# Chapter II

## REVIEW OF LITERATURE

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Adjustment Problem</td>
</tr>
<tr>
<td>2.2</td>
<td>Stress and Stressful Life Events</td>
</tr>
</tbody>
</table>
Chapter -II

REVIEW OF LITERATURE

Introduction:

The present review of literature will consider the conceptual phenomena as well as the variables under study assess empirical implications. Any research needs support, verification and clarification by having through critical evaluation of the literature available to the researcher to investigate the prescribed objectives of the study.

It has been a tradition to consult and review the earlier work on the related topics before analysing and investigating the problem on hand. The process of accumulation of scientific knowledge is slow, steady and gradual. One investigator builds on the work of the other and in turn, contributes his own share and which sometimes acts as a precursor to future researches. Some times the previous work throws a challenge or leads to disagreement on some derived theories. In some cases either an examination of specialized theory may leave many problem unresolved or may give rise to new applications, which may not be revolutionary in form but are meaningful from the point of view of gradual accumulation of scientific knowledge.

One of the simplest ways of economising effect in an inquiry is to review and build upon the work done by others investigations. A comprehensive review of literature is must in any research endeavour
and requires a thorough consideration and efforts on parts of investigator. The investigator made a survey of literature by reviewing pertinent research related to the area. An in-depth literature review facilitates in knowing trend of thought and researches already done in the specific area of interest and in streamlining the present plan of work. This chapter attempts to give an overview of the literature reviewed by the investigator to tie the theoretical and empirical aspects of the study more securely.

2.1 Adjustment Problem

Ravinder Kaur, Naginder Kaur and Harpreet Kaur (2008) This paper is a study of the psycho-social problems of women teachers due to institution (school/college), area (rural/urban) and age (<35 years and >35 years) in the State of Punjab. Out of the sample of 1000 women teachers, 500 (250 rural and 250 urban) were from schools and 500 (250 rural and 250 urban) from colleges. The data were subjected to statistical analysis and the results revealed that no significant difference existed in psycho-social problems of women teachers working in schools and colleges, in rural and urban areas of Punjab. Significant difference existed in psycho-social problems of school teachers of age <35 years and >35 years.

Women face different problems at different age group. Gender differences led women to bear dual role responsibility, which starts affecting health status in middle age with the onset of physical
decline. Working women’s problems are of three types viz., environmental, social and psychological. In each of them the problems emerge due to the stained situations at home and work place. In turn they are due to two factors, one is the inner conflict due to dual commitment and concern, and the other is the practical difficulty of combing the dual commitment. The aim of the present work was to assess the psychosocial and family status of middle aged (45-55 yrs) women working as school teacher. Total number of subjects selected for study was 50 (n=50). An interview schedule and Psycho Social Stress Scale questionnaire were simultaneously administered to the selected subjects. Results indicate that women’s psychosocial health status may likely to get affected during middle age due to psychological changes occurring in this phase primarily because of biological changes and changes in the familial environment. Programmed interventions like, meditation, relaxation and other sensitization programs, aiming at lifestyle changes will change their attitudes, behaviours, cognitions, quality of life, thereby maintaining their overall status. M. Singh & G. Singh : 2006

Ms. Hina Ahmed Hashmi†, Ms. Maryam Khurshid‡ and Dr. Ishtiaq Hassan (2006) studied the relationship between marital adjustment, stress and depression. Sample of the study consisted of 150 working and non-working married women (working married women = 75, non-working married women = 75). Their age ranged between 18 to 50 years. Their education was at least gradation and above. They belong
to middle and high socio-economic status. Urdu Translation of Dyadic Adjustment Scale (2000), Beck Depression Inventory (1996) and Stress Scale (1991) were used. Results indicated highly significant relationship between marital adjustment, depression and stress. The findings of the results also show that working married women have to face more problems in their married life as compared to non-working married women. The results further show that highly educated working and non-working married women can perform well in their married life and they are free from depression as compared to educated working and non-working married women.

**G. W. Mcgee and others (1986)** developed and tested a multivariate model of marital adjustment among men and women in dual-earner marriages. Through the use of structural equation analysis (LISREL VI), the same theoretical model was estimated separately for men and women. For both genders, higher levels of occupational commitment by wives adversely affected marital adjustment, whereas both men and women perceived that marital adjustment was unaffected by the occupational commitment of husbands. For women, higher levels of occupational commitment had a significant influence on perceptions of a supportive family environment, which in turn positively influenced marital adjustment. Although the path from occupational commitment to supportive family environment was not significant in the men's model, greater perceived emphasis on a supportive family environment positively influenced the marital adjustment of men. The
results of this study emphasize the importance of family system characteristics for understanding the impact of high work commitment on the marital relationship.

Charles J. Holahan and Rudolf H. Moos (1982) estimated the relationship between social support and physical and psychological adjustment, using measures that afford a qualitative assessment of social support. Qualitative indices of social support in family (Family Relationships index) and work (Work Relationships Index) environments were derived from available social climate measures. Respondents were a randomly selected community sample of 267 male and 267 female adult family members. Results support hypotheses that qualitative measures of support in family and work environments predict psychosomatic complaints and depression after variance due to negative life change and quantitative measures of social support is accounted for. While the work environment is a more important source of support for men than women, the family environment provides an especially potent source of support for working and non working women. These findings clearly indicate that both the family and work environment can contribute significantly to psychological adjustment.

A central premise underlying both the philosophy and practice of community psychology is a belief that individual adjustment is linked to the character of the social environment that encompasses the individual's functioning (Kelly, Snowden, & Munoz, 1977).
Community psychologists have addressed particular attention to the health-inducing properties of natural systems of social support. For example, Smith and Hobbs (1966) argue that mental illness is not the natural sources of social support in the individual's life involving family, job, friendship, and religious affiliation. A social support system incorporates an enduring pattern of ties (Caplan, 1974) or a network of relationships (Sarason, 1976) that are an individual's link to essential resources. In times of need, the social support system can provide emotional support, tangible assistance, and informational guidance (Caplan, 1974).

Recently, empirical evidence from a variety of sources has supported the contention that social support is positively associated with physical and mental health. For example, reduced levels of social support have been related to various indices of psychological distress and psychiatric symptomatology (Eaton, 1978; Hirsch, 1979; -Lin, Simeone, Ensel, & Kuo, 1979). Further, low social support has been found to relate to a range of psychosomatic complaints and physical ailments (Gore, 1978; Medalie & Goldbourt, 1976; Theorell, 1976). Although existing empirical data offer a clear picture of a relationship between social support and physical and psychological health, research in this area by community psychologists has been subject to a number of limitations.

Some investigators have suggested that the salutary role of social support may be more a function of the quality of support than of its...
absolute quantity (Chan, 1977; Porritt, 1979). Finally, little is known about how alternative sources of social support relate to health for different groups of persons.

**White (1956)** commented excellently. White stated that the concept of adjustment implies a constant interaction between the person and the environment, each making demands on the other. Sometime adjustment is accomplished when the person yields and accepts conditions which are beyond his power to change. Sometimes it is achieved when the environment yield to the person activities. In most cases adjustment is a compromise between these two extremes and maladjustment is a failure to achieve a satisfactory compromise.

The above obtained result get indirect support from the study of **Helene Ballmer and Paul C. Cozby (1981)** who have investigated various aspects of the impact on family environments when mature married women return to college. Thirty-nine women who had returned to college and their husbands were compared to 39 non returnees and their husbands on the Moos Family Environment Scale and the Locke-Wallace Marital Adjustment Scale. It was found that there were both positive (e.g., intellectual-cultural) and negative (e.g., greater conflict) aspects of family environments of returning women.

### 2.2 Stress and Stressful Life Events

Previous research has documented consistently that persons holding low-socioeconomic status (SES) positions are more strongly
affected emotionally by undesirable life events than are their higher-status counterparts. Two types of resources have been implicated in this differential vulnerability: financial resources and a broader class of coping resources, including social support and resilient personality characteristics. In this regard Jane D. And Ronald C. (1990) presented an analysis that disaggregates measure of life events and of SES to identify which events and which components of SES are most important for understanding differential vulnerability. We document that the lower-SES vulnerability persists across all types of personal events. In addition, we find that differential vulnerability is not confined to income but extends to education and occupational status as well. On the basis of these patterns, we conclude that differential vulnerability reflects more than a simple economic reality. Previous research offers speculative evidence that status differences in past and current social environments may explain differential vulnerability, especially through their effects on the socialization of resilient personality characteristics. We propose future research that could help to evaluate the validity of these speculations.

Murry, Velma M, Harrell, Amanda W, Brody, Gene H, Chen, Yi-Fu, Simons, Ronald L, Black, Angela R, Cutrona, Carolyn E, Gibbons, Frederick X (2008) investigated of the effects of stressful life events on rural African American women’s relationship well-being, psychological functioning, and parenting included 361 married or long-term cohabiting women. Associations among stressful events,
socioeconomic status, perceived racial discrimination, coping strategies, psychological functioning, relationship well-being, and parenting were tested. Stressful events were related directly to diminished relationship well-being and heightened psychological distress and indirectly to compromised parenting. The results can inform research and intervention with African American women. A significant difference in chi-square indicates a moderation effect. As hypothesized, the association between stressful life events and relationship well-being was stronger for women of high SES than for those of low SES (standardized β = -.34 for high vs. -.10 for low SES).

Previous research indicates that relatively disadvantaged sociodemographic groups (women, the poor, the unmarried) are more vulnerable to the impacts of life events. More recently, researchers have hypothesized that the psychological vulnerability of these groups may be due to the joint occurrence of many stress events and few psychological resources with which to cope with such events. This latter hypothesis is called here the applied buffering hypothesis. Using data from the New Haven Community Survey, the existence of differential psychological vulnerability is first reconfirmed. Women; older adults; unmarried persons; those with less education, income, and occupational prestige; married women; and unmarried women are found significantly more distressed by the experience of life events than their sociodemographic counterparts. The applied buffering hypothesis is then tested with several measures of social support.
Little support for the hypothesis is found. That is, the psychological vulnerability of low status groups cannot be explained by the interaction of many events and few available sources of social support (Peggy A. Thoits; 2006)

Ayo Hammed (2008) examined the relationships between stress, social support and work/family conflict on Nigerian women’s mental health. The sample consisted of two hundred working women from the teaching and health care professions. To achieve the objective of the study six hypotheses were formulated and tested. The data were analyzed using the student t-test statistics. The findings of the study revealed that there is significant difference between young and old women in the level of stress experienced, and there is no significant difference between junior and senior staff in their experience of work/family conflict. Also, there is significant difference existed between single and married women based on their experience of work/family conflict. Based on these findings, it was recommended, among others, that direct efforts specific to primary prevention of mental disorders should be made, that employers of labour should establish family supportive and friendly interventions to assist women in their ability to cope with competing demands, and that women should be integrated into social network and high levels of social support as this will neutralize and control situations of stress, work/family conflict and mental health problems.
P. Aujla, Harshpinder, R.Gill and P. Sandhu's study was aimed to isolate the sociological and environmental factors causing stress and different stress management techniques used by 75 working and 75 nonworking women of Ludhiana. Results showed that working women were significantly more stressed. Highest-ranking social pressure was ‘unexpected guests’ (as felt by working women) followed by ‘compulsory socialization’ as disclosed by both the categories of respondents. All the respondents agreed that husband’s stress was also the major factor contributing to their own stress followed by stress due to modification of their personal goals. Main stress point related to their children’s future was also agreed upon by both the groups of respondents. Extremely hot weather and natural calamities were also identified as main environmental factors causing stress among all respondents. Majority of respondents in both the categories were using various stress management techniques viz. relaxation, music, prayers, recreation with family, Planning etc. Planning and relaxation were most preferred techniques whereas medical and natural therapy was the least preferred ones.

Our family environment is entangled with stress and strains where homemakers are directly affected by the same. Problem further intensifies in case of working women as they have to cope up with all pressures of a worker as well as of a housewife (Bolger et al 1989). Pearlin and Schooler (1978) conducted the study with following specific objectives: To examine the factors contributing to stress
among working and nonworking women and to find out the stress management techniques used by working and non working women. On the basis of result he has reported that the concept of stressors, not only refers to major life events but also encompasses ongoing minor events like electricity failure, maid not turned up, unexpected guests and child’s misbehaviour. Stress is not uncontrollable. With proper understanding of the different stressors that cause stress, the situation can be well managed. In India research work on family stress management had been low priority because of lack of awareness of importance of stress in our family life.

Harshpinder and Paramjit Aujla (2006) Psychological and physiological stressors among working and non-working women have been examined in the present study. Data were collected from 75 working and 75 non-working women from four localities of Ludhiana city. Results indicated that common factors of stress in both categories were unfinished tasks, compulsion of doing disliked activities, death of close relative, improper sleep. In working women, stressors were ‘pleasing others’ (mean score 0.92) and overburden of work (1.04), whereas in non-working women stressors were ‘wrong working posture’ (0.97) and ‘non – involvement in decision making by family’ (1.02). This study shows that working women were more stressed as compared to non-working women.

Stress has been defined both as a non specific adaptive response of the body to any demand and an internal and external stimulus. Stress
can be said to involve three major conceptual domains: sources of stress, moderators of stress and the manifestations of stress (Pearlin et al., 1981). To cope up with stress, it is very important to have a proper understanding of the different processes that are the main factors of stress. Physiological factors of stress are mainly the bodily resources viz. life experience, genetic, congenital factors etc. Psychological factors are based on internal operations of human mind. It is more serious as it includes life crisis, frustration etc.

Pearlin and Schooler (1978) reported that the concept of stressors, not only refers to major life events but also encompasses ongoing stress such as lack of health, too many interruptions and various decisions to be made. Speckhard (1985) found that the type of abortion (i.e. spontaneous or induced) is related to the symptoms of stress following abortion. Polubinski (1987) classified major and minor stressful life events and reported that factors related to work, home, marriage were identified as major life events causing stress.

According to McGown and Fraser (1995), the more one perceives the hassles to be of greater concern, the more likely one have physical manifestations of stress. Demas (1990) identified diabetes as a source of psychological stress.

Stress has been defined both as a non specific adaptive response of the body to any demand and an internal and external stimulus. Stress can be said to involve three major conceptual domains: sources of
stress, moderators of stress and the manifestations of stress (Pearlin et al., 1981). To cope up with stress, it is very important to have a proper understanding of the different processes that are the main factors of stress. Physiological factors of stress are mainly the bodily resources viz. life experience, genetic, congenital factors etc. Psychological factors are based on internal operations of human mind. It is more serious as it includes life crisis, frustration etc.

Pearlin and Schooler (1978) reported that the concept of stressors, not only refers to major life events but also encompasses ongoing stress such as lack of health, too many interruptions and various decisions to be made. Speckhard (1985) found that the type of abortion (i.e. spontaneous or induced) is related to the symptoms of stress following abortion. Polubinski (1987) classified major and minor stressful life events and reported that factors related to work, home, marriage were identified as major life events causing stress.

According to McGown and Fraser (1995), the more one perceives the hassles to be of greater concern, the more likely one have physical manifestations of stress. Factors of stress are different for different occupations and vary according to the individual’s psychological maturity. The remedial measures cannot be undertaken against stress unless the causes are known. So the present study was undertaken to advance the knowledge in area of stressor among married women in relation to some factor namely work status, family pattern and socio economic.
Experiencing loss is one of the major factors in the explanation of stress reactions. According to Hobfoll's (1989, 1998) conservation of resources (COR) theory, the threat or the actual loss of resources are considered to be powerful predictors of psychological stress. These can occur in many ways: loss of health, job, property, and loved ones. For most stressful life events, loss is an inherent characteristic.

Loss of a spouse is regarded as the most stressful experience on the Social Readjustment Rating Scale (SRRS) of Holmes and Rahe (1967). Considering the frequency and likelihood of such an event among those who have close long-term relationships, the relevance of research in this field becomes evident. In fact, the only way to protect oneself from that experience is to die either before or at the same time as the partner.

The effects of bereavement on morbidity and mortality have been widely studied (for an overview, Cf. M. Stroebe, Stroebe, & Hansson, 2000; W. Stroebe & Stroebe, 1992). In particular, gender and age differences in responding to the death of a spouse have received most attention.

A quarter of a century ago, Bartrop, Luckhurst, Lazarus, Kiloh, and Penny (1977) described immunological changes associated with conjugal loss. The death of a spouse is suspected to lead to increased mortality in response to diseases that are presumed to depress the immune function (reduced lymphoproliferative responses, impaired
NK cell activity). It has not been demonstrated, however, that morbidity and mortality following conjugal loss are the direct results of stressor-induced changes in immune function (Ader).

Considerable differences between widowers and widows regarding the physical and psychological reactions to an event as well as the coping strategies have been found. One set of studies suggest that men suffer more after losing their partner than women, whereas others report more health complaints of bereaved women.

**Miller and Wortman** (in press) suggest to examine the impact of loss for the one who is left behind. One might conclude that women should be at more of a disadvantage. Is there any evidence for such an assumption? Traditionally, women depend economically on their husbands. Although norms and values regarding self-determination and economic independence of women have greatly changed over the past decades, especially elderly couples are more bound to traditional roles. Therefore, in addition to the loss of the intimate partner, women also face the loss of income and financial security, which in turn could enhance the vulnerability for illness and the frequency of ailments. With increasing age, conjugal loss becomes a normative life event more often for widows, who outlive their husbands. In turn, widowers have a greater chance to engage in a new romantic relationship simply because there are more potential partners available. These objective disadvantages for widows obviously do not translate into greater
health impairment. In contrast, bereaved men are those who are at higher risk for mental health problems, morbidity, and mortality.

For decades, studies that have addressed this question have found, on average, that the mortality risk for widows/widowers is increased, compared to those who do not experience this loss (see M. Stroebe et al., 2000). The risk seems to be greatest for men during the first six months of bereavement. There may be several reasons for this gender difference: Men typically have a smaller social network than women, so their loss cuts more deeply into their network (Weidner, in press). Also, bereavement occurs at an older age for men than for women because men, on average, die earlier than their spouses, due to age differences in couples and biological gender differences in longevity. As a result, the death of a wife leaves a man who is older and more in need for support. Moreover, men usually confide in their spouse as their only intimate partner, whereas women cultivate a larger network of family members and friends, to whom they find it easier to turn in times of need. This higher social integration and support may buffer the stressful experience of losing their husbands.

Traumatic grief has been shown to be a risk factor for mental and physical morbidity (Miller & Wortman, in press). When widowers feel socially isolated during the grieving process, they may develop depression and loneliness, which in turn may lead to more severe consequences. For example, in some cases men commit suicide. This is thought to happen five times more often to widowers than to
widows. In other cases, their immune system or cardiovascular reactivity may be affected in the long run, resulting in illness and eventually in death. The mechanism of pathogenesis needs to be further explored. Not only death from all causes is higher among widowers, but also specific causes of death, such as suicide. Widowed individuals show impaired psychological and social functioning, including depression, and some studies report a significant decline in physical health, mainly for men. Frequency of sick days, use of ambulant physician services, and onset of illness according to medical diagnosis seem to be about the same for widowed persons and for controls. Schwarzer and Rieckmann (in press), examining the effects of social support on cardiovascular disease and mortality, found that cardiac events are more frequent among isolated and unsupported widowers.

Miller and Wortman (in press) analyzed data from 13 studies in terms of gender differences in mortality and morbidity following conjugal bereavement. They provide evidence that widowers are more likely to become depressed, to become susceptible for various diseases, and to experience greater mortality than widows. These effects are more pronounced among younger men. Some of the causes of death among widowers are alcohol-related diseases, accidents, suicide, and chronic ischemic heart disease. Various possible explanations for their findings were discussed. The first reason for experiencing widowhood differently may be the different marital roles.
Men tend to rely solely on their spouses in many ways. Wives are often the main confidant for their husbands, but they also tend to have larger and tighter social networks that they can mobilize and rely on in taxing situations. Second, in many studies women are found to recognize themselves as support providers rather than as receiver. Until recently, women naturally bear the main responsibility for household and childcare. If such a strong anchor is lost, bereaved men’s stress is doubled, not only by taking on new roles in the family, but also by lacking adequate support. Third, for men, widowerhood takes away a powerful agent for social control. Lack of control can translate into a higher risk for men to engage in health-compromising behavior, for example heavy drinking or risky driving. In many marriages, women are responsible for the family’s psychological and physical wellbeing.

Wives provide care during illness, are likely to be attentive to necessary changes in health behaviour (e.g., dieting), and remind their husbands of regular health check-ups or prevent them from engaging in behaviours that are hazardous to their health.

Whenever a person becomes the victim of an intentional negative act, we speak of criminal victimization. Clements and Sawhney (2000) investigated coping of women exposed to domestic violence. Almost half of the battered women reported dysphoria consistent with a clinical syndrome of depression. Abusive severity seemingly did not play a role.
**Feeny, Zoellner, And Foa (2000)** report that 33% of the women living in the United States will experience a sexual or nonsexual assault at least once in their lifetime. Although victims of domestic violence, rape, burglary, robbery, and other severe traumatic events, such as accidents, show surprising commonality in their emotional reactions to the event (Hanson Frieze & Bookwala, 1996), the physical effects of each of the events listed can differ greatly. The immediate response after confronting extreme stressors may be denial, disbelief, self-blame, numbness, and disorientation. Another common outcome of exposure to unusually stressful situations is PTSD. Symptoms include, for example, re-experiencing the event, avoiding reminders, trouble with sleeping, nightmares, and chronic hyperarousal.

Traumatic events not only contribute to mental health problems, they also lead to an increase of physical health complaints. According to **Zoellner, Goodwin, and Foa (2000)**, unspecific complaints, such as headaches, stomachaches, back pain, cardiac arrhythmia, and menstrual symptoms, are among the most common problems.

To date, research on the relationship between a stressful event and physical health with PTSD as the moderating variable has remained relatively scarce. **Zoellner et al. (2000)** conducted a study with 76 women who were victims of sexual assault suffering from chronic PTSD and who were seeking treatment. The results show negative life events, anger, depression, and PTSD severity related to self-reported
physical symptoms. Moreover, PTSD severity predicted self-reported physical symptoms above and beyond these factors.

Migration is increasingly becoming a typical facet of modern society. The globalization and internationalization of industries contribute to a constant flow of people from one country to another. The reasons why people migrate range from economic difficulties, evil wars, ecological disasters (e.g., repeated drought or flood), and political persecution affecting their work and study. Forceful displacement, uprooting from the homeland, and resettlement in a new environment cause physical as well as psychological scars. Extreme stress can occur at any point of the migration process—prior to, during and after. Thus, exposure to a number of stressors may cumulate and can be responsible for health problems long after migration. **Hobfoll's (1998)** COR theory, migration stress can be explained by the threat of loss and actual loss of resources of any kind. The chances to compensate these losses and to restore one's resources are very limited, at least at the beginning of the adaptation process in a new country.

Living in a foreign country is inevitably associated with social and material losses as well as new challenges, regardless of the duration or purpose of the stay. To some extent, all newly arrived travelers, sojourners, immigrants, and refugees face similar challenges: different climate, new language, and unfamiliar customs, cultural norms, and values. In cases of involuntary relocation, uncertainty about the duration of the stay can contribute to elevated levels of stress. Also,
the greater the cultural differences between the indigenous and host cultures, the more stress is likely to be expected.

Acculturation stress (Berry & Kim, 1988; Schwarzer, Hahn, & Schröder, 1994.) Often emerges in conflicting situations with members of the own ethnic or cultural group and the dominant group of that society. Potential stressors range from everyday life with the family or at the workplace to direct effects that are often associated with migration, such as status loss, discrimination, and prejudice. Acculturative stress and the behavior that results from coping with it are very likely responsible for mental health problems and somatic complaints.

Another common source of continuing stress are bad news from the home country, survivor guilt related to leaving family and friends behind, and thoughts about the duty to care for them (Graham & Khosravi, 1997; Lipson, 1993).

Studies by Yee (1995) on Southeast Asians in the USA as well as Tran (1993) on Vietnamese confirmed the hypothesis that acculturation stress coupled with stressful experiences lead to poorer health. Along this line, Cheung and Spears (1995) assume a strong association between negative life events and depression among Cambodian immigrants in New Zealand. Moreover, they identified lack of acculturation, feelings of discrimination, and poor language skills as risk factors for mental disorders.
**Chung and Kagawa-Singer (1993)** examined predictors of psychological distress among Southeast Asian refugees. Even five years after arrival in the USA, premigration stressors, such as number of years in the refugee camp, number of traumatic events, and loss of family members, significantly predicted depression. Apart from cultural changes, living conditions for immigrants are often below average, especially for refugees from Third World countries. Here, postmigration factors (e.g., income, work situation, language skills) also played a role in the development of mental health problems (e.g., **Hyman, Vu, & Beiser, 2000**).

**Lipson (1993)** reviewed studies on Afghan refugees' mental health. Afghan refugees residing in California displayed high levels of depression and psychosomatic symptoms of stress. This is assumed to be due to family role changes and the resulting conflict in the American society. Furthermore, loneliness as well as isolation among the elderly has been linked to psychiatric morbidity.

One of the rare studies on the physical health of refugees comes from **Hondious, van Willigen, Kleijn, and van der Ploeg (2000)**, who investigated health problems of Latin American and Middle Eastern refugees in the Netherlands, with special focus on traumatic experience and ongoing stress. Study participants, who had experienced torture, reported medical complaints. Surprisingly, PTSD was identified only among few of the respondents. However, not only traumatic experience prior to migration, but also worries about
current legal status, duration of stay, and family problems contributed to ill health.