DETERMINING IF POST TRAUMATIC STRESS DISORDER IS AN APPROPRIATE DIAGNOSIS FOR EX-OFFENDERS

by

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ABSTRACT

DETERMINING IF POST TRAUMATIC STRESS DISORDER IS AN APPROPRIATE DIAGNOSIS FOR EX-OFFENDERS

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This study was conducted in order to determine if incarceration in the Texas prison system qualifies as a traumatic stressor responsible for Post Traumatic Stress Disorder (P.T.S.D.). The subjects under study consisted of 100 parolees from the Texas Department of Criminal Justice, Institutional Division, residing in halfway houses in the Houston, Texas area. These residents completed a questionaire describing the symptoms used to make a diagnosis of P.T.S.D. The instrument used to collect the data was designed according to guidelines set forth in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (D.S.M.-III-R.). There were no age or gender requirements, although all of the respondents were male as reflected by the Department of Criminal Justice statistics.

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CHAPTER 1: INTRODUCTION

DEFINING P.T.S.D.

Post Traumatic Stress Disorder (P.T.S.D.) is an anxiety disorder distinguished by the presence of a psychologically distressing event that is outside the range of usual human experience (D.S.M.III-R, 1987). It is most commonly associated with Vietnam veterans and their problems adjusting to civilian life after experiencing the horrors of combat, although it has also been studied in conjunction with Holocaust survivors, concentration camp internees, Cambodian refugees, as well as people that have been exposed to natural disasters such as floods or tornadoes.

There are five criteria required to make a diagnosis of P.T.S.D. and all are related to the traumatic stressor. The first one is the presence of the event that is outside the range of usual human experience. The second one is a persistent reexperiencing of the event such as in nightmares, intrusive memories, or in extreme cases a dissociative state in which the event is relived. The third criteria deals with avoidance of stimuli associated with the event even if they are merely symbolic. This category also includes an emotional state called psychic numbing where one's feelings, good or bad, are suppressed. The fourth criteria concerns increased arousal or hypervigilance. The last one has to do with duration of

the symptoms. These symptoms must last at least 30 days (Maramar 1988).

P.T.S.D. can also be brought on when a person is exposed to common street crimes, where the life threatened is that of a loved one, or even from the destruction of one's home or community (D.S.M.-III-R 1987). The trauma can be experienced in groups, such as combat soldiers, or alone, as in a rape or assault. Whatever form the stressor takes it usually involves death or the threat of death. The presence of this traumatic stressor is the characteristic that distinguishes P.T.S.D. from other diagnoses such as Depressive or Adjustment disorders. Using these criteria it would seem appropriate that a diagnosis of P.T.S.D. could be applied to someone exposed to a term in a penal institution.

P.T.S.D. has three phases dealing with when the symptoms occur in relation to the encounter with traumatic stressor and they are acute, delayed, or chronic (D.S.M.-III-R, 1987). The acute phase is when the symptoms appear soon after the encounter with the traumatic stressor, such as when a combat soldier shows symptoms soon after a firefight. The delayed/chronic phase applys when symptoms don't appear until much later, after that same soldier returns home to wife or family, well away from the traumatic event.

PURPOSE OF THE STUDY

The purpose of this research is to determine if parolees from the Texas Department of Criminal Justice suffer from Post Traumatic Stress Disorder (P.T.S.D.). The hypothesis being that exposure to a prison environment is sufficiently stressful to be considered a traumatic stressor capable of causing P.T.S.D. If this hypothesis proves to be correct it may help to explain why the recidivism rate is so high in Texas, and why parolees have such a difficult time reintegrating into society. The results of the study could be used to design more effective programs to help rehabilitate ex-offenders and help them move successfully back into their communities.

CHAPTER 2: STUDIES OF SPECIAL POPULATIONS

HISTORY OF P.T.S.D. IN COMBAT

P.T.S.D. was first acknowledged as a clinical syndrome early in this century during World War I. At that time it was called shell shock and was believed to be caused by prolonged exposure to artillery barrages. It was believed that the high air pressure caused by the exploding shells was responsible for physiological damage. Toward the end of the war the symptoms were attributed for the first time to psychological causes rather than medical ones. P.T.S.D. was then relabeled war neurosis and was then believed to be caused by predisposing personality characteristics instead of the trauma of combat (Glass, 1954). This view held through the beginning of World War II and was responsible for the high rates of rejection of draftees for psychiatric reasons (Figley, 1978). There was one point in the war where psychiatric rejections exceeded the pool of new draftees (Goodwin, 1966). Toward the end of World War II the idea that the physical and emotional rigors of combat may have more to do with psychological casualties than any predisposing character flaws became accepted, and the term war neurosis was changed to combat fatigue (Goodwin, 1980).

During the Korean War a new technique was tried for psychological casualties. Clinicians were on hand to treat individual breakdowns as they occurred with the goal of

returning the combatant to duty as soon as possible. The results of this approach were startling. During World War II psychiatric evacuations reached 23%, but during Korea they dropped to 6% (Bourne, 1970). It was during this time that the original D.S.M.-I came out and in it was a category called gross stress reaction, which was characterized by the individual being exposed to extreme physical and emotional stress, and combat was specifically listed as a stressor (D.S.M.-I).

During the Vietnam war psychiatric evacuations reached an all time low, 12 per 1000, and it was assumed that techniques learned in previous wars had solved the problems of psychological breakdown during combat (Bourne,1970). This assumption was reinforced by another observation. In previous wars there was a direct correlation between the intensity of combat and the number of combat breakdowns. As the intensity of combat increased so did the breakdowns. This was not the case in Vietnam. It was not until the war started winding down that the incidence of combat related problems began to increase.

After World War II it was noticed that some of the veterans who had displayed no symptoms at wars end began complaining of problems identical to those of their peers that had suffered from combat fatigue during the war. These symptoms included intense anxiety, depression, explosive aggressive behavior, combat nightmares, and problems with interpersonal relationships. This phenomena was documented in two studies, one after 5 years

(Futterman & Pumpian-Mindlin, 1951), and another after 20 years (Archibald & Tuddenham, 1965). As the war in Vietnam began to wind down in the early 70's the incidence of veterans complaining of similar problems began to increase, as had their World War II counterparts (Goodwin,1980). The main difference between the two groups was that the World War II veterans spent weeks or months returning from overseas, and they helped each other sort out the emotions stemming from combat. The Vietnam veterans returned home alone and went from war zone to civilian society in a matter of hours.

During the Vietnam war the D.S.M.-II was released and had dropped the gross stress reaction category and put combat related problems in the adjustment disorder category (D.S.M.-II,1968). During the same period psychologists began to notice that civilians that had experienced traumatic events such as natural disasters, terrorism, plane crashes, or fires suffered from almost identical symptoms as the veterans, and lobbied to have to have a stress disorder category restored. In 1980 the D.S.M.-III was published and the name post traumatic stress disorder was applied to those individuals displaying similar symptoms under similar circumstances. P.T.S.D. covered acute stages where individuals displayed symptoms soon after exposure to the stressor, as well as chronic or delayed stages where symptoms showed up much later.

There are a number of symptoms that would indicate a

person is suffering from P.T.S.D. and most of them are directly related to the traumatic stressor. It is common for an individual to have recollections of the traumatic event intruding upon their daily routine. In more severe cases the recollections can become dissociative states in which the event is relived. These flashbacks can last anywhere from a few seconds to several hours, and in rare instances can go on for several days (D.S.M.-III-R,1987). When a person is exposed to some stimulus that symbolizes an aspect of the traumatic event it can cause severe emotional distress. In the case of combat veterans these stimuli include the sound of a helicopter flying overhead, the smell of urine, (the bladder evacuates at the time of death), the smell of diesel fuel, the sound of popcorn popping (small arms fire), any loud discharge, a rainy day (monsoon season), or sometimes the sight of Vietnamese refugees (Williams,1980). Since contact with these stimuli can trigger such emotional distress there is often a conscious effort to avoid them. In more extreme cases the avoidance of reminders of the trauma may include psychogenic amnesia for an important aspect of the event (D.S.M.-III-R,1987).

In order to deal with the horrors of their traumatic episode many people shut down their feelings altogether. This psychic numbing usually begins soon after the trauma. A person may complain of feeling detached or estranged from other people, that they've lost interest in previously enjoyed activities, or that the ability to feel

emotions of any type, especially those associated with intimacy, tenderness, and sexuality are greatly decreased (D.S.M.-III-R,1987). This emotional anesthesia may be of great help in dealing with the pain of the event, but it has the side effect of not allowing the individual to enjoy life. In one study of Vietnam veterans they described themselves as being emotionally dead (Shatan, 1973). In another study veterans expressed the concern that if they ever allow themselves to feel, they may never stop crying, or may completely lose control (Williams,1980). By continuing with this defense mechanism a person can cope with the trauma, but may sabotage their marriage and push away their family. They have successfully blocked the pain, but they have also eliminated the joy from life.

In many cases individuals will report increased arousal that was not present before the trauma, and can include difficulty falling or staying asleep. They also report recurring nightmares, hypervigilance, and an exaggerated startle response (D.S.M.-III-R,1987). Many veterans report dreaming night after night about the death of a close friend, or of a death they caused in combat (Williams, 1980). With veterans the survival techniques they learned in combat become part of their daily routine. They will feel uncomfortable in open spaces, preferring to be behind some large object. When sitting in a room full of people they prefer to have their back against the wall. Loud noises cause them to jump (Parson,1987). Many veterans

also possess weapons, another survival technique learned in combat. Audie Murphy, Americas most decorated hero of World War II, kept a loaded German automatic pistol under his pillow up to the day he died (Shatan,1977). The weapons can be a double edged sword, used on others in a fit of rage, or on themselves in a period of depression.

One of the more disturbing symptoms displayed by P.T.S.D. sufferers are explosive outbursts of rage. In milder cases this may take the form of irritability or fear of losing control. In more severe cases, particularly where the survivor has committed acts of violence, as in war veterans, the fear is conscious and pervasive, and the reduced capacity for modulation may express itself in unpredictable explosions of aggressive behavior and an inability to express angry feelings (Parson,1987). In the case of veterans their rage is frightening to them and to those around them. For no apparent reason, they will strike out at whomever is near. Frequently this includes wives and children (Williams,1980). In the case of veterans their are many reasons for the aggressive behavior. Military training equated the rage with masculine identity in the performance of military duty (Eisenhart,1975). Whether in combat or not the military experience stirred up more resentment than most had ever felt (Egendorf,1975). While in Vietnam the veteran had no enemy to release their rage upon. The soldiers were fighting booby traps, land mines, ambushes, and quick retreats. Often they unleashed their anger at

indiscriminate objects for want of more suitable targets (Shatan,1977). When the veterans returned from Vietnam, the rage that had been tapped in combat was displaced against those in authority. It was directed against those the veterans felt were responsible for getting them involved in the war in the first place, and would not support them when they returned home (Howard,1975). All this pent up anger is directly related to the traumatic stressor and can cause problems in a number of ways. If not released it can cause fear and anxiety, alienating the P.T.S.D. victim from his or her family.

STUDIES OF HOLOCAUST SURVIVORS

Early research on Holocaust survivors was based on psychiatric models and generally portrayed them as a homogeneous group that was scarred for life, and had little chance of ever adapting effectively to post war life. More recent research seems to indicate that a large percentage of concentration camp survivors adjusted well to their new environments and have become productive citizens (Kahana,Harel,1988). Early literature depicted survivors as displaying classic symptoms of P.T.S.D. such irritability, sleeplessness, nightmares relating to the camps, and emotional numbing. Some even report that these victims had amnesia concerning most of the Holocaust (Kahana,Harel,1988).

Newer research on Holocaust survivors indicate that

many are coping well with their early trauma. One study indicates that camp survivors had a high degree of religiosity (Klein-Parker,1988). Another study showed that many were married to Holocaust victims, and that the ability to share and disclose their wartime experiences had a significant impact on the well being of the survivors (Klein-Parker,1988). Most of the research indicates that although these people had lived through horrific experiences they had eventually adapted to their new lives, and have become productive citizens.

P.T.S.D. AND CAMBODIAN REFUGEES

Although there has been little research conducted with Cambodian refugees the literature suggests that those that survived the regime of the Khmer Rhouge may be enduring massive trauma. From 1975 to 1980 when the communists ruled Cambodia, it is estimated that between 1 million to 3 million people, out of a population of 7 million, were executed (Kinzie,1988). Descriptions of severity of symptoms is similar to that of the Jewish survivors when they first emerged from the Nazi concentration camps. One study of Cambodian adolescents in an Oregon high school indicated that 50% of them met the criteria to make a diagnosis of P.T.S.D., and that of those remaining, all but two missed fitting the criteria by only one symptom (Kinzie, Sack, Angell, Manson, & Rath, 1986). In an initial study of Cambodian adults in treatment, 12 of 13

had reduced symptoms of P.T.S.D. after a year, but continued to have depressive episodes (Kinzie, Tran, Breckrinridge, & Bloom, 1980). Although there has been marked improvement in the Cambodian patients some symptoms seem to return in times of stress (Kinzie, 1988).

VIOLENCE IN TEXAS PRISONS

The psychological make up of the inmates of the Texas Department of Criminal Justice can be reflected in the type of offense these inmates are serving time for. Fully 50% of the inmates are there for violent crimes (Texas Dept. of Criminal Justice Fiscal Year Summary, 1988). The crimes listed as violent include murder, kidnaping, sexual assault, robbery, and assault. There are prison gangs perfectly willing to use violence to gain control of rackets such as drugs and prostitution (Prison Gangs Struggle for Control,1984). Assault is a common occurrence and at times a murder has been recorded at least once a week (T.D.C. Violence Reaches all Time High,1984). The inmates are not the only people one has to fear in prison. Some of the guards can be just as violent as the inmates, and will contract inmates to carry out assaults (T.D.C. Guards Indicted,1984). A good case can be made showing that the prison environment is a violent one.

SUMMARY

For most of the latter half of the twentieth century a great deal of research has been devoted to demonstrating the effects of extreme violence on the human psyche. The coping mechanisms individuals devise to survive difficult situations can severely impair that individuals ability to function in a normal environment. Sometimes the fact that the individual survived, when their comrades didn't, can cause emotional difficulties. Many times, with help, these issues can be resolved but there can be no doubt that exposure to extreme stress can be traumatic.

HYPOTHESES

A term in a Texas prison should meet the qualifications set out in the D.S.M.-III-R. as a traumatic stressor capable of causing P.T.S.D. Serving time in a penal institution would certainly be a psychologically distressing event for most people. A prison sentence is also outside the range of usual human existence. Spending time in a prison environment would also pose a serious threat to one's physical well being. At least half the population of the Texas prison system have demonstrated a capability of posing a threat to one's physical well being. Prison is a violent place filled with violent people, and physical harm or death is a possibility at almost any time. Since the prison environment fits the

criteria as a traumatic stressor, it seems likely that exposure to this stressor could induce P.T.S.D. in an individual.

CHAPTER 3: METHODS

SUBJECTS

There were 100 subjects in this study and were drawn from two halfway houses in Houston, Texas. They were all male and were either residents of these facilities or were non-residents taking advantage of services provided for ex-offenders. All of the subjects had at one time been incarcerated in the Texas prison system for a felony offense. No attempt was made to determine what the subjects had been incarcerated for or how long they had been an inmate of the Texas Department of Criminal Justice. The only requirement to participate in this study was to have lived in a prison environment.

INSTRUMENT

The instrument used to collect the data was a self report questionnaire consisting of 17 items requiring either a yes or a no answer. Each question described a symptom displayed by an individual that might be suffering from P.T.S.D. There was one additional question asking the participant how long they had been out of the prison environment. This question was included since the D.S.M.-III-R. requires that these symptoms persist for at least 30 days after exposure to the traumatic stressor before a diagnosis of P.T.S.D. can be considered. All of

the items on the instrument are listed in the D.S.M.-III-R. as a symptom of P.T.S.D. although some of the questions were modified to eliminate technical language. Most of the other questions were modified so they dealt specifically with the prison environment.

PROCEDURES

The questionnaires were administered either at educational or support groups. The educational groups were vocational classes where job hunting or interviewing skills were being taught. The support groups were either A.A. or N.A. meetings. Permission was obtained from the instructor or facilitator, and before group started the questionnaires were distributed for participants to complete. Scoring on the instrument was conducted according to D.S.M.-III-R. guidelines. In order to consider a diagnosis of P.T.S.D. the respondent must display a certain number of symptoms in each of three categories on the questionaire. A yes answer was considered a display of that symptom. If the participant answered yes to at least 1 of questions 1-4, to at least 3 of questions 5-11, and to at least 2 of questions 12-17, and had been out of prison for at least 30 days, that questionaire was considered a positive response for P.T.S.D.

DATA ANALYSIS

After separating from the consent form and scoring, random samples were drawn from the group of questionnaires to determine what percentage of the participants gave either a positive or a negative response for P.T.S.D. In addition to type of response, the questionnaires were examined to determine how long the respondent had been out of prison to see if this variable had any relation to whether participant's response was positive or negative. There were 3 time variables used for this analysis, less than a year, 1-3 years, and more than 3 years.

CHAPTER 4: RESULTS

INCIDENCE OF P.T.S.D.

The results of the study indicate that there may be a problem with P.T.S.D. in individuals leaving the Texas Department of Criminal Justice. Out of 100 questionnaires distributed to parolees, 9 could not be evaluated because they had been out of prison less than the required 30 days. Two more questionnaires had to be discarded because on question number 18 where time since release was indicated the respondent placed only a number and did not indicate whether that number referred to weeks, days, months or years. Out of the 89 remaining questionnaires 64% of the respondents indicated that they displayed the symptoms of P.T.S.D. While a positive response on this instrument does not constitute a diagnosis of P.T.S.D., it does indicate they are having trouble coping with the free world due to their experience in prison.

RELATIONSHIP BETWEEN P.T.S.D. AND TIME OF RELEASE

In the analysis of any relationship between the amount of time the participant had been out of prison and whether they had a positive or negative response for P.T.S.D., a similar ratio applied in all three categories. In the category of less than a year since their release, 54% of the participants gave positive responses for P.T.S.D. In

the category of 1-3 years, 66% gave positive responses. In the category of more than 3 years the ratio was 48%. So while there was a slight decline in positive responses in the longer category,half of the respondents continued to be bothered by the time they spent in prison.

SUMMARY

While these results cannot be taken as an indication that half the people that go to prison will come out with P.T.S.D., it does point to a possible problem if these individuals are ever to lead productive lives. Research indicates that the ability to talk about shared experiences are important in the recovery from a traumatic period in one's life. Support groups could be designed to help with the adjustment. Combined with programs already in place it could be the answer to the recidivism problem. If the goal of incarceration is eventual rehabilitation, then some thought must be given to helping these individuals adjust to the free world once they are released.

CHAPTER 5: DISCUSSION

LIMITATIONS OF THE STUDY

There were at least two limitations in conducting this study. One was the lack of demographic data. With the information available all that could be determined was that a problem may exist in this particular population. There was no way to determine if the incidence of P.T.S.D. was more prevalent in certain age groups or ethnic groups. There was also no question about gender to determine any differences in that respect. This limitation pointed out one of the problems in the criminal justice system, and that is a shortage of rehabilitation facilities for women. Had the survey taken into account the need for demographics, female respondents would have been difficult to locate. The vast majority of programs designed to assist ex-offenders are for males.

The second limitation was in the design of the study. While this survey was adequate as an initial step to determine if a possible problem existed, a diagnosis of P.T.S.D. should not be made from a questionaire. To determine if this is actually a problem that ex-offenders are struggling with, an interview form of data collection should be designed. The interview should include not only demographics, but also a psychosocial assessment. This would eliminate any possibility that a previous traumatic event is the cause of the P.T.S.D. even though the

questions were prison specific.

SUGGESTIONS FOR REHABILITATION

While the study indicates that ex-offenders face readjustment problems when they are returned to society, some of which may stem directly from their incarceration, in most cases these problems are not insurmountable. There are already educational programs in place, mostly aimed at teaching the ex-offender job search and interviewing skills. In addition to these vocational programs there are support groups to deal with the problem of substance abuse, some of which are tailored specifically for ex-offenders. These programs are laudable and should be expanded. However there are few if any programs to deal with possible problems stemming directly from the incarceration itself. A program designed to screen for psychological problems, such as P.T.S.D., could possibly pick up other disorders that may prevent the ex-offender from ever living a productive life. Support groups could be implemented to deal with these problems, and if necessary refer appropriate individuals to therapy. Without such programs spiraling costs for both crime and incarceration are inevitable.

SUGGESTIONS FOR FUTURE RESEARCH

Future research should investigate the possibility that recidivism may stem directly from incarceration itself. If ex-offenders are trying to cope with adjustment problems caused by their incarceration, such as P.T.S.D., these problems need to be clearly identified. In addition to identifying the problem, research should try to identify appropriate solutions.

APPENDICES

SURVEY OF P.T.S.D. IN EX-OFFENDERS

1. ___Yes___No Do you have troubling memories about your time in prison that come up again and again?

2. ___Yes___No Do you have troubling dreams about your time in prison that come up again and again?

3. ___Yes___No Do you sometimes act or feel as if you were back in prison?

4. ___Yes___No Do you sometimes have strong troubling feelings when you run into something that reminds you of some part of your time in prison?

5. ___Yes___No Do you try to avoid thoughts or feelings that remind you of your time in prison?

6. ___Yes___No Do you avoid doing things or visiting places that remind you of your time in prison?

7. ___Yes___No Are you unable to remember important parts of your time in prison?

8. ___Yes___No Have you lost interest in doing things that used to be important to you?

9. ___Yes___No Do you feel different from everyone, that you don't belong anywhere?

10. ___Yes___No Are you unable to have loving feelings?

11.___Yes___No Do you expect to have a good job, marriage, children, or a long life?

12.___Yes___No Do you have trouble falling or staying asleep?

13.___Yes___No Are you grouchy or have outbursts of anger?

14.___Yes___No Do you have trouble keeping your mind on what you are doing?

15.___Yes___No Do you have trouble relaxing?

16.___Yes___No Are you easily startled (jumpy)?

17.___Yes___No Are there changes in your body when you see or hear something that reminds you of your time in prison?

18.__________ How long have you been out of prison?

CONSENT FORM

The purpose of this study is to determine if spending time in a prison environment is sufficiently stressful to cause Post Stress Traumatic Disorder (P.T.S.D.). It is possible that the results of the information gathered in this study can be used to design programs that will help the ex-offender adjust to life outside prison. It is also possible that participating in this study could identify the source of problems the ex-offender may be having in the freeworld.

Participation in this study could cause emotional distress due to the fact that the participant will be examining a painful period in their life. If this occurs the investigator, Denny Morrison, can be reached at (713) 333-2311. Mr. Morrison can answer questions or refer to counseling.

Participation in this study is voluntary and can be withdrawn at any time without penalty.

______________________________ ____________

Signature Date

This project has been reviewed by the University of Houston/Clear Lake, Committee for the Protection of Human Subjects, (phone number 713-283-3015).

BIBLIOGRAPHY

American Psychiatric Association. (1952). Diagnostic and statistical manual of mental disorders (1st ed.). Washington, D.C: Author.

American Psychiatric Association. (1968). Diagnostic and statistical manual of mental disorders (2nd. ed.). Washington, D.C: Author.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd. ed.). Washington, D.C: Author.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd. ed. rev.). Washington, D.C: Author.

Archibald, H.E. & Tuddenham, R.D. (1965). Persistent stress reactions after combat: A twenty year follow up. Archives of General Psychiatry, 12: 475-481.

Bourne, P.G. (1970). Men, stress, and Vietnam. Boston: Little, Brown.

Egendorf,A. (1975). Vietnam veteran rap groups and themes of postwar life. In D.M. Mantell & Pilisuk (Eds.), Journal of social issues: Soldiers in and after Vietnam, 31 (4): 13-23.

Eisenhart, R.W. (1975). You can't hack it little girl: a discussion of the covert psychological agenda of modern combat training. In D.W. Mantell & Pilisuk (Eds.), Journal of social issues: Soldiers in and after Vietnam, (31) 4:13-23.

Figley, C.R. (1977). Psychosocial adjustment among Vietnam veterans: An overview of the research. In C.R. Figley (Ed.), Stress disorders among Vietnam veterans: Theory, research, and treatment. New York: Brunner/Mazel.

Futterman, S. & Pumpian-Mindlin, E. (1951). Traumatic war neurosis five years later. American Journal of Psychiatry, 108 (6), 401-408.

Glass, A. J. (1954). Psychotherapy in the combat zone. American Journal of Psychiatry, 110, 725-731.

Goodwin, J. (1980). The etiology of combat-related post traumatic stress disorders. In T. Williams (Ed.), Post traumatic stress disorders of the Vietnam veteran (pp. 1-21). Cincinnati: Disabled American Veterans Press.

Howard, S. (1976). The Vietnam warrior: His experience and implications for psychotherapy. American Journal of Psychotherapy, 30 (1), 121-135.

Kahana, B. & Harel, Z. (1988). Predictors of psychological well being among survivors of the holocaust. In J. Wilson, Z. Harel, & B. Kahana (Eds.), Human Adaptation to extreme stress. (pp. 171-176). New York: Plenum Press.

Kinzie, J. (1988). The psychiatric effects of massive trauma on Cambodian refugees. In J. Wilson, Z. Harel, & B. Kahana (Eds.), Human adaptation to extreme stress. (pp. 305-316). New York: Plenum Press.

Kinzie, J., Sack, W., Angell, R., Manson, S., & Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children. In Journal of the American Academy of Child Psychiatry, 25, 370-376.

Klein-Parker, F. (1988). Dominant attitudes of adult children of holocaust survivors toward their parents. In J. Wilson, Z. Harel, & B. Kahana (Eds.), Human adaptation to extreme stress (p. 194). New York: Plenum Press.

Parson, E. R. (1987). The reparation of the self: Clinical and theoretical dimensions in the treatment of Vietnam combat veterans. In W. Quaytman (Ed.), The Vietnam veteran: Studies in post traumatic shock disorders (pp.6-44). New York: Human Sciences Press.

Prison struggle for control. (1984, April). Houston Chronicle, (pp. 1,22)

Shatan, C. (1977). Bogus manhood, bogus honor: Surrender and transfiguration in the United States marine corp. Psychoanalytic Review, 64, 585-610.

Shatan, C. (1973). The grief of soldiers: Vietnam combat veterans self-help movement. American Journal of Orthopsychiatry, 43 (4), 540-553.

Texas Department of Criminal Justice. (1989). Fiscal Year Summary.

T.D.C. guards indicted. (1984, May). Houston Chronicle, (pp. 1,16).

T.D.C. violence reaches all time high. (1984, May). Houston Chronicle, (pp. 1,22).

T.D.C. violence sets new record. (1984, May). Houston Chronicle, (pp. 1,22).

Williams, T. (1980). Introduction. In T. Williams (Ed.) Post traumatic stress disorder of the Vietnam veteran. Cincinnati: Disabled American Veteran Press.