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A N N E X 21

Report of the Professor Dr. Armando Roa regarding the observations made by Dr. James S. Gordon in relation with Mrs. Isabel Morel de Letelier.

SANTIAGO, November 26, 1991

MISTER  
GUILLERMO PIEDRABUENA  
PRESIDENT  
STATE DEFENSE COUNCIL  
SANTIAGO

DISTINGUISHED MISTER PRESIDENT:

In response to your request in reference to Dr. James S. Gordon's observations about my analysis of his "Psychiatric Report" regarding Mrs. Isabel Morel de Letelier, permit me to express the following:

FIRST: It is not true, as he affirms, that in the diagnosis of Post-traumatic Stress I did not take into account his "extensive clinical and biographical tests." On the contrary, because I do take them very much into account I note the absence of the following fundamental considerations for a report of this nature:

Rigorous Clinical Examination of Personality, since normal as well as abnormal personalities are divided into types, their identification is necessary. In no part have I insinuated even the possibility of a "personality disturbance" or of a previous psychiatric history of Mrs. Morel de Letelier as Dr. Gordon affirms. What is requested is to know her possible personality type, since as is known, the degree of repercussion of Stress varies according to which personality type the person belongs. As well, it is common psychiatric experience, that syndromes of this type sometimes provoke personality changes or accentuates its characteristics. It is evident that in order to clarify this possibility, the previous characteristics and those characteristics today, must be pointed out in a precise manner.

The establishment of precise differential diagnoses with symptoms that could be similar to those already mentioned in my report. The differential diagnoses are obligatory in any scientific investigation, since

otherwise the mere principle of authority would be adhered to -rejected centuries ago by science-, by virtue of which if a doctor affirms a diagnosis, by this simple fact the other doctors must also accept it.

**SECOND:** Regarding Mrs. Morel de Letelier's biography, it would be interesting to have information based on a study made by specialists and with the rigor required for such reports, of what would have been the course of her life and also her marriage in the years previous to the bomb attempt. It is known, for example, that the existence or not of previous feelings of guilt - of self or heteroguilt- is important in the repercussions of any death, more so in dealing with an unjust as well as unfortunate kind of incident suffered by Mrs. Morel de Letelier.

**THIRD:** When speaking about Neurosis for compensation, or when using similar names, almost no psychiatrist today believes that this has to do with obtaining pecuniary earnings on the basis of unconsciously created symptoms; behind such neurosis there is generally a noble concern to obtain justice when faced with and being a victim to something despicable and cunning.

**FOURTH:** Not in any part of my report have I said or insinuated, as Dr. Gordon affirms, that anyone suffering from post-traumatic Stress "should always be unhappy and incapable of expressing themselves and that Mrs. Letelier's high level of general functioning indicates that in a certain way she is pretending and simulating a pathological condition." However, regarding Mrs. Morel de Letelier's high functioning level I refer to what is established in the DSM-IIIR and the CIE-10 Draft (Europe's most recent classification of Chronic Post-traumatic Stress, which demand the presence of some type of alteration in relation with daily activities. (I attach a photocopy of both documents.)

.3.

With respect to the prognosis of these symptoms, which all psychiatrists have seen cases of notable improvement throughout time, I ask that you review what is written in the CIE-10 Draft (Page 101).

**FIFTH:** Having known the tragic experience suffered by Mrs. Morel de Letelier, which no one with feelings and ethical principles could keep from lamenting, does not mean that only by this and based exclusively upon the out-dated principle of authority which Dr. Gordon seems to invoke ("I say"), must we blindly believe in his diagnosis. Although it could well be true, in order to corroborate it, all those elements required by the actual state of medical science must be made evident.

Very truly yours,

(signature)  
PROF. DR. ARMANDO ROA

(Pages 300/301 - Diagnosis categories/Anxiety disorders)

Criteria for the diagnosis of post-traumatic stress disorder  
(309.89)

- A. The individual has lived an event that is beyond the usual frame of human experiences and that would be notably painful for almost anyone; for example, a serious threat to his own life or physical integrity, threat or injury to his children, his spouse or other close relatives and friends, sudden destruction of his home or community, witnessing of how a person is seriously injured or dies as a result of an accident or physical violence.
- B. The traumatic event is persistently re-experienced at least in one of the following manners:
- 1) Unpleasant, recurrent and pervading memories of the event (in small children, repetitive games in which the themes or aspects of the traumatism are expressed);
  - 2) Unpleasant and recurring dreams of the event;
  - 3) Sudden behavior and feelings that appear as if the traumatic agent would be operating again (in these phenomena are included the sensation of re-living the experience, illusions, hallucinations, and disassociative episodes (flashback), even when they happen upon awakening, or as a consequence of an intoxication with drugs);
  - 4) intense psychological indisposition upon being exposed to events that symbolize or recall some aspect of the traumatic event, as may even be an anniversary.
- C. Persistent avoidance of the stimuli associated with the trauma or lack of general response capacity (non-existent prior to the trauma), revealed by at least three of the following phenomena:
- 1) efforts to avoid thoughts or sensation associated with the trauma;
  - 2) efforts to avoid activities or situations that provoke the memory of the trauma;
  - 3) incapacity of remembering some of the important aspects of the trauma (psychogenic amnesia);
  - 4) notable diminution of interest in significant activities (in small children, for example, loss of recently acquired development abilities, such as toilette or language);
  - 5) sense of distance or removal from others;
  - 6) restricted affection; for example, incapacity of amorous experiences;
  - 7) sense of shortening of the future (careers, marriage, children and a long life, for example, are not expected).
- D. Persistent symptoms of increase in activation (arousal) (non-existent prior to trauma), revealed by at least two of the following phenomena:
- 1) difficulty in falling or remaining asleep;
  - 2) irritation or explosions of anger;

- 3) difficulty in concentration;
- 4) hypervigilance;
- 5) exaggerated response of alarm;
- 6) physiological reactiveness in being exposed to those events that symbolize or recollect some aspect of the traumatic event; for example, a woman that has been raped in an elevator begins to perspire upon entering one.

E. The duration of the disorder (symptoms of B, C and D) has been at least one month.

Specify retarded beginning if the appearance of the symptoms has taken place at least six months after the traumatism.

(NEXT PAGE)

CIE-10 (Spanish version, draft N°2) - page 100 -

#### Guidelines for diagnosis

There must be a clear and immediate temporal relation between the impact of an exceptional stressing agent and the appearance of symptoms, which are present at the most after a few minutes, if not immediately. Further, the symptoms: a) appear mixed and mutable, adding to the initial state of "dulling", depression, anxiety, anger, desperation, hyperactivity or distancing from reality, although none of these symptoms predominate over the others for long, and 2) have a rapid resolution, at the most in a few hours in cases in which it is possible to remove the subject from the stressing environment. In cases in which the stressing situation is of its nature continuous or irreversible, the symptoms begin to subside after 24 to 48 hours and are at a minimum after about three days.

This diagnosis must not be used for individuals that previously may have had symptoms that satisfy criteria for other psychiatric disorders with the exception of F60 and F61 (Personality disorders and Acute personality traits). Nevertheless, records of past psychiatric disorders do not invalidate this diagnosis.

Includes: CIE-9 308: acute reaction of stress, state of crisis, acute crisis reaction.

#### F43.1 Post-Traumatic Stress Disorder

Disorder that emerges as a retarded or differed response to a stressing event or to a situation of an exceptionally threatening or catastrophic nature, which would cause of themselves persistent pain in almost anyone (for example natural or man-made catastrophes, combat, serious accidents, witnessing of someone's violent death, being victim of torture, rape or other crimes).

Certain character traits (for example, compulsives or asthenics) or records of a neurotic disease, if they are present, can be predisposing elements and lower the threshold for the appearance of the syndrome or for aggravating its course, but these factors are neither necessary nor sufficient to explain the appearance of the same.

The typical characteristics of post traumatic stress disorder are: reiterates episodes of reliving the trauma in daydreams, dreams or nightmares that take place upon a persistent basis on the sensation of "being buried" and emotional drowsiness, of aloofment from others, of the lack of capacity to respond to surroundings, "anhedonia" and of avoiding activities and situations which evoke trauma. They usually are afraid of, and avoid as well, situations that remind or suggest the trauma. In rare occasions, dramatic outbursts can be present and as well as sharp fear, panic or aggressivity, unleashed by stimuli that produce sudden reminders, a recall, or both at the same time, of the trauma or of the original reaction. Generally there is a state of vegetative hyperactivity with hypersurveillance, an increase in shock reaction and insomnia. The symptoms are accompanied by anxiety and depression and suicidal tendencies are not rare. The excessive use of drugs or alcohol can be a worsening factor.

At the beginning of the trauma, there is a period of latency which lasts from a few weeks to months (but rarely exceeds six months). The course fluctuates, but recuperation can be expected in the majority of cases. In a small percentage of individuals the disorder can take a chronic and evolutionary course for many years toward a Permanent Transformation of personality. (see F62.0).

#### Guidelines for the diagnosis

This disorder must not be diagnosed unless it is absolutely clear that it has appeared within six months of a traumatic act of exceptional intensity. A "probable" diagnosis could even be possible if the time transpired between the act and the beginning of the symptoms is greater than six months, as long as the clinical manifestations are typical and not verosimil any other alternative diagnosis (for example, Anxiety disorders, Obsessive-Compulsive or Depressive State Disorders). In addition to the proof of the trauma, it must be taken into account the evoking or the incidence of representations of the event in the form of reminders or images during wakefulness or reiterated daydreams. A clear emotional detachment, with affective dulling and the avoidance of stimulus that could reactivate the reminder of the trauma, often occur, although it is not essential for a diagnosis. The vegetative symptoms, the disorder of a state of mind and abnormal conduct also contribute to the diagnosis, but are not of eminent importance.

The aftereffects of devastating stresses, that is, those that manifest themselves decades after the stressful experience, must be classified within the F62.0.