Chapter 15

MILITARY PSYCHIATRY AND REFUGEES

FRANKLIN D. JONES, M.D., F.A.P.A.,* PINCHAS HARRIS, M.D.,† MANUEL FEBO, M.D.,‡ AND PEDRO J. CRUZ, M.D.§

*Colonel (ret), Medical Corps, U.S. Army; Clinical Professor, Uniformed Services University of the Health Sciences; Past President and Secretary and Current Honorary President of the Military Section, World Psychiatric Association
†Director of Rehabilitation Services, Herzliya Medical Center—Haifa, Israel; formerly Medical Officer, Israeli Defence Forces
‡Colonel (ret), Medical Corps, U.S. Army; formerly Psychiatry Consultant to The Surgeon General, U.S. Army; formerly Chief, Inpatient Psychiatry, Walter Reed Army Medical Center, Washington, D.C.
§Chief, Department of Psychiatry, Caguas Regional Hospital, Caguas, Puerto Rico

INTRODUCTION

The 20th century may be described as the century of the uprooted or homeless man.[1] Since the beginning of the century and especially since World War II, there have been millions of displaced persons in various parts of the world at the same time. As of April 1991, there were nearly 15 million refugees worldwide, mostly women and children. More than 2 million are "boat people" escaped from repressive regimes or civil war in Southeast Asia, and 1.6 million of these were resettled in 30 countries since 1975.[2] The 1991 to 1992 dissolution of Yugoslavia and ethnic fighting have added several more millions to these figures.[3,4] The recent tribal fighting in Rwanda has added over 200,000 refugees fleeing to neighboring countries.[5]

Much has been written in the scientific literature[1] on the various aspects of the refugee problem, but relatively little has appeared in the psychiatric literature until recently. Psychiatrists have usually been interested in psychiatric morbidity of the resettled refugees, while only a few papers have been devoted to psychiatric phenomena encountered in the initial stages of refugee resettlement.[6]

An area of particular interest for psychiatrists is treating the post-traumatic stress disorders that refugees may suffer as a result of exposure to mass violence and torture. A few studies[7,8,9] have indicated that psychiatric interventions may be helpful in reducing depression and anxiety symptoms in these refugee populations.

The military is called to assist when the influx of refugees is so great that civilian organizations have difficulties in coping with all of the initial problems.[10,11] Such a state has developed numerous times in the United States. In 1975, the large number of Vietnam refugees who arrived in California were assisted by the navy.[12] In 1979 and 1980, the influx of Cubans who arrived in Florida required the army to assist in various aspects.[13] In 1992 and 1993, an influx of Haitian refugees was threatened and only aborted by a navy blockade of Haiti.[14] Naval action was also required to stem an influx of refugees from China.[15] Most of these recent refugees are seeking to better their economic situation, a chronic cause of illegal aliens from Latin America and developing nations.[16]

Another such situation requiring military assistance occurred in the summer of 1992 when Hurricane Andrew devastated areas of southern Florida and Louisiana, the costliest natural disaster in U.S. history up to that time. The military was required to maintain order and set up refugee camps.[17] Finally, large-scale flooding in the midwest United States resulted in massive numbers of refugees in 1993.[18]

Under current policy and law, military assistance is only temporary and only in the initial stages until civilian organizations can take over completely. We shall describe, therefore, psychiatric and psychological phenomena that can be seen in the early stages of resettlement, after first defining different categories of displaced persons.

TYPES OF DISPLACEMENT

Refugees

The most common type of displacement of modern times is the refugee. In this situation, the individual is forced to leave his previous home and does not expect to be able to return home in the future. Refugee situations occur as a result of war (for example, Afghanistan, Iran, Iraq, Yugoslavia, and Central America) or as a result of political changes that force specific communities and racial, ethnic, religious, or political groups to leave their homes and countries (for example, Vietnam, Cambodia, Laos, Haiti, Bulgaria, and Rwanda). It is refugees that we discuss in detail later. Refugee status may also be transient as occurred with Hurricane Andrew and the 1993 Midwest flooding in the United States. In this chapter, we will use the term *refugee* to refer to someone who has left his country of origin, unless otherwise stated.

Migrants

A migrant is someone who voluntarily decides to leave his homeland, looking for a new life in a new country. The individual in this situation has the possibility of returning to his previous country so that there need not be a total discontinuation with the past. Even though this is a self-initiated process

controlled by international agreements, the receiving country can be faced by large numbers of immigrants. This situation rarely needs assistance from military sources because the influx is regulated and the immigrant is required to have a sponsor.

Voluntary Exiles

Voluntary exiles are people who, by voluntarily leaving their homeland, know that they cannot return, that is, unless there is a radical political change in their country of origin. This type of displacement is encountered when people leave totalitarian regimes of their own accord. This group is the smallest of all types of displacement and rarely causes strain on immigration authorities of the accepting countries although there are some instances of mass voluntary departure of individuals from their homeland. The influx of Cubans to the United States in 1979 and 1980[19] and the Jewish flight from the former Soviet Union[20] can be seen as examples. In addition, the 1992 flight of ethnic groups from Yugoslavia sparked riots in Germany where they were viewed as competitors for scarce jobs and welfare resources.[21] Some phenomena in the various stages of resettlement are common to all types, the main sufferer being the refugee who had no control over his flight.

SOCIAL IMPLICATIONS

Three social conditions are common to almost all refugees: statelessness, homelessness, and powerlessness.

By being forced to leave his country, either by reason of war or politics, a refugee becomes stateless. He loses his status of citizenship and thus loses the rights and the protection each citizen receives from his country. Being evicted from his home, a refugee becomes homeless. He loses his economic stability, gives up previous personal and cultural ties, and becomes a stranger in a new society.

A refugee is generally a person who has no home, who has no power or control over his flight or fate, and who is in the hands of others for survival and later resettlement. When the individual overcomes these obstacles, he ceases to be a refugee.

PSYCHOLOGICAL IMPLICATIONS

The clinical picture encountered among refugees is extremely varied both in individual responses and in changes within the individual over time. To understand these phenomena, we suggest the following phases of responses be considered in what shall be called the refugee syndrome. Our suggestion is based in part on what Tyhurst[22] calls the social displacement syndrome. The phases are initial phase, phase of preentry, phase of entry, period of psychological arrival, and period of resettlement.

Initial Phase

The initial phase is the period in which the individual becomes a refugee. He has been evicted from his home and surroundings. The refugee in this stage usually has terrifying or threatening experiences caused by war, disaster situations, or captivity and jailing because of political reasons. This period is characterized by various degrees of physical discomfort such as hunger, physical illness or injury, torture, and so forth.

The initial phase terminates when the individual has successfully managed to arrive in a new surrounding that does not impose any specific danger to him. The suffering in this phase can definitely impair the resettlement of the refugee.

The psychological phenomenon seen in this stage can be defined as "survival." The individual wants to live, and he does everything in his power, consciously and unconsciously, to remain alive.

Phase of Preentry

In the phase of preentry, the refugee has arrived at a safe place, but as yet he does not know where he is going to settle or which country is going to allow him to enter. This phase is mainly seen when there is a mass influx of refugees to a country that cannot or that is unwilling to resettle all of the refugees. The period can last for years, with the refugee being in an internment camp without being able to begin the process of resettlement.

This period can also be a period of selection, when one country agrees to accept a certain number

of refugees for resettlement. The obvious choice for selection are the young, the healthy, the skilled, and the more educated, while the others await some other solution.

Psychological phenomena encountered in this period are comparable with those experienced during phases of disaster, namely the recoil period.[10] Responses consist of three main behavior patterns: (1) effectiveness, (2) dependency, and (3) noneffectiveness. Generally, preexisting personality type and occupational role determine which behavior pattern a refugee will exhibit. Firefighters, police, and medical workers, for example, tend to be effective. Dependent and histrionic personalities tend to be noneffective.

The clinical picture here is complicated by the unknown future, the feeling of insecurity, and sometimes the fear of being repatriated to the country of origin. Group cohesion is of great value in this stage in combatting these fears. Individuals tend to coalesce into groups according to cultural background, with the emergence of leaders as in times of disaster. Mental health intervention at this stage is similar to that for combat stress casualties—restoration of physiological deficits and restoration of morale.[23]

Phase of Entry

The phase of entry is the initial period when the refugee arrives in the country in which he is to resettle. The harrowing experiences of the past are behind him, and theoretically, at least, the refugee can begin rebuilding his life. Strangely, the refugee shows more concern over the immediate past than the present or future during this period. His interest in the present is directed mainly toward fulfillment of basic physiological needs such as food, sleep, shelter, and so forth. Concern about the future seems lulled.[24]

Psychological characteristics common to this phase are usually a sense of well-being, in some euphoria; increased psychomotor activity, usually nonconstructive; dependency, more so than in the previous stage of preentry; and finally feelings of unreality and confusion, described by some refugees as being "as if it were a dream."[10] The first two characteristics apply usually to those who were previously effective, while the fourth characteristic is often found in those who were noneffective. The third characteristic of increased dependency usually occurs in those who had been dependent during preentry. This initial period can last for 2 months after entry, and it is during this phase that we see the influence of the group and leadership diminishing.[10]

Period of Psychological Arrival

The period of psychological arrival is the time when the refugee awakens from his "daze" and begins to realize the difficulties of building a new life. The period can last up to 1 year after arrival in the new country; it is an extremely trying period for both the refugee and for the authorities assisting in resettlement.[10]

It is difficult to categorize the quite varied psychological phenomena of this phase, but the more common characteristics are feelings of insecurity, isolation, resentment, unhappiness, guilt, inadequacy, and so forth. We believe it is more appropriate to define the psychological reactions in terms of the clinical entities most commonly encountered:[1,24,25]

- Somatic ailments. Refugees frequently complain of various physical discomforts. Their complaints are usually of pain, with a tendency to shift complaints from one system to another.
- Anxiety and depression. Anxiety is more common among the younger refugees, while depression is found more often among the older ones.
- Paranoid reactions. Paranoid trends and varying degrees of suspiciousness are quite common among refugees. True paranoid psychoses, however, usually appear at a later stage.

During this period, the individual has to make significant readjustments in major ways of life; to learn a new language, new culture, and new professional skills; to adapt to a new social and economic status; and so on. It is the individual's personal attempt to build a new life. There is very little group reinforcement at this time, and it is quite common to see severe strains in previous interpersonal relationships.[1,24,25]

Period of Resettlement

In the period of resettlement, by definition, the individual has ceased to be a refugee; he has attained residency or citizenship, a home, and power. This period lasts for the rest of the refugee's life, and although resettlement can be complete, most refu-

gees suffer to some extent from events of their past.[24–27]

Psychiatric literature[24–27] reveals much interest in this stage, with a number of studies showing higher psychiatric morbidity among resettled refugees than that found in the equivalent population in the same area and, in some cases, compared with psychiatric morbidity of the country of origin of the refugee. Depression and post-traumatic stress disorders are common, especially if torture occurred.[22] Apparently, an individual cannot sever his original ties to his homeland; longing for his past home or nostalgia remains with the refugee for the rest of his life.

MILITARY ASSISTANCE: THE CUBAN MARIEL BOAT PEOPLE

In the spring of 1980, Fidel Castro allowed the emigration of approximately 125,000 Cubans. Unlike the 1 million earlier Cuban refugees who had been predominantly from middle-class backgrounds, these refugees were mainly from lower social economic classes and included many elderly, many mentally ill, and some criminals. Most of the emigres were housed in four military camps with miliary and civilian assistance including military psychiatric personnel. In the ensuing months, problems of chronic mental illness, rioting, and stress-induced emotional problems as well as general medical problems were managed. Lessons learned included the need for a clear authority structure with security measures; the need for segregation by culture, class, and family; and the need for personnel familiar with the culture. The growing number of Hispanic refugees due to the conflicts in Central America makes the most important lesson, the need for preplanning, vital.[19]

Burkle stated that one of the unfortunate "phenomena of the 70's is the instant refugee camp."[28(p800)] The "Freedom Flotilla" in May 1980 introduced the same phenomena in the 1980s, with the migration of approximately 125,000 Cuban people to the United States and the establishment of four refugee camps in Florida, Arkansas, Pennsylvania, and Wisconsin. We will describe the psychosocial aspects of one of these camps, Fort Chaffee, Arkansas, and although it is not representative of all the camps, it describes some elements common to them. This information is derived from the assignment of one of the authors (Pedro Cruz) as psychiatrist for the refugee camp at Fort Chaffee. It is based on his observations and clinical experiences while he was there.

Psychological Phases

Prerefugee Camp

As retold by many of the Cuban refugees, life under the Communist regime of Castro brought many dramatic changes to the Cuban people. Castro's announcement of his embracing Communist doctrine led to the realization of a new form of government resulting in a wave of migration that started in the 1960s and continues sporadically more than 30 years later. The motivating factor was primarily political, and the Cuban society was depleted of its upper class, middle class professional, semiprofessional, managerial, and business elements. Those who remained were the uneducated, unskilled, and lower socioeconomic strata.[19]

The new government provided a political structure that demanded unquestioning loyalty to the state and the sacrifice of traditional institutions and values (the family, friendship, religion, ownership of land and businesses, and military structures). The extended family, one of the strongholds of Cuban society, was torn apart, and a new entity was born—the nuclear family—committed to survival and void of strong family ties with an increasing sense of isolation because neighbors and family were encouraged to report on one another for possible disloyal activities. With promises that the government would provide everything and the barren reality of the situation, covert black-market activities flourished, bringing new dangers to individuals and their families as well as adding to the existing feelings of isolation.[19]

Refugee Camp

As increasing numbers of refugees overwhelmed resources in southern Florida, the U.S. government set up four refugee camps, including the one at Fort Chaffee, Arkansas. Refugee camps were not a new experience to the nearby Arkansas community. During the mid-1970s, it was the temporary home for thousands of Vietnamese refugees and provided a good source of income to an economically depressed area. The local population had viewed its past experience as a positive one and viewed the advent of the new camp primarily as an economic

blessing. As the news coverage revealed that these Cubans were different from the Vietnamese in every aspect and that Castro had emptied Cuban jails and mental hospitals, the economic dream threatened to become a horrifying nightmare. Rumors of rape, murder, and pillage were born in the local populace, fed by the national press, confirmed by a few isolated incidents, and probably immortalized in the mind of the American public.[29]

Refugee camps were also not new to many of the personnel of the federal and volunteer agencies involved in the management and administration of the resettlement camp. Like the local populace, many had been involved with the Vietnamese refugees and many remembered the experience as a positive one. Like the local populace, many did not know that Asians and Hispanics could be diametrically opposite in cultural, psychological, and behavioral aspects.

Plans had been made by personnel lacking knowledge of these differences to operationally set up the camp as it had been set up for the Vietnamese. Planners believed that any Hispanic or Spanish surnamed individual would be competent to deal with the cultural issues of this group of refugees, as was the view of the local populace. This did not account for whether the Hispanic was from the Caribbean, Central America, or South America or whether the Hispanic was a first, second, or third generation Hispanic-American. This apparent lack of a clearly organized and centralized authority structure in the initial phase of establishing the camp contributed to the confusion inherent to a chaotic and stressful event.

Entry Phase at Fort Chaffee

During the month of May 1980, approximately 19,000 Cuban refugees were flown to Fort Chaffee from Florida. It is located in the western part of Arkansas. The entry process to the United States consists of a medical evaluation, issuance of a temporary identification card and number, a series of interviews by federal agencies that can lead to a Washington clearance for entry, and issuance of an immigration card and work permit. Release into the general population takes place once a sponsor for the refugee has been found.

The refugees were housed in World War II barracks by random assignments of both families and unaccompanied individuals to the same buildings—a practice utilized during the Vietnamese operation. Meals were served in military dining facilities, and clothing was provided by relief agencies. The medical services were primarily of two types: (1) various triage and treatment facilities through the compound for providing initial screening and referral to (2) central emergency service for triaging and provision of both inpatient and outpatient medical care set up in tents by the field hospital.

As refugees and camp personnel increased their daily contacts and interactions, there emerged a series of psychosocial phenomena that can be divided into three phases. The initial phase—entry phase—lasted about 2 weeks and was characterized by a period of euphoria shared by both the refugees and camp personnel. On the part of the Marielitos (a term for refugees from Cuba derived from their departure port, El Mariel), it was based on having the perilous boat trip over and reaching the land that promised freedom and a better life; on the part of the camp staff, it was based on feelings of satisfaction from helping people. Accompanying this euphoria was a hyperactivity throughout camp as people celebrated their good fortune and searched for families and friends. Confusion for the camp staff was also a hallmark of this period because the central authority was not able to provide the daily decisions on issues concerning the increasing influx of refugees, the lack of adherence to procedural guidelines by agencies, and refugees switching assigned quarters without informing the authorities. The psychiatric casualties were few and consisted mainly of adjustment reactions to the relocation because some people were separated from their families or feared being sent to places other than Florida.

A second phase—the reactive phase—was of 1 month's duration and was characterized by fear, insecurities, and regression to behavioral patterns that were more characteristic of their homeland. With the surfacing of the criminal element, violent behavior, black-market activities, gang formation, and the manufacturing of homemade weapons occurred. As the families who shared the buildings were beginning to be threatened and victimized, they reacted in a similar fashion of manufacturing weapons and forming groups for individual and family protection. The confusion for the camp staff further increased as this unexpected group emerged and there was no provision of personnel or security measures.

As the news of the prisoner element hit the local news, there were local demonstrations against the refugees that created a panic reaction in the refugees and resulted in the riot of 1 June 1980. The

army's response was to bring in 1,500 troops to control the riot and maintain a sense of order. Under a new administration, steps were taken to segregate the unaccompanied refugees (those not traveling with family) in their own barracks.

Psychiatric casualties were surfacing in large numbers during this period primarily as adjustment reactions due to the stress of camp. In addition, the chronic psychiatrically ill began to surface because they were beginning to run out of medication or the levels of the medication in their systems were diminishing. Another behavior peculiar to this phase was the hoarding of food (perhaps a carryover from their homeland experience) although it was obvious that there was enough food for everyone. An epidemic of food poisoning ensued because of spoiled hoarded food, and a special ward was opened to treat the many dehydrated patients.

The third phase—the depressive phase—that lasted the remaining time of the camp was characterized by resignation, depression, a feeling of hopelessness, and acting out behavior. During this phase, the camp staff had organized themselves under a clear line of authority with role definition among the existing agencies, and the issue of personal safety for everyone was resolved. Many of the refugees were leaving, and those left behind were becoming irritable, depressed, and angry at the lengthy process of leaving camp. Some wished to return to Cuba and referred to the Americans as no better than Castro's police force. Others resigned themselves to the situation and waited for the resolution of their problems. Psychiatric casualties were more on the depressive spectrum with suicidal ideation or gestures. A pattern of self-mutilation surfaced as the remaining population dwindled to unaccompanied males, many of whom had been released directly from jail to El Mariel. The depressive illnesses were directly related to the waiting time in camp and a feeling that the promised land was not what they had been led to believe.

Patient Data Profile

The psychiatric team providing services consisted of a psychiatrist, a psychiatric nurse, and two behavioral science specialists—all military personnel. Around-the-clock emergency services, coordination of transfers to community facilities, outpatient follow-up, and later an inpatient service were provided by the team. A total of 465 people were referred from mid-May to mid-August, with a total of 993 patient contacts. Of the 465 referrals, 41 (9%) patients required hospitalization in the camp inpatient facility or the community facility for the more severe cases. A review of 200 of the outpatient records revealed that the majority of the patients (93%) were referred from medical sources because of "nervousness" or "depression." These patients also had a previous psychiatric history (78.0%), and a substantial percentage (20.0%) had a previous history of incarceration. Evaluation revealed that these patients were undergoing an adjustment disorder, and they received outpatient treatment with medication. These data are presented in Tables 15–1 and 15–2.

The population evaluated can be subdivided into three subgroups: (1) those with prior psychiatric histories but no prison experience (120 cases); (2) those with histories of imprisonment (40 cases), and (3) those who had no histories of either (40 cases). All of the three groups were predominantly

TABLE 15–1

PSYCHIATRIC PATIENT PROFILE (N=200)
DEMOGRAPHICS

	Category	No.	(%)
Age (yr)			
	0–17	15	(7.5)
	18–25	73	(36.5)
	26–35	71	(35.5}
	36–45	28	(14.0)
	46–55	11	(5.5)
	56–65	2	(1.0)
Sex			
	Male	150	(75.0)
	Female	50	(25.0)
Marital Status			
	Single	50	(25.0)
	Married	29	(14.5)
	Unknown	121	(60.5)
Legal Status (history of incarceration)			
	Present	40	(20.0)
	Absent	53	(26.5)
	Unknown	107	(53.5)
Referral Source			
	Medical	186	(93.0)
	Agencies	14	(7.0)

in the age range of 18 to 36 years, were predominantly males, and were medically referred. In the psychiatric group, the disorders were primarily chronic in nature with psychotic disorders (28.3%) being the most common, followed by affective disorders (26.6%), anxiety disorders (15.8%), and disorders of impulse (15.0%). In the prison group, 77.5% of the patients had previous psychiatric histories, with disorders of impulse (37.5%) being the predominant entity, followed by psychotic disorders (25.0%), anxiety disorders (25.0%), and affective disorders (12.5%).

TABLE 15–2

PSYCHIATRIC PATIENT PROFILE (N=200)
PSYCHIATRIC ISSUES

Category	No.		(%)
Previous Psychiatric History			
Present	156		(78.0)
Inpatient	79	(39.5)	
Outpatient	77	(38.5)	
Medication History	139		(69.5)
Presenting Complaints			
Nervousness	49		(24.5)
Depression	34		(17.0)
Insomnia	24		(12.0)
Evaluation	23		(11.5)
Medication	17		(8.5)
Suicide gesture	11		(5.5)
Anxious and depressed	6		(3.0)
Self-mutilation	5		(2.5)
Suicidal ideation	4		(2.0)
Sexual dysfunction	4		(2.0)
Diagnosis (Axis I only)			
Adjustment disorder	79		(39.5)
Schizophrenic disorder	28		(14.0)
Affective disorder	24		(12.0)
No diagnosis	21		(10.5)
Impulse disorder	17		(8.5)
V codes	7		(3.5)
Deferred	6		(3.0)
Anxiety disorder	6		(3.0)
Somatoform disorder	6		(3.0)
Psychosis/other	3		(1.5)
Psychosexual disorder	3		(1.5)
Disposition			
Medications and outpatient	118		(59.0)
Hospitalization	29		(14.5)
No follow-up	26		(13.0)

The impulse disorders in both groups were characterized by episodic outbursts of anger, violence towards self and others, and an inability to remember these outbursts. Eleven of the prisoners (27.5%) reported their symptoms to have first manifested themselves while incarcerated. In addition, eight (20.0%) of these reported being in jail for political reasons. In the psychiatric group, 55.8% of the patients had been hospitalized at least once, while 30.0% of the prisoners had also received inpatient services; 44.2% and 60.0%, respectively, had received outpatient services. In the psychiatric and prison group, the primary reason for referral was nervousness, while the third group was referred for evaluation to rule out a psychiatric condition.

The incidence of suicide gestures was highest in the group that had negative histories for psychiatric problems or incarceration, 10.0% (4/40), followed by the prison group, 7.5% (3/40), and the psychiatric group, 3.3% (4/120). The prison group showed the highest incidence of self-mutilation, 7.5% (3/40), followed by the nonpsychiatric nonprison group, 2.5% (1/40), and the psychiatric group, 0.8% (1/120).

In all three groups, the most frequently diagnosed condition was an adjustment disorder. Surprisingly, the nonpsychiatric nonprison group showed the highest number of hospitalizations, 25.0% (10/40), followed by 13.3% (16/120) in the psychiatric group and 7.5% (3/40) in the prison group. The relatively low hospitalization rate compared with the nonpsychiatric nonprison group related to the fact that a large percentage of the psychiatric group were stabilized on psychotropic medications; the nonpsychiatric nonprison group included many adolescents, some of whom were hospitalized for their own protection (fear of rape or physical violence).

Discussion

Current literature on mass migratory events emphasizes a multidimensional approach when trying to study the psychosocial factors and psychiatric morbidity of immigrants.[10,11,19,22,24–28,30,31] The interplay of cultural, social, psychological make-up, the presence or absence of psychiatric illness, and the stressors of the migratory event all contribute to the manifestation of clinical psychiatric entities.

One of the striking phenomena encountered with the Cuban refugee group in Arkansas was, despite contrary rumors, the low psychiatric morbidity (2.9%) in a population that was thought to be high in the number of mentally ill individuals. Several

factors account for this figure: this population was confined in a similar situation before leaving Cuba, which served as a premigratory conditioning for the events to come, many of the refugee population came as intact families with built-in support systems, the expectation of being absorbed into well-established Cuban communities in this country, and the rapid release of the majority of the refugees into the general population.

The number of psychiatric cases identified were primarily the manifestations of disorders in predisposed individuals or exacerbation of established disorders where the stress of the migration and the conditions of the camp were the precipitating causes. The most common reasons for referral were "nervousness" and "depression," which were the presenting complaints in 44.5% of patients and similar to the findings of Nguyen[26,30] in his studies of the Southeast Asian population in Canada. Whereas Nguyen's group fell into the diagnostic categories of affective disorders (39.0%), psychotic disorders (20.0%), and anxiety disorders (18.0%), the Cuban group fell into diagnostic categories of adjustment disorders (39.5%), psychotic disorders (15.5%), and depressive disorders (12.0%). The difference was that the Cuban group was in its initial phase of arrival in the country, while the Asian group had resettled into the general population.[26]

The subgroup of patients with a history of incarceration is similar to the group described by Bach-Y-Rita[32,33] in the study of 62 prisoners with histories of habitual violence and self-mutilation and who were very impulsive and "would warrant the diagnosis of explosive personality or impulsive character disorder."[33(p1015)] Bach-Y-Rita also points out that neurological impairment was a contributing factor and has to be kept in mind when these patients are being evaluated.

Several authors[10,19,26] have described psychosocial phenomena associated with displacement of masses of people in terms of group dynamics. Nguyen[26] lists three stages in the adjustment of an Asian population in Canada. Harris et al[10] have coined the term *the refugee syndrome* and ascribe five phases in the adaptive process. Both reports describe euphoria, hyperactivity, anxiety, and depression as some of the psychological manifestations in the initial phase of resettlement. These manifestations were also evident in the Cuban experience and give support that the phenomena transcend the cultural boundaries of refugee groups. Unique to the Cuban group, however, was the hyperactivity accompanying the initial euphoria, which later on was transformed and associated with the threat of physical violence posed by the prison population, lack of organizational effectiveness, and the hostile reactions of the local populace. The hyperactivity culminated in the riot responsible for the provision of measures of safety and the segregation of unaccompanied refugees.

The Hispanic component of the camp personnel needs to be addressed in its role in the provision of medical and psychiatric services to the refugee population. Many of the personnel were of Mexican-American extraction and of second- or third-generation Hispanic-American families. For all practical purposes, these individuals were Americans with Spanish surnames and had lost the language, cultural, and other characteristics unique to the Latin-American people. Although the situation was of an acute nature and these differences generally did not matter, in the gathering of information for medical and psychiatric purposes, the language factor is definitely critical.

SUMMARY AND CONCLUSION

The acceptance of emigres has been an element in the history of the United States, and one can assume that it will also be part of the future. The Mariel Cuban experience was a recapitulation of events experienced by other refugee groups, and it reemphasized the importance of the multiplicity of factors contributing to the psychosocial profile of migrant groups. Cultural variables, provision of basic needs (especially individual safety), clear authority structure, segregation of refugees according to social parameters unique to the migrant group, and education of the general populace are critical in the preplanning phase of resettlement operations to reduce the psychiatric morbidity of these groups.

Understanding the various periods of the refugee syndrome is of utmost importance to the mental health worker who can be called to assist in such situations. Military assistance in these matters is an extraordinary basis; therefore, the advisory role of the mental health worker is to be emphasized more than the role of the therapist.

The possibility of military assistance in refugee situations is usually limited to three of the previously described phases. Military aid may definitely

be involved in the initial phase as it was for (1) the Shiite refugees in southern Iraq (where U.S. troops watched them being massacred by the Republican Guard, forbidden to intervene until they had run or crawled to U.S. checkpoints, at which point, U.S. personnel could begin giving emergency medical life support, food, and so on); (2) the Kurds in northern Iraq in Operation Provide Comfort; (3) disaster relief operations such as those in Nicaragua, Armenia, and so on after earthquakes while U.S. personnel helped to dig the survivors out of the rubble; and (4) United Nations observers and peacekeeping units in Bosnia, Croatia, Cambodia, and so on that the United States may join. In the initial phase, the mental health and combat stress control personnel must be sensitive to the psychological reactions and trauma of the victims as well as to their physiological needs. Intervention will be at a system level rather than one-on-one because of the pressure of workload. Cultural factors and differences must also be recognized and adjusted to. The principal mental health and combat stress control role in this phase will be to sustain and debrief the rescuers and caregivers so that the latter can continue to give psychologically sensitive care. Suggestions for psychiatric assistance are directed, therefore, to the periods of preentry, entry, and psychological arrival.

The principles of combat psychiatry that apply to most situations of acute and chronic stress need little modification in dealing with the refugee. Rapid interventions and simple, supportive treatments, such as providing shelter, nutrition, and rest, are critical. A positive expectancy of normal functioning and eventual social stability must be maintained. This can be assisted by activities such as learning the new native language and teaching cultural mores and job skills when time allows. The principle of centrality is embodied in a single authority with the power to enforce rules and ensure protection.

During the preentry period, the mental health worker should educate authorities and medical teams about the future difficulties ahead for the refugee. This period can also be utilized for the education of the refugee to assist him during following periods. It must be stressed that the period of preentry can be one of inactivity and boredom, possibly lasting for years. The longer this situation lasts, the more difficult it will be to readjust in the future. Accordingly, the mental health worker should emphasize the need for constructive activity among refugees. These activities may involve learning languages and skills.

The refugees who may need direct psychiatric treatment will be found in the ineffective group. It is advisable for these patients to be treated by the regular medical teams if they are available, with advice from the assisting mental health worker, and only in extreme cases should they be treated initially by the assisting mental health worker.

It is possible at entry time for the assisting mental health worker to gain an impression of well-being among refugees. This impression is accurate to some extent, but it is definitely temporary. Even though this period lasts only for about 2 months, it is our belief that the shorter the period, the easier it will be for the refugee to face the following period.

Decreasing morbidity during this period can be achieved by creating constructive activities such as learning a language or job skills. This may be a difficult task among refugees who have had lengthy periods of inactivity. Gradual exposure to the new surroundings is suggested to avoid the overwhelming effect of new impressions and experiences, a kind of sensory overload. It is important that the refugee's basic physiological needs be met to relieve him of this worry, which can be a convenient excuse for inactivity. Other ways to decrease morbidity include assuring the free flow of accurate news and information to the refugees and the suppression of rumors and fostering self-help programs to build and maintain hygiene and sanitary facilities, recreational and educational activities, and traditional and occupational skills. (Occupational therapists are members of the mental health team.) A knowledge of the cultures of the refugees is essential to providing accurate mental health consultation or direct intervention. Potential sources for this information are the civil affairs staff and especially the special operations and civil affairs units that are expert in this region of the world.

As stated above, this is the period when the influence of the group diminishes, a process that can be slowed if proper attention is given. The mental health worker must stress these points to the receiving authorities. He himself can assist only minimally in direct interventions, but he can explain the future outcome of mistreatment during this phase. The mental health worker's role as a therapist should be directed to treating the more confused refugees. Our suggestion is to give extremely brief psychotherapy and attempt to avoid drug therapy that can complicate the situation even more.

In the period of psychological arrival, the mental health worker's assistance as a therapist can be of

great importance; however, it is our strong belief that the mental health worker should mainly advise local medical teams in the treatment of the troubled refugee, and only in the more severe cases act as a therapist.

The following three points should be stressed to treating physicians:

1. They must become aware of psychological disturbances among patients, especially those who often present changing and unexplained physical symptoms.
2. They must give reassurance and reinforcement to those who appear anxious or depressed. Brief psychotherapy is of greater value than any type of medication.
3. Kindness and understanding must be shown to those who show signs of suspiciousness and paranoid trends. Overt sympathy is to be avoided because it tends to aggravate these feelings.

The influence of the group in this period is minimal, and the refugee's attempt at readjustment is as an individual. Simple and brief "group therapy" could be of aid in helping the refugee to understand his personal hardships and interpersonal difficulties. This method could also assist in the reformation of constructive grouping, which is of prime importance for individuals in extreme stress. The mental health worker's influence and assistance in this field could be his greatest contribution in helping refugees in this trying period.

We have described some of the psychological and social phenomena seen in the refugee syndrome. Our intention was to outline points of importance that can be of guidance to mental health professionals who might be called to assist in refugee situations. It is our belief that appropriate advice and help can lessen the suffering of the refugee in three of the periods of the syndrome and, by doing so, assist him in rebuilding a healthier and happier life.

REFERENCES

1. Rumbaut RG. Mental health and the refugee experience: A comparative study of Southeast Asian refugees. In: Owan TC, ed. *Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research.* Washington, DC: DHHS; 1985: 433–486. Publication No. (ADM) 85–1399.

2. Holman RL. Spain honors U.N. agency (United Nations High Commission for Refugees). *Wall Street Journal*. 29 April 1991: A10.

3. US Congress. Senate Committee on Armed Services. Current military operations: Hearings before the Committee on Armed Services, US Senate, 103rd Congress, 1st Session, 6 August, 4, 7, 12–13 October 1993. Washington, DC: GPO; 1994.

4. Gunby P. Changing of the medical guard in Croatia. *JAMA*. 1994;271(2):894.

5. Richburg KH. Instant city of misery in a lush land: Ruwandan refugees crowd into Tanzanian border camp. *Washington Post*. 4 May 1994: A1, A31.

6. Owan TC, ed. *Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research.* Washington, DC: DHHS; 1985. Publication No. (ADM) 85–1399.

7. Mollica RF, Wyshak G, Lavelle J, Tuong T, Tor S, Yang T. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. *Am J Psychiatry*. 1990;147(1):83–88.

8. Goldfield AE, Mollica RF, Pesavento BH, et al. The physical and psychological sequelae of torture: Symptomatology and diagnosis. *JAMA*. 1988;259:2725–2729.

9. Bosoglu M, Marks I. Torture: Research needed into how to help those who have been tortured. *Br Med J*. 1988;297:1423–1424.

10. Harris P, Jones FD, Fong Y. Applications of military psychiatry in civilian disturbances: Disasters, terrorism, hostage and refugee situations. In: Pichot P, Berner P, Wolf R, Thau K, eds. *Psychiatry: The State of the Art.* Vol 6. New York: Plenum; 1985: 465–470.

11. Jones FD. How to treat refugees' special problems. *Behav Today*. 1986;17(25):4–5.

12. Rahe RH, Genender E. Adaptation to and recovery from captivity stress. *Milit Med*. 1983;148(7):577–585.

13. Cruz P, Febo M, Jones FD. Cuban refugee camps: Psychological perspectives. 1986. Syllabus.

14. Pine A. US moves to stifle Haitian exodus. *Los Angeles Times*. 16 January 1993. Vol 112:A12.

15. Kamen A. US seizes illegal aliens from China. *Washington Post*. 5 September 1991. Vol 108:A5.

16. Fritz S, Mann J. House votes to suspend deporting illegal aliens of 3 nations. *Los Angeles Times*. 26 October 1989. Vol 108:A13.

17. Healy M, Stolberg S. Hurricane relief blows in winds of change for military. *Los Angeles Times*. 11 September 1992. Vol 111:A24.

18. Parrett C, Melcher NB, James RW. *Flood Discharges in the Upper Mississippi River Basin, 1993.* Washington, DC: GPO; 1993.

19. Rumbaut RD, Rumbaut RG. The family in exile: Cuban expatriates in the United States. *Am J Psychiatry*. 1976;133(4):395–399.

20. US Congress. Staff Report. *Soviet Jews Arriving in Israel: The Humanitarian Needs.* Washington, DC: GPO; 1992.

21. Vogel S. German anti-foreigner riots in 4th night. *Washington Post*. 26 August 1992. Vol 115:A7.

22. Tyhurst L. Displacement and migration: A study in social psychiatry. *Am J Psychiatry*. 1951;101:561–568.

23. Jones FD, Johnson AW. Medical and psychiatric treatment policy and practice in Vietnam. *J Soc Issues*. 1975;31(4):49–65.

24. Cohen JD. Psychological adaptation and dysfunction among refugees. *Int Migration Rev*. 1981;15(1):255–275.

25. Burwill PW. Immigration and mental disease. *Aust N Z J Psychiatry*. 1973;7:155–162.

26. Nguyen SD. The psycho-social adjustment and the mental health needs of Southeast Asian refugees. *Can J Psychiatric Nurs*. 1984;(April/May/June):6–8.

27. Valdes T, Baxter J. The social readjustment rating questionnaire: A study of Cuban exiles. *J Psychosom Res*. 1976;20:231–236.

28. Burkle FM. Coping with stress under conditions of disaster and refugee care. *Milit Med*. 1983;148(10):800–803.

29. *New York Times*. Cuba denies accord with US on criminals (says it did not agree to accept 1,500 Cuban prisoners from the US). *New York Times*. 10 October 1993. Vol 143:12(N), 24(L).

30. Nguyen SD. Mental health services for refugees and immigrants. *Psychiatr J Univ Ottawa.* 1984;9(2):85–91.

31. Pedersen S. Psychopathological reactions to extreme social displacement (refugee neurosis). *Psychoanal Rev*. 1949;33:344–354.

32. Bach-y-Rita G. Habitual violence and self-mutilation. *Am J Psychiatry*. 1974;131(9):1018–1020.

33. Bach-y-Rita G, Veno A. Habitual violence: A profile of 62 men. *Am J Psychiatry*. 1974;131(9):1015–1017.