COMMUNITY VIOLENCE-RELATED PTSD IN CHILDREN AND ADOLESCENTS

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Homicide has become the leading cause of death among minority adolescent males in some inner city areas. Recent media attention has been focused on the plight of inadvertent victims of violent street crime, and the issue of community violence is now recognized as a major public health issue—more than a criminal justice problem—especially among youths. Early studies of youths’ experiences with community violence focused primarily upon the issue of recidivism among adolescent perpetrators. More recently, studies have begun to examine a spectrum of community violence and its traumatic consequences to youth victims.

This article is intended to provide an up-to-date overview of this relatively new area of trauma study. To narrow the definition of community violence for the purposes of this article, distinction is made between studies of crime-related trauma, which are most often conducted with adult samples, and studies of community violence exposure in children and adolescents. (See Resnick & Kilpatrick, 1994, for an overview of crime-related PTSD among adults.) Several types of possible violent interpersonal events among youths are examined. In the context of the ongoing national epidemic of inner city violence, key risk factors are identified for victimization of children and adolescents. Findings from recent studies examining violence-related PTSD symptomatology in adolescent survivors are then presented. Methodologic issues in operationally defining and assessing key variables in the study of community violence-related PTSD are discussed, and selected instruments that have proven useful are described. Finally, the article raises two critical clinical issues for future direction: treatment of community violence-related distress in adolescents; and violence prevention efforts.

Critical Issues in Research on Community Violence and its Mental Health Consequences. One of the primary limitations in existing research on community violence is the use of convenient, non-representative samples. Studies primarily focus on inner-city, minority youths. To date, only one study (Boney-McCoy & Finkelhor, 1995) that used a national sample has been reported. Although the definition of community violence used in most studies reflects its chronic nature (Garbarino, 1993) and includes the assessment of exposure to multiple community violence events, different operational definitions are used and exposure to other types of trauma (e.g. childhood physical or sexual abuse) is frequently not assessed (McLain et al., 1998). In most studies of community violence, a lifetime approach to assessing trauma is taken in which questions about exposure are posed in the “have you ever experienced...” format. Unfortunately, few studies have incorporated recency or frequency of exposure as critical variables in the conceptualization of community violence exposure, thereby limiting the representation of exposure severity to a basic screening level. In most present studies, use of control groups or other appropriate methods to isolate community violence exposure as the salient independent variable have been lacking. Finally, most existing studies do not feature longitudinal designs that would permit examination of temporality between community violence exposure and psychological distress manifestations.

Prevalence, Descriptive Characteristics, and Risk Factors for Exposure to Community Violence. The phenomenon of community violence exposure is conceptually complex. The kinds of experiences covered under the community violence concept include both predatory violence and violence arising from non-family interpersonal conflicts (Bell, 1997). In the case of predatory violent incidents, the perpetrator’s objective is to take something of value from the victim (usually a stranger), and physical threats or direct violence to the victim are means to achieve that goal. Conversely, participants in violent interpersonal conflicts are usually acquaintances involved in an altercation in which the distinction between perpetrator and victim is not clearly defined. Bell (1997) points out that gang-related and drug-related violence can represent either predatory or conflictual types, and that an additional form of community violence occurs (through negligence) when “innocent victims” are caught incidentally in the line of fire.

The community violence concept applies not only to direct personal exposure (happened to you), it also includes exposure through witnessing (saw it happen to someone else) and vicarious (know someone it happened to) routes. Instruments that are used to mea-
sure community violence exposure take these different forms of exposure into account, providing separate items and summary scores for each type. Available instruments with established psychometrics include the Survey of Children’s Exposure to Community Violence (SCECV; Richters and Saltzman, 1990) and the Screen for Adolescent Violence Exposure (SAVE; Hastings & Kelley, 1997).

Risk for victimization has been found to be disproportionately distributed across demographic categories, including gender, socioeconomic status (SES), race, level of community urbanization, and age (e.g. Fitzpatrick & Boldizar, 1993). Risk for community violence exposure is higher among the poor, the non-white, and those who live in densely populated urban areas. Studies found that late adolescence, ages 15-19, represents the period of highest risk for community violence exposure.

Although high rates of community exposure are reported among urban minority youths, this problem may not be unique to the inner city. In the only study using a national sample of adolescents, over one third of the youths reported having directly experienced community violence in the form of assault (Boney-McCoy & Finkelhor, 1995). Large gender differences were found, with 35% of males reporting victimization, compared to 13% of females. Conversely, 15% of females reported having been sexually assaulted, compared to 6% of the males. Because the study did not differentiate between familial and non-familial types of sexual assault, the proportion of sexual assault cases representing community violence could not be determined. In addition, the study did not include rates of victimization through witnessing or vicarious routes of exposure.

Other studies on prevalence of community violence have examined rates of victimization related to direct, witnessing, and vicarious types of exposure. These studies have consistently identified higher levels of indirect (witnessing and vicarious) than direct exposure to community violence among urban youths (e.g. Fitzpatrick & Boldizar, 1993). Males reported significantly higher direct and witnessing exposure, but not more vicarious exposure than females. Most community violence studies with adolescents use the youths’ self-report as the basis for determining community violence exposure. Youths’ self-report may be preferred because studies comparing parents’ reports of their child’s community violence exposure and trauma-related psychological distress to the child’s report found that parents reported significantly less exposure (Hill & Jones, 1997) and distress (Martinez & Richters, 1993).

Gang affiliation has also emerged as a key risk factor for victimization. Gang-related violence has become one of the most pervasive, brutal, and multifaceted forms of community violence, frequently taking the form of being “jumped in” or “jumped out” of the gang, or fighting members of a rival gang. Armed robberies, high-speed car chases with rival gangs or police, beatings, muggings, gang or individual rapes, stabbings, drive-by or walk-by shootings, shootouts, and kidnappings represent other violent activities in which gang members may be involved (Burton et al., 1994).

Prevalence and Risk Factors for Community Violence-related PTSD. Validated self-report instruments for assessing PTSD symptoms in youth samples are now available (e.g. Foy et al., 1997). Consistent with findings from studies on other types of trauma, studies of community violence among urban youth have also revealed positive correlations between the degree of exposure and reported levels of psychological distress (e.g. Burton et al., 1994; Fitzpatrick & Boldizar, 1993; Lynch & Cicchetti, 1998). High rates of PTSD (25-30%) among highly exposed adolescents have been reported. Among studies that measured rates of exposure by modality, direct victimization correlated more strongly with measures of distress than exposure via witnessing or vicarious victimization, although each modality has been demonstrated to induce PTSD in children (Saigh, 1991).

A recent review of 55 studies on youth PTSD found 8 studies that examined etiologic factors in community violence-related PTSD (McLain et al., 1998). Prior trauma exposure was significantly related to community violence-related PTSD severity in all three of the studies in which it was assessed. Studies examining age, gender, and ethnicity as potential risk factors produced mixed findings. To date, there are more studies reporting insignificant results for these demographic variables, although definitive patterns are not yet evident. The possible mediating role of social support was examined in another recent study of children’s psychological adjustment following community violence exposure. Results showed that community violence exposure was most highly related (inverse correlation) to well-being in those children with low social support or high levels of social strain (Kliewer et al., 1998).

Future Directions in Treatment and Prevention. In view of the high rates of community violence exposure and risk for PTSD among inner city minority youth, increased efforts to provide appropriate clinical services are needed (Osofsky, 1995, 1997). Hospital emergency departments where community violence-related physical injuries are treated represent a realistic starting point for crisis intervention and short-term treatment for residual PTSD symptoms in youth who have recently survived a life-threatening episode (e.g. Pynoos & Nader, 1988). School-based clinics are another site where services can be provided, especially for youths victimized through witnessing or vicarious trauma. Considering options in form, individual treatment provides a controlled, supportive therapeutic environment; group methods offer validation and normalization of traumatic reactions through sharing with other members. While empirical validation of specific treatments for community violence-related PTSD is lacking, an empirically based form of cognitive-behavioral group therapy that has been used with another youth trauma population is available (March et al., 1998).

Relatively more progress has been made in developing violence prevention programs. Gang prevention and conflict resolution skill-building programs for high-risk youth currently dominate the focus in these programs (Hausman et al., 1994). However, a recent review of the community
violence prevention literature found that prevention efforts appear to be more effective if children are engaged early (beginning before age 6), and the program includes intervention in children’s social environments at home and at school (Kellerman et al., 1998). Additionally, programs should continue to make specific efforts to reduce obvious high-risk behaviors such as gang involvement, heavy drinking, and carrying handguns among adolescents.

REFERENCES


SELECTED ABSTRACTS

BELL, C.C. (1997). Community violence: causes, prevention, and intervention. Journal of the National Medical Association, 89, 657-662. Presents pragmatic schemata for understanding various types and motivations for community violence. This understanding is essential to frame prevention, intervention, and postvention strategies designed to reduce the phenomena of violence in society. Each category of violence (collective, individual, drug-related, gang-related, etc.) lists examples of prevention, intervention, and postvention strategies. This article is intended to broaden the understanding of violence so that strategies to address violence will become more specific and measurable.

BONEY-MCCOY, S. & FINKELHOR, D. (1995). Psychosocial sequelae of violent victimization in a national youth sample. Journal of Consulting and Clinical Psychology 63, 726-736. In a national telephone sample of youths aged 10-16 years, over one third reported having been the victims of an assault. Victimized respondents displayed significantly more psychological and behavioral symptomatology than did nonvictimized respondents (more symptomatology related to PTSD, more sadness, and more school difficulties), even after controlling for some other possible sources of distress. Sexual assault was associated with particularly high levels of symptomatology. However, victims of other forms of assault—nonfamily assaults involving weapons or physical injury (agrivated assaults), assaults by parents, violence to genitals, and attempted kidnappings—also evidenced levels of distress that were not statistically lower than those suffered by victims of sexual assault. The findings suggest that substantial mental health morbidity in the general child and adolescent population is associated with victimization.

BURTON, D., FOY, D.W., BWANAUSI, C., JOHNSON, J., & MOORE, L. (1994). The relationship between traumatic exposure, family dysfunction, and post-traumatic stress symptoms in male juvenile offenders. Journal of Traumatic Stress, 7, 83-93. This study examined some chronic, stressful conditions and some acute, traumatic events which may place youths at risk for specific types of psychopathology. 91 delinquent adolescents with histories of serious and repeated crimes were assessed for their exposure to 11 different types of trauma. The subjects were also tested using measures which assess family functioning, and frequency and intensity of PTSD symptoms. Results indicated that 24 percent of the subjects tested met full DSM III-R criteria for PTSD. Both exposure to violence and family dysfunction were significantly associated with PTSD symptomatology. These findings suggest that juvenile offenders may constitute a high risk group for exposure to multiple types of trauma and the development of PTSD symptoms related to such exposure. This study provides a rationale for future cross-trauma research both within the juvenile offender population and between it and other identified trauma groups.

FITZPATRICK, K.M. & BOLDIZAR, J.P. (1993). The prevalence and consequences of exposure to violence among African-American youth. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 424-430. The objective of this study was to examine the relationship between chronic exposure to community violence and PTSD symptoms in a nonrandom sample (N = 221) of low-income African-American youth between 7 and 18 years old. Results showed males were more likely than females to be victims of and witnesses to violent acts; there were no other significant sociodemographic differences in the degree of exposure to violence. PTSD symptoms reporting was moderately high for this sample of youth; 54 youth (27.1 percent) met all three of the diagnostic criteria considered. Regression analyses revealed that being victimized and witnessing violence were significantly related to the reporting of PTSD symptoms. These symptoms were more extreme among victimized females and victimized youth who had no primary males living with them in the household (i.e., fathers and/or brothers). Exposure to violence among youth is clearly significant to their reporting of PTSD symptomatology, yet the clinical implications of this relationship remain largely unexplored.

FOY, D.W., WOOD, J.L., KING, D.W., KING, L.A., RESNICK, H.S. (1997). Los Angeles Symptom Checklist: psychometric evidence with an adolescent sample. Assessment, 4, 377-384. The Los Angeles Symptom Checklist (LASC) is a self-report measure of PTSD and general distress that has been used with a variety of adult trauma populations. This study provided psychometric support for the instrument’s use with adolescents. Internal consistency estimates were .90 and .95 for the 17-item PTSD index and the 43-item full-scale index, respectively. When mean scores were compared across trauma exposure groups, results were supportive of the LASC’s ability to detect symptoms of posttrauma sequelae. Confirmatory factor analysis findings supported 3 highly correlated factors representing the DSM-IV symptom categories of reexperiencing, avoidance and numbing, and arousal.

GARBARINO, J. (1993). *Children’s response to community violence: What do we know?* Infant Mental Health Journal, 14, 103-115. Presents a framework for understanding the developmental significance of violence-related trauma in the lives of young children. Acute trauma is more readily dealt with through psychological first aid and a therapy of reassurance. Chronic trauma requires a more systematic reconstruction of the child’s social map of the world. Situations of chronic danger can stimulate the process of moral development if they are matched by an interactive climate created by adults and if the child is free of debilitating psychopathology. Socioeconomic and demographic correlates of violent trauma predict an accumulation of risk factors in the child’s life that compounds the problem of developmental disability. The problem community violence poses for the child must be understood in the larger context of greater risk for family disruption, domestic violence, poverty, and minority group status.

HAUSMAN, A.J., SPIVAK, H., PROTHROW-SMITH, D. (1994). *Adolescents’ knowledge and attitudes about and experience with violence.* Journal of Adolescent Health, 15, 400-406. PURPOSE: Educational interventions directed to the prevented of youth interpersonal violence make assumptions about the educational needs of adolescents for violence-prevention despite little available data. This paper provides new information on background levels of adolescents’ knowledge of, attitudes about and experience with violence. METHODS: Over 400 teens across Boston’s neighborhoods were surveyed by random-digit dialed telephone techniques. RESULTS: Results show that while boys are more often involved in violence, almost one quarter of girls report fighting. Black teens witness more violence and are threatened more often than whites, but they do not fight more. Knowledge scores indicate a need for improvement in adolescents’ understanding of risk factors. Attitude scores indicate that adolescents believe fighting can and should be avoided, but they lack knowledge of behavioral options. Regression analyses show a positive relationship between violence experience and knowledge and attitudes. CONCLUSION: These data suggest that preventive interventions should be directed to both improving adolescents’ knowledge of and understanding of personal risk and increasing their repertoire of conflict-resolution skills.

HILL, H.M. & JONES, L.P. (1997). *Children’s and parents’ perceptions of children’s exposure to violence in urban neighborhoods.* Journal of the National Medical Association, 89, 270-276. Examined child and parent perceptions of children’s exposure to community violence among 50 male and 46 female 4th-6th graders (aged 9-12 yrs.), 51 from high- and 45 from low-violence neighborhoods in 6 elementary schools in Washington, D.C. More than 75% of the African-American elementary school children sampled indicated that they had witnessed incidents of community violence ranging from homicides to nonfatal shootings, physical assaults, gang violence, robbery with assaults, and rape in their neighborhoods. Yet almost half of the children’s mothers in the study denied that their children had been exposed to any community violence. When these discrepancies were examined, results reveal that approximately 50% of the children’s mothers were in disagreement regarding their exposure to community violence were less likely to experience social support from their peers. Mothers’ possible lack of awareness as to the experience of their children may place them at further risk by eliminating the possibility for adult-child interaction and guidance regarding their experience with violence in their neighborhoods.

KELLERMAN, A.L., FUQUA-WHITLEY, D.S., & MERCY, J. (1998). *Preventing youth violence: What works?* Annual Review of Public Health, 19, 271-292. Between 1985 and 1992, serious youth violence in the United States surged to unprecedented levels. The growing use of firearms to settle disputes has contributed to this phenomenon. Youth are most often victimized by one of their peers. In response to this problem, a wide variety of programs have been implemented in an attempt to prevent youth violence or reduce its severity. Few have been adequately evaluated. In general, interventions applied between the prenatal period and age 6 appear to be more effective than interventions initiated in later childhood or adolescence. Community-based programs that target certain high-risk behaviors may be beneficial as well. A sustained commitment to evaluation research is needed to identify the most effective approaches to youth violence prevention.

KLIEWER, W., LEPORE, S.J., OSKIN, D., & JOHNSON, P.D. (1998). *The role of social and cognitive processes in children’s adjustment to community violence.* Journal of Consulting and Clinical Psychology, 66, 199-209. This study examined associations of community violence exposure and psychological well-being among 99 8-12-year-old children (M = 10.7 years) using home interviews with mothers and children. Both moderators and mediators of the links between violence exposure and well-being were tested. After demographics and concurrent life stressors were controlled for, violence exposure was significantly associated with intrusive thinking, anxiety, and depression. Regression analyses indicated that intrusive thinking partially mediated associations between violence exposure and internalizing symptoms. Planned comparisons revealed that violence exposure had the strongest effect on well-being among children with low social support or high levels of social strains. Furthermore, children with high levels of intrusive thinking were most likely to show heightened internalizing symptoms when they had inadequate social support.

LYNCH, M. & CICCHETTI, D. (1998). *An ecological-transactional analysis of children and contents: The longitudinal interplay among child maltreatment, community violence, and children’s symptomatology.* Development and Psychopathology, 10, 235-257. Ciccetti and Lynch have conceptualized ecological contexts as consisting of nested levels with varying degrees of proximity to the individual. These levels of the environment interact and transact with each other over time in shaping individual development and adaptation. With a sample of maltreated (n = 188) and nonmaltreated (n = 134) children between the ages of 7 and 12 years, this investigation employed a 1-year longitudinal design to conduct an ecological-transactional analysis of the mutual relationships among community violence, child maltreatment, and children’s functioning over time. Indicators of children’s functioning were externalizing and internalizing behavior problems and self-rated traumatic stress reactions, depressive symptomatology, and self-esteem. Either full or partial support was obtained for the study’s primary hypotheses. Rates of maltreatment, particularly physical abuse, were related to levels of child-reported violence in the community. In addition, child maltreatment and exposure to community violence were related to different aspects of children’s functioning. Specific effects were observed for neglect and sexual abuse and for witnessing and being victimized by violence in the community. Finally, there was evidence that children and their contexts mutually influence each other over time. Results were discussed within the framework of an ecological-transactional model of development.

quences of violence squarely on the public health agenda. The U.S. Government’s Year 2000 National Health Promotion and Disease Prevention Objectives includes a full chapter devoted to violence issues and delineates a number of goals and programs aimed at reducing the number of deaths and injuries associated with violence. Notably absent from these objectives, however, is attention to the possible adverse psychological consequences of exposure to acute or chronic violence. Nonetheless, in light of numerous media reports of children’s exposure to community violence and recent reports documenting high levels of exposure even among very young children, it is reasonable to question whether the risks of exposure extend beyond death and physical injury to psychological well-being.

MCLAIN, S.L., MORLAND, L.A., SHAPIRO, J.A., & FOY, D.W. (1998). Etiologic factors in posttraumatic stress disorder in children: Comparing child abuse to other trauma types. *Family Violence and Sexual Assault Bulletin, 14* (1-2), 27-30. Research on the incidence of childhood trauma and its psychological consequences has grown rapidly in the last 10 years. To help professionals stay abreast of key findings from these studies, we present results from a comprehensive review of 55 articles on (community violence-N-8) on the etiology of child and adolescent PTSD. 85 percent of those 31 studies that examined linkages between trauma exposure severity and PTSD symptomatology demonstrated significant relationships. Prior trauma exposure was also consistently associated with increased PTSD symptomatology. This pattern of findings is highly consistent with 2 decades of research in other trauma-exposed populations (e.g., combat veterans), where robust dose-response associations between trauma severity and PTSD symptomatology have been established. Findings regarding the role of demographic variables as possible moderators of exposure-distress relationships were more equivocal. Age, gender, and ethnicity were significantly related to PTSD in some studies, but more studies are needed before definitive patterns are discernible.

OSOFSKY, J.D. (1995). The effects of exposure to violence on young children. *American Psychologist, 50,* 782-788. Violence has been characterized as a “public health epidemic” in the United States. At the same time, children’s witnessing of violence is frequently overlooked by law enforcement officers, families, and others at the time of a violent incident. Although mothers describe the panic and fear in their children and themselves when violence occurs, little research or clinical attention has focused on the potential impact on children of living under conditions of chronic community violence. The purpose of this article is to present an overview of available research and clinical understanding of the effects of exposure to violence on school-age and younger children. Suggestions for future research and public policy initiatives are offered.

OSOFSKY, J.D. (1997). Commentary: community-based approaches to violence prevention. *Developmental and Behavioral Pediatrics, 18,* 405-407. Briefly describes the Violence Intervention Project for Children and Families, which was developed in New Orleans in 1993 to address youth violence. The project combines early intervention, counseling, and treatment, as well as a communication hotline and the education of people officers to enhance their skills in dealing with violent incidents.

**ADDITIONAL CITATIONS**

Annotated by the Editors


DURANT, R.H., GETTS, A., CADENHEAD, C., EMANS, S.J., & WOODS, E.R. (1995). Exposure to violence and victimization and depression, hopelessness, and purpose in life among adolescents living in and around public housing. *Journal of Developmental and Behavioral Pediatrics, 16,* 233-237. Administered a questionnaire to 225 black adolescents (44% male) to study violence exposure, family factors, and psychological outcomes. Corporal punishment was significantly associated with depression, hopelessness, and lack of purpose in life even when a number of other factors were accounted for in multiple regression.

FREEMAN, L.N., MOKROS, H., & POZNANSKI, E.O. (1993). Violent events reported by normal urban school-aged children: characteristics and depression correlates. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 419-423. Studied 223 inner-city children who ranged in age from 6-12 years. Just over one-quarter of the sample had experienced violence. These children were at increased risk of depressive symptoms, low self-esteem, weeping, and worries about death or injury. The authors suggest that history of violence exposure be included in psychiatric assessment of inner-city youth.


violence in adolescents. Exploratory and confirmatory factor analysis identified 3 factors: traumatic violence, indirect violence, and physical/verbal abuse. Data are presented to demonstrate the validity of the measure.


Assessed relationships among coping strategies, exposure to community violence, and interpersonal victimization in 136 African-American mothers. Use of coping strategies varied as a function of amount of violence within a social context and of socioeconomic factors. Coping strategies also differed based on violence exposure.


Describes several large studies conducted by the authors to study the effects of direct and indirect exposure to urban violence on children. After reviewing their findings, the authors raise ethical questions in the conduct of research on urban violence and pose questions for future investigation.


Reviews theory and data regarding the effects of violence on children. Early intervention strategies and treatment approaches are discussed in terms of posttraumatic stress, grief, worry, and prior trauma. Interventions are discussed at the level of the child, the family, the classroom, and the group.


Highlights general population studies of crime-related PTSD that provide descriptive characteristics of crime events and information relevant to the study of PTSD etiology. Includes abstracts of selected articles and additional citations with annotations.


Surveyed 246 predominantly black, inner-city youth, age 14-23, regarding exposure to and participation in violence. Based on psychological interview, 14% were judged to be at high risk for involvement in violent acts. Predictors of being in this high risk category were low socioeconomic status and childhood physical abuse, but not witnessing violence.


Recruited 115 mothers with children 1-5 years of age from a pediatric primary care clinic in a large urban metropolitan area. According to the mothers’ reports, 10% of the children had witnessed a killing or shooting, and 47% had heard gunshots. Mothers of children who had witnessed violence were more likely than mothers whose children had not witnessed violence to worry about safety and limit their movements in their neighborhoods.


Reviews the epidemiological and clinical data on exposure to violence among children. Parenting issues are discussed, and a research agenda for the area is presented. The author also includes policy recommendations for parents and communities.

**PILOTS UPDATE**

(Continued from Page 8)

tment of Japanese Americans and the response of German psychiatrists to war neuroses after the First World War; analyses of writing about PTSD in novels and autobiographies; and psychometric studies of the Personality Assessment Inventory, Everstine Trauma Response Index, and several other instruments. These are all subjects poorly represented in the existing corpus of journal articles and book chapters indexed in the PILOTS database.

While it is true that the most significant findings of the best dissertations and theses will probably find their way into peer-reviewed journal articles, this may take several years to happen. And there are many studies whose results are never published elsewhere, but which may still contain precisely the information needed to help solve a research or clinical problem. We believe that theses and dissertations represent a potentially valuable part of the traumatic stress literature, and we hope that the inclusion of this material in the PILOTS database will increase its availability to scholars, students, and practitioners.

Theses and dissertations make up one category of what information scientists call “grey literature.” This term is used to describe “literature which is not readily available through normal book selling channels, and therefore difficult to identify and obtain.” Since this definition was first written, nearly twenty years ago, there has been much progress in making grey literature bibliographically accessible. There are databases that index technical reports in many disciplines and the government publications of many nations. Bibliographic coverage of conference proceedings and unpublished translations has also improved.

The PILOTS database was established to provide a single access point to an international interdisciplinary literature. We intend to expand its coverage to provide users with the same ability to identify relevant materials in the grey literature that we provide for more conventional publications. We welcome suggestions from the traumatic stress community as to which classes of grey-literature materials should receive our highest priority.
THE MATSUNAGA VIETNAM VETERANS PROJECT

Matthew J. Friedman, MD, PhD

The Matsunaga Vietnam Veterans Project (MVVP) was mandated by Public Law 101-507, which directed the National Center for PTSD to conduct an epidemiologic study among American Indian and Asian-Pacific Islander Vietnam veterans because they had not been sampled in the National Vietnam Veterans Readjustment Study (NVVRS). NVVRS had focused on White, Black, and Hispanic Vietnam veterans but not on other minority veteran samples. Because the legislation stipulated that MVVP should be an “NVVRS-like” study, the MVVP focused primarily on findings pertinent to the most important results in the NVVRS Final Report. These included prevalence of PTSD, comorbid psychiatric diagnoses, readjustment problems, physical health problems, and clinical utilization.

MVVP had two components. The American Indian Vietnam Veterans Project (AIVVP) was conducted by the National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, Denver, CO. It surveyed Southwest (SW) and Northern Plains (NP) American Indian veterans living on or near their respective reservations. The Hawaii Vietnam Veterans Project (HVVVP) surveyed Native Hawaiian (NH) and Americans of Japanese Ancestry (AJA) veterans living in Hawaii. It was conducted by VA’s Northwest Center for Cooperative Studies in Health Service in Seattle, WA. I was responsible for overall supervision of the entire project and chaired the MVVP Executive Committee, which included Drs. Marie Ashcraft, Janette Beals, Terence Keane, Spero Manson, and Anthony Marsella.

Current PTSD prevalence was highest among American Indian (NP, 31.0% and SW, 26.8%) and lowest for AJA (2.9%) veterans. Current PTSD prevalence for NH veterans (12.0%) was in between and not significantly different from current prevalence for Hispanic (27.0%), Black (20.6%), or White (13.7%) veterans.

Within MVVP and NVVRS cohorts, between one-third and two-thirds of all veterans who ever suffered from PTSD still met full DSM-III-R diagnostic criteria at the time of the survey. Lifetime PTSD prevalence was highest among all minority veteran samples except for AJA veterans: NP (57.2%), SW (45.3%), NH (38.1%), Black (35.4%), and Hispanic (33.7%). There were no significant differences among these groups. The lowest lifetime prevalence for PTSD was found among White (19.9%) and AJA (8.7%) veterans; the difference between these two samples was not statistically significant.

War-zone exposure was the best predictor of PTSD prevalence, explaining between 26% and 39% of the variance. This is an unusually powerful finding in social science research. Risk factors that affected one’s likelihood of developing war-zone-related PTSD were: a family history of substance abuse, physical abuse as a child, a negative relationship with one’s parents, deviant behavior as a child, lower educational attainment, non-officer status in Vietnam, and service in I-Corps (where the heaviest fighting took place) during the war.

Most results in this report are presented in two ways, as unadjusted and adjusted findings. Many significant differences between groups obtained from analyses of the raw data appeared to be due to PTSD symptoms and war-zone exposure after the data were adjusted. For example, SW, NP, and NH cohorts reported greater distress than did AJA or NVVRS cohorts. The high unadjusted prevalence of alcohol abuse/dependence among American Indian veterans appeared to be explained by comorbidity with PTSD symptoms. In contrast, the adjusted prevalence data for comorbid disorders indicate that both the NH and AJA samples were more likely than the American Indian samples to meet diagnostic criteria for at least one psychiatric disorder that was not positively associated with PTSD or war-zone exposure.

Postwar readjustment problems tended to be highest among both American Indian cohorts, followed by Black and Hispanic cohorts. AJA and White veterans reported the lowest levels, and NH veterans were in between. Such problems included educational attainment, vocational status, drug and alcohol use, legal difficulties, family problems, social isolation, and a history of homelessness or vagrancy. Following adjustment of the data, most ethnic differences appeared to be due to PTSD symptoms and war-zone exposure. American Indian veterans reported the poorest perceived health status and the greatest number of chronic health problems. Some, but not all, of these differences disappeared after data adjustment for PTSD symptoms and war-zone exposure.

American Indian veterans reported the highest amount of clinical service utilization while AJA veterans reported the lowest. Treatment-seeking behavior was predicted by perceived health status and by the number of chronic health problems reported by all ethnic groups except for AJA veterans. AJA veterans appeared to utilize fewer clinical services than would have been predicted by reported symptomology. With few exceptions, PTSD symptoms were highly correlated with clinical utilization by all ethnic groups. This was true for all VA utilization (medical, psychiatric, inpatient, outpatient, and Vet Center). It was also true for non-VA mental but not physical health-care utilization. Over half of SW American Indian veterans had participated in culture-specific traditional healing ceremonies for physical and mental health problems, followed by NP (13-16%), NH (7%), and AJA (1-5%) veterans. Furthermore, two-thirds of all American Indian veterans who had ever made use of such services had done so during the previous six months.

We believe that MVVP represents a major step forward in psychiatric epidemiologic research among minority veterans (and non-veterans). We hope that these results will be deemed useful by the United States Congress and by the VA. We also hope that MVVP findings will result in improved sensitivity towards and treatment for all veterans suffering from war-zone-related PTSD.
PILOTS UPDATE

With the Fall update we added citations and abstracts for 266 recent English-language doctoral dissertations and master’s theses to the PILOTS database. We hope in the near future to add several hundred earlier dissertations and theses, and to add new ones on a regular basis. (We would also like to include foreign-language academic publications to the database, though this is unlikely to happen in the immediate future.)

Over one million doctoral dissertations have been accepted by North American universities since 1861. While there already exists an apparatus for searching this literature, only one in a thousand of these documents deals with PTSD or some other topic related to traumatic stress studies. By including references to relevant dissertations and theses in the PILOTS database, we hope to make it easier for researchers and clinicians to find those that might contain information useful to their work.

Most modern American and Canadian dissertations, as well as an increasing number from other countries, are listed in bibliographies compiled by UMI (formerly University Microfilms International) of Ann Arbor, Michigan. Because UMI serves as a clearinghouse for the distribution of most of these publications, PILOTS database entries for dissertations and theses include the UMI order number in the “Availability” field (visible in “long format” displays). In addition to UMI’s database, we are searching other bibliographies to identify dissertations that we might otherwise miss.

While many researchers are skeptical about the value of dissertations and theses, it is worth noting that these documents often provide the only detailed information on a particular subject. The requirement that a doctoral dissertation present original research means that candidates are careful to select topics that are not fully covered in the published literature. Whatever methodological shortcomings there might be to dissertation research, it often anticipates by several years the availability of more authoritative studies.

Dissertations and theses may be of special interest to clinicians or researchers interested in a particular population. Among the narrow groups studied in the dissertations just added to the PILOTS database are athletic trainers, North Dakota peace officers, wives of fire fighters, and sexual assault nurse examiners. The treatment of Haitian immigrants, Cuban rafter refugee children, and Latvian expatriates are among the topics covered. There are also historical studies of the consequences of the wartime (Continues on Page 6)