Towards An Understanding Of Post-Traumatic Stress Disorders Among Vietnam Veterans

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I. Introduction

The purpose of my testimony today is to briefly present an overview of material that allows us to understand Post-Traumatic Stress Disorders (PTSD) among Vietnam Veterans. In order to develop an adequate theoretical framework to fully understand the antecedents, dynamics and phases of post-traumatic stress disorders among these men and women it is necessary to know: (1) the nature of the stressors in the war zone and their relation to (PTSD); (2) the nature of the veterans re-integration process into society; (3) the nature and dynamics of PTSD and (4) the relationship of PTSD to personality development in the life-cycle.

II. Nature of the Vietnam War

In recent years much has been written on the special nature of the Vietnam War (e.g., Webb, 1978; Caputo, 1977, Herr, 1977). However, it is now generally recognized that the Vietnam War was different from other 20th Century American Wars in important ways. Broadly conceived these differences include: (1) the longest war in our history, 1962-1975; (2) an unconventional guerrilla war against indigenous revolutionary forces; (3) the most politically controversial war, one which divided the nation; (4) a war in which there was not a full-scale national commitment to the war effort itself; (5) the use of highly sophisticated weaponry which included land-mines, napalm, defoliants, electronic reconnaisance apparatus and other "high" technology equipment; (6) the lack of an over-arching ideological justification for the war, a factor which made it difficult for the typical soldier to feel a strong and deep-rooted sense of purpose, pride or patriotism in his mission; (7) the failure to advance the war geographically be securing and

pacifying villages and cities. The same terrain objectives were repeatedly secured at a great expense of lives and the eventual measure of progress became the "body count" of reported enemy dead; (8) difficult geographical conditions in which to fight and the inability to easily, reliably and accurately discern the enemy; (9) the unpredictability of enemy-attacks created an anxiety arousing and frightening psychological milieu; (10) the factors listed above led to a "survivor mentality" in which the typical combatant came to believe that the war was not being won and his 'role' was to survive the one-year tour of duty; (11) Morale problems: There were re-curring racial tensions, conflicts and rifts between officers and enlisted men. Research evidence indicates that the typical soldier had respect for his immediate commanding officer but tended to mistrust high ranking senior officers who were often anxious to make their career advancements during their 6 month command tour-of-duty; (12) the one-year tour of duty led to the adoption of a "survival mentality" and "short-timers syndrome" which often under-cut the soldiers capacity to make a full commitment to the war effort; (13) the typical soldier went to and from Vietnam singly; units were composed in Vietnam in-the-field and the men typically had different DEROS (date of expected return from overseas service), a fact that undermined unit integrity, cohesiveness and emotional support; (14) upon DEROS the rotation from the war zone to the United States occurred quickly. Men flew home on jet airplanes and frequently made the transition from the status of "combatant" to civilian in less than 48 hours with virtually no "decompression" of the experience. He was out-processed in the midst of strangers and sent home. Thus, there was virtually no

opportunity to 'work-through' the war experience with fellow soldiers from his unit; (15) there were no victory parades and hero's welcome for the returning soldier. Indeed most men came home while the war went on and found it difficult to talk about their experiences since they were often stigmatized as "losers" and "drug-crazed psychopathic" killers; (16) once home the young veteran who went to war at 18 years of age found it difficult to re-enter the mainstream of society since he was typically under-educated and ill-trained for a civilian job. Furthermore, an inadequate G.I. Bill and difficult economic conditions compounded the complex task of entering adulthood with a changed sense of ego-identity, one in which there was often confusion, anger, rage and alienation. Taken as a set these 16 factors (and others not discussed) serve to delineate some of the major differences between the Vietnam War and other wars in recent U.S. history.

III. Stressors in the Vietnam War

A stressor is generally thought of as an event which "taxes or exceeds the resources of the system or, to put it in a slightly different way, demands to which there are no readily available or automatic adaptive responses (Antonovsky, 1979)." In the guerrilla warfare of Vietnam there were many events which can be construed to be stressors when considered individually or in their collective, additive sense. To summarize briefly these stressors included: (1) the unpredictability of enemy attacks, their identity and whereabouts; (2) the unpredictability of fire fights and anti-personnel mines (booby-traps, etc.); (3) the inability to advance the war geographically or politically; (4) the social-political controversy of the war "back home"; (5) the inability to fulfill the role of a successful combatant-warrior;

(6) the constant exposure to life-death situations; (7) the participation in or exposure to atrocities; (8) the repeated capture and loss of terrain objectives; (9) the failure of the A.R.V.N. to make a full-scale commitment to the war effort; (10) the one-year tour of duty and "survival mentality;" (11) ineffective high ranking military leadership; (12) the problem of ideological justification when faced with the continual death or loss of buddies or comrades; (13) the availability of high quality illicit psychoactive substances at low cost on the "black-market"; (14) the technological nature of the war (Napalm, rocket launchers, landmines, etc.) coupled with the dehumanization of the enemy ("gooks").

While it is true that all wars are stressful, indeed catastrophically stressful, few have ever had the long-term guerrilla nature or psychological elements of the Vietnam War. The typical <u>combatant</u> in Vietnam fought in a maximally stressful environment; one in which it was impossible, short of delusion, to have some sense of control or predictability over events. In its most obvious form it was almost always difficult to: (1) know for certain who the enemy really was - i.e., pro-South Vietnamese or Viet Cong; (2) trust the ARVN as a reliable Army prepared to fight; (3) know for certain that the women, children and elderly <u>were not</u> Viet Cong; (4) know for certain that there were not land-mines or other booby traps implanted throughout the jungles, rice-paddies or mountains; (5) know with reasonable certainty whether or not an attack or ambush was forthcoming; (6) know for certain that the war was worth one's life and whether or not one would come home and (7) know for certain that orders were tactically proper and effective for the mission objective. These and other stressful events served to characterize the typical psychological milieu of the <u>combatant</u>. And while many men found ways to survive and cope with these

experiences there was often the gnawing sense that it "was all for nothing" and that the stated purpose of the war was false, a fact exacerbated by Vietnamese sentiment that the American forces should "go home." Thus, the typical corbatant had to face twin sets of stressors: those indigenous to the guerrilla war and those generated by the dissonance produced by ideological incongruency. Stated simply, we can say that in any war it is difficult to lay one's life-on-the-line but it becomes doubly difficult to do so when faced with the existential task of creating meaning in a environment of seemingly meaningless death. It is of little wonder then that the sensitive journalists and writers have independently chosen the word "surreal" to describe much of the existential quagmire that became the sordid mosaic of the war itself. Clearly, all of the above described stressors would tax even the strongest and healthiest person's ability to the point of "over-load." But these facts take on added significance when we remember that the typical combatant was 19.2 years old and just beginning the normative developmental process of identity formation and integration. As we shall see in the next section this fact contributes much to our understanding of PTSD.

IV. The process of re-entry: maximizing the negative effects of stressors encountered in Vietnam

If you were daemonic and powerful enough to want to make someone "crazy" following a war like Vietnam how would you do it? If you wanted to maximize the negative effects of the stressors encountered in the line of duty in the war zone how would you do it? What would be the worst set of social, economic, political and psychological conditions you could create for the returnee?

First, you would send a young man fresh out of high school to an unpopular, controversial guerrilla war far away from home. In that war you would expose him to a high level of intensely stressful events, some so horrible that it would be impossible to really talk about them later to anyone else except fellow "survivors." However, to insure maximal stress you would create a one-year tour of duty during which the combatant flies to and from the war zone singly, <u>without</u> a cohesive, intact and emotionally supportive unit with high morale. You would also create the one-year rotation to instill a "survivor mentality" which would under-cut the process of ideological commitment to winning the war and seeing it as a noble cause. Then, at DEROS, you would rapidly remove the combatant from his foxhole and <u>singly</u> return him to his front porch <u>without</u> an opportunity to sort-out the meaning of the experiences with the men in <u>his</u> unit. Rather you would want to outprocess him into civilian status as quickly as possible. No decompression. No deprogramming. No readjustment counseling. No homecoming welcome or victory parades. Ah, but yes, since you are daemonic enough you make sure that the veteran is stigmatized and portrayed to the public as a "drug-crazed psychopathic killer" with no morals or impulse control over aggressive feelings. Then, too, by virtue of clever selection by the selective service system the 21 or 22 yr. old veteran would be unable to easily re-enter the mainstream of society because he is undereducated and lacks marketable job skills. Thus, he has to struggle to establish his personal identity and niche in society. Further, since the war itself was so difficult you would want to make sure that there were no supportive systems in society for him, especially among mental health professionals at VA hospitals who would find his nightmares and residual war-related

anxieties unintelligible. Finally, you would want to establish a GI Bill with inadequate benefits to pay for education and job training coupled with an economy of high inflation and unemployment. Last, but not least, you would want him to feel isolated, stigmatized, unappreciated and exploited for volunteering to serve his country. If, then, you were to do all of these things you would surely maximize the effects of war related stressess and insure their prolonged deleterious effects in his life. Tragically, of course, this scenario is not fictictious; it was the homecoming for most Vietnam veterans.

V. Post-Traumatic Stress Disorders Among Vietnam Veterans

It is really of little wonder to me that given the age of the combatant, the nature of the war and the genuine absence of significant societal support for the returning veteran, that for many men, perhaps as many as 750,000-800,000, the stressors of the war and the stressors of the homecoming impacted on the process of identity formation and the process of adaptation to the various stressful events. We now know that PTSD is a dynamic survivor response to the catastrophic stressors experienced in the war and to the intense social stressors after it. The symptoms which define the PTSD syndrome among Vietnam veterans are virtually identical to those observed among the survivors of the atomic bomb at Hiroshima, Korean P.O.W. camps, the Nazi holocaust and the Buffalo Creek Dam disaster. Specifically, however, the symptoms of PTSD among Vietnam veterans include the following characteristics.

A. Emotional Responses

1. Psychic or emotional numbing or anesthesia
2. Depression - feelings of helplessness, apathy, dejection, withdrawal, isolation
3. Anger - rage, hostility (feeling like a walking time bomb)
4. Anxiety - and specific fears associated with combat experiences

5. Emotional constriction and unresponsiveness to self and others
6. Tendency to react under stress with "survival tactics."
7. Sleep disturbances and recurring nightmares of combat.
8. Loss of interest in work and activities; fatigue, lethargy.
9. Hyper-alertness; startles-easily, irritability.
10. Avoidance of activities that arouse memories of trauma in war zone.
11. Intensification of normal developmental growth crisis
12. Suicidal feelings and thoughts; self-destructive behav ior tendencies.
13. Survivor Guilt
14. "Flashbacks to traumatic events experienced in war; intrusive thoughts

B. Cognitive Ideation
1. Fantasies of retaliation and destruction; ideological changes and confusion in value system.
2. Cynicism and mistrust of government and authority
3. Alienation; feeling estranged; existential malaise and meaninglessness.
4. Tendency to be humanistic and prosocial in values but also hedonistic and self-indulging.
5. Negative self-image; low-self-esteem.
6. Memory impairment especially during times of stress.
7. Hypersensitivity to issues of equity, justice, fairness, equality and legitimacy.

C. Interpersonal Relationships
1. Problems in establishing or maintaining intimate relationships.
2. Tendency to have difficulty with authoritative figures (challenging; and testing authroity, rules and regulations)
3. Emotional distance from children and concern about anger alienating children, wife and others.
4. Self-deceiving and self-punishing patterns of intimacy functioning:
   a. inability to talk about war experiences and personal emotions.
   b. Fears of loss of others, rage loosing control or wanting to secretly return to Vietnam
   c. Tendency to explode in fits of rage and anger; especially when disinhibited by drugs.

D. Phasic sequence to PTSD

Those individuals experiencing the symptoms of PTSD often passes through a series of different psychic states before recovering from the disorder. My colleagues Dr. Charles R. Figley and Dr. Mardi Horowitz have written on the nature and organization of these phases of adaptation to PTSD. Briefly, however, they are as follows:

I. Emergency or Outcry. In this state the person feels vulnerable, helpless, panicked, exhausted and recognizes the "death imprint." All resources are used to survive the life-threatening experience and focus on immediate survival and functioning.

II. Denial. In this state the person is numb (psychic numbing) emotionally constricted, confused, narrow in focus and interests, inattentive, experiences memory impairment, distorts the meaning of events or trauma, and uses fantasy to cope with reality.

III. Instrusive or Flashback Phase. In this state of adaptation there are experienced cycles of emotion, preoccupation with the war (compulsion to talk or think about experiences, fears of loss of significant others, merger with victim, or impulse control; survival guilt; sadness and remorse over those who died or were severely injured; startle reactions; recurring nightmares, flashbacks and intrusive thoughts of war experiences; re-enactments of traumatic and a tendency to use survivor tactics; hyperalertness and vigilance; obcessive ideation concerning the meaning of the war and its events.

IV. Reflective-Transition Phase. In this state the symptoms of the earlier phases abate. The individual begins developing a larger, personal perspective and rationale for the events which occurred. More constructive and appropriate coping and ego-defensive styles are employed as the anger, rage and cynicism give way to more prosocial, constructive and positive modes of working and relating. The person still feels like a survivor but now is more sponstaneous and future-oriented. The war is now "put in the past" and the struggles with PTSD are now viewed as "strengthening" the character.

V. Completion or Integration. At the end of the transition phase the individual successfully integrates the previously stressful experiences into a new ego-synthesis that once again restores a sense of self-sameness and continuity to the identity structure.

V. Differential Diagnosis of PTSD and other Psychiatric Syndromes

Unfortunately, our knowledge of PTSD has not grown at the same rate as the number of men suffering from the disorder. Thus, one unfortunate consequence has been that many Vietnam veterans seeking psychological counseling have been misdiagnosed as sociopathic or psychotic when in fact they were suffering from PTSD or the delayed stress syndrome. Briefly, what differentiates PTSD

from other forms of human adaptation are as follows: (1) the general absence of delusions, hallucinations and disorded thought; (2) the general absence of anti-social, ego-centric, immoral and self-destructive cycles of behavior; (3) the capacity, if muted, to be genuinely sensitive to other's needs and values; (4) the general absence of exploitive interpersonal relationships; (5) the presence of strong emotional states, especially survivor guilt and anxiety over appropriate impulse control; (6) the general absence of classical hysterical symptoms and mechanisms; (7) the feeling of being a survivor whose sense of identity and personal continuty is impaired; (8) the presence of depression which is reactive to situational stress rather than neurotic or characterological; (9) the general absence of any significant pre-morbid history; (10) the presence of combat-related nightmares and flashbacks; (11) the presence of hyperesthesia; (12) irritability, moodiness and startle reactions; (13) avoidance of activities that arouse memories of traumas connected to a war zone; (14) the presence of cynicism, alienation and mistrust of authority; (15) the presence of a humanistic value orientation overlayed by hedonistic tendencies; (16) the presence of hypersensitivity to issues of equity, justice and fairness; (17) the presence of interpersonal difficulties; (18) an existential quest for meaning in life juxtaposed with the need to find purpose in the experiences of Vietnam; (19) the presence of difficulty in establishing future goals; (20) a strong "death-imprint" and the presence of existential anxiety over creating meaning in forms of experience. Taken as a set, these characteristics differentiate post-traumatic stress disorder from other classifications of human adaptation to acutely stressful and catatastrophic events and further our understanding of survivor responses to profound life-death experiences.

VI. The Delayed Stress Syndrome: The Need for Operation Outreach

Based on several well-designed research studies conducted with large, representative samples of Vietnam Era veterans, we now know that 40-60% of Vietnam veterans suffer from acute, chronic or cyclical forms of PTSD. However, when there is latency between discharge from the military and the onset of the symptoms we find it appropriate to talk about a delayed stress syndrome (DSRS) or form of PTSD. Further, the research evidence also makes it clear that there is widespread alienation and mistrust of the government, especially the VA system. Thus, one consequence of this fact is that many veterans suffering from PTSD do not go to VA Hospitals for psychiatric care. Because of this, then, two national outreach programs have been created by the Disabled American Veterans (DAV) and the Veterans Administration (VA). I have worked most closely with the DAV's program since its inception which began, in part, in response to my DAV funded research studies on Vietnam veterans. Briefly, the essence of their program is to provide a wide-range of needed services to the veteran in one outreach location. We felt that it was important to locate the "storefront" in the veterans community and to create a trusting mileu in which a "survivor" could contact another veteran who "spoke the same language" since they had experienced similar events during the war. One aspect of this service has been to establish "rap-groups" in which the men can openly share their experiences with each other. To date these groups have been enormously effective and provide many functions that facilitate a healing of the wounds from the war. Briefly, these functions include: (1) Reducing stigmatization and feelings of isolation, loneliness and fear of being labeled a

doped -up killer; (2) Secret pride - many men did much to be proud of in Vietnam - e.g., saving lives of friends or administering help to the S. Vietnamese. These feelings of pride in having been competent as a soldier and acting periodically as humanitarian in Vietnam surface in the group and bring individual recognition and confirmation. (3) Remove fear of mental illness - the group can help the veteran learn that he/she suffers from PTSD and to understand the nature of "survivor syndromes." The relief that is experienced permits the person to "open-up" and talk more freely about themselves; (4) Learn alternative ways to view one's problems and cope effectively with them. The groups can provide a forum for learning new ways to cope with problems. Sharing experiences facilitates the development of more constructive problem solving and coping with personal problems; (5) Express emotions freely - the groups can help the individuals learn to express difficult feelings which typically "free-up" the person and raise self-confidence. (6) Provide a Community - One of the most important group functions is to create a meaningful, supportive and caring community in which the individual can feel rooted and some sense of identification and belongingness. The group helps to create a brotherhood and broadens the network of significant others who can serve as supportive friends; (7) The group can help to clarify thinking on identity, ideology, the nature and purpose of the war and to resolve issues within the value system; (8) The group can be a forum to frame a new political social perspective of the war itself.

The DAV undertook an evaluation of the pilot phase of Operation Outreach and so far our preliminary data indicate that the program has been an overwhelming success. We know that we are reaching the disenfranchised veteran and especially those with (DSRS). Based on our

preliminary statistical analyses it appears that we are successfully helping over 60% of those who contact the DAV Outreach Center. And it is the strong conviction of the service officers that those men would not have gone to VA hospitals or other traditional health care delivery systems.

Since my time is running short let me end with an encouraging note and a warning. On the positive side we have at last identified, labeled and begun to understand DSRS. We've also begun outreach programs that are just now discovering the tip of an immense iceberg. Much more intervention is needed immediately to treat PTSD. If (DSRS) is not treated successfully it will eventually develop into more serious forms of pathology, primarily chronic depression and alcoholism.

The spectre of loosing 500,000 or more men to these preventable mental illnesses is a tragic one. We need more help from professionals willing to help with outreach programs and more government funding to reverse the shameful legacy of Vietnam.