A Portrait of the Problem
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PTSD A Portrait Of the Problem

By Sandra L. Huppenbauer

The popular adage, "time heals all wounds," applies to many of life's unpleasant situations. Most depressions are self-limiting. People routinely adapt both to illness and loss and, in time, return to productive living. Time has not, however, healed the wounds of many Vietnam combat veterans, thousands of whom continue to struggle with war-related mental health problems, specifically, post-traumatic stress disorder.

The Background

The Vietnam war differed significantly from past U.S. wars. These differences, discussed below, contributed to the development of psychiatric difficulties, particularly in combat veterans.

Political climate. The Vietnam war created national unrest as its morality was debated. Activists demonstrated; many draft-eligible young men sought deferments or left the country to avoid induction into military service. The warriors as well as the war were attacked by many. In some cases, the Vietnam veterans themselves joined the anti-war protests. Given the tenor of the times, it is not surprising that returning veterans did not feel comfortable talking about their combat experiences. The nation appeared to be denying the Vietnam problem and, in so doing, denied the returning combatants an opportunity to ventilate and work through their feelings.

In Southeast Asia, American troops were not greeted enthusiastically. The war-wearied peasant population seemed to be less concerned with political leadership than with day-to-day survival. U.S. soldiers soon began to wonder why they were laying down their lives for a seemingly ungrateful populace.

Nature of combat. Guerrilla tactics were the primary mode of warfare in Vietnam. The amorphous enemy, protected by dense jungles, could not be beaten with conventional strategy and weaponry. Areas of land were not fought for, taken, and held as in other wars. Instead, soldiers on search and destroy missions sought out the enemy, who was as likely to be a woman or child as a uniformed soldier.

In an attempt to reduce the emotional strain on the combatants, combat exposure was purposefully shorter in Vietnam than in other wars and was routinely interrupted by rotation to areas of safety(1). But the fact that individual men, rather than units, were rotated worked against group cohesiveness and fidelity.

Use of mind-altering substances. The widespread availability and use of both alcohol and illicit drugs provided the soldier with a means of adapting to the situation by numbing his feelings and clouding his awareness. The results, however, were long-term substance addiction problems.

Age. The average age of the American soldier in Vietnam was 19.2 years, much younger than participants in earlier wars(2). The less mature soldier was more susceptible to the stresses of war than was his older counterpart in World War II and Korea. The youth of the men, coupled with some of the idiosyncratic features of Vietnam (unfamiliar culture, jungle terrain, guerrilla warfare, and availability of drugs and alcohol), created a rich medium for psychiatric disturbances.

Morale. Many veterans report that they felt militarily impotent—that they were placed in a no-win situation in Vietnam. They were restrained militarily for what they consider to be political reasons and were unable to employ the available weaponry in an all-out effort to win the war. The result was a sense of helplessness that lowered morale and escalated feelings of anger and rage. In addition, the nature of the war made it increasingly difficult to justify the deaths of friends.

Individual return dates. In earlier U.S. wars, combatants returned to the country in groups. Following a long journey home aboard ships, there were parades and heroes' welcomes. These events eased reassimilation into civilian life. Vietnam was different by design. Because World War II statistics had shown that those with the most combat exposure had the highest incidence of psychiatric symptoms, a new system called DEROS (date of expected return from overseas) was devised(3). Each participant knew, before going overseas, when he was scheduled to return home. For Marines it was a thirteen-

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month tour of duty; for all others it was twelve months.

While DEROS did provide for a shorter combat exposure, veterans were rotated out of the war just as they had been rotated into and out of combat, individually, on their predetermined date. They were evacuated by air, sometimes in midbattle, and often deplaned alone at home less than thirty-six hours later, still wearing the blood- and mud-encrusted uniforms from their last fire fight. Some homecomings were marred by name-calling and other debasements. There were no parades.

Vietnam veterans had no period of reorientation upon their return, and since most were unprepared for the many cultural changes that had taken place during their absence, they felt alienated and isolated.

Preventive measures in Vietnam. Despite the great potential for psychiatric breakdown in Vietnam, emotional casualties during the war itself were much lower than those documented for either World War II or Korea. Overall, the incidence of psychiatric breakdown was 12 per 1000 per year as compared with 40 per 1000 per year in Korea and 100 per 1000 per year in World War II(2).

Four treatment principles, described below, are credited with the low neuropsychiatric casualty rates(4).

Immediacy—Treatment was begun as soon as possible and as near the combat unit as possible.

Simplicity—Brief forms of psychotherapy were employed. Repression and suppression were favored over exploring or uncovering techniques.

Expectancy—The treatment attitude was that the combatant would be expected to return to his job as soon as treatment could be terminated.

Centrality—When evacuation was necessary, the patient was sent to the nearest psychiatric facility with a psychiatrist.

While the statistics indicate that the incidence of acute psychiatric disorders during the war was the lowest ever experienced, it has since become apparent that Vietnam veterans are more susceptable to chronic emotional difficulties than were the veterans of previous wars. Their high incidence of emotional problems is reflected in their divorce, unemployment, crime, and suicide statistics(4).

The Symptoms

In general, the symptoms of PTSD began to occur when the elation of having survived the war had begun to wear off—nine to thirty months following discharge(5). The duration of symptoms, however, has yet to be documented because many veterans are only now seeking treatment. The predominant symptoms of PTSD are listed below.

Anger. In a combat situation anger is a normal and expected response to a dangerous situation over which the individual has little control. The man who witnesses the death of friends and who cannot retaliate because of the elusive nature of the enemy (as well as his orders to remain in a defensive rather than offensive position) is susceptible to rage—a rage that sometimes led to publicized atrocities.

When the anger persists years after the danger and sense of helplessness have passed, however, it may be emanating from feelings that have been either repressed or intentionally suppressed through treatment. Examples of repressed feelings include guilt over the death of friends, separation anxieties, low self-esteem over having failed to win the war in the usual American "John Wayne" fashion, or persistent feelings of hopelessness.

The sustained anger may also represent a means of maintaining pride. The veteran knows, on the cognitive level, that he did not win the war. An angry, macho demeanor may be a defense mechanism that prevents the veteran from experiencing the loss of the war on an affective level.

People who have PTSD express anger in a number of ways; the most publicized is random violence. The mass media have often portrayed the Vietnam veteran as a surly recluse who unexpectedly begins sniping at innocent people. While there have been isolated cases to substantiate this portrayal, those of us who work closely with the veterans know that the violent outbursts are usually of a more personal nature, involving wife and child abuse, as well as aborted and successful suicide attempts.

Some veterans describe their anger as a pervasive, unrelenting rage over which they must maintain constant vigilance. Many have become adept at displacing it; they hit walls instead of people. Many keep weapons.

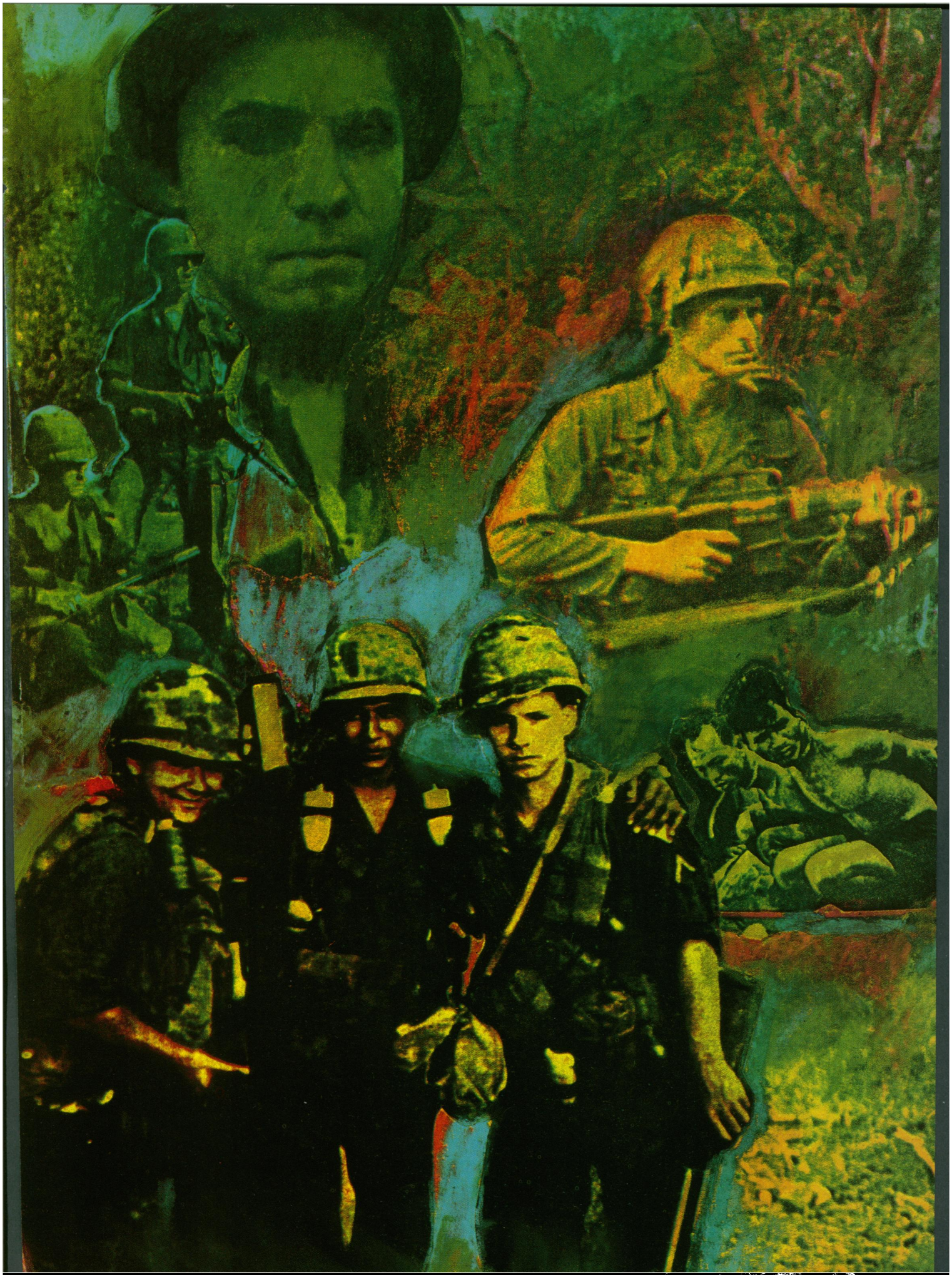
Still others have internalized the anger and express it as depression. In fact, a common presenting symptom of PTSD is a chronic, retardive depression that includes symptoms of apathy, irritability, insomnia, and feelings of alienation. Other veterans who have PTSD may enter the health care system for treatment of ulcers, rheumatoid arthritis, or hypertension, all of which may be linked to the suppression of anger.

Guilt. A second primary symptom of PTSD is an overwhelming feeling of guilt. According to Egendorf, the guilt has three sources—acts of commission, omission, and association(6).

The combatant *committed* by necessity acts that conflicted with his personal values. He was purposefully trained to react without questioning or thinking. His survival may have been dependent upon his ability to behave in what he previously felt to be an antisocial, inhumane, or even bestial manner. Now, as he looks back, he judges himself, not by the standards that prevailed during the war, but by his pre- and postwar values. According to these values he has committed acts that are unforgivable.

The Vietnam veteran may also feel guilty because of what he *didn't* do, for failing to follow the dictates of his conscience. He may not have objected to orders that he felt to be unethical. His negligence under stress may have resulted in casualties.

The veteran may feel guilty for having been *associated* with a war he felt to be immoral. He may



believe he is responsible for a friend's unpreventable death, or he may feel guilty for having felt relieved that it was his friend and not he who died.

He may feel guilty because his persistent feelings about the war are causing him to neglect current responsibilities. Finally, just having survived when friends did not may produce "survivor's guilt," illustrated by a veteran who tearfully described how, 13 years ago, a large proportion of the men in his unit were killed. When asked what could have been done to change the situation, he replied, "Nothing, but at least I could have died with them."

Psychic numbing. The veteran characteristically reports that he has turned off all feelings, that he feels nothing, or that he feels dead inside. Numbing was an adaptive mechanism in the combat situation, for by emotionally isolating himself, he was less susceptible to feelings associated with loss. He quickly learned to avoid emotional attachments and to hold back feelings of caring and trust.

Now that the war is over, his emotional detachment and inability to trust and love others have contributed to marital, family, peer, and employment problems. Pushing others away for fear of losing them has left the veteran isolated and detached.

Periodically, some veterans try to assure themselves that they are still capable of feeling by engaging in such thrill-seeking behavior as shooting guns, driving at dangerously high speeds, and putting themselves in life-threatening situations. Others flirt with economic destruction by compulsive gambling. Still others report that everything is emotionally anticlimactic after their highly charged combat experiences; they say that death holds little fear and life no joy.

Other behaviors that should lead the clinician to suspect PTSD in a Vietnam veteran include reports of disturbing, recurrent nightmares; intrusive thoughts; unstable postwar employment history; difficulties with authority figures; past or present history of alcohol or marijuana abuse; unstable marriage and family life, including wife and/or child abuse; social isolation, irritability; overreactive startle reflex; and an underlying distrustful or sometimes overtly paranoid outlook on life.

Before making a diagnosis of PTSD, however, it is imperative that the clinician investigate the veteran's early life experiences, including his educational and vocational histories, and his relationships with his family, peers, and authority figures. If, for example, a veteran who is depressed, abusing his family, and unable to deal with authority figures reveals a past history of disturbed interpersonal relationships, substance abuse, and criminal activities, then a personality disorder, rather than PTSD, may be the primary diagnosis. In such cases, however, PTSD might well be a secondary diagnosis.

If there is an uneventful precombat history and if the veteran began to display antisocial and disturbed behavior a year to two after returning from Vietnam and if that behavior reflects the symptoms described, PTSD should be fully investigated as the primary diagnosis.

Overall, in order to establish the diagnosis and plan treatment, the clinician needs to take an extensive premorbid history, conduct a detailed exploration of combat experiences, and thoroughly assess the veteran's defenses prior to the war and after it, up to the present(7).

Shatam has described the veteran's condition as impacted grief. Lacking appropriate social institutions or mechanisms to assist him with his grief, the veteran did not progress through the process of adaptation to loss; he remained in a state of maladaptation(5). For years the condition festered as the veteran attempted, essentially alone, to deal with his pain.

Therapeutic Intervention

The goal of all intervention for PTSD is to encourage the veteran to express his grief, so that he can go on with his life. While the Vietnam veterans' problems have unique features, PTSD can be successfully treated with conventional methods—individual, group, and family psychotherapy.

In order to work effectively with Vietnam veterans, the therapist needs to examine his or her own feelings about the war. The veteran will undoubtedly test the therapist's commitment to and interest in him by relating combat experiences. Responses of shock and disdain on the part of the therapist can hamper the formation of a working relationship and reinforce the veteran's poor self-image and sense of guilt. Reading extensively about the Vietnam war and the experiences of combat veterans—particularly the killing of women and children and atrocities that included mutilation of the enemy—will prepare the therapist for some of the events clients will most certainly describe.

The first treatment objective is to establish a trusting relationship with the veteran. His basic distrust, poor self-image, difficulties with authority figures, and fear that he cannot control impulses make this a challenging task.

As with most patients, the clinician can best foster the development of trust by accepting the patient at his current level of functioning and by assuming a positive, consistent, honest, and nonjudgmental attitude.

The veteran who fears loss of control over angry impulses can be helped to regain control by being encouraged to express his anger in words and to identify situations in which he has lost control. Talking about the past events and precipitating factors is an important initial step. Horowicz and Solomon call this process conceptual labeling, and they believe that it increases the veteran's problem-solving abilities and enables him to later deal with his anger by adopting the techniques of intellectualization and rationalization(1).

As the therapeutic relationship develops, the therapist's approval becomes increasingly important. This is illustrated by a veteran who was subjected to a long wait for a clinic appointment. At an earlier point in his treatment, he would not have tolerated the wait; he might have responded by becoming loud and verbally abusive, or by storming out of the clinic and displacing his anger onto his family. This time, however, he waited it out. When asked to explain his success, he

For Further Information on PTSD ...

Organizations

Disabled American Veterans
National Headquarters
P.O. Box 14301
Cincinnati, Ohio 45214

Veterans Administration Operation Outreach
Vietnam Veterans Readjustment Counseling Centers (Vet Centers)
The Vet Center in your area can be located by calling the local Veterans Administration hospital.

Vietnam Veterans of America
329 Eighth St., N.E.
Washington, D.C. 20002

Pilot studies are now under way to examine the effects of the Vietnam war on nurse veterans. Information can be obtained from Lynda VanDeVanter at Vietnam Veterans of America.

Additional Reading*

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Emerson, Gloria. *Winners and Losers.* New York, Random House, 1972.

Figley, C. R., and Levantman, S., eds. *Strangers at Home: Vietnam Veterans Since the War.* New York, Praeger Publishers, 1980.

FitzGerald, Frances. *Fire in the Lake.* New York, Random House, 1972

Webb, J. H. *Fields of Fire.* Englewood Cliffs, N. J., Prentice-Hall, 1978.

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replied, "I kept thinking about how disappointed you would be if I didn't handle it." Thus, through the mechanism of introjection, the patient was able to borrow ego strength from the therapist.

A technique that has been used with some success in marriage counseling is a joint assessment of a typical angry outburst. The assessment is done when the veteran is calm and in good control. Both parties identify how an angry situation escalates and explore preventive measures that the spouse can take to help the veteran retain control. For example, one veteran's wife stated that when her husband yells "get out of my face," she knows that physical abuse may follow. She has learned, through joint exploration, that if she leaves the house and returns in an hour, her husband will have regained control and their disagreement can be resolved without violence.

If a veteran is having difficulty controlling the urge to physically abuse others, he can be taught how to displace that anger. Providing a safe, staff-monitored room for pounding and throwing clay has worked in some instances. Other veterans have found that destroying "things" prevents them from hurting people.

The next step is to help the veteran move from physical to verbal expression of his anger—getting relief from shouting, rather than striking—and finally to help him deal constructively with anger.

Lifton differentiates between neurotic guilt (experienced by many and related to childhood fantasies) and the shame and guilt of the Vietnam veteran, precipitated by real actions (killing and mutilation) which violated a consciously held moral code. Thus, Lifton postulates that the usual therapeutic techniques are ineffective with the PTSD patient and instead suggests a three-step process: clarification, atonement, and restitution(8).

Clarification involves helping the veteran to understand that he was not in a position to apply his precombat value system in Vietnam. Helping him to put his behavior into perspective is an important initial step in alleviating guilt.

Next, he can be led to discover that he has already atoned for his transgressions by socially isolating himself and engaging in self-destructive behavior. How much longer does he intend to punish himself, he can be asked, before he will permit himself to stop?

Often, a clergyman can offer church-sanctioned forgiveness that helps the veteran to conquer his guilt, provided the veteran has begun to accept authority and to trust others. Group therapy with other Vietnam veterans can provide the peer support he needs to forgive himself. Some veterans benefit from assisting other veterans who have PTSD. Such assistance serves the dual purpose of alleviating guilt and building a healthier self-concept.

It has been nine years since American troops were actively involved in Vietnam, but for many veterans the horrors of the war are as vivid today as they were then. The wounds can be healed with time, but not with time alone. Clients who have PTSD need the help of informed therapists who are able to apply their knowledge of the mourning process to the special needs of those who survived the Vietnam conflict.

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