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In this issue:

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The National Center for Post-Traumatic Stress Disorder

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THE NATIONAL CENTER FOR PTSD

The National Center for Post-Traumatic Stress Disorder was mandated by the U.S. Congress in l984 under Public Law 98-528 to carry out a broad range of multidisciplinary activities in research, education, and training. Such initiatives support system-wide efforts by the Department of Veterans Affairs to understand, diagnose, and treat PTSD in veterans who have developed psychiatric symptoms following exposure to warzone stress. Publication of the *PTSD Research Quarterly* is one such initiative.

Initially located at the VA Medical Center in Brecksville OH, the National Center was reestablished in 1989 following a national competition in response to a Request for Proposals issued by the VA Central Office. At this time the National Center is a four-part consortium with divisions located at VA Medical Centers in White River Junction VT, West Haven CT, Menlo Park CA, and Boston MA.

The Office of the Executive Director and PTSD Resource Center are located at White River Junction. This office, directed by Matthew J. Friedman, MD, PhD, carries out strategic planning, directs the overall operation of the National Center, and interfaces with VA and non-VA programs and organizations. The Resource Center, directed by Fred Lerner, DLS, is establishing a comprehensive PTSD bibliographic database that will include not only journal articles, but also book chapters, conference proceedings, government reports, and other articles from the nonarchival "fugitive" literature that are not usually accessible through standard library searches.

The Clinical Neuroscience Division at West Haven is under the direction of Dennis S. Charney, MD. This division studies the effects of severe stress on brain function and develops new treatments for trauma victims. It consists of four separate laboratories specializing in neuropharmacology and neuroendocrinology, brain imaging, clinical psychopharmacology, and genetics and family studies. In these laboratories, basic and clinical investigations are conducted by internationally known scientists. In addition, great emphasis is placed upon training the next generation of researchers.

The Clinical Laboratory and Educational Division at Menlo Park is under the direction of Fred D. Gusman, MSW. It is built around a 120-bed inpatient PTSD and Dual Diagnosis program that will serve as a major site for inpatient research protocols, sleep studies, and cross-cultural investigations. Educational activities directed by Joan Furey, RN, MS, include development of a variety of educational materials such as videotapes, audiotapes, manuals, publications, teleconferences, workshops, formal conferences, on-site training curricula, and publication of the quarterly *NCP Clinical Newsletter*.

The Behavioral Science Division at Boston, under the direction of Terence M. Keane, PhD, is developing standardized criteria for psychological and psychophysiological assessment of PTSD. It also conducts research on information processing, behavioral treatment, gender issues, family and social support factors, and chemical abuse/dependency.

Finally, although not officially funded by the National Center, the Northeast Program Evaluation Center (NEPEC) at West Haven is programmatically linked with all four divisions. Under the direction of Robert Rosenheck, MD, NEPEC performs ongoing evaluation and monitoring of all VA hospital-based PTSD programs throughout the nation.

1989: THE YEAR'S WORK IN PTSD

by Matthew J. Friedman

Our inaugural issue of the *PTSD Research Quarterly* contains an overview of articles that appeared during 1989. In this regard, it differs somewhat from future issues, which will focus on specific topic areas such as theory, biology, epidemiology, assessment/diagnosis, treatment, cross-cultural issues, and risk factors. Editorial choices were based largely on scientific merit, but other factors, such as an article's interest to the field, also influenced selection. In some cases we have included descriptive and clinical papers on important questions that we hope will be addressed rigorously in future research protocols.

The 18 papers from 1989 abstracted in the following pages demonstrate the breadth and diversity of recent PTSD publications. In addition, we present (on pages 5-7) an additional 27 citations, as an annotated bibliography that should also interest our readers.

VAN DER KOLK AND VAN DER HART present a seminal reappraisal of Pierre Janet's *L'automatisme psychologique*, published in 1889, which offered the first systematic understanding of how the mind can dissociate in the face of overwhelming threat. Janet's eclectic model addressed biological, behavioral, cognitive, and emotional dimensions. Four other articles on Janet's work have appeared in *Journal of Traumatic Stress, 2*, 365-431 (October, 1989).

Four papers address assessment and diagnosis of PTSD. RAPHAEL ET AL. have published a monograph that is actually an excellent "primer" for anyone undertaking research on disasters. It addresses a broad range of relevant methodological issues and its 50-page appendix displays 24 scales that have been used in disaster research. DAVIDSON ET AL. report on the reliability and validity of their Structured Interview for PTSD (SI-PTSD), a 13-item five-point observer rating scale. The SI-PTSD was developed to meet the need for an observer rating assessment instrument to monitor treatment response to pharmacotherapeutic or behavioral interventions. GERARDI ET AL. present a provocative study in which PTSD and non-PTSD Vietnam veterans were asked to fake their psychophysiological responses to auditory combat stimuli. Despite the ability of non-PTSD (but not PTSD) subjects to alter their response, it was possible to classify correctly 92.3% of the total sample. The implications of this study for diagnosis are obvious. ROSEN ET AL. report that among 42 World War II veterans admitted to a psychogeriatric ward for other reasons, 27% and 54% met DSM-III criteria for current and lifetime PTSD, respectively. Besides showing the persistence of PTSD for over four decades, this study underscores the importance of obtaining a traumatic history in all patients.

Because our next issue will focus on biological research and treatment, we now limit ourselves to three important papers in that area. KRYSTAL ET AL. have written a scholarly and comprehensive review of animal and clinical studies pertinent to PTSD, spanning literature on molecular substrates of neural and behavioral plasticity, CNS noradrenergic dysregulation, the inescapable shock model, neurobiologic studies in PTSD patients, and research on clinical psychopharmacology. It is an excellent introduction to the field. ORNITZ AND PYNOOS's contribution is one of the first psychophysiological studies on the startle response in PTSD. It is especially noteworthy that this is the first rigorous biological study on PTSD in children. The startle laboratory paradigm may have useful potential in the future diagnosis and treatment of PTSD, especially in younger children. ROSS ET AL. have written an instructive and lucid review on sleep abnormalities and nightmares in PTSD. The authors point out many of the contradictions and unanswered questions in the current literature. Their hypothesis that PTSD may be fundamentally a disorder of REM sleep is presented forcefully, while considerations about non-REM sleep in PTSD receive much less attention.

Three papers compare the relative importance of the trauma itself vs. pre-traumatic factors for predicting subsequent psychiatric symptoms within three different military cohorts. BAKER ET AL. report on the premilitary, postmilitary, and current status of 100 women who served in Vietnam as Army nurses and another 20 Air Force and Navy nurses. Questionnaire data assessed health, psychosocial, and career issues for each respondent. This is one of very few publications to address the specific stresses and risk factors of the female military nursing experience in Vietnam. SOLOMON addresses the question of predicting the subsequent development of PTSD among 329 Israeli combat veterans. She reports that development of acute combat stress reaction (CSR) predicts later development of psychiatric symptoms (including PTSD) whereas premilitary factors lack predictive power. SPEED ET AL. studied relationships among 62 World War II prisoners of war, 50% and 29% of whom met criteria for lifetime and current PTSD, respectively. Traumatic exposure strongly predicted PTSD, whereas precaptivity variables had little predictive value.

Two abstracts concern risk factors for developing post-traumatic symptomatology following disasters. In a paper that won the annual research award from the Brazilian Psychiatric Association (ABP Award), LIMA ET AL. report on emotional symptoms among 150 survivors of the 1987 earthquake in Ecuador. Self-perceptions of pre-traumatic physical and mental health as well as marital status predicted post-traumatic symptomatology. GIBBS provides a valuable comprehensive literature review on pre-traumatic factors thought to affect vulnerability to a disaster, including age, gender, previous level of psychopathology, social class, birth order, and psychological coping strategies.

Among the four articles on treatment, two are controlled trials in which PTSD patients receiving treatment are compared with a waiting-list control group. In both studies, measurements were obtained before, immediately

after, and several months after completion of therapy. BROM ET AL. randomly assessed 112 Dutch outpatients to one of three treatments: trauma desensitization, hypnotherapy, and psychodynamic therapy. KEANE ET AL. randomly assigned combat veterans to implosive (flooding) therapy or a waiting list. Both studies report positive results from all therapeutic approaches but a different pattern of improvement depending on the treatment. In another vein, LINDY eloquently and thoroughly delineates the complex factors affecting transference in psychodynamic therapy with PTSD patients. And KINZIE, drawing on his extensive experience with traumatized Cambodian refugees, presents a comprehensive review of cross-cultural issues that have a major impact on diagnosis and treatment of PTSD in these patients.

Finally, not abstracted but strongly recommended by the editor, is a case report, "Cross-species applicability of psychiatric diagnosis and treatment" (Montague, L. R., *British Medical Journal, 299*, 1569). The patient, a female tortoiseshell-and-white cat, is pictured in the article with a mask discreetly drawn to protect her identity. After being misdiagnosed as having a senile dementia, her post-bereavement psychosis was correctly identified and appropriate therapeutic measures were implemented successfully.

SELECTED ABSTRACTS

BAKER, R. R., MENARD, S. W., & JOHNS, L. A. (1989). **The military nurse experience in Vietnam: Stress and impact.** *Journal of Clinical Psychology, 45*, 736-744. Demographic, health, and psychosocial data from two studies are presented on military nurses assigned to Vietnam. Army nurse subjects in the first study were grouped for comparison on three major variables: assignment to Vietnam before versus after the 1968 TET Offensive, type of nursing duties performed, and years of experience as a registered nurse (RN) prior to assignment in Vietnam. The second study compared another group of Army nurses with a group of Air Force and Navy nurses also assigned to Vietnam. Army nurses with less than two years RN experience prior to their assignment were found to be more at risk for such negative outcomes as difficulty establishing personal relationships and difficulty coping with stressful situations. Stress experiences, career dissatisfaction data, and health problems of military nurses and their children are reported. Also described are positive experiences of nurses in developing personal relationships in a rewarding professional environment.

BROM, D., KLEBER, R. J., & DEFARES, P. B. (1989). **Brief psychotherapy for posttraumatic stress disorders.** *Journal of Consulting and Clinical Psychology, 57*, 607-612. A large-scale study of the effectiveness of psychotherapeutic methods for the treatment of PTSD was conducted. The sample consisted of 112 persons suffering from serious disorders resulting from traumatic events (bereavement, acts of violence, and traffic accidents) that had taken place not more than 5 years before. Trauma desensitization, hypnotherapy, and psychodynamic therapy were tested for their effectiveness in comparison with a waiting-list control
group. The results indicated that treated cases were significantly lower in trauma-related symptoms than the control group.

DAVIDSON, J., SMITH, R., & KUDLER, H. (1989). **Validity and reliability of the DSM-III criteria for posttraumatic stress disorder**. *Journal of Nervous and Mental Disease, 177*, 336-341. The DSM-III criteria for PTSD were operationally defined for use in a structured interview. Acceptable interrater and test-retest reliabilities were shown; diagnostic validity was demonstrated relative to a standard diagnostic interview procedure; construct validity was shown in relation to a PTSD self-rating scale and to degree of combat exposure; the structured interview score correlated significantly with observer symptom scales for depression and anxiety.

GERARDI, R. J., BLANCHARD, E. B., & KOLB, L. C. (1989). **Ability of Vietnam veterans to dissimulate a psychophysiological assessment for post-traumatic stress disorder**. *Behavior Therapy, 20*, 229-243. Psychophysiological assessment procedures have begun to play an important adjunctive role in the diagnosis of PTSD. The present study sought to examine the ability of Vietnam veterans with and without PTSD to fake the psychophysiological assessment. The study replicated previous findings in demonstrating that PTSD veterans respond to combat stimuli with significantly greater increases in psychophysiology than veterans without the disorder. When subjects were instructed to alter their psychophysiological responses to the combat stimuli, subjects with PTSD were unable to do so. However, subjects without PTSD were able to increase certain psychophysiological responses to appear more like the PTSD veterans. Despite the ability of some non-PTSD veterans to control these responses, PTSD and non-PTSD subjects were still discriminated at a high rate. This study also found relatively good short-term test-retest reliability for heart rate and skin conductance in subjects given no instructions to fake.

GIBBS, M. S. (1989). **Factors in the victim that mediate between disaster and psychopathology: A review**. *Journal of Traumatic Stress, 2*, 489-514. A review of the research literature is provided regarding vulnerability and psychological resource characteristics of the victim that mediate between disaster and psychopathology. Common generalizations about the effect of vulnerability variables such as age, gender, and previous level of functioning are seldom supported. Coping styles appear promising predictive variables. Attitude variables deserve further attention. More complex designs are suggested to determine interaction effects between disaster and victim variables.

KEANE, T. M., FAIRBANK, J. A., CADDELL, J. M., & ZIMERING, R. T. (1989). **Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans**. *Behavior Therapy, 20*, 245-260. In a randomized clinical trial, 24 Vietnam veterans with a diagnosis of PTSD were randomly assigned either to a group receiving 14 to 16 sessions of implosive (flooding) therapy or to a waiting-list control. Standard psychometrics were administered before, following, and six months after treatment, and therapist ratings of symptomatology were concurrently obtained in personal interviews. When compared to the waiting-list control, those subjects receiving implosive therapy showed significant improvement across many of the psychometric measures

and the therapist ratings of psychopathology. Specific changes in the re-experiencing dimensions of PTSD, anxiety, and depression were notable, while treatment did not seem to influence the numbing and social avoidance aspects of PTSD. The results are discussed with respect to the importance of systematic exposure to traumatic memories, as one component of comprehensive treatment of combat-related PTSD, and the need for skills training interventions directed at improving social competence in interpersonal interactions.

KINZIE, J. D. (1989). **Therapeutic approaches to traumatized Cambodian refugees**. *Journal of Traumatic Stress, 2*, 75-91. The treatment of severely traumatized Cambodian refugees is a difficult task. Through an understanding of the patient's culture and the posttraumatic stress disorder, the author recommends several treatment approaches. These include: supportive long-term therapy, case management, reinforcing traditional values, socialization group therapy, and specific medication. Through a sensitive, flexible approach, the Western practitioner can greatly reduce the suffering of these patients.

KRYSTAL, J. H., KOSTEN, T. R., SOUTHWICK, S., MASON, J. W., PERRY, B. D., & GILLER, E. L. (1989). **Neurobiological aspects of PTSD: Review of clinical and preclinical studies**. *Behavior Therapy, 20*, 177-198. Although physiologic studies of PTSD date to World War I, clinical neuroscience has only recently explored biological mechanisms involved in this disorder. This review will selectively consider clinical and preclinical studies pertaining to biological theories and pharmacological treatments for PTSD, highlighting the role of central noradrenergic systems in its pathophysiology.

LIMA, B. R., CHAVEZ, H., SAMANIEGO, N., POMPEI, M. S., PAI, S., SANTACRUZ, H., & LOZANO, J. (1989). **Disaster severity and emotional disturbance: Implications for primary mental health care in developing countries**. *Acta Psychiatrica Scandinavica, 79*, 74-82. Two months following the 1987 earthquakes in Ecuador, 150 patients in the primary health care clinics of the area were screened for emotional problems; 40% of them were emotionally distressed. Risk factors included not being married, reporting poor physical or emotional health, and having ill-defined physical complaints. The findings from this research are discussed in relation to a disaster of much greater intensity, whose victims were studied by the authors, utilizing the same instrument and research design. The comparison between these 2 groups of disaster victims revealed that: 1) the prevalence of emotional distress was smaller among the Ecuador victims, but the frequency of symptoms among the distressed was similar for both groups; 2) the symptom profiles were remarkably similar; and 3) the most frequent symptoms and the strongest predictors of emotional distress were very similar. These findings support a focused training of health care workers on selected emotional problems that are regularly present among victims of different disasters.

LINDY, J. D. (1989). **Transference and post-traumatic stress disorder**. *Journal of The American Academy of Psychoanalysis, 17*, 397-413. Transferences from the field of battle were a nearly ubiquitous phenomenon in the psychotherapy of combat veterans with PTSD. Systematic examination of 37 cases allowed us to look at transference from the patient's, the therapist's, and a follow-up analyst's perspectives. The treatment situation, particularly its "terrain", served as day residue onto which traumas affix themselves. In the revived trauma the therapist is assigned differing positive and negative roles that at times need to be clarified. Nonspecific attributes of the therapist that become transferentially valued serve healing-providing auxiliary functions for the patient's reality testing, impulse control, and discontinuous sense of self.

ORNITZ, E. M., & PYNOOS, R. S. (1989). **Startle modulation in children with posttraumatic stress disorder**. *American Journal of Psychiatry, 146*, 866-870. Startle responses to bursts of white noise were recorded as blink reflexes 17-21 months after a traumatic event in six children with PTSD and in six normal control children. A seventh child with PTSD was studied on four occasions during the 2 years following a stressful event. The startle responses were modulated by nonstartling acoustic prestimulation in order to study the inhibitory and facilitatory modulation of startle reaction by brainstem mechanisms. The children with PTSD experienced a significant loss of the normal inhibitory modulation of startle response, suggesting the traumatic experience had induced a long-lasting brainstem dysfunction.

RAPHAEL, B., LUNDIN, T., & WISAETH, L. (1989). **A research method for the study of psychological and psychiatric aspects of disaster.** *Acta Psychiatrica Scandinavica, 80, Suppl. 355*, 1-75. This paper attempts to draw together some of the current questions related to the methodology of exploring the psychological and psychiatric aspects of human response to disaster. It sets out some of the key areas in which research questions might be mounted. A range of relevant instruments are suggested. The value of a structured interview which can explore issues of relevance to disaster victims is demonstrated. Early screening measures and proposals regarding these, as well as the particular instruments for longer term follow-up and assessment of outcome, are discussed in considerable detail. The article concludes with an overview of the principal issues to be addressed in methodology research, and emphasises the need for a collaborative approach using core items so that studies embracing different disasters and different countries can have some comparative basis.

ROSEN, J., FIELDS, R. B., HAND, A. M., FALSETTIE, G., & VAN KAMMEN, D. P. (1989). **Concurrent posttraumatic stress disorder in psychogeriatric patients.** *Journal of Geriatric Psychiatry and Neurology, 2*, 65-69. This study explores the presence of the diagnosis of PTSD in an inpatient sample of 42 World War II veterans with an admission diagnosis other than PTSD. Following a structured diagnostic interview, a second examiner, blind to the patients' combat history, interviewed the subjects to obtain information regarding the past and current impact of the "most stressful experience" of their lives. Subjects were instructed not to reveal the nature of the stressor until completion of the study. Fifty-four percent of the combat-exposed veterans (14 of 26) spontaneously listed combat as the most significant stressor in their life. Furthermore, 54% of the combat-exposed veterans met DSM-III criteria for past PTSD and 27% met criteria for current PTSD in
addition to another axis I diagnosis. These preliminary findings underscore the need for clinicians to assess the long-term effects of combat trauma in psychogeriatric patients.

ROSS, R. J., BALL, W. A., SULLIVAN, K. A., & CAROFF, S. N. (1989). **Sleep disturbance as the hallmark of posttraumatic stress disorder**. *American Journal of Psychiatry, 146*, 697-707. The reexperiencing of a traumatic event in the form of repetitive dreams, memories, or flashbacks is one of the cardinal manifestations of PTSD. The dream disturbance associated with PTSD may

be relatively specific for this disorder, and dysfunctional REM sleep mechanisms may be involved in the pathogenesis of the posttraumatic anxiety dream. Furthermore, the results of neurophysiological studies in animals suggest that CNS processes generating REM sleep may participate in the control of the classical startle response, which may be akin to the startle behavior commonly described in PTSD patients. Speculating that PTSD may be fundamentally a disorder of REM sleep mechanisms, the authors suggest several strategies for future research.

SMITH, M. A., DAVIDSON, J., RITCHIE, J. C., KUDLER, H., LIPPER, S., CHAPPELL, P., & NEMEROFF, C. B. (1989). **The corticotropin-releasing hormone test in patients with posttraumatic stress disorder**. *Biological Psychiatry, 26*, 349-355. To evaluate the hypothalmic-pituitary-adrenal (HPA) axis in patients with PTSD, we measured adrenocorticotropin hormone (ACTH) and cortisol responses following administration of corticotropin-releasing hormone (CRH) in 8 combat veterans with chronic PTSD. The PTSD patients had a significantly lower ACTH response to CRH compared to a control group of normal volunteers. Blunted ACTH responses occurred in patients with PTSD alone, as well as those PTSD patients who also had major depression. The cortisol response, although reduced, was not significantly different from normal. The blunted ACTH response to CRH in PTSD patients is similar to that seen in other psychiatric disorders, such as depression, panic disorder, and anorexia nervosa.

SOLOMON, Z. (1989). **Characteristic psychiatric symptomatology of post-traumatic stress disorder in veterans: A three year follow-up.** *Psychological Medicine, 19*, 927-936. This study assessed the clinical picture of two groups of Israeli veterans of the Lebanon war: (a) veterans who sustained a combat stress reaction (CSR) (N = 213), and (b) matched controls not so diagnosed (N = 116). Subjects were screened at three points—one, two, and three years after their participation in the war. The results indicated that PTSD was correlated with a wider range of general psychiatric symptomatology, as measured by the SCL-90. Moreover, among PTSD veterans, those who suffered from an antecedent CSR reported wider and more severe symptomatology. This trend was observed at all three time points. The most salient symptoms were obsessive-compulsive tendencies and anxiety, followed by depression and hostility.

SPEED, N., ENGDAHL, B., SCHWARTZ, J., & EBERLY, R. (1989). **Posttraumatic stress disorder as a consequence of the POW experience**. *Journal of Nervous and Mental Disease, 177*, 147-153. To estimate the relative contributions of trauma and premorbid disposition in the development and persistence of PTSD symptoms, we conducted structured psychiatric interviews of 62 former World War II POWs. Half of these men satisfied DSM-III criteria for PTSD in the year following repatriation. Eighteen (29%) continued to meet the criteria for PTSD 40 years later. Family history of mental illness and preexisting psychopathology were at best only weakly correlated with persistent PTSD symptoms. The strongest predictors of PTSD were proportion of body weight lost and the experience of torture during captivity. This study demonstrates that former POWs frequently develop PTSD and that for one half of those who develop the symptoms, they persist for over 40 years. Familial risk factors and preexisting psychopathology are superseded by the overwhelming nature of the trauma. The persistence of the symptoms for many years is a reflection of the severity of the trauma.

VAN DER KOLK, B. A., & VAN DER HART, O. (1989). **Pierre Janet and the breakdown of adaptation in psychological trauma**. *American Journal of Psychiatry, 146*, 1530-1540. In this reappraisal of the work of Pierre Janet at the centenary of the publication of *L'automatisme psychologique*, the authors review his investigations into the mental processes that transform traumatic experiences into psychopathology. Janet was the first to systematically study dissociation as the crucial psychological process with which the organism reacts to overwhelming experiences and show that traumatic memories may be expressed as sensory perceptions, affect states, and behavioral reenactments. Janet provided a broad framework that unifies into a larger perspective the various approaches to psychological functioning which have developed along independent lines in this century. Today his integrated approach may help clarify the interrelationships among such diverse topics as memory processes, state-dependent learning, dissociative reactions, and posttraumatic psychopathology.

ADDITIONAL CITATIONS
Annotated by the Editors

AGGER, I. (1989). **Sexual torture of political prisoners: An overview**. *Journal of Traumatic Stress, 2*, 305-318.
Proposes a theory of the psychodynamics of sexual torture based on clinical experience with refugees from the Middle East, North Africa, and Latin America, as well as on collections of mainly unpublished material on the subject. The testimony method is introduced as an important tool for sexological treatment inventories.

BROM, D., & KLEBER, R. J. (1989). P**revention of posttraumatic stress disorders**. *Journal of Traumatic Stress, 2*, 335-351.
Outlines a general theoretical perspective on coping with traumatic stress events, analyzes the various aspects of mental health intervention after such events, and presents the authors' different approach to health care. A specific program is described for Dutch victims of violence such as bank robberies and hijackings.

CERVANTES, R. C., SALGADO DE SNYDER, V. N., & PADILLA, A. M. (1989). **Posttraumatic stress in immigrants from Central America and Mexico.** *Hospital and Community Psychiatry, 40*, 615-619.
Presents self-reported symptoms among 258 recent immigrants from either Mexico or Central America, 188 Mexican Americans born in the USA and 141 Anglo Americans. High rates of PTSD symptoms (49-52%) were found among Central Americans whether or not they reported that their reason for migrating was due to civil-war-related trauma.

COONS, P. M., BOWMAN, E. S., PELLOW, T. A., & SCHNEIDER, P. (1989). **Post-traumatic aspects of the treatment of victims of sexual abuse and incest.** *Psychiatric Clinics of North America, 12*, 325-335.
Assesses the frequency of childhood abuse and adult traumatization as well as the presence of symptoms of PTSD and of dissociation across different DSM-III diagnostic categories. Subjects were 43 male and 97 female psychiatric inpatients. High levels of child abuse were found among patients with dissociative disorder and borderline personality disorder.

DEBLINGER, E., MCLEER, S. V., ATKINS, M. S., RALPHE, D., & FOA, E. (1989). **Post-traumatic stress in sexually abused, physically abused, and nonabused children**. *Child Abuse & Neglect, 13*, 403-408.

Compares rates of PTSD symptoms across sexually abused, physically abused, and nonabused psychiatrically hospitalized children. High rates (6.9% - 20.7%) were found in all groups. Sexually abused children exhibited higher rates of inappropriate sexual behaviors, whereas both abused groups were more likely to exhibit avoidant/dissociative symptoms.

FEINSTEIN, A. (1989). **Posttraumatic stress disorder: A descriptive study supporting DSM-III-R criteria**. *American Journal of Psychiatry, 146*, 665-666.

Reports on symptoms of PTSD in a military unit subsequent to an ambush. All men involved in the ambush met DSM-III criteria for PTSD for up to 24 days after the attack but continued to function efficiently. The author interprets his findings as supporting the DSM-III-R requirement of 1-month duration of symptoms for a diagnosis of PTSD.

GERARDI, R., KEANE, T. M., & PENK, W. (1989). **Utility: Sensitivity and specificity in developing diagnostic tests of combat-related post-traumatic stress disorder (PTSD)**. *Journal of Clinical Psychology, 45*, 691-703.

Reviews issues in the evaluation of a test's clinical utility and critically summarizes these issues with regard to instruments used to diagnose PTSD. The authors conclude that self-report measures show high sensitivity, whereas psychophysiological measures show high specificity.

HRYVNIAK, M., & ROSSE, R. B. (1989). **Concurrent psychiatric illness in inpatients with post-traumatic stress disorder.** *Military Medicine, 154*, 399-401.

Reviews diagnostic comorbidities among 63 PTSD patients in comparison with 311 non-PTSD patients admitted to a VA psychiatric ward. The number and pattern of co-diagnoses was different for PTSD vs. non-PTSD patients.

HYER, L., WOODS, M., HARRISON, W. R., BOUDEWYNS, P., & O'LEARY, W. C. (1989). **MMPI F-K index among hospitalized Vietnam veterans**. *Journal of Clinical Psychology, 45*, 250-254.

Uses the F-K index of the MMPI to assess symptom overreporting in psychiatric inpatient Vietnam in-country veterans and Vietnam-era veterans. Overreporting was common in both groups, but higher among in-country veterans, especially those with high scores on the MMPI PTSD scale. The authors discuss dissimulation as a symptom of PTSD.

KEANE, T. M., FAIRBANK, J. A., CADDEL**L,** J. M., ZIMERING, R. T., TAYLOR, K. L., & MORA, C. A. **(1989). Clinical evaluation of a measure to assess combat exposure**. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*, 53-55.

Provides information about the psychometric properties of the 7-item Combat Exposure Scale. Results show high internal consistency and very high stability. Also, scores were higher among veterans with PTSD than among non-PTSD veterans.

KINZIE, J. D., SACK, W., ANGELL, R., CLARKE, G., & BEN, R. (1989). **A three-year follow-up of Cambodian young people traumatized as children**. *American Academy of Child and Adolescent Psychiatry, 28*, 501-504.

Presents data on 27 Cambodian children, severely traumatized at ages 8 to 12, who were followed for three years. Results indicated that PTSD remained a major disorder and showed persistence over time, with prominence of avoidant symptoms. Depression was highly associated with PTSD in these youths.

KOLB, L. C. (editorial) (1989).**Chronic post-traumatic stress disorder: Implications of recent epidemiological and neuropsychological studies.** *Psychological Medicine, 19***,** 821-824.

Addresses recent epidemiological findings, recognition and diagnosis, psychophysiological and neurobiological findings, rearousal of symptoms following secondary traumatization, medical implications, risk factors, and prognosis. This is a lucid and succinct editorial on many key issues in PTSD.

KRIPPNER, S., & COLODZIN, B. (1989). **Multi-cultural methods of treating Vietnam veterans with post-traumatic stress disorder**. *International Journal of Psychosomatics, 36*, 79-85.

Reviews various methods of treating Vietnam veterans with PTSD, including approaches by traditional Native American and Asian practitioners. Techniques addressed include acupuncture, moxibustion, herbal remedies, purification ceremonies (such as the Native American sweat lodge), dream interpretation, and empowering rituals.

KROLL, J., HABENICHT, M., MACKENZIE, T., YANG, M., CHAN, S., VANG, T., NGUYEN, T., LY, M., PHOMMA-SOUVANH, B., NGUYEN, H., VANG, Y., SOUVANNA-SOTH, L., & CABUGAO, R. (1989). **Depression and posttraumatic stress disorder in Southeast Asian refugees.** *American Journal of Psychiatry, 146*, 1592-1597.

Reports on 404 Southeast Asian refugees seen at a community clinic. Seventy-three percent met DSM-III criteria for major depressive disorder (MDD) and 14% for PTSD. The authors argue that the diagnosis "MDD" does not adequately describe the "sad, distraught, and demoralized" clinical presentation of this population.

LITZ, B. T.,& KEANE, T. M. (1989). **Information processing in anxiety disorders: Application to the understanding of post-traumatic stress disorder.** *Clinical Psychology Review, 9*, 243-257.

Reviews the recent literature on information processing in PTSD in the larger context of research on cognition in anxiety disorders. Drawing on this background, the authors present a heuristic model for future empirical work.

MAJ, M., STARACE, F., CREPET, P., LOBRACE, S., VELTRO, F., DE MARCO, F., & KEMALI, D. (1989). **Prevalence of psychiatric disorders among subjects exposed to a natural disaster.** *Acta Psychiatrica Scandinavica, 79*, 544-549.

Reports on post-traumatic psychiatric symptoms among Italians who had been relocated because of seismic activity from a nearby volcano. They emphasize that in addition to exposure to the trauma itself, factors following the trauma, such as housing, may significantly affect symptomatology.

MCCAFFREY, R. J., HICKLING, E. J., & MARRAZO, M. J. (1989). **Civilian-related post-traumatic stress disorder: Assessment-related issues.** *Journal of Clinical Psychology, 45*, 72-

76.

Compares MMPI profiles of civilian PTSD and non-PTSD cases in a group of 26 psychiatric outpatients, all of whom had experienced a traumatic event. The authors failed to find statistically significant differences between groups on either the MMPI clinical scales or on the MMPI PTSD subscale.

MCFARLANE, A. C. (1989). **The treatment of post-traumatic stress disorder**. *British Journal of Medical Psychology, 62*, 81-90.

Reviews treatment studies of PTSD, most of which are descriptive and poorly controlled. Treatment issues highlighted include: the therapeutic alliance, nonspecific elements, coexistent psychiatric disorder, the degree of disturbed attention and arousal, the nature of traumatic preoccupation, and the patient's social and occupational functioning.

MILLER, T. W., MARTIN, W., & SPIRO, K. (1989). **Traumatic stress disorder: Diagnostic and clinical issues in former prisoners of war.** *Comprehensive Psychiatry, 30*, 139-148.

Reviews issues in the diagnosis and treatment of PTSD in former prisoners of war (POWs). The authors also present data on 62 former POWs showing that Japanese-held POWs reported more traumatizing events and psychiatric symptoms under capture than did German-held POWs. Japanese-held POWs also had higher elevations on most MMPI clinical scales.

MURPHY, S. A. (1989). **An explanatory model of recovery from disaster loss**. *Research in Nursing & Health, 12*, 67-76.

Describes an explanatory model of recovery from disaster loss based on longitudinal observations of people followed for up to three years following the volcanic eruption of Mt. St. Helens. Most predictive of 3-year postdisaster mental distress were 1-year postdisaster distress and negative ratings associated with disaster loss.

NORTH, C. S., SMITH, E. M., MCCOOL, R. E., & SHEA, J. M. (1989). **Short-term psychopathology in eyewitnesses to mass murder.** *Hospital and Community Psychiatry, 40*, 1293-1295.

Measures PTSD symptoms following a mass murder in Arkansas in which a gunman went on a shooting spree, killing and injuring people in a downtown business area. Eleven adult eyewitnesses are compared with 7 employees absent from work during the shootings. Most eyewitnesses in contrast to few absentees reported PTSD symptoms 4-6 weeks after the event.

PENK, W. E., ROBINOWITZ, R., BLACK, J., DOLAN, M., BELL, W., DORSETT, D., AMES, M., & NORIEGA, L. (1989). **Ethnicity: Post-traumatic stress disorder (PTSD) differences among Black, White, and Hispanic veterans who differ in degrees of exposure to combat in Vietnam.** *Journal of Clinical Psychology, 45*, 729-735.

Presents MMPI and PTSD scale data on 60 Hispanic, 280 Black, and 430 White Vietnam veterans admitted to either a drug or alcohol dependence program at a VA hospital. Blacks scored significantly higher than either the White or the Hispanic group on the MMPI clinical and PTSD scales, as well as on the Figley PTSD checklist. The authors state that the data do not support a view of minority groups as uniformly more vulnerable than the majority group to PTSD.

PENK, W., ROBINOWITZ, R., BLACK, J., DOLAN, M., BELL, W., ROBERTS, W., & SKINNER, J. (1989). **Co-morbidity: Lessons learned about post-traumatic stress disorder (PTSD) from developing PTSD scales for the MMPI.** *Journal of Clinical Psychology, 45*, 709-717.

Reports that PTSD as diagnosed by the MMPI varies as a function of comorbidity with other psychiatric disorders. The authors also show that the MMPI items best able to discriminate PTSD cases from noncases vary as a function of type of other psychiatric disorder in the sample. The authors suggest that a family of PTSD scales may be needed to adequately measure the disorder in different populations.

SHORE, J. H., VOLLMER, W. M., & TATUM, E. L. (1989). **Community patterns of posttraumatic stress disorders.** *Journal of Nervous and Mental Disease, 177*, 681-685.

Reports the lifetime prevalence of PTSD as diagnosed by the Diagnostic Interview Schedule in a rural community affected by the Mt. St. Helens eruption and in a similar community in a neighboring state. Among males, prevalence of PTSD from all sources was higher in the Mt. St. Helens community than in the control community, but the reverse was true for females. The authors dismiss this anomaly by citing the small number of PTSD cases in either community and discuss issues relevant to the assessment of PTSD in community samples.

SOLOMONS, K. (1989). **The dynamics of posttraumatic stress disorder in South African political ex-detainees**. *American Journal of Psychotherapy, 43*, 208-217

Explores the dynamic factors involved in the generation of PTSD in black South African political ex-detainees. It examines the necessary preconditions for the development of PTSD, the impact of the ego on serious trauma, and the ego transformation induced by the trauma.

SOLOMON, Z., MIKULINCER, M., & BENBENISHTY, R. (1989). **Locus of control and combat-related post-traumatic stress disorder: The intervening role of battle intensity, threat appraisal and coping.** *British Journal of Clinical Psychology, 28*, 131-144.

Investigates the role of control expectancies in PTSD among cases of acute combat stress reaction. The number of PTSD symptoms was predicted by threat appraisal, negative emotion, and an emotion-focused coping style. Locus of control was related to PTSD only for combatants who reported lower battle intensity. Results are discussed in terms of Lazarus's stress-illness model.

WATSON, C. G., KUCALA, T., MANIFOLD, V., & VASSAR, P. (1989). **Childhood stress disorder behaviors in veterans who do and do not develop posttraumatic stress disorder**. *Journal of Nervous and Mental Disease, 177*, 92-95.

Tests stress evaporation and residual stress models of PTSD by comparing retrospective self-ratings of PTSD symptoms in childhood made by PTSD patients, psychiatric controls, and normals. Results showed few differences between groups, which the authors interpret as a problem for the residual stress formulation.

PILOTS: THE PTSD DATABASE

PILOTS is a bibliographical database covering Published International Literature On Traumatic Stress. It is produced at the headquarters of the National Center for Post-Traumatic Stress Disorder in White River Junction. Although it is sponsored by the VA, the PILOTS database is not limited to literature on PTSD among veterans. Its goal is to include citations to all literature on PTSD, without disciplinary, linguistic, or geographical limitations, and to offer both current and retrospective coverage.

PILOTS is constructed using Pro-Cite, a commercial software package designed for bibliographic records. When the database is ready for distribution to users outside the National Center for PTSD, records will be converted to the formats required by the database utilities or CD-ROM producers who will make PILOTS available for public use. Users who are beta-testing PILOTS in its present development stage are using Pro-Cite software to search the database.

PILOTS records may be searched by author (those with multiple authors may be searched by any of them), by publisher, by word or phrase in the title, by word or phrase in the abstract, and by index term. Boolean searching (the use of "and," "or," and "not" in conjunction with multiple search terms), limitation by date, and truncation of search terms allow precision and flexibility in finding citations. The index terms consist of descriptors taken from the PTSD Thesaurus (a controlled vocabulary of terms arranged in a hierarchical format that shows the relationship between concepts represented) and identifiers representing concepts too narrow to be included in the Thesaurus (such as the names of specific persons, places, incidents, psychological tests, and therapeutic drugs). Authority lists can be used to select search terms that match precisely those used in indexing the database.

Though the PILOTS database is limited to bibliographical citations, in many cases the abstracts included in the records are extensive enough to allow the user to decide whether he or she needs to consult the original document. The PTSD Resource Center collects all documents cited in the PILOTS database, and hopes to be able to supply copies to clinicians and researchers who are unable to obtain them locally, subject to copyright laws and budgetary constraints. The Resource Center is also considering the possibility of including the full text of selected documents in a CD-ROM product that would also contain the PILOTS database, a directory of PTSD research and treatment facilities, and other information useful to those working in the PTSD field.

The National Center for Post-Traumatic Stress Disorder hopes that its bibliographic work, including the PILOTS database, will make a significant contribution to the study and treatment of PTSD, and thus to the lives of combat veterans, rape and torture victims, survivors of natural and technological disasters, and others whose lives have been affected by experiences beyond the normal stresses of everyday existence.

Sample PILOTS record as it would appear in Pro-Cite format on the screen of a Macintosh computer

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Auth    Allen, Irving M
AuRo
Affl    Health Service, Harvard University, Cambridge MA
Titl    Posttraumatic stress disorder among black Vietnam veterans
Medm    Journal Article
CoPh
Auth
AuRo
Titl    Hospital and Community Psychiatry
Date    January 1986
VoID    37
IsID    1
Loc     55-61
Lang    English
CODN
ISSN    0022-1597
Note
Abst      Because of racism in the military and racial and social upheaval in the United States
during the          Vietnam War years, as well as limited opportunities for blacks in the postwar
period, black              veterans of the Vietnam War often harbor conflicting feelings about their
wartime experiences and          have difficulty rationalizing brutality from PTSD at a higher rate
than white veterans. Diagnosis          and treatment of PTSD in black veterans is complicated by
the tendency to misdiagnose black pa-          tients, by the varied manifestations of PTSD, and by
patients' frequent alcohol and drug abuse and        medical, legal, personality, and vocational
problems.  The author presents his and others' recommen-          dations about ways to treat black
veterans with PTSD.
Call    00352
Indx    African Americans/Case Histories/Treatment/Veterans/Vietnam War
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