide a full elementary school education for her daughter, who had talked about becoming a physician. However, she had contemplated separation from her husband because of repeated instances of domestic violence.

Vocational history: María helped on the family farm as a youngster. Following her early marriage, she sewed clothing for sale, cared for her children, raised and slaughtered pigs, and ran a small general store while her husband worked as a campesino/farmer. When they began to fear for their lives, she sold the pigs and began sleeping in the hills, as the family sold their belongings and prepared to flee.

Health history: María had good general health during childhood. However, she sleepwalked and suffered from frequent nightmares. Since her arrival in this country, she has complained of breast pains, difficult menstrual periods, "nervios", and stomach pains. She fights to push down feelings of survivor guilt and, in general, "numb". She tries hard not to remember.

Participant Number 2: José

Precipitating trauma:

Because this young man's life has contained so many potentially traumatic events, it is difficult to determine those which have been most significant with regard to José's development. Jose lived with his grandparents until age five years. However, his parents, who did not live with the extended family, were political activists. While Jose was attending kindergarten, he was taken to the local reform school. Despite his grandfather's repeated pleas, he spent the rest of his childhood first there and subsequently at a worse reform school. Among the punishments which Jose experienced as a child inmate were beatings upon the soles of the feet, required completions of hundreds of knee bends without pausing, and beatings with a knotted rope.

In 1979, still an adolescent, José was released after persistent efforts pursued by his grandfather. By his own report, he was full of hate and fury. However, he soon began training in glasscutting for construction of windows and began to draw as well. (José's face softened as he spoke of this interlude.)

José's respite was short-lived. While on his way to visit his parents, he was informed that a death squad had arrived at their home. From hiding, José watched helplessly as soldiers decapitated his mother and father. As he described the experience, "Había muchos de ellos y yo estuve solo. No más los

miraba". (There were many of them and I was alone. All I could do was watch them".)

José began to work vigorously as an urban liaison for the anti-government forces. Following the insurrection of January 10, 1981, he was captured and tortured. That February, guards knocked out one of his teeth during a beating. He still carries scars on his stomach. Electroshock torture was also initiated. After approximately six weeks of imprisonment, he was blindfolded with a cloth soaked in vinegar. (He still remembers how his eyes burned.) José was pulled up some stairs by the hair then bound to a "cama electrica" (electric bed). There, a masked worker, who by the color of his eyes, hair and arms, appeared to be North American, shaved his head and injected him with an unknown substance. He was again tortured with electroshock and questioned.

In 1983, José was released, but was followed by a van of the design frequently used by death squads. After shots were fired toward him, he escaped. Shortly afterward, he was captured by the National Police. Eventually he was imprisoned in a large institution with "approximately 600 political prisoners." He was released in April, 1985 and, with the help of church workers, fled to Mexico.

Current status: When interviewed for this study, José was living as a guest in a home in Tucson. He had developed a friendly "older brother" role with regard to the family's two sons. He was very active in the refugee community and continued to work on

political issues. José confided that the only thing which seemed to have helped him with nightmares and anxiety was drawing and he recommended that other refugees experiencing stress explore artistic expression.

Family atmosphere during childhood: José remembered his grandparents as his primary caretakers. While he expressed affection toward both of them, he repeatedly spoke of his grandfather with great warmth. He denied specific early recollections other than that of being taken away to the reformatory.

When describing the reformatories in which he was subsequently reared, José spoke of them as hellish places in which children of activists were sometimes placed both in order to control their parents' political activities and in order to break the children's spirit. His facial expression and gestures underlined the pain and aversion with which he remembered these settings. He remembered having no friends, as "no one could be trusted." However, he did remember learning about politics from a few boys with whom he was confined. This, he said, gave him a sense of purpose.

Family history prior to trauma: Further information was unavailable.

Vocational history: As noted above, José was trained briefly as a glasscutter. However, most of his young adult life has been dedicated to political organizing. It should be observed that José has good basic academic skills and that, in addition to drawing, he

reads copiously.

Health history: José's health has been generally good. However, he suffers from intermittent nightmares and sometimes has vivid recollections of his experiences during imprisonment. He also reported considerable emotional numbing.

PARTICIPANT NUMBER 3: FELIPE

Precipitating trauma:

Felipe, a Guatemalan refugee, was 48 years of age at the time of his interview. He had been in the United States for only two weeks, following a two month stay in Mexico, where he received short-term psychiatric care. It should be noted that Felipe's political refugee status was substantiated by a card provided by the United Nations High Commission on Refugees, which has an outreach office in Mexico City.

During the past three years, Felipe had become active in union activities within his place of employment. When, after prolonged difficulties, the union leaders were invited to a meeting with the new management, he believed that his work situation would soon return to normal. Instead, those leaders attending the meeting were arrested by the military police and were imprisoned without trial.

Prior to his escape from Guatemala, Felipe, endured 52 days of imprisonment during which he suffered abuse which included cigarette burns, beatings, pistol-whipping, and frequent immersions in a container of water called "la pila" (the battery), while electrodes were connected to his body and he was tortured with electroshock.

Felipe reported vivid memories of his torture. He recalled that his tormenters were young boys who "laughed like demons". He

recalled arguing with them, asking them "Are we not all children of God?" He felt that they wanted to hear victims scream and that failure to do so enraged them. He indicated that his torturers were often drugged and speculated that, for them, (torture) was "like a work of art".

It should be noted that Felipe bore scars of a pistol-whipping next to one of his eyes and that optic nerve damage had reportedly been diagnosed. He also bore symmetrical scars on each leg, reportedly due to electrode burns.

During Felipe's imprisonment, his wife was murdered and he lost both his sister and brother-in-law to death squads. He stated that, at this time, the most anguishing thing for him was not knowing the fates of his children, ages 13, 15 and 17 years.

Felipe was rescued when, after a release from prison (often a brief reprieve before a final shooting or "disappearance"), unionists from southern Mexico smuggled him over the border.

Family atmosphere during childhood: Felipe's father was an office worker and his mother was a housewife. His father was described as a very kind man who "looked for the good part of life" and who "always loved us...and never punished us." His mother, on the other hand, was described as an energetic parent who was the family disciplinarian but who "loved us a lot in her own way." Felipe's parents never fought in their children's presence. Rather, the children sometimes intuited that "they may have argued the night

before." The couple were married in the Church and the family attended Mass regularly on Sundays.

Felipe stated proudly that his had been a very close family. His father did not smoke or drink. Social responsibility was a strong family value. The children were taught to respect both the old and the poor. When beggars came to the door, said Felipe, "If we had two loaves of bread, we gave them one." His father was seen as the defender of the family and, when he became ill, his mother worked. A month after his death, she died as well.

Felipe had a younger sister and brother. However, at the time of this interview, he had just learned of their violent deaths and was actively grieving. As it was obvious that it was extremely painful for Felipe to talk about them, no questions regarding family constellation were pursued.

Family atmosphere prior to trauma: Felipe was married and the couple had three children ages 13, 15 and 17 years. The oldest and youngest were boys and the middle child, a girl. Like his own father, Felipe encouraged his children to study. He said that he and his wife were very close. He enjoyed organizing soccer games and indicated that he had one or two close friends but many casual ones with whom he enjoyed organized sports.

At the beginning of the labor difficulties, when his daughter was 12 years old, she became concerned about injustices and asked his permission to participate in the student movement in support of labor.

As the situation worsened, Felipe and other leaders received death threats. His daughter became chronically nervous. This was less true of the boys, the older of whom was preparing to exhibit his drawings and the younger of whom "loved music and studying".

Vocational history: Felipe studied through third year of secondary school, an education which, in Guatemala, represents adequate preparation for most commercial and middle class jobs. He studied accounting, worked in a bank, and finally worked for a Guatemalan branch of a large United States enterprise. He had many accounts and was, by his own account, popular with his customers.

Health history: Prior to the precipitating trauma(s), Felipe had excellent general health. Subsequently, he has experienced severe insomnia, hypervigilance, memory deficits, dizziness, visual acuity problems related to his injuries, and headaches.

Participant Number 4: María de la Luz

Precipitating trauma:

María de la Luz is the 53 year old daughter of peasant farmers from El Salvador. She came to Tucson in the summer of 1986 following extensive family difficulties which included the multiple instances of torture and rape of her daughter, Cecilia, the subsequent premature birth of a grandson, threats to her own and her son's lives, and the beating of her learning-disabled son, Jesús, when he attempted to protect his sister from soldiers.

Current status: María de la Luz is married. Her husband, who accompanied her to this country, is an artisan. Both young adult daughters, her son, and her grandson are here. As Cecilia initially had difficulty in bonding with the infant, María de la Luz remains his primary caretaker. She is the ultimate authority in her family, although she indicated that all decisions regarding purchases are made by consensus during a gathering around the kitchen table. She is fierce in protecting her children and assists in tutoring Jesús. She sometimes works outside the home, cleaning houses. María de la Luz is active in the refugee community, cooking for special events and otherwise donating time. She sees herself as a survivor, and is determined to make a new life for herself and her family in the United States. Her greatest wish is that her mother be able to join the family here.

Family atmosphere during childhood: María de la Luz is the eldest of four children of a peasant family. Her family had livestock as well as garden produce and she remembers her childhood as a happy one. She described her mother as very affectionate and as a woman who dedicated herself to her children stating that "she more than anyone, gave me the courage to come here." When asked about her father, she indicated that he was a hard worker and also very affectionate. She denied that either parent had favorites among the children. However, the birth story which she remembered was that all family members quarreled about whose name she was to receive. An aunt "won". María de la Luz recalled that, as far back as she can remember, her dream was to be a mother. The most traumatic memory of her childhood was that of poverty.

Family history prior to trauma: María de la Luz reported that her family was a happy, close-knit one prior to the events which led up to the family's flight from El Salvador. The family lived in a large city, where her husband worked as a carpenter and one daughter was enrolled in post-secondary commercial training, while the other taught elementary school. All family members were quite protective of Jesus, who had not had access to special education services and who could not read. There was a strong emphasis placed upon education as a goal for family members.

Vocational history: María de la Luz attended school only through the second grade. However, she had some additional literacy training

as an adult and always sought to improve her basic skills. She indicated that she has always suspected that she has good intelligence and that, given an opportunity for more formal schooling, she might have studied for a profession. Valuing education, she used the opportunities available to her to secure an education for her children.

María de la Luz became a very fine cook and gradually moved from work in restaurants to work in homes of the wealthy. As she had a very strong social conscience, she felt that she could help in the civil conflict by sharing information thus obtained with dissident groups. Unfortunately, she finally became suspect and eventually had to live in hiding for six months. She felt that her daughter was persecuted not just because of her role as a teacher, but because of her mother's suspected role as well.

Health history: María de la Luz had excellent general health both during childhood and prior to the precipitating trauma. However, since her stay in the United States, she has developed a gastric ulcer, for which she has received ongoing medical treatment.

Participant Number 5: Margarita

Precipitating trauma:

Margarita is a 31 year old woman who has been in the United States for approximately eight years. She indicated that she came to the United States because of the political situation in El Salvador. She worked in an area in which many violent confrontations occurred and remembered frequently hiding under furniture when gunfire interrupted her work. She also described a vivid memory of seeing a woman and her children slaughtered with a machine gun. Margarita stated that she had lost cousins and a nephew during the violence in her country. She recalled that her uncle had hidden from death squads after he advised her grandfather that he was about to be killed. Her most detailed recollection was of an instance in which the military police came to her home and beat her father severely while she watched. They accused her family of supporting the guerrillas and, she felt, were on the point of killing them when her mother began praying to God to do with the family as he would, since, she said, they had been falsely accused by an envious neighbor. For an unknown reason, the police refrained from further violence. Margarita fled the country shortly afterwards.

Current status: Margarita now lives in Tucson with her Mexican-American husband, their three year old son, two older children who have recently joined her, and numerous nieces and nephews. While her husband is a citizen, he is disabled and unemployed. Due to this

difficulty, Margarita and her family are living with her husband's relatives. She said that she frequently finds herself crying when her children ask her to purchase things for them and she has no money. She said that sometimes she is uncomfortable asking her husband's family for even a morsel of food, even though her little boy is hungry.

Margarita said that her children have been the source of her strength to keep on surviving. Nevertheless, she is unable to see any future for herself. While all other relatives have been given asylum, hers alone has been denied. She does not know what the future may bring and expressed no hope.

Although her conversation was initially animated and warm, Margarita appeared very fearful as she discussed her future. It should be noted that, while she denied experiencing most post-traumatic stress disorder symptoms described on the questionnaire, she became increasingly agitated during the last portion of the interview, finally turning on her husband in anger and asking the interviewer whether she should leave him as a poor provider. Her husband indicated that she often becomes "like this" and that, when she does so, he sleeps in the car until she is once again calm.

Toward the end of the interview, Margarita mentioned, as if in passing, a suicide attempt three years ago and an experience with counseling after striking her little boy in anger. When questioned directly by the interviewer, she indicated that she frequently experiences "enojos" (rages) accompanied by a feeling of helplessness.

During this portion of the interview, her speech rate was initially quite rapid, slowing down only at the end of the conversation.

Family atmosphere during childhood: Margarita was the second daughter in a family of 11 children, which included six girls and two boys. She mentioned that her mother lost three children but denied any memory of them and gave no details. Margarita described herself as her father's favorite child and indicated that her mother became "hysterical" with anger when her father indulged her. She reported, however, that her mother now considers her her favorite child.

When asked whether she remembered a story about her birth, Margarita recounted an incident at age five or six months in which she was said to have almost burned to death when her house caught fire while her grandmother was caring for her in her parents' absence. She indicated that her grandmother became extrememly fond of her and stated, "Mi mamá nunca fue a otro baile", (my mother never went to another dance").

When asked to describe her health during childhood, Margarita recalled repeated instances of sleep-walking at age two years, after each of which she was found by family members while wading into the river.

Margarita also stated that her mother had told her that, at age three years, some "rich people" had asked permission to adopt her. When she asked her mother why she had not allowed this, she exclaimed, "How could I give my daughter away!"

During Margarita's childhood, both parents used the belt for discipline. Milder beatings were administered by her mother, with major ones assigned to her father, who "hit harder". She recalled frequent quarrels with a younger sister, whom her father subsequently scolded, saying that it was important to respect her older sister. Once again, Margarita indicated that a relationship had improved, saying that this sister now defends her whenever the need arises.

Childhood friendships were reportedly problematic. Margarita reported that she had friends but that they often quarreled with her. Margarita spent a great deal of time working at home and helping her family with housework and childcare.

Family history prior to trauma: Margarita provided few details of family history during her young adulthood. She indicated that she had a child and that she was living with her parents immediately preceding her flight from El Salvador. Due to the conditions of her escape, she left her three month old daughter with her mother.

Vocational history: Margarita worked doing housework and cooking as a young adult in El Salvador. She attended primary school for a brief period but beased to do so when her family required her help at home.

Health history: During childhood, Margarita's health was good. Since her arrival in the United States, she has suffered from episodic attacks of "nervios" (nervousness). During one such episode, she burned herself while cooking and was subsequently

hospitalized. Subsequently, her only difficulty has been with an instance of dizziness related to birth control pills, which rapidly subsided following a change of prescriptions.

Participant Number 6: Juan

Precipitating trauma:

Juan is a 25 year old artisan from rural Guatemala, who was drafted by the military at age 18 years. He described his indoctrination as a brutal experience which included beatings and harangues. Three months later, after learning that he was expected to help to commit atrocities, Juan deserted but was caught and returned. His punishment included beating, dousings with cold water, and more harangues.

Subsequently, Juan was required to participate in the cordoning off of three villages, while inhabitants were massacred. He recalled that, in one, 80 people were dragged from their homes and killed. In another, 20 people died. He remembered that many victims were hacked apart with machetes, while others were shot. He repeatedly stated during the interview, "I keep seeing their faces. I keep seeing their bodies . . . I keep seeing my companions' faces."

After six months, Juan ran away again and lived in hiding for an extended period. A friend, who had returned to work a week late due to drunkenness while on a 24 hour leave had been beaten to death during questioning.

Subsequently, Juan's employer demanded identification papers in order to satisfy new government requirements. As Juan could not provide these, he lost his work. Seeing no alternative, he fled the country.

Family atmosphere during childhood: Juan was the fourth child in a family of six siblings. He indicated that his parents had no preferences with regard to any of the children, but stated that they were affectionate with all of them. His father was a peasant farmer and his mother took care of the home. Juan's parents had no formal education but made sure, at great sacrifice, that their sons completed primary school. No alcoholism or family dysfunction was reported. However, Juan did indicate that, during his adolescence, his maternal grandmother often experienced "sustos", when angry, going into apparent shock and ceasing to speak until she was treated at the hospital. It was unclear whether this was an effective reaction or whether she may have been experiencing a seizure disorder. Medical history was unremarkable prior to the precipitating traumas. Juan recalled no birth stories. He remembered that he made friends quite easily during his boyhood.

Vocational history: Juan indicated that, as a child, his dream was to drive a car. He explained that there were few vocational possibilities open to boys of his background due to the situation in Guatemala. He expected to be a peasant farmer. After his military desertion, he learned artisanry skills in Guatemala City. He also worked in a restaurant.

Health history: Although Juan experienced no health problems prior to his army experience, he subsequently developed severe insomnia, which persists to the present, intermittent bouts of

weakness, headaches, and miscellaneous, intermittent pains in various parts of his body.

• **Current status:** Juan has been in the United States for 14 months. He indicated that his flight from Guatemala was an "all or nothing" proposition - - "to die or to live". He is living in a residence with other refugees and has unspecified difficulties in interacting with them. When questioned about the source of his strength for making the journey and for carrying on in this country, he was unable to reply. He is anguished at the separation from his parents and frequently is apprehensive that "something has happened to them on my account". He wishes that they could join him here. His hopes for the future are centered on seeing his parents and on "being the way I was before . . . my memory . . . regaining my mental health."

TABLE I

POST-TRAUMATIC STRESS DISORDER SYMPTOMS REPORTED BY PARTICIPANTS

SYMPTOMS	PARTICIPANTS					
	1	2	3	4	5	6
Nightmares			X			X
Emotional numbing	X	X	X		X	X
Hypervigilance	X		X		X	X
Intrusive recollections	X	X		X	X	X
Insomnia	X	X	X		X	X
Flashbacks						X
Memory dysfunction	X	X				X
Survival guilt	X					X
Fear of catastrophe			X	X		X
Somatic symptoms	X	X	X	X	X	X
N =	7	5	6	3	5	10

TABLE II

POST-TRAUMATIC STRESS DISORDER SYMPTOMS REPORTED BY FEMALE VS. MALE PARTICIPANTS

SYMPTOMS	FEMALES	MALES
Nightmares	0	2
Emotional numbing	2	3
Hypervigilance	2	2
Intrusive recollections	3	2
Insomnia	2	3
Flashbacks	0	1
Memory dysfunction	1	2
Survival guilt	1	1
Fear of catastrophe	1	2
Somatic symptoms	3	3
	15	21

Results

Based upon the above case summaries and upon participant responses to questionnaires based on post-traumatic stress disorder (Appendix E), the following information was obtained:

1. All participants but one reported experiencing at least five symptoms associated with the diagnostic category "Post-Traumatic Stress Disorder" as stated in Diagnostic and Statistical Manual, III, with 10 symptoms, the maximum reported by a single participant. (See Tables I and II).

2. All subjects had experienced a recognizable stressor consistent with the diagnosis.

3. All subjects had re-experienced the trauma through recurrent dreams and/or intrusive recollections.

4. All subjects had experienced numbing of responsiveness to or reduced involvement with external world.

5. All subjects had experienced at least two of the following symptoms which are associated with post-traumatic stress disorder and which were not present prior to the precipitating trauma:

   a. hypervigilance or exaggerated startle response

   b. sleep disturbance

   c. memory impairment or trouble concentrating

In all subjects, symptoms continued to be present, although for most, some symptoms had decreased in severity or frequency over time.

6. Those participants who arrived in the United States unaccompanied by family members, (Felipe, Margarita, Juan and José),

reported, if not more numerous, more severe stress-related symptoms than did those who came along with significant others and, implicitly, ongoing social roles.

7. All participants had reportedly experienced good health prior to trauma, although Margarita had a history of sleepwalking. Somaticization following trauma appeared to take many forms. Maria del Carmen reported breast pains and another participant reported pains in his extremities. However, stomach pains, headaches and insomnia were those somatic symptoms most commonly reported by participants.

8. No consistent relationship was apparent between pretrauma family environment and lifestyle and subsequent severity of symptoms. However, for all female participants, a strong identification with a parenting role was stated. All had children in the home at the times of their interviews. Two of the women were firstborn children and these were also the participants who experienced the mildest stress-related symptoms.

9. The only participant who reported flashbacks was a former soldier who, in that role, had witnessed atrocities.

10. Considerable chronicity of post-traumatic stress disorder symptoms appeared to be present. In two severe cases, symptoms had persisted for, respectively, seven to eight years.

11. No clear correspondence was inferred between object severity of stressors and severity of post-traumatic stress disorder symptoms experienced by participants in this study. This may have been due to the limited sample used for this study or to the subjective nature of individuals' experiences.

Coping strategies used by participants at the time of their escapes from the country of origin include faith in God, the need to remain united with or to save one's children, personal endurance and bravery, and, in Jose's case, assistance from other prisoners. Margarita said that she managed to escape by "aguantando todo . . . y llorando" (by bearing everything . . . and crying). Juan stated that he had simply made a "morir o vivir" (to die or to live) decision. (See Table III).

In describing present coping strategies, religious faith was again cited by two refugees and María de la Luz stated that for her, the important thing was that she still had her husband and children and that her children were all studying. Margarita and Juan, who had both expressed distress during their interviews, were unable to identify sources of strength for use at this time. (See Table IV)

A comparison of post-traumatic stress disorder symptoms experienced by participants in this study with those reported in other populations suggested that autonomic nervous system symptoms are almost universal. Somatic disorders were reported in all populations studied. Hypervigilance or anxiety and sleep

disturbances were reported in Holocaust survivors, Vietnam veterans and Chileans who had experienced stressors similar to those inflicted upon participants in this study. However, flashbacks, which are frequently reported by Vietnam veterans (Parson, 1985) were experienced by only one participant, who had been a soldier witnessing a village massacre. Both Chileans and Southeast Asian refugees described feelings of helplessness, which were not reported by participants in this study, depressive themes and affect dominated responses provided by Juan and Margarita during interviews with this author.

It is interesting to note that Maria de la Luz, who had the fewest and mildest stress-induced symptoms, was also the only refugee who anticipated receiving legal asylum in the United States. The others looked forward to protracted legal battles and perhaps, to possible third country asylum in Canada. Margarita, who cried during her interview, was reportedly appealing a deportation order.

In summary, five out of six participants met the DSM III criteria for diagnosis of post-traumatic stress disorder. While the remaining participant did not report the minimum of five symptoms, including a somatic complaint, were present. Somaticization, sleep disturbances and hypervigilance were the most commonly reported symptoms. These reportedly occur in widely disparate cultural and geographic groups.

TABLE III

COPING STRATEGIES REPORTED BY PARTICIPANTS

Source of Strength of Escape and to Begin Life as a Refugee

Participant	
María del Carmen	"Trying hard and being brave and not separating myself from my children."
José	"Others in prison taught me and helped me."
Felipe	"My faith in God."
María de la Luz	"The desire that my children live . . . 11 days of thinking during the journey . . . praying to God that he take me to a tranquil place."
Margarita	"Bearing everything, crying."
Juan	"A 'win or lose', 'death or life' decision."

TABLE IV

COPING STRATEGIES REPORTED BY PARTICIPANTS

Source of Strength to Keep on Going

Participant	
María del Carmen	"From my body, my energies and everything."
	"Going on and praying to God to have strength."
José	"We must educate the people about what is going on in my country."
Felipe	"My faith in God."
María de la Luz	"I have my children with me and also my husband and that is the important thing . . . All my children study."
Margarita	None stated. (Began crying.)
Juan	None stated.

TABLE V

POST-TRAUMATIC STRESS DISORDER

SYMPTOMS ACROSS POPULATIONS

Holocaust Survivors

hypervigilance - - fear/catastrophe (Eaton, 1985)

'hyperamnesia" (Poltawka in Kestenberg, 1985)

past-orientation (Lomanz, 1985)

"silent families" vs. families who tell every detail (Krell, 1979)

children seen as a source of new hope and meaning, and may experience consequent guilt, depresion and repression of anger, (Nadler et al., 1985)

Southeast Asian Refugees

learned helplessness (Nicassio, 1985)

Somatization - - frequent symptoms of emotional distress

Stigmatization of mental health problems (Nguyen, 1982)

Vietnam Veterans

Alienation, mistrust (Glover, 1985)

Somatic disorders: autonomic nervous system, sensory, proprioceptive enteroceptive and kinesthetic (Parson, 1986), sleep disturbances

Depressive symptoms (Kinzie, 1978): nightmares, flashbacks, alcohol misuse

Guatemalan and Salvadoran refugees

frequent somatization

intrusive recollections

sleep disturbances

flashbacks (one participant)

emotional numbing

hyperalertness

fear of catastrophe

Chileans

helplessness, anxiety, sleep disturbances, feelings of disintegration, impaired concentration and memory, specific or generalized fears, social withdrawal, loss of appetite, irritability, and diverse somatic complaints.

TABLE VI

ESTIMATED SEVERITY OF POST-TRAUMATIC STRESS DISORDER

SYMPTOMS AND CURRENT ADJUSTMENT

Participant	Estimated Severity of PTSD Symptoms	Summary of Current Adjustment
1	Mild	Self-supporting. Lives with children. Has applied for asylum. Receives social service support. Active in refugee community. Legal status: Pending. Mild PTSD symptoms.
2	Moderate	When last contacted, lived with host family. Active in political work within refugee community. Still without ties to significant others. Legal status: Pending.
3	Severe	When last heard from, was in on-going flight from city to city. Obsessed with fate of his children, need to start a new life, difficulties with memory.
4	Slight	Lives with husband and children in Tucson. Works cleaning houses. Keeps close watch over all family members. Participates in activities in refugee community. Mild PTSD symptoms.
5	Severe	Living with husband's relatives. Experiencing severe mood swings which include frequent periods of rage. "Sees no future".
6	Severe	Living with other refugees. No family members in United States. Performing unskilled labor. Very frequent intrusive recollections, almost constant insomnia. Varying sematic complaints. Extreme difficulty in forming close relationships.

CHAPTER V

CONCLUSIONS, DISCUSSION AND IMPLICATIONS FOR INTERVENTION

The results of this study appear to indicate that post-traumatic stress disorder does, indeed, affect Guatemalan and Salvadoran refugees living in Tucson. Post-traumatic stress disorder appeared to be problematic for this population with regard to health as well as vocational and social spheres of living. Findings suggested that severe stressors may have long-term, debilitating effects which interfere with adjustment to life outside the country of origin. In this chapter, patterns observed among participant responses are considered and implications for interventions are discussed.

Limitations

This investigation was based upon a single subject model as a pilot study intended to provide direction for further research. It contains intrinsic limitations based upon sample size and nonrandomized subject selection. Due to geographic mobility of some of the participants, it was not possible to obtain longitudinal data, which would have been very helpful in predicting future adjustment. Nevertheless, it is believed that this investigation does provide useful information addressing its research questions.

Discussion

Both Guatemalan and Salvadoran participants in this study experienced multiple symptoms associated with post-traumatic stress disorder. In five participants, symptoms were sufficient in number

and severity to meet the DSM III criteria for post-traumatic stress disorder. The sole exception was a Salvadoran woman, who, nonetheless, exhibited three stress-related symptoms, including a gastric ulcer.

Post-traumatic stress disorder among the study participants was most often characterized by hypervigilance, sleep disorders intrusive recollections, and somatization. In this, most participants appeared to resemble Southeast Asian refugees more than they did Vietnam veterans. However, some symptoms (e.g., sleep disturbances, somatization) were described across several populations.

Flashbacks were reported by only one participant. It was unclear as to whether this information was fully disclosed by other individuals, who may have feared social stigma. However, it is interesting to note that this was the symptom of greatest concern to the young military deserter in this sample.

Implications for Intervention

The participants in this study, whose somatic complaints and affective difficulties are similar to those of others informally interviewed by this writer during course of social service and rehabilitation work, are facing multiple difficulties. Not only must they deal with the cultural, linguistic and economic challenges implicit in their immigrant status; but they must do so in the face of stress-related complications such as insomnia, somatic symptoms, hypervigilance and intrusive recollections.

A further difficulty is presented by the improbability of achieving legal status in the United States for most Salvadoran and Guatemalan refugees, whose applications for political asylum are usually denied by the Immigration and Naturalization Service. Unlike Jews arriving in Israel after the Holocaust and unlike Southeast Asian refugees who have come to the United States, most Guatemalan and Salvadoran refugees in this country face the strong possibility of eventual deportation to the lands from which they fled in fear. For these individuals, the recurring fear of catastrophe, which is listed as one of the principal symptoms of post-traumatic stress disorder, is a realistic response based upon knowledge of what may await them upon return to the country of origin and upon uncertainty regarding the fates of significant others who remain endangered there.

This brings one to the question of intervention. Most behavioral, cognitive and psychoanalytic treatment protocols described in this thesis have been developed for individuals who have reached a safe haven in a country of refuge. They are based upon the assumption that the individual is free to work and to focus upon the process of healing. For individuals who are in ongoing danger, hypervigilance may well be an adaptive, albeit uncomfortable behavioral style.

In Toronto, Dr. Frederick Allodi has provided psychiatric care for refugees from Central America as well as from other regions.

In a paper presented to the World Medical Association (1982), he states that the principal need of the refugee is a safe environment, adding that psychotherapy outside the framework of ongoing social services has been of little interest to clients. Rather, he says:

> "Once economic and language barriers are eliminated, utilization is enhanced by the integration of medical, psychological, social and legal services in a climate of empathy for the client and collaboration among the various agencies." (74)

Allodi adds that, for rehabilitation to take place, the refugee must regain an "acceptable concept of himself or herself and of the world as a fairly secure and predictable place . . . and (must) find the meaning of, and some personal satisfaction with his role in the context of his traumatic experiences." (75) Like Cienfuegos, he emphasizes the importance of treating refugees as normal individuals who have undergone major trauma, rather than as patients who are ill.

Unfortunately, most refugees interviewed for this study did not yet feel that their lives were in any sense safe or secure. For individuals in such situations, intervention must, indeed, be holistic and must address environmental concerns as well as more traditional counseling issues. Based upon a review of the literature, this author's findings with regard to the present study, and personal impressions based on social service experience with the refugee population, the following strategies are recommended:

1. Environmental Interventions:

a. Reestablishment of the family unit or approximation of a family unit through a host family or group home. Whenever possible, a mentoring situation involving either a bilingual volunteer from the host culture or another refugee with minimal post-traumatic stress disorder symptoms and some knowledge of the host culture should be established.

b. Provision of safety. This should include establishment of some kind of legal status, albeit transitional, and provision of ongoing legal services. The individual should have access to a telephone at all times and, if he/she so desires, should receive an unlisted telephone number upon establishing his/her own residence. This is important in view of death threats which have been reportedly received by some refugees.

c. Provision of education. Most individuals require a gradual, informal introduction to the host culture prior to more formal training, such as enrollment in English classes. As stated by several participants in this study, families who arrive in the United States with their chidren may derive great comfort and help from the ready availability of free public education. Whenever possible, supportive school staff should be contacted as advocates for these youngsters during their initial adjustment process.

d. Provision of an appropriate religious community. As indicated in Westermeyer's (1986) study of mental health in Hmong refugees, difficulties ensue when the support of one's religious and cultural community is unavailable. Thus, Evangelical refugees should be placed in contact with local Hispanics who share their beliefs and Catholic refugees should be assisted in contacting other Catholic Spanish-speakers in the host community.

2. Medical Services:

a. Elicitation of a medical history from each individual preceding initial examination. This should include an assessment of the individual's concerns regarding his/her health and should also address diseases (e.g., parasites) which may be unfamiliar to physicians in the host community.

Individuals who have experienced major trauma preceding the journey to the host country should be administered a health questionnaire addressing PTSD symptomatology. (See Appendix C).

b. Provision of a culturally sensitive interpreter at medical appointments if a bilingual physician is unavailable. Whenever possible, the physician and/or the interpreter should be of the same sex as the refugee.

c. Provision of follow-up education regarding appropriate use of medications. Medications may ameliorate sleep disorders, persons experiencing PTSD frequently attempt to self-medicate

through use of either alcohol or other chemical substances. No medication appears to be a treatment for the broad range of stress-induced symptoms.

e. Based upon research with Vietnam veterans (Jelaneck, et al, 1984) it is recommended that individuals who are engaged in alcohol or other substance abuse receive treatment for that either prior to intervention for reduction of PTSD symptoms or concurrently with that intervention.

In summary, the results of this study, together with the literature on post-traumatic stress disorder, indicate that this disorder does indeed exist in the Central American refugee community. Results indicate a need for culturally appropriate intervention models which, while recognizing the commonalities of human experience underlying it, respect the uniqueness of the individual within the context of his/her personal history. It is hoped that programs will address treatment of stress-induced disorders within the framework of providing social support, medical services and legal assistance during the process of adjustment to the host society.

APPENDIX A

INFORMACION DE PARTICIPANTES

Fecha_____

de la entrevista_____

Pseudonombre:

Caso N.:

Edad:

Sexo:

País de origen:

¿Cúanto tiempo ha pasado Ud. en los Estados Unidos?

¿Qué clase de trabajo hace (hacía) su padre? . . . ¿Su madre?

¿Cuántos hermanos u otros niñas de su familia vivián con Ud.?

¿Cuantos años tenían ellos cuando Ud. tenís 8 años?

Name	Edad	Sexo	Parentezco

¿Se le murió alguno de sus hermanos u otros familiares durante su niñez (de Ud.)?

¿Alguien en la familia padecía de alguna enfermedad crónica o continua? . . . Por favor platíqueme sobre ella.

De todos los hijos, ¿cúal era el preferido (o el consentido) de su papá? ¿Por qué?

¿Y el consentido de su maḿa? ¿Por qué?

(Se puede sustuir el nombre de uno de los padres por el de otra persona quien le crió.)

Háble me algo sobre su maḿa . . . ¿Cómo era? . . . ¿Cómo se portaba con Uds.?

¿Sus padres se casaron en la iglesia? ¿Cuándo?

¿Alguien en la familia de ha contado alguna historia sobre su nacimiento (de Ud.)? ¿Como era de bebé?

¿Cómo era su salud durante la niñez? Padecía de alguna enfermedad severa o crónica (larga o continua) de bebé? . . . ¿De chiquito, antes de cumplir los 6 años? ¿Entre las edades de 6 años y 12 años? ¿De Platíqueme sobre ella.

¿Padecía uno de sus familiares de "nervios", "susto", "ataques", "embrujamiento" u otra condición parecida? Por favor expliquemela.

De todos los niños que fueron criados con Ud., ¿cúal era:

1. El más diferente de Ud.?

   ¿Cómo?

2. El más parecido a Ud.?

   ¿Cómo?

¿Cúales jugaban juntos?

¿Cúales pelearon o discutieron lo más?

¿Cuáles eran las experanzas o ilusiones que su padre tenía para el futuro de Ud.?

¿Y las esperanzas de su madre?

¿Cómo era el matrimonio de sus padres?

¿Cómo se portaba su padre con los niños?

¿Con su mamá?

¿Cómo les mostraba su cariño?

¿Cómo se portaba su madre con los hijos?

¿Con su padre?

¿Como les mostraba su cariño?

¿Quién hacía las decisiones sobre el dinero?

¿Había discusiones en la familia?

¿Qué hacián sus padres para solucionar problemas o conflictos?

¿Quiénes disciplinaron a los niños?

¿Cómo?

¿Qué quería Ud. hacer de grande?

¿Cuáles eran los heroes de su niñez?

¿En veces tenía pesadillas?

¿Había algo en su aparencia física lo cual le hacia sentirse incómodo o inseguro de sí mismo(a)?

¿Si era así, le sigue siendo un problema?

¿Quiénes reaccionaron a ello?

¿Cómo reaccionabon la gente a ello?

El desarrollo sexual -

¿Sufrió Ud. algun abuso sexual en su niñez?

¿Le pasóalgo traumático o muy trágico durante la niñez?

¿Durante la niñez, ¿Ud. hacía amistades fácilmente o le era un problema?

Esperiencias en el trabajo y la escuela:

¿Cuánta escuela tuvo Ud.?

¿Qué clase de amistades tenía?

Historia del trabajo:

Antes de los problemas que le hicieron salir del pais, ¿qué clase de trabajo hacía?

¿Y cuando le comenzaron a pasar estos problemas?

¿Y desde aquel entonces?

Antes de que le pasaron estos problemas, ¿estaba Ud. casado(a)?

¿Y en el tiempo cuando todo esto le pasó?

¿Y desde aquel entonces?

¿Tiene (tenía) Ud. hijos?

Por favor cuénteme sus edades y dígame si son (eran) hombres a mujeres.

Para cada uno de ellos por favor dígame qué le gusta hacer, cómo es y cómo estos problemas le han afectado:

¿A causa de cúal problema salió Ud. del país?

¿Ha perdido algunos parientes o amigos debido a la situación política en su país? ¿Ha desaparecido alguno de ellos?

¿Ud. u otra persona de su familia o amigo(a) suyo(a) ha sido encarcelado o torturado?

¿Ud. u otra persona de su familia o de sus amistades ha directamente observado la violencia política en su país?

¿Ud. u otra persona en su familia ha tenido que esconderse por un tiempo? Si es así, ¿por cuánto tiempo y bajo cuáles circumstancias o condiciones?

¿Ha Ud. experimentado separaciones de otros familiares a causa de la situación política en su país? ¿Como le pasó eso?

Para Ud., ¿cuál cosa se le hace la más dura de todo lo que le ha pasado?

Y estándose aquí en Tucson de refugiado(a) . . . ¿cuál cosa se le hace la más dura?

¿Ud. recuerda una experiencia reciente de refugiado(a) que se le hacia muy defícil o triste?

Ahora, vamos a imaginar que Ud. puede ver el futuro 5 años en adelante de ahora . . . ¿Que ve en su vida (de Ud.)?

¿Y para su familia?

¿Qué cosa en el futuro le asusta lo peor?

¿Qué cosa le da lo mas esperanza?

¿Cómo es que Ud. ha podido completar este viaje largo y duro para comenzar a hacer un lugar por sí y por su familia en esta cultura tan diferente?

¿De dónde encuentra Ud. la fuerza para seguir en adelante?

Appendix B

SEMI-STRUCTURED INTERVIEW

SUBJECT INFORMATION

Named used:

Case #:

Age:

Sex:

Country of origin:

Length of time in U.S.:

Brief statement of reason for leaving country of origin:

Personal History:

What kind of community were you born/raised in?

What did your father/mother do for a living?

How many brothers /sisters/other children lived with you?

How old were they when you were eight years old?

Name	Age	Sex	Relationship

Did any of your brothers, sisters or other relatives living in the home die during your childhood?

Were you or any member of your family chronically ill? Please tell me about it.

Who was your father's/mother's/significant other(s) favorite? Why? (To be done for each parent/caretaker/in the nuclear or extended family.)

Tell me about your mother. What was she like?
(Repeat for father, each caretaker.)

Did your mother and father ever get married in the Church? When?

Have any family members told you stories about your birth? . . . . What kind of baby were you?

What was your health like during childhood? Did you have any serious or ongoing illnesses during infancy? . . during your early childhood before age six? . . between ages 6-12? . . during adolescence? . . during adulthood?

Please give me the details for each illness or injury.

Did any member of your family suffer from "nervios"? . . "susto"? . . "ataques"? . . "embrujamiento"?

Please tell me about it.

Who (among brothers, sisters and other children raised with you) was:

Most different from you? How?

Most like you? How?

Who played together?

Who fought the most?

What were your father's/mother's/significant other - caretakers's ambitions for you? (Do for each)

What was your parents' (step-parents') marriage like?

What was your father like with the children? With your mother?

How did he show affection for you?

What was your mother like with the children? With your father?

How did she show affection for your?

Who made decisions about money?

Were there disagreements in your family? How were they handled?

How were children disciplined and by whom?

What did you want to be when you grew up? Who were your childhood heroes?

Did you ever have nightmares?

What kind of things were you afraid of when you were little?

Was there anything about your physical self which make you uncomfortable?

Is so, is it a problem for you now?

Who responded?

How did people respond to it?

Sexual development: Religious/family education/atmosphere:

Any sexual abuse?

Traumatic experiences?

Social development pre-primary trauma:

Was making friends an issue at any time during your childhood or youth?

School and work experience: What/how far did you study in school?

How did you do in school?

What kinds of friendships did you tend to have?

Work history:

Pre-primary trauma:

During primary trauma:

Post-primary trauma:

Marital history:

Pre-primary trauma:

During primary trauma:

Post-primary trauma:

Children: Age and sex of each, interests /adjustment for each pre - during - post primary trauma:

Description of primary trauma:

Have you lost any relatives or people close to you due to the political situation in your country? Has anyone close to you disappeared?

Have you or has anyone close to you experienced imprisonment/and/or torture?

Have you or has anyone close to you (to your knowledge) witnessed violence related to the political situation in your country?

Have you or has anyone in your family lived in hiding? Please give details as to circumstances and duration.

Have you experienced any family separations due to the political situation in your country? Please give details.

What is the hardest thing for you about what you've been through? . . . about being a refugee in Tucson?

Do you remember a recent experience as a refugee that you found very hard? (Pinpointing):

Let's pretend that you can look ahead and see the future five years from now . . What do you see for yourself? For your family?

What frightens you the most about the future?

What gives you the most hope?

How is it that you've been able to complete this long journey and to begin to make a place for yourself (and your family) in this very different culture?

Where do you get the strength to go on?

APPENDIX C

CUESTIONARIO: La entrevistora le la oración y el sujeto indica la frecuencia del problema abajo mencionado.

unas veces al dia	unas veces a la semana	una vez a la semana	una vez al mes	una vez cada 2 o 3 meses	casi nunca	nunca

1. Sigo teniendo las mismas pesadillas una vez tras otra.

2. De repente, algo me pasa que me hace recordar lo que me pasó y me siento como si me lo estuviera pasando todos de nuevo.

3. Sé bien que debiera de tener ganas de hacer cosas con mi familia y mis amistades; pero de alguna forma me siento ajenado(a) de ellos.

4. Se me duermen las emociones. Ni me pongo triste ni feliz como me ponía de antes.

5. Tengo problemas para dormir.

6. Me siento nervioso y me asusto facilmente.

7. Me siento culpable que yo salí con mi vida mientras uno(s) de mis familiares o mi(s) amigos no escaparon de ahí.

8. Tengo dificultades para concentrar o para recordar cosas.

9. No puedo aguantar el hacer ciertas cosas que me recuerdan de lo que me pasó.

10. Cuando cosas pasan las cuales me recuerdan de lo que me pasó, mis (síntomas reportadas durante las entrevista) se me empeoran.

11. Me dan dolores de cabeza.

12. Me da miedo de que alguna cosa terrible me va a pasar a mí o a mi familia.

13. Me da dolor de estómago muy seguido.

14. Me da rasguera seguido.

15. Me siento enfermo pero el médico me insiste que no tengo nada.

16. Me siento débil o atarantado(a).

17. (Mujeres) Me da dolor de las senas (los pechos) o me da mucho dolor cuando me baja la regla (durante la menstruación).

QUESTIONNAIRE:

APPENDIX D

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. I have the same dreams about what happened over and over.

2. All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.

3. I know I should want to do things with my friends and family, but somehow I feel removed from them.

4. I feel numb . . . I don't seem to feel happy or sad the way I used to.

5. I have trouble sleeping.

6. I feel jumpy and nervous.

7. I feel guilty that I made it out while some of my friends and family didn't.

8. I have trouble concentrating or remembering things.

9. I can't stand doing certain things that remind me of what happened.

10. When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.

11. I have headaches.

12. I have fears that something terrible is going to happen to me or my family.

13. I have rashes.

14. I feel sick but the doctor says there's nothing wrong with me.

15. I feel weak or dizzy.

16. (Women only) I have menstrual or breast pain.

Appendix E

Participant Number 1.
Maria del Carmen

PARTICIPANT HEALTH QUESTIONNAIRE (English Translating)

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. **I have the same dreams about what happened over and over.**
   "No. I think about everything in the daytime".

2. **All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.**
   "No".

3. **I know I should want to do things with my friends and family, but somehow I feel removed from them.**
   "No".

4. **I feel numb . . . I don't seem to feel happy or sad the way I used to.**
   "Whenever I'm with friends, dancing. About once a week".

5. **I have trouble sleeping.**
   "No".

6. **I feel jumpy and nervous.**
   "Once a day. When I'm working the silence makes me think . . .

7. **I feel guilty that I made it out while some of my friends and family didn't.**
   "I try not to think about it".

8. **I have trouble concentrating or remembering things.**
   "Once a week".

9. **I can't stand doing certain things that remind me of what happened.**
   "Portest marches - I feel happy but just 'a bit' -.I begin to remember".

Maria del Carmen

10. **When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.**
"Two or three times a month".

11. **I have headaches.**
"No".

12. **I have fears that something terrible is going to happen to me or my family.**
"No".

13. **I have rashes.**
"Yes. I have stomach aches that come back two or three times a month".

14. **I feel sick but the doctor says there's nothing wrong with me.**
"No".

15. **I feel weak or dizzy.**
"I saw specialists after leaving the coast. They know (about this). They said 'It's your nerves".

16. **(Women only) I have menstrual or breast pain.**
"Almost daily". "When I get nervous my breasts hurt".

Participant Number 2.
José

PARTICIPANT HEALTH QUESTIONNAIRE (English Translating)

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. **I have the same dreams about what happened over and over.**
   "No".

2. **All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.**
   "This used to happen to me often and sometimes it still does. I try to concentrate on my work".

3. **I know I should want to do things with my friends and family, but somehow I feel removed from them.**
   "I do my political work. It is important to educate the people".

4. **I feel numb . . . I don't seem to feel happy or sad the way I used to.**
   "I don't feel things the way I used to. It isn't the same".

5. **I have trouble sleeping.**
   "Sometimes I have a lot of touble".

6. **I feel jumpy and nervous.**
   "I used to be very nervous. It's better now".

7. **I feel guilty that I made it out while some of my friends and family didn't.**
   "There was nothing I could do. When they killed my parents, there were many of them and I was alone".

8. **I have trouble concentrating or remembering things.**
   "I used to have difficulties. I draw now. This helps. You might tell other people to try drawing".

9. **I can't stand doing certain things that remind me of what happened.**
   "No".

José

10. **When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.**

"I don't let myself think about it".

11. **I have headaches.**

"Sometimes".

12. **I have fears that something terrible is going to happen to me or my family.**

"Sometimes".

13. **I have rashes.**

"Once in a long time".

14. **I feel sick but the doctor says there's nothing wrong with me.**

"No".

15. **I feel weak or dizzy.**

"I have scars here and here and here from torture and the beatings they gave me. I have a photo of my scars for my case.

16. **(Women only) I have menstrual or breast pain.**

Participant Number 3.
Felipe

PARTICIPANT HEALTH QUESTIONNAIRE (English Translating)

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. **I have the same dreams about what happened over and over.**
   "Nightmares - once in Mexico and once (no flashbacks, removal/actions) in the hospital".

2. **All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.**
   "No"

3. **I know I should want to do things with my friends and family, but somehow I feel removed from them.**
   "No"

4. **I feel numb . . . I don't seem to feel happy or sad the way I used to.**
   Numbness - "Even my bloodpressure went up. I think - I lacked air, as if I were in a cloud."

5. **I have trouble sleeping.**
   Insomnia - "Here frequently. Last night I did not sleep. I slept ½ an hour in the daytime. But I've slept better since I've been here.

6. **I feel jumpy and nervous.**
   I feel nervous. - "But I'm over it. I received a treatment in Mexico. Dr. _____, a neuro_____ to repair one's constitution - with medicines.

7. **I feel guilty that I made it out while some of my friends and family didn't.**
   "I haven't blamed myself".

8. **I have trouble concentrating or remembering things.**
   "Difficulties remembering - many times a day. I had a very good memory. I took a little gift to every customer on my delivery route on their children's birthdays and I knew them all by heart. There must have been over 50.

9. **I can't stand doing certain things that remind me of what happened.**
   "No"

Felipe

10. **When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.**
"Yes . . . when I remember"

11. **I have headaches.**
"All of a sudden, I get a pain in this part in the back (of my head)"

12. **I have fears that something terrible is going to happen to me or my family.**
"Yes, about once a week. Whenever I receive news from Guatemala"

13. **I have rashes.**
"Stomach pains - once a day"

14. **I feel sick but the doctor says there's nothing wrong with me.**
"I haven't been able to see a doctor (since arriving here).

15. **I feel weak or dizzy.**
"I feel dizzy, every other day"

16. **(Women only) I have menstrual or breast pain.**

Participant Number 4.
Maria de la Luz

PARTICIPANT HEALTH QUESTIONNAIRE (English Translating)

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. **I have the same dreams about what happened over and over.**
   "No"

2. **All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.**
   "I don't allow myself to remember. I don't want to remember"

3. **I know I should want to do things with my friends and family, but somehow I feel removed from them.**
   "Sometimes. There are people who criticize one for what has happened to that person"

4. **I feel numb . . . I don't seem to feel happy or sad the way I used to.**
   "I feel normal. Here I have been born again. I have changed. I have no fear - I go to bed tranquil"

5. **I have trouble sleeping.**
   "Almost never"

6. **I feel jumpy and nervous.**
   "Every two or three months. It's rare. If someone speaks behind me"

7. **I feel guilty that I made it out while some of my friends and family didn't.**
   "No"

8. **I have trouble concentrating or remembering things.**
   "No"

9. **I can't stand doing certain things that remind me of what happened.**
   "No"

Maria de la Luz

10. **When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.**

"Sometimes I feel like crying when I think about what happened"

11. **I have headaches.**

"Almost never"

12. **I have fears that something terrible is going to happen to me or my family.**

"Once a month. But I say again to God, 'No Lord! This doesn't have to happen!' Because he protects me"

13. **I have rashes.**

"Four months ago, I came down with an ulcer. When I eat greasy food it hurts me. Also, sometimes I feel hate for soldiers"

14. **I feel sick but the doctor says there's nothing wrong with me.**

15. **I feel weak or dizzy.**

16. **(Women only) I have menstrual or breast pain.**

Participant Number 5.
Margarita

PARTICIPANT HEALTH QUESTIONNAIRE (English Translating)

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. **I have the same dreams about what happened over and over.**
   "Never"

2. **All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.**
   "When I don't have work - twice a day"

3. **I know I should want to do things with my friends and family, but somehow I feel removed from them.**
   "Once a month"

4. **I feel numb . . . I don't seem to feel happy or sad the way I used to.**
   "I can't feel anything when it happens. Once in a long time"

5. **I have trouble sleeping.**
   "Three times a month"

6. **I feel jumpy and nervous.**
   "Once I got (so) nervous that I broke the dishes - I broke them from 'nerves'. In '86 and '87, I talked with La Frontera"

7. **I feel guilty that I made it out while some of my friends and family didn't.**
   "No"

8. **I have trouble concentrating or remembering things.**
   "No"

9. **I can't stand doing certain things that remind me of what happened.**
   (Margarita was unable to answer. She broke down in tears)

Margarita

10. **When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.**
(Continued crying) "Sometimes I think about going back. Taking the children with me"

11. **I have headaches.**

"When I think a lot"

12. **I have fears that something terrible is going to happen to me or my family.**
"I took pills to kill myself. I (did it) by myself"

13. **I have rashes.**

"When I was pregnant with my little boy"

14. **I feel sick but the doctor says there's nothing wrong with me.**
"I haven't gone (to see) him. Last time, I had anemia"

15. **I feel weak or dizzy.**

"Two months ago I got very dizzy. The doctor changed by birth control pills"

16. **(Women only) I have menstrual or breast pain.**
"No"

Participant Number 6.
Juan

PARTICIPANT HEALTH QUESTIONNAIRE (English Translating)

The following statements will be read to the subject, who will be asked to rate frequency of occurrence for each according to the following scale:

Sev. times a day	Daily	Sev. times a week	Weekly	Sev. times a month	Monthly	Once every several months	Almost Never	Never

1. **I have the same dreams about what happened over and over.**
   "Before, when I came, yes. Now just three times a month."

2. **All of a sudden, something happens to remind me of it and I feel as if it's happening all over again.**
   "When I see a movie - It's as if I'm seeing my companions - those who were with me"

3. **I know I should want to do things with my friends and family, but somehow I feel removed from them.**
   "I've tried to do it . . . They've invited us out various places . . . I've tried to be happy . . . and then it all comes back to me"

4. **I feel numb . . . I don't seem to feel happy or sad the way I used to.**
   "About once a month"

5. **I have trouble sleeping.**
   "Almost daily. I close my eyes and it's as if I were watching it..."

6. **I feel jumpy and nervous.**
   "When I wake up nervous/or I feel they're doing something to me . . . whenever I'm distracted and someone speaks to me from behind my back"

7. **I feel guilty that I made it out while some of my friends and family didn't.**
   "Yes, I get to thinking about why I got out alive. People are always asking me at work . . . why I left"

8. **I have trouble concentrating or remembering things.**
   "I have a hard time concentrating. Sometimes it costs me work. I can't. I can't remember things. Addresses where I'm supposed to go. Maybe that's why I can't remember new English words they teach me at work"

9. **I can't stand doing certain things that remind me of what happened.**
   "What I can't do is watch movies"

Juan

10. **When things happen that remind me of what I suffered, my (symptoms reported during interview) get worse.**
"Yes. Very often"

11. **I have headaches.**
"Two or three times a month"

12. **I have fears that something terrible is going to happen to me or my family.**
"There are times when the telephone rings in the morning. I'm afraid it's someone calling (to say) that something has happened to my parents"

13. **I have rashes.**
"No"

14. **I feel sick but the doctor says there's nothing wrong with me.**
"Yes, very often. The last time I had pain in my back . . . in my kidneys. And she said there was nothing wrong?

15. **I feel weak or dizzy.**
"Two or three times a month"

16. **(Women only) I have menstrual or breast pain.**

APPENDIX F

DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER

DSM III, 1980

308.30 Post-Traumatic Stress Disorder, Acute

309.81 Post-Traumatic Stress Disorder, Chronic or Delayed

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

The characteristic symptoms involve re-experiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of sutonomic, dysphoric, or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g., torture) and others produce it only occasionally (e.g., car accidents).

Frequently there is a concomitant physical component to the trauma which may even involve direct damage to the central nervous system (e.g., malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. The severity of the stressor should be recorded and the specific stressor may be noted on Axis IV (p. 26).

The traumatic event can be re-experienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is re-experienced. In rare instances there are dissociativelike states, lasting from a few minutes to several hours or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. Such states have been reported in combat veterans. Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia", usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed significant activities, or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated

startle response, and difficulty falling asleep. Recurrent nightmares during which the traumatic event is relived and which are sometimes accompanied by middle or terminal sleep disturbance may be present. Some complain of impaired memory or difficulty in concentrating or completing tasks. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when many did not, or about the things they had to do in order to survive. Activities or situations that may arouse recollections of the traumatic event are often avoided. Symptoms characteristic of post-traumatic stress disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolize the original trauma (e.g., cold snowy weather or uniformed guards for death-camp survivors, hot, humid weather for veterans of the South Pacific).

Associated features. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an anxiety or depressive disorder. Increased irritability may be associated with sporadic and unpredictable explosions of aggressive behavior, upon even minimal or no provocation. The latter symptom has been reported to be particularly characteristic of war veterans with this disorder. Impulsive behavior can occur, such as sudden trips, unexplained absences, or changes in life-style or residence. Survivors of death camps sometimes have symptoms of an organic mental disorder, such as failing memory, difficulty in

concentrating, emotional lability, autonomic lability, headache, and vertigo.

Age at onset. The disorder can occur at any age, including during childhood.

Course and subtypes. Symptoms may begin immediately or soon after the trauma. It is not unusual, however, for the symptoms to emerge after latency period of months or years following the trauma.

When the symptoms begin within six months of the trauma and have not lasted more than six months, the acute subtype is diagnosed, and the prognosis for remission is good. If the symptoms either develop more than six months after the trauma or last six months or more, the chronic or delayed subtype is diagnosed.

Impairment and complications. Impairment may either be mild or affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolizing the original trauma may result in occupational or recreational impairment. "Psychic numbing" may interfere with interpersonal relationships, such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Substance use disorders may develop.

Predisposing factors. Pre-existing psychopathology apparently predisposes to the development of the disorder.

Prevalence. No information.

Sex ratio and familial pattern. No information.

Differential diagnosis. If an **anxiety, depressive or organic mental disorder** develops following the trauma, these diagnoses should also be made.

In **adjustment disorder,** the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of post-traumatic stress disorder, such as re-experiencing the trauma, are absent.

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