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Missing After Action: A study of the Alienation and Withdrawal of Vietnam Veterans from Contemporary American Society

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MISSING AFTER ACTION: A STUDY OF THE ALIENATION AND WITHDRAWL OF VIETNAM VETERANS FROM CONTEMPORARY AMERICAN SOCIETY

by

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This thesis submitted by Richard L. Kuschel in partial fulfillment of the requirements for the Degree of Master of Science at St. Cloud State University is hereby approved by the final evaluation committee.

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MISSING AFTER ACTION: A STUDY OF THE ALIENATION AND WITHDRAWL OF VIETNAM VETERANS FROM CONTEMPORARY AMERICAN SOCIETY

Richard L. Kuschel

The purpose of this thesis is to examine the relationship: (a) between severity of stressors in combat, (b) post-traumatic stress disorder symptomology, and (c) subsequent alienation, withdrawal and isolation of Vietnam combat veterans from contemporary American society.

This thesis deals specifically with the diagnostic criterion "feeling of detachment or estrangement from others," as stated in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, third edition revised, section 309.89 (post-traumatic stress disorder), part C, item no. 5.

The sample population for this study is a group of Vietnam combat veterans who live in Northern Minnesota. All of these men meet the diagnostic criteria for post-traumatic stress disorder to some degree. The data consists of: (1) survey results, (2) interviews, (3) group discussions, and (4) personal observations of these men by the researcher. Results of this study are compared to other assessment methods which are currently being used for the diagnosis of post-traumatic stress disorder. Unusual types of stressors and symptoms are explained and examples of current assessment tools are presented. The phenomena of alienation, withdrawal and isolation are also examined in the perspective of a natural result of unnatural circumstances.

This study indicates that there is a relationship between: (a) the severity of stressors, (b) the post-traumatic stress disorder symptomology, and (c) subsequent alienation, withdrawal and isolation. The variables of this relationship are discussed, but levels of significance are omitted due to the limited number of subjects available. The conclusions indicate that present treatment methods are inadequate and there is a tremendous need for further research to develop treatment programs to bring these veterans out of isolation (both physically and

psychologically) and facilitate their reentry and useful integration back into the mainstream of American society. The relationship between stressors, PTSD symptomology and eventual isolation also support efforts toward preventative techniques.

After examining the literature review, questionnaire results, group sessions and personal interviews of this study, it is evident that there is a relationship between (a) severity of stressors, (b) PTSD symptomology, and (c) subsequent alienation, withdrawal and isolation of Vietnam combat veterans from contemporary American society. Because of the relatively small number of subjects who participated in this study (20), statistical levels of significance were not used. The relationship indicated progresses from a to b to c, but not directly from a to c. There are many variables to consider when assessing severity of stressors and PTSD on an individual level and there is a definite need for further research which would lend to more adequate treatment methods for PTSD. It also seems obvious that there is a need for more preventative efforts in the form of immediate therapy for those exposed to extreme stressors such as those experienced in combat.

February 14, 1990
Month Year

Approved by Research Committee:

Mary Dwyer
Mary Dwyer Chairperson

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of earlier wars were treated and appreciated by their nation."

George Washington, 1776

"The responsibility of the U.S. Government is . . . to care for him who shall have borne the battle, and for his widow and his orphan."

Abraham Lincoln, 1862

TABLE OF CONTENTS

LIST OF TABLES

Chapter 1

INTRODUCTION

Post-traumatic stress disorder (PTSD) is the natural result of human reactions to unnatural or extremely stressful experiences. Sufferers include victims from all nations, all cultures, and all levels of society. They do not necessarily have to be combat veterans, as are the subjects of this thesis. They can be victims of many other types of traumatic stressors, such as floods, fires, hurricanes, earthquakes, car accidents, train wrecks, plane crashes, personal assaults like rape, incest, muggings, or other forms of violence and abuse. All of these different types of trauma victims share similar symptoms. The severity and results of these symptoms differ according to the severity of the stressors, individual susceptibility at the time of the trauma, and the availability of treatment and support after the injury has occurred. These symptoms can be chronic if untreated and can become permanent personality characteristics or even result in suicide. Because of the lack of knowledge about PTSD, and the lack of adequate treatment for it, there are many chronic sufferers in American society today.

The diagnosis of PTSD was not even listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders until the third edition which was published in 1980. Most of the research which led to this classification was done because of the epidemic of PTSD among Vietnam veterans. This diagnostic category was revised in 1987 in the new DSM III-R (Appendix B) and is in the process of being revised again. Recent research findings which have led to these revisions are the results of research projects which have taken years to accumulate large enough sample populations to produce significant results. Part of the problem in accumulating these results is that available information is generally limited to those who have sought treatment, and this particular group can provide biased information. Another part of the problem is the common aversion of Vietnam veterans to anything government or Veterans Administration. This phenomenon of avoidance is recognized in the DSM III-R Diagnostic Criteria, Section 309.89, Part C, item number 5, as: "feeling of detachment or estrangement from others." The frequent occurrence of this particular diagnostic criteria not only hinders research efforts, but it also has serious implications towards treatment. The tendency of these veterans to withdraw from others and isolate themselves is generally recognized by researchers and therapists alike and is a problem which needs to be dealt with first and foremost

in providing assistance to the veterans. This tendency of Vietnam veterans to withdraw from others and isolate themselves is represented by the phrase "missing after action" (MAA) in the title of this thesis. War statistics (Appendix A) indicate that there are still 2,459 Americans listed as MIA (missing in action) as a result of combat in Vietnam and outreach workers and other mental health professionals estimate that there are presently 35,000 to 45,000 Vietnam veterans living in isolation. This post-war phenomenon of "missing after action" is a problem which has received even less attention from American society than has the issue of the missing in action. The etiology of this problem is the object of this thesis.

Consistent with other PTSD diagnoses, the DSM III-R presents descriptively a set of symptoms/criteria which, taken together, characterize the disorder. This syndrome can also be seen as reflecting a dynamic process by which a survivor attempts to integrate a traumatic event into his or her self-structure. The process itself is a natural one and is not labeled as pathological (i.e., as a disorder) unless it is prolonged, blocked, or exceeds a tolerable quality (Zilberg, Weiss, & Horowitz, 1982).

Psychic trauma results when a person experiences an adverse event that is beyond personal control, and causes undue stress. Clinical evidence indicates that a lack of control over an adverse event will cause neurobiological

and behavioral anomalies (Kolb, 1987). It is these changes, brought about by psychic trauma, that cause sudden and severe loss of psychological integrity and cohesiveness (Kohut, 1977). "In most cases the trauma is the result of a massive psychological assault, but may result from continued exposure to high intensity stressors" (Kolb, 1987, p. 990). The combat experiences of Vietnam were a combination of massive psychological assaults and continued exposure to high intensity stressors. The examples, or subjects of the survey questionnaires, groups, and interviews studied for this thesis were those Vietnam veterans who met the DSM III-R criteria for PTSD. Examples of some of their psychic traumas and PTSD symptomology are included in this text.

Before effective therapy can be implemented for treating these victims of psychic trauma, many variables have to be considered. Demographic variables (e.g., age, social class, level of education) seem to affect adjustment potential, and man-made versus natural disasters seem to affect the severity of the symptoms and the recovery process (Bettleheim, 1943). In Vietnam, victims were not always passive, but were agents of trauma as well as victims (i.e., they were active combatants who caused harm, suffering and death to others). This fact can complicate both symptomology and recovery. There are sociological variables, such as social acceptance and support versus rejection in the attitudes of society which affect the

recovery process. Spiritual counseling is another area which has to be considered. These variables, and their relationships to the phenomena of alienation of Vietnam veterans from American society are the focus of this thesis. It is the hypothesis of this researcher that a better understanding of these variables is the key to the therapeutic process and resocialization of these veterans and of American society. It is the purpose of this thesis to investigate these variables and present them for group discussion with the veterans who participated in this study.

Noone seems to know for sure just how many Vietnam veterans were exposed to combat, or to what extent they were exposed to combat. Records are poor or non-existent, and the combat veterans themselves are not likely to tell of their experiences. The archetypal horrors of war are not often spoken about by veterans of any war. The misrepresentation of facts, as well as the sensationalism and over-capitalization of the misfortunes of the Vietnam veteran by movies, television shows, and the news media have created an image of him as a drug-crazed psychopathic killer. Although this is gradually changing now, after twenty some years, this false image in itself has helped to alienate the Vietnam veteran from the rest of American society. Although a few of these veterans have helped create and maintain this image, most have learned not to mention the fact that they were ever in Vietnam at all.

There are, however, several excellent books available which have been written by Vietnam veterans about their combat experiences. Research psychologists have shown a recently renewed interest in PTSD and the Vietnam veteran. For example, the January, 1987 issue of the Journal of Clinical Psychology is devoted entirely to the publication of recent information about PTSD and its implications for other family, mental health and social interaction problems. Besides this particular journal, there are a multitude of other research findings. Because the incidence of PTSD is so high among veterans of the particular type of warfare common to Vietnam and some of the other "conflicts" going on around the world, other governments, such as those in Israel and the Soviet Union are starting to contribute to the research on the subject of PTSD. Review materials which were read and used in the preparation of this thesis represent only a small selected portion of the total amount of research available on the subject of PTSD.

Chapter 2

THE PROBLEM

Although there seems to be an abundance of literature available, the Vietnam veteran population has been a difficult one to study. Most studies have been limited to veterans who have sought treatment in facilities which share information and statistics. Private treatment facilities do not generally divulge any information about their clientele, and Vietnam veterans have a tendency to avoid government facilities. The following statistics are an example of the information that is available. Many veterans organizations consider these to be conservative estimates. The incidence of isolation and suicide reflect the anomie of this veteran population.

> Over 8.5 million American people served in the Armed forces during the Vietnam war. Approximately 4 million actually served in Vietnam. Of these 4 million, 500,000 to 1,500,000 (3.75% to 12.5%) either saw active combat or were exposed to hostile situations. Presently, 58,156 (4%-12%) of those exposed to hostile situations are listed as killed in action (KIA) or missing in action (MIA). Another 303,000 (20%) were wounded; 75,000 sustained serious wounds resulting in permanent impairment, 18.4% of which sustained multiple amputations. It is estimated that 20% to 60% of all who served in Indochina may be suffering emotional repercussions of their war experience (800,000 to 1,500,000 people). It is also estimated that between 54,000 and 108,000 veterans have committed suicide

since the war. Outreach workers and other mental health professionals estimate that there are between 35,000 and 45,000 veterans presently living in isolation. (Vietnam Learning Center statistics from Appendix A)

The symptoms of post-traumatic stress disorder (PTSD) are experienced by all Vietnam combat veterans to varying degrees (Disabled American Veterans, 1987). For some with the most extensive combat histories, Vietnam related problems have persisted in disrupting all areas of life experiences. Without any intervention, what was once a reaction to a traumatic episode may become for many almost unchangeable personality characteristics. Many become so frustrated and depressed that they turn to suicide. (The estimate in the previous list of statistics is only from 1978 to date, and some veterans returned home at least ten years before that.) PTSD has become a chronic lifestyle affecting not only the veterans but countless millions of persons who are in contact with them (Wilson, 1978). The problems of these veterans affect more than just their immediate families and have a long range effect which cannot be ignored by American society any longer. The cumulative effect of the neglected psychological difficulties of the veteran has resulted in a sociological dilemma for American society. The solution of the problem lies in the resocialization of not just the Vietnam veteran, but of the whole American society.

The problem, then, is a very complex one which requires, first of all, a clearer definition. An evaluation of the relationship between stressors, PTSD symptomology and estrangement of Vietnam veterans leads to an analysis of the very basic assumptions concerning the causes of PTSD. Some of these assumptions are discussed within the scope of this thesis. The parameters of the diagnostic criteria are set by the DSM III-R, and many mental health professionals neither understand nor look beyond these parameters (yet these parameters are presently being revised again). The only resource that promises any relief for the problem is the "system" (Federal programming), and veterans are encouraged to become dependent upon the Veterans Administration and Vet Centers to meet their needs. (Vet Centers are independent of the Veterans Administration and were created specifically for dealing with this problem.) Unfortunately, this resource has been hamstrung by Federal budget cuts until it is understaffed and overcrowded and the red tape frustrates and further alienates the Vietnam veteran who has learned to withdraw from stress. This primary frustration was one of the topics discussed during the groups which were conducted during this research. In essence, veterans become even more isolated, but now they know why. This thesis attempts to explain some of the reasons for this isolation and its relationship to effective treatment.

Private hospitals and clinics generally do not have staff who are trained to treat PTSD, nor do they have programs that are set up to handle the problems of these veterans. Besides that, they are too expensive for many veterans. Even if the veteran has insurance to cover treatment, employers see the diagnosis on the insurance forms and are very likely to dismiss the veteran because they do not understand PTSD and believe the stereotype that Vietnam veterans are like the drug crazed psychotic killers they see on television. Veterans preference for hiring seems to have reversed. Unfortunately, here is another reason why many veterans hide their problems and become more estranged and isolated. (Examples of this type of situation were also discussed during group sessions.)

Most counseling that veterans are likely to receive is done in isolation, that is, apart from their significant relationships. Family therapy rarely occurs, although the effects of PTSD on families are common knowledge to therapists. This type of "secret" treatment is like treating the symptom of a problem and sending the client back to be re-exposed to the same stressors in a more vulnerable state. The results can be devastating. Focusing on the identification of pain and loneliness, without the means for re-connection with supportive relationships can lead the veteran down the path to a trip wire of withdrawal and depression and the ultimate isolation of suicide.

Several examples of suicides during "treatment" were also discussed during our group sessions.

Humans are social animals. Even "primitive" people knew the value of social bonding and social structure. Primitive societies knew that the worst form of punishment they could impose on an offender was to banish him from living with his own people. The rejection and isolation of the Vietnam veteran from American society is very similar to this early form of punishment.

Because American society is basically a Judeo-Christian culture with deep-rooted Judeo-Christian values, standards, laws, and language, the problem of alienation of the Vietnam veteran also has a theological aspect to it. Vietnam veterans were enculturated into this culture as part of their American heritage. They suffered an extreme form of culture shock in Vietnam, and have had profound difficulty becoming reenculturated after they returned home, their basic value system destroyed by the inhumaneness they had witnessed. The Judeo-Christian based values of American culture were countered by acts of terrorism and torture in many extreme ways. These veterans saw women and children and old people who were burned by our own napalm and killed by our own bombs or troops. They saw naked disemboweled women hanging from trees by their toes and found dead babies in wells. They saw Buddhist monks pour gasoline on themselves and burn themselves to death. They saw friends

killed and learned to kill and sometimes performed "atrocities" themselves. Examples of these horrors live on endlessly in the memories and nightmares of our veterans. Many emerged "psychically numbed" by their experiences. The moral and spiritual pain of these veterans has been severely neglected by the American clergy, as well as by modern psychotherapists. This neglect is qualified in further chapters as an additional factor of alienation. To quote William Mahedy, a priest who served as a chaplain in Vietnam and has worked extensively with Vietnam veterans:

> Tragically, the Church has played as yet almost no role in assisting the veterans to readjust back in the world. The religious and moral dimensions of their crisis have passed unnoticed by religious leaders, theologians, and the people in the pews. (1986)

A comprehensive evaluation of the problem becomes a metalogue between anthropology, psychology, sociology, and theology. It includes predispositions, personality theory, social structure, and levels of maturity and spiritual development. All of these things have to be considered while evaluating stressors of combat, symptomology of PTSD, and the causes and effects of isolation.

Chapter 3

LITERATURE REVIEW

Factors Influencing PTSD: Individual Characteristics

The extent to which personality characteristics affect response to stress is still being debated. Researchers take an interactional approach, assuming that neither individual characteristics nor aspects of the stressful event solely determine outcome (Wilson, Smith, & Johnson, 1984). Lazarus and his colleagues (Lazarus, Averill, & Opton, 1974) have developed a model of the coping process that takes into account not only the stressor itself, but the person's appraisal of that stressor based on his or her prior experience. DSM-III suggests that preexisting psychopathology predisposes individuals to develop PTSD. This has not yet been empirically investigated. There is some evidence that prior characteristics of the individual do predict post-traumatic adjustment (Helzer, Robins, Wish, & Hesselbrock, 1979). Relative to preexisting personality is the notion that "prior stressful events" may make a person more vulnerable and/or affect his or her appraisal of the situation. These have been related to outcome in such

situations as well (Green et al., in press). Coping mechanisms of the individual have also been studied in this context. This variable has clearly been empirically demonstrated to mediate the relationship between a stressful experience and its outcome (Anderson, 1976; Gleser et al., 1981; Weisman & Worden, 1977).

Experience of the Psychic Trauma

A relatively recent development is the growing literature which is attempting to relate specific aspects of a person's experience during a catastrophic event to their later psychological functioning. There is some beginning evidence that certain experiences are empirically connected with long term functioning. Some of these experiences, when examined within collectively stressful circumstances (disasters, war), and shown to be related to the outcome, include the following: Bereavement (Gleser et al., 1981; Green, Grace, & Gleser, in press; Green, Grace, Lindy, Titchner, & Lindy, 1983); Displacement (Gleser et al., 1981; Huerta & Horton, 1978); Life threat (Adler, 1943; Gleser et al., 1981; Green et al., in press); Exposure to grotesque sights (Green et al., in press; Taylor & Frazer, 1982); and Combat stress (Foy, Sipprelle, Rueger, & Carroll, 1984; Penk, Robinowitz, Roberts, Patterson, Dolan, & Atkins, 1981); and The particular role taken by the survivor (Green, Wilson, Lindy, 1984). An example of survivor role pertinent

to this study is that a soldier in combat not only has experiences happen to him, but he acts on the environment as well and may be involved in killing or injuring others. Such circumstances would increase the risk for later impairment.

The Recovery Environment

Least emphasized in the current literature have been those aspects of the social environment which may contribute to the person's ultimate adaptation. The most often explained variable is that of "social supports" and, not surprisingly, more supportive environments tend to be associated with a better adjustment to stress (Andrews, Tennant, Hewsow, & Vaillant, 1978; Burge & Figley, in press; Green et al., in press). This variable may be viewed as either an individual characteristic of the social system, i.e., more supports may be available in a particular recovery environment and some people may make better use of such available supports than others, whether it is encouraged or not. Other social variables have been less conceptualized and studied. Lindy, Green, & Green (1981) discussed the potential impact of cultural characteristics on the particular way in which survivors respond. Lindy et al. (1981) also discusses an aspect of the recovery environment called the "trauma membrane," a phenomenon which plays an important role in efforts to reach out to a

population in order to study, educate, and treat the survivors. Family and friends of survivors often form a sort of membrane around the survivors which functions to protect them from people and circumstance that threatens to be further traumatic. To penetrate the membrane (for study and therapeutic intervention), one has to be screened in some fashion and ultimately viewed as helpful, not harmful. The extent to which this membrane is ultimately helpful to the survivor, or serves to keep him or her from getting help, could not be determined.

An additional set of variables contributing to the appraisal and working through of a traumatic experience are called demographic characteristics (e.g., age, sex, social class, level of education) (Lumsden, 1975). These factors would represent the groups with which a person is identified within a particular society. For example, better educated people seem to make a better adjustment following a disaster (Gleser et al., 1981; Green et al., in press), and younger people, such as the young soldier (average age 19.2) in Vietnam, seem to have a more difficult time adjusting (Figley & Levantman, 1980; Kolb, 1984).

A very important aspect of the recovery environment which is just recently beginning to receive attention involves the attitudes of the society, and of family and friends within that society toward the traumatic event. This variable is receiving the most attention with regard to

the veterans of the Vietnam war (Figley, 1978; Levantman, 1980). "Homecoming" for these individuals is being increasingly focused on, since it appears that in some cases, the return to an environment hostile to the traumatic event (the war) and to those who participated (and were traumatized) at the least exacerbates the psychological effects of combat, and may well account directly for some of the negative effects. There are other experiences, such as rape, in which the victim may be "blamed" that would also fall into this category.

Spiritual Issues

> While moral and spiritual issues have been identified by Peter Marin and William Mahedy as being of central importance for combat veterans still suffering mentally from the experiences of war, to my knowledge no empirical studies have been conducted addressing the relationship between moral (or spiritual) development and the incidence of PTSD and its specific symptomology.

Chaplain Gary Berg of the St. Cloud Veterans Administration Hospital made this statement in a research proposal for a project which will measure moral development in Vietnam veterans. It is his hypothesis that combat veterans of "post-conventional" or "principled" levels of moral development will experience symptoms related to guilt, depression, remorse, unresolved grief, and a sense of purposelessness and meaninglessness or existential anxiety. John Wilson (1978) states that the existential anxiety (in

contrast to neurotic or basic character anxiety) of the Vietnam veteran

> stems from having a different set of moral judgments and ideological perspectives than the conventional social order. This, in turn, makes the process of finding a niche in society difficult because he needs to feel intimate, productive, creative, and committed to his principles with integrity.

As much as the combat veteran longed to return to "the world," when he finally did arrive, he realized that "he now marched to the beat of a different drummer"; he no longer fit in (Wilson, 1978). This was particularly true for those veterans who experienced what Wilson identifies as "psychological acceleration," a process he identifies as a "psychological time warp because of the kinds of questions the veterans ask themselves today; their ultimate concerns in life, their interpersonal orientation and view of society are often characteristic of those which normatively emerge later in life" (Ibid). In contrast to veterans who reflect post-conventional levels of moral development, Wilson goes on to suggest that veterans with low P-scores will exhibit symptoms of alienation and anomie fueled by anger, rage and despair. It is also Chaplain Berg's hypothesis that PTSD is an expression of cognitive dissonance, i.e.,

> The veteran's role as a maker and sustainer of moral values to be passed on to the next generation may collide with what he experienced in war. Reflection on this dissonance may surface old wounds at mid-life or long after the initial stressors were felt. (p. 6)

Chaplain Berg postulates that one of the primary stressors of the Vietnam war was the conflict between moral behavior and moral judgment. Because the conflict in value systems has been so enormous for Vietnam combat veterans, they have, through reflective reorganization of their basic value system, been motivated to a higher level of moral development. He argues that a principle consequence of combat for many Vietnam veterans has been a tremendous cognitive disequilibrium that they are still trying to resolve, and that such cognitive dissonance is a primary ingredient in the syndrome known as PTSD.

While the literature has identified moral issues and moral pain as playing a significant role in PTSD, most research and treatment to date has been concentrated in areas other than existential. The Vietnam veterans, in their quest for justice and meaning in what they experienced, have not yet realized that they are the ones who have the responsibility of creating this justice and meaning. As Peter Marin (1982) stated it: "Like most Americans, they (the Vietnam veterans) do not have a sense of themselves as makers and sustainers of moral values, even though, without knowing it, that is what many of them have become."

To quote Uwe Siemon-Netto (1988), a war correspondent who was in Vietnam for five years and is now a Lutheran minister:

Thus even without reference to any Christian doctrine the suffering of as large a group as the Vietnam veterans must surely be seen as a momentous event in the history of this young nation; it must have an impact on its future development. Furthermore, the agony of the veterans should give their country a new sense of purpose.

Chapter 4

STRESSORS OF THE VIETNAM WAR AND POST-TRAUMATIC STRESS DISORDER

The Vietnam war and PTSD literature has demonstrated that there are several dimensions of war stress which must be examined in analyzing the incidence and prevalence of PTSD in Vietnam veterans. Thus the 1987 revision of its DSM-III-R criteria and the present efforts of revising them again.

Stressors

There is general consensus that combat experience is a central element in estimating the effects of the war experience (Card, 1983; Dewane, 1984; Disabled American Veterans, 1987; Figley, 1978 & 1980; Hendin & Haas, 1984; Horowitz, 1986; Howard, 1976; Kolb, 1984 & 1987; Laufer, Frey-Wouters, & Donellan, 1981; Lifton, 1979; Lipkin, Blank, Parson, & Smith, 1982; Walker & Cavenar, 1987; Wilson, 1978). Combat exposure, however, is not the sole traumatic experience in a war situation. Other research has demonstrated that there are additional aspects of war stress which need to be incorporated into a conceptualization of traumatic war experiences. In his Vietnam Experience Scale,

Foy (1980) suggested that atrocities were likely to contribute to PTSD. Other research reports (Laufer, Brett, & Gallops, 1893; Laufer, Gallops, & Frey-Wouters, 1984) have demonstrated that exposure to abusive violence does contribute to PTSD independently of the effect of combat. Wilson's work (Wilson & Krauss, 1982) suggests that the physical environment, e.g., the terrain and weather, and subjective reports of stress in combat also play important roles in long term response to the trauma. The accumulating evidence indicates that there are a wide range of independent stressors implicated in PTSD among Vietnam veterans. Besides the terrain and weather, which could be anywhere from hot, dry, and sandy; hot, humid, and muddy; to cold, wet, muddy, and slippery, there were daily casualties from heat exhaustion, heat stroke, "jungle rot" (itchy and painful skin rash), rat bites, rabies, poisonous snake bites, poisonous centipede bites, leech bites, ant bites, termite bites, hordes of mosquitoes, malaria, amoebic dysentery, typhus, encephalitis, cholera, typhoid, bubonic plague, hepatitis, tuberculosis, parasitic intestinal worms, boils and infections, long periods without food, water or sleep, physical exhaustion, booby traps, snipers, piles of accumulated and stinking bodies, having to do "body counts," and the common knowledge that the people back in "the world" didn't care. The lack of meaning and purpose for all this suffering destroyed morale and replaced it with depression

and rage. One independent stressor that is usually never mentioned is that of Americans being killed by other Americans, instead of by the enemy. This happened quite frequently as the result of accidents, misdirected air support or artillery, "fire fights" with other American patrols, by helicopter gunships or spotter airplanes, euthanasia of the wounded in extreme circumstances, and outright murder--usually of persons in authority whose incompetence needlessly cost the lives of others. This subject was discussed in several of our "Rap Groups" and was included on the questionnaire.

In a guerrilla war environment, all the people are at war: men, women, boys, girls, the aged, and the infirmed. Thus everyone is suspect and poses a potential threat to one`s life and safety. No one can be trusted, and there are no front lines to demarcate areas of danger from those of relative safety. The soldier in Vietnam was therefore not as concerned about winning the war as he was about surviving: staying alive by watching, constantly watching, watching everything that moved, watching the inanimate, not knowing who the enemy would be, when he would strike, or from where. As Watson (1978) remarks, "Survival is living where others would die." The unseen, omnipresent "enemies" of survival were pain, fatigue, boredom, loneliness, demoralization, and lack of purposefulness to the war effort.

PTSD--The Clinical Entity

Reactions and coping styles develop over time and become conditioned. The cumulative effects of hardship, constant danger, loss, grief, anger, hate and rage not only affect symptomology, but contribute to long term outcomes. Although DSM III-R (Appendix B-Criteria) specifies the symptoms that constitute the presence of disorder, it does not provide criteria concerning the intensity or duration required for determining when symptom occurrence is significant (Laufer, Brett, & Gallops, 1984). Such criteria are particularly important when information is collected in survey interviews on symptom experience as well as stressor experience. Different traumatic stressors such as exposure to combat and participation in abusive violence appear to result in different patterns of stress symptoms (Ibid). Some stressors frequently produce the disorder (e.g., torture), and others produce it only occasionally (e.g., natural disasters or car accidents). Sometimes there is a concomitant physical component of the trauma, which may even involve direct damage to the central nervous system (e.g., malnutrition, head injury). The disorder is apparently more severe and longer lasting when the stressor is of human design. The specific stressor and its severity should be recorded on Axis IV (DSM III-R, 1978). The following is the DSM III-R description of it's criteria for PTSD:

> The essential feature of post-traumatic stress disorder is the development of characteristic symptoms following

> a psychologically distressing event that is outside the range of human experience (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness. The characteristic symptoms involve reexperiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal. The diagnosis is not made if the disturbance lasts less than one month. The most common trauma involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one's child has been kidnapped, tortured, or killed.

The traumatic event can be reexperienced in a variety of ways. Commonly the person has recurrent and intrusive recollections of the event or recurring distressing dreams during which the event is reexperienced. In rare instances there are dissociative states, lasting from a few seconds to several hours, or even days, during which components of the event are relived, and the person behaves as though experiencing the event at that moment. There is often intense psychological distress when the person is exposed to events that resemble an aspect of the traumatic event or that symbolize the traumatic event, such as anniversaries of the event.

In addition to the reexperiencing of the trauma, there is persistent avoidance of stimuli associated with it, or a

numbing of general responsiveness that was not present before the trauma. The person commonly makes deliberate efforts to avoid thoughts or feelings about the traumatic event and about activities or situations that arouse recollections of it. This avoidance of reminders of the trauma may include psychogenic amnesia for an important aspect of the traumatic event.

Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed activities, or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

Persistent symptoms of increased arousal that were not present before the trauma include difficulty falling or staying asleep, (recurrent nightmares during which the traumatic event is relived are sometimes accompanied by middle or terminal sleep disturbance), hypervigilance, and exaggerated startle response. Some complain of difficulty in concentrating or in completing tasks. Many report changes in aggression. In mild cases this may take the form of irritability with fears of losing control. In more severe forms, particularly in cases in which the survivor has actually committed acts of violence (as in veterans),

the fear is conscious and pervasive, and the reduced capacity for modulation may express itself in unpredictable explosions of aggressive behavior or an inability to express angry feelings.

Symptoms characteristic of post-traumatic stress disorder, or physiologic reactivity, are often intensified or precipitated when the person is exposed to situations or activities that resemble or symbolize the original trauma (e.g., cold snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for veterans of the South Pacific).

Associated Features

Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an anxiety or depressive disorder. Impulsive behavior can occur, such as suddenly changing places of residence, unexplained absences, or other changes in lifestyle. There may be symptoms of an organic mental disorder, such as failing memory, difficulty in concentrating, emotional lability, headache, and vertigo. In the case of a life threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when others did not, or about the things they had to do in order to survive.

Age at Onset

The disorder can occur at any age, including during childhood.

Course and Subtypes

Symptoms usually begin immediately or soon after the trauma. Reexperiencing symptoms may develop after a latency period of months or years following the trauma, though avoidance symptoms have usually been present during this period.

Impairment and Complications

Impairment may be either mild or severe and affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolizing the original trauma may interfere with interpersonal relationships such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Psychoactive substance use disorders are common complications.

Predisposing Factors

Several studies indicate that preexisting psychopathological conditions predispose to the development of this disorder. However, the disorder can develop in people without any such preexisting conditions, particularly if the stressor is extreme.

Prevalence, Sex Ratio, and Familial Pattern

No information.

Differential Diagnosis

If an anxiety, depressive, or organic mental disorder develops following the trauma, these diagnoses should also be made. In adjustment disorder the stressor is usually less severe and within the range of common experience, and the characteristic symptoms of post-traumatic stress disorder, such as reexperiencing the trauma, are absent.

Chapter 5

ALIENATION

In the DSM III-R criteria for PTSD, Part C, Item #5, the phenomena of alienation is referred to as "feeling of detachment or estrangement from others." In most of the research literature pertaining to PTSD and the Vietnam veteran, alienation, isolation, withdrawal, avoidance of feelings, suspicion, and distrust of others, intimacy and interrelationship difficulties, or other forms of emotional "aloneness" are common themes of discussion indicating a general awareness of this DSM III-R "feelings of detachment or estrangement from others." Alienation, however, is not only a symptom of PTSD, but it is also the result of, and sometimes the terminal stage of PTSD. The dilemma of the Vietnam veterans is two dimensional: first of all, the combat veterans are still afflicted with the psychological aftermath of the war, and secondly, Vietnam veterans are the victims of a sociological situation which continues to obstruct their ability to become therapeutically reintegrated back into their rightful places in contemporary American society.

Sociological Variables

Besides the trauma of combat, there are other factors which have a tremendous impact on the alienation of this veteran population. These other "sociological" factors are responsible for the continuing pathology of the mental wounds of these veterans. Although the American Armed Forces never lost a major battle in Vietnam, the dissention of the civilian population back in the States lost the war for them (Burchett, 1977; Banerian, 1985, Emerson, 1977; Giap, 1967). They came home as losers and were rejected instead of welcomed home (Downs, 1984; Horne, 1981; Illman, 1978; Levantman, 1975; Lifton, 1975; Polner, 1971; Walker, 1983, Worthington, 1976). They are probably the first soldiers in history who were spat upon and insulted by the civilian population of their own country. They were even turned away by churches and VFW (Veterans of Foreign Wars) Clubs and turned down by the opposite sex for no other reason than their service in an unpopular war--a service most of them performed by force of law because they had been subject to conscription. The "ROTC Club" (veteran terminology for "run off to Canada"), on the other hand, was granted amnesty and welcomed home as heros. The Vietnam veterans returned to a society of mini skirts, "mind-expanding" drugs, and "flower-power", a self-indulgent society whose motto is "Do your own thing." They just could not fit in anywhere. They had witnessed death, destruction,

and inhumanity, and risked death and mutilation, to return and realize that they were only part of a national embarrassment. They were "blamed" for their part in the war.

Many of these veterans have become "social outcasts," living on the fringes of society (Fortier, 1973), some remain isolated within society (they don't participate in community functions, they don't vote, etc.), and many have opted out of American society completely, even to the point of giving up their citizenship and moving to other countries (Hendin & Haas, 1984; Siemon-Netto, 1988; personal interviews).

Some of the native American subcultures have offered support to veterans (white included) via traditional rites of passage for returning warriors. Since the ten year anniversary of the withdrawal of the last American forces from Vietnam (May, 1985), there have been some recent attempts by American society to give recognition to our forgotten warriors. One of these attempts, by the American Legion, has been in the form of dinners where Vietnam service coins are handed out to Vietnam veterans as a token medal for their service in Vietnam. Another has been a renewed interest in the POW issue (prisoners of war). Most veterans, however, are "dug in" with their bitterness, pain, and anger, and they view these token attempts to recognize their issues as "about 20 years too late", or "as more

attempts by the media (and some individuals) to sensationalize and capitalize on their misfortunes." These issues were discussed at length in our "Rap Groups."

Intimate Relationships and Teams

The subjects of "blunted emotions" and inter-relationship difficulties was another topic which kept resurfacing in our Rap Groups. The frequency and hostility of the so-called "Dear John" letter has never been so high as during the Vietnam war (Tanay, 1969). The feelings aroused by these letters were the cause of many veteran deaths, both during and since the war. Patricia Sheehan, in her article, "Fears Block Intimate Relationships for Some Vietnam Veterans," uses a "fear of intimacy" model developed by Larry Feldman in her work as a marital therapist. She says that behavior in war has to be looked at in the context of war, not by civilian standards, and recognizes that values and priorities change in war, for survival purposes; some veterans feel guilty about what they did or witnessed; they see themselves as bad, weak, or unacceptable people, and, "unfortunately, some veterans are too hard on themselves." Veterans become reluctant to share themselves with another person. They are afraid the other person could or would not understand or accept them. Veterans learned that part of their lives, part of themselves, was unacceptable. Sheehan also says that the "fear of

abandonment" is a part of their emotional blunting process:

> Fear of abandonment is losing a loved one. This loss can be through death, divorce, or emotional detachment. Vietnam veterans experienced numerous forms of abandonment. Many received "Dear John" letters, buddies were killed or left combat before they did, and they felt abandoned by the people at home and by their government. When they came home, they did not fit in anymore. They had changed and so had the country. The divorce rate for returning veterans was very high (80-85%). Many veterans are afraid to take a chance on being hurt by abandonment again. (p. 2)

Another fear, from Sheehan's format, is "fear of attack," or the fear of being hurt emotionally or physically. As intimacy builds in a relationship, both people learn where the other is vulnerable. They learn what really hurts the other's feelings. Anger or fear, however, can motivate us to go for the jugular. Psychological attack is one of the most common ways of decreasing intimacy in a relationship. Attacks by our intimate partner hurt more than the attack of a neighbor or co-worker. Our intimate partner is supposed to be the person we can count on above all others. A common emotional reaction to attack is to distance ourselves emotionally.

Vietnam veterans experienced the obvious attacking of combat and being in dangerous situations. Many had to be constantly suspicious and untrusting. Coming home, some were attacked by their own countrymen. They were called "baby burners" or ridiculed for being so stupid as to fight in that war. Many learned to expect verbal attack from

others about Vietnam. They faced rejection from the very people they thought they had been fighting for.

Many veterans were forced to alienate themselves out of the fear of what they might do if they unleashed their anger:

> Most combat veterans have to deal with the fact that they have killed. All humans have this potential, but it is more real to veterans who have killed in combat. So, for them, getting in touch with anger can result in "fear of destructive impulses" which can be carried to extremes-fear of losing control and killing the one they love. Having to control violent impulses leads to withdrawal, alienation, subsequent blunting of emotions and inhibited interrelationships.

Sexual Identity

The preceding rationale as to why Vietnam veterans could have more intense fears of intimacy is further supported by the fact that most veterans went to Vietnam when they were developmentally ready for intimacy (average age of Vietnam veteran = 19.2). Most developmental schools of thought in our society designate the late teens and early twenties as the time to establish an intimate, love relationship, a time for choosing a life mate. One aspect of development influenced by the military experience (Petrik, Rosenberg, Watson, 1983) is that of sexual identity. In the military, attitudes towards women in general tend to be chauvinistic, to put it mildly. Sexual relations with women tend to be transient. A good deal of prostitution and general debasement of females tends to be

prevalent around large bases and in combat areas. In general, attitudes which degrade women are prominent, while those exalting the strength and power of men are prevalent. This often makes it difficult for military oriented men to get along with women or to experience them as capable of contributing to their happiness and personal fulfillment. During the sixties and early seventies, when Vietnam veterans were coming home, sex had become something not so private or secret or intimate anymore and distrust became a major obstacle to intimacy in relationships.

Interpersonal Theory of Fear, Anxiety and Isolation

According to Harry Stack Sullivan (1953) in his "Interpersonal Theory of Psychiatry," "malevolence, hatred, and isolating techniques are the result of fear and anxiety which is experienced in early childhood." Many parents, for a variety of reasons, subject children to anxiety as well as pain. Punishment, the causing of pain and anxiety, is used as an educative influence which shows up as actual fear of the capacity of the authority carrying figure to impose pain. Punishment which causes pain, fear, and anxiety is likely to happen when irritable, ill-tempered parents who are afflicted by many anxiety producing circumstances in their own lives tend, rather strikingly, to take it out on the dog or the cat or whatever gets in their way. The imposition on the child of the concepts of duties and

responsibilities is certainly good preparation for life in a social order, but in cases where the parents are uninformed or suffering from unfortunate peculiarities of personality, it can cause deviate adaptations for violating authority, reduce foresight in interpersonal relations, conceal emotions, and produce other inappropriate behaviors, such as imitating the abusive behaviors of their parents.

While many current research psychologists and psychiatrists believe that psychic trauma superimposes its effects over the effects of previous life experiences, it is also possible that previously developed personality characteristics predispose certain individuals to react more severely. PTSD is an anxiety reaction to psychic trauma which could possibly, in some cases, have been predisposed by childhood fears and anxieties. This PTSD may manifest itself in an intense form of malevolence, hatred, and isolation in regards to the military authority, the government, and the society which used and abused the Vietnam veteran. The therapist might have to deal with deep-rooted anxiety reactions which had developed before the major psychic trauma for treatment to become complete.

In 1926 Freud said, "Missing someone who is loved and longed for is the key to an understanding of anxiety." In 1969, Tanay said,

> The painful feeling of anxiety is the basic concept of modern psychiatry. This concept is utilized by all psychiatrists and accepted to be of significance.

> There is less agreement about the origins of this distressing emotion.

Although PTSD is recognized as an anxiety disorder, the complexity of its origins are sometimes difficult to discover and understand. Severe cases may be many faceted. An understanding of the origin of PTSD, however, is necessary before effective therapy can be implemented. The following chapter explores the PTSD origins of 20 Vietnam combat veterans through the use of a survey questionnaire and discussion groups to process the results of the questionnaire as well as several related topics which were stimulated by the group process.

Chapter 6

METHOD

The participants of this study were all Vietnam combat veterans who are recently living in northern Minnesota. All of them manifested a history of adjustment problems related to PTSD. Most of the study was done within two closed groups of pre-selected men, with individual screening sessions conducted for the purpose of signing consent forms, explaining the purpose of the groups, and arranging satisfactory meeting times. One group was held in St. Cloud, and the other was held in Brainerd. Both consisted of weekly two hour sessions over a period of ten weeks. Arrangements were made with the Veterans Administration Mental Hygiene Clinic to have staff available at all times during this period to treat any abreactions or any other problems which might surface during, or as a result of our groups. These groups were supervised by Dr. Arthur Kuhne, Coordinator of the Mental Hygiene Clinic at the St. Cloud Veterans Administration Hospital, and by Dr. James Tuorila, VAMC (Veterans Administration Medical Center) psychologist who is presently in charge of all the Vietnam veteran treatment groups within and affiliated with

the St. Cloud VAMC. Either one or both of them supervised all sessions.

The groups which participated in this study were co-facilitated by Uwe Siemon-Netto, a graduate student from the Lutheran School of Theology at Chicago, and this writer, Richard Kuschel, a graduate student of Psychology from St. Cloud State University, St. Cloud, MN. Mr. Siemon-Netto, who was doing a chaplaincy internship at the St. Cloud VAMC at the time of this research, was a war correspondent in Vietnam for five years. I was a hospital corpsman (field medic) with the first battalion, Third Marine Division, I Corps, in Vietnam. As combat veterans ourselves, both of us were accepted by both groups of veterans as peers, and group process was spontaneous and very productive.

The survey questionnaire was administered and the results shared by both graduate students, although our emphasis areas were slightly different. Mr. Siemon-Netto has since used this shared data to help complete his Master's thesis entitled, "Vanguards of a World Come of Age: A Study of the Plight of Vietnam Veterans in the Light of Dietrich Bonhoeffer's Theology of Suffering," with a special focus on his essay, "After Ten Years." Some reference is made in this thesis to Mr. Siemon-Netto's conclusions in regard to spiritual issues. Spirituality, intimacy and interrelationship difficulties, isolation, DSM III-R

criteria for PTSD, and Vietnam war history were the main topics discussed in our "Rap Groups."

Because age and intensity of stressors seem to be the most significant initial contributing factors to the incidence and severity of PTSD, the first thirteen questions of the survey serve to establish the age and existence of significant stress factors while in Vietnam. The rest of the questions in the survey were designed to estimate the level of intimacy disruption and interrelationship difficulties in the veterans' post war relationships. Although the term interrelationship includes possible interactions with anyone other than self, for the purpose of this study the focus is to examine the subject of intimacy in relationship to wives or girlfriends. The object of this part of our study was to examine how the effects of combat in Vietnam are likely to contribute to interrelationship problems and consequently cause disruption in the dynamics of the family.

There are certainly other contributing factors which probably influence the veterans' post war relationships and may also be the result of combat experiences (i.e., unemployment, drug and alcohol abuse, anti-social behaviors, etc.), but these factors cannot be examined within the limited scope of this thesis.

While this study only consists of two small and select groups of veterans, it has stimulated ongoing research

projects by both researchers. Mr. Siemon-Netto is conducting further research with others on moral and spiritual issues and this researcher has initiated a study of veterans who have opted out of American society. This study will involve three researchers: Dr. Arthur Kuhne, V.A. psychologist, Dr. Dale Schwerdtfeger, Anthropology professor at St. Cloud State University, and myself.

The total number of men between these two groups is not high enough to produce any significant statistics, but the results of the questionnaire do establish more than enough cumulative experience to discuss any topic related to combat or combat stressors. The participation of these veterans in this study was very valuable to the preliminary studies of these two researchers.

Chapter 7

RESULTS

Analysis of Questionnaire and Group Process

Table 1, of the survey results, shows an average age of 21.7 in our two combat veteran groups. This is slightly above the national average of 19.2 for the entire Vietnam war. In combat conditions, however, there are usually many more regular enlisted men than career men. We had three career men out of our combined group total of twenty men.

The use of these particular age groups for our tables not only shows that our median age was close to the national average, but it breaks up the groups into ages which fit into the developmental stages which were used for another part of our study.

Table 1

Age of Combat Veterans

	Age Groups 1 (17-21)	2 (22-25)	3 (25-34)
Age During Military	12	5	3
Age During Combat	12	5	3
Length of Time in Combat (Average Number of Months)	11.1	5	18

The group average for time spent under combat conditions was 11.4 months. The national average length of time in combat is not available, but according to the response to the combat stressors in our survey, most group members were exposed to extremely high levels of stress. According to the general consensus of the group during a discussion on the subject, those who were killed or wounded badly enough to be taken out of action usually received their injuries during their first months of combat, with survival skills improving with time and exposure to combat.

Tables 2 and 3 established a high level of combat stressors for all group members. This was expected because these men were all chosen to participate in this study on the basis of their combat experiences and their willingness to participate in the groups. For the purpose of this

study, and to stimulate group discussion, it was necessary to assess the level and types of combat stressors that these men had been exposed to. Group discussion of these topics was very intense and emotional, but our supervisors assured us that it was therapeutic for these men to be able to self disclose in a "safe" atmosphere. Some of the men reported more intense nightmares and somatic complaints during the course of our group process, but they also reported that they felt better after having the opportunity to share their feelings and receive support from their combat group. The following excerpts from some of our group discussions were chosen to demonstrate significant and relevant issues which were processed during our groups.

Table 2

Level of Combat Stressors

	Age Groups		
	Gr.1 (F S N)	Gr.2 (F S N)	Gr.3 (F S N)
Involved in Combat	9 3 0	1 4 0	3 0 0
Saw Dead/Wounded Enemy	8 4 0	2 1 2	2 1 0
Saw Dead/Wounded Americans	10 2 0	1 4 0	2 1 0
Killed Enemy	4 8 0	0 1 4	0 2 1
	(17-21)	(22-25)	(25-34)

Key: F=Frequently
S=Seldom
N=Never

Table 3

Types of Combat

	Age Groups					
	Gr.1		Gr.2		Gr.3	
	YES	NO	YES	NO	YES	NO
Wounded in Action	10	2	1	4	1	2
Lost Close Friends	11	1	4	1	3	0
Witnessed Friends' Death	10	2	4	1	2	1
Witnessed Atrocities	9	3	0	5	1	2
Killed Friends/Comrades	4	8	0	5	0	3
	(17-21)		(22-25)		(25-34)	

In relation to the questions concerning killing the enemy or witnessing dead or wounded enemy soldiers, one group member commented,

> Most of the time you never know for sure whether you killed anybody or not, (because) most of the fighting we did was at night, was over with quickly, and we either left the scene or they (the enemy) removed all their dead and wounded before daylight and all we found was blood and drag marks and sometimes graves. Then we would have to dig up the graves to count the bodies and look for caches underneath the bodies. Sometimes they would booby-trap the graves and more guys would get blown away trying to dig them up.

Most of the men in the two groups had been wounded at least once, most of them had lost close friends and/or witnessed the deaths of their friends, and half of them admitted to having witnessed or performed atrocities. Most

of these atrocities consisted of the killing of civilians. A few group members reported finding the bodies of civilians who had been tortured during acts of terrorism. Some thought that this had probably been done by the Americans, but made to look like the enemy had done it. This was done frequently as a part of "Operation Phoenix" (a covert operation of assassination and terrorism).

The last question in Table 3, which was not asked on any other assessment questionnaire that could be located by this researcher, produced one of the "heaviest" discussions. Four out of these twenty men reported having killed other Americans while in combat situations. Discussion of this subject brought out some bitter and painful memories. Euthanasia, which was commonly the responsibility of the medics or corpsmen, was the most common circumstance, but there were other instances discussed which included having to kill men who could not keep up and would have been captured if left behind or having to kill someone who was delirious and screaming in pain and endangering everyone else by giving away their position. There were other instances of patrols from different units mistaking each other for enemy patrols with casualties resulting; times when American helicopters, artillery and Navy gunfire killed other Americans, when bombs, napalm, and even chemicals were dropped on other Americans, and instances of murder which

was believed to be justified under conditions where the person murdered was endangering the lives of others.

One group member had gone out one morning looking for a missing LP (listening post), one member of which was his best friend, a friend from home whom he had joined the military with. He found his friend, who had been captured and tortured all night right outside the perimeter, screaming in pain for all to hear. His friend was tied to a tree with barbed wire, still alive but horribly maimed, with his own genitals stuffed into his mouth. He emptied the magazine of his rifle into his friend to kill him--because he knew his friend would have done it for him. This sort of trauma is usually never mentioned to civilians, but all veterans know about similar incidents of this sort. This is the type of psychic trauma which continues incessantly in the nightmares and flashbacks of these veterans.

As another group member commented, "And it was all for nothin'." This very critical existential feeling that "it was all for nothin'," was a predominant feeling in these veteran groups and was the focus of many group discussions. These feelings of grief, anger, and despair are still eating away at these men, twenty years later, and the only support most of them ever have found is from each other. Just about everything that has ever been done for Vietnam veterans has been done by Vietnam veterans: the Vet Center Outreach Program, Vietnam Veterans of America and their "Viet Vet

Survival Guide for Vietnam Vets in Civilian Life," "Flower of the Dragon"--a Vietnam veterans self-help organization, "An American Sunrise: The Vietnam Veterans Leadership Program," and many other smaller indigenous support groups. They had to take care of each other in "the Nam," and they continue to do so now. This self-help tendency of veterans helping vets was another focus of group discussion. Many of these veterans wear "Vets Helping Vets" t-shirts to proclaim what they are doing for each other. Mutual suffering and support has created an unsurpassed bond of brotherhood among these veterans.

Tables 4 through 7 provide information pertaining to sexual development and attitudes toward women, as well as interrelationship difficulties. This information, and the group discussions stemming from these questions, strongly support the hypothesis that combat stressors adversely affect interrelationship abilities. Voluntary comments written on some of the questionnaires involve themes of trust, anger, rage, disrespect, abuse, morality, Dear John letters, and derogatory comments about American women. Forty-six percent of them have been divorced at least once, (7 more than once), while one had never been married at all. Only three had talked extensively with their partners about their combat experiences, twelve had talked very little about it, and six not at all. The three who had talked extensively with their partners had all been through marital

therapy and treatment for Vietnam veterans. Some of the veterans who withheld information of their experiences from their partners did so to protect them the horror of war, some had never been encouraged to talk about it, some had been blatantly discouraged, and some just did not think there was any point in it because they believe that no one could understand anyway unless they were there.

Spiritual and moral issues were the focus of some of our most intense group discussions. Many felt that they had been deserted by God in Vietnam and no longer believed in Him, although they still had a belief in a "Higher Power" that they could not explain. Some preferred Native American or Eastern philosophies to the traditional ones that they had grown up with and rejected while they were in Vietnam. One man reported that he went to church when he came home from Vietnam and his minister asked him to leave because, "They didn't need his kind in their church." This man still will not go in a church because of the impact of this rejection. Despite the loss of faith in God by many of these men, the concern they have for each other, and the existential pain they live with could be "felt" in these groups.

Several of the men in these groups had been involved in some sort of treatment for PTSD. Some of them felt that treatment had been adequate. Some of them felt like treatment just opened up old wounds, poured salt on them to

renew and intensify the pain, and then left them to fester. Nothing had been resolved and they had just become more aware of their own misery and that of their cohorts. Others had become dependent upon weekly outpatient Rap Groups which offered them some form of support and camaraderie. Most of these types of groups do not provide, nor are they intended to provide, any intense therapy. Any serious problems encountered in these groups are referred to inpatient treatment facilities. Because there are so few inpatient treatment facilities available for the treatment of PTSD, waiting lists are long and waiting periods add to the veterans' frustrations. There are a few support groups in existence for wives or "significant others," but treatment facilities are usually too far away from home to be available for most veterans' families. Post-treatment care is difficult because there is no one qualified to assist the veteran in his home area. Spiritual care is usually available in treatment facilities, but it is not an active part of therapy. Besides that, V.A. chaplains (called "sky-pilots by veterans), are usually not trusted by veterans any more than the officer/chaplains who let them down in Vietnam. Many of the treatment facilities have therapists and treatment methods that are authoritarian and abusive and only serve to increase the veteran's frustration, anger, and despair.

Without having access to a larger number of combat veterans to work with during the time of this study, the results of our questionnaire and the conclusions of our group process strongly support the hypothesis that there is indeed a relationship between severity of stressors, Post-Traumatic Stress Disorder, and the degree to which a veteran may become alienated from society.

Table 4

Marital Status

	Gr.1		Gr.2		Gr.3	
	Yes	No	Yes	No	Yes	No
Married Before Military	1	11	1	4	3	0
Married During Military	0	0	1	0	0	0
Married Since Military	11	1	2	0	0	0
Divorced	8	4	3	2	2	1
More Than Once	7	5	0	5	0	3
Since Military	8	4	1	4	2	1
Since Combat	8	4	2	3	2	1
Still Virgin Before Combat	2	10	1	4	1	2
	(17-21)		(22-25)		(25-34)	

Table 5

Shared Vietnam Experiences

	Gr.1			Gr.2			Gr.3		
	E	L	N	E	L	N	E	L	N
Talked About Combat Experiences With Partners	1	8	3	1	3	1	1	1	1

Key: E=Extensively
L=Little
N=Never

Table 6

Relationships Other Than Marriage

	Gr.1				Gr.2				Gr.3			
	S	F	O	N	S	F	O	N	S	F	O	N
Relationships Other Than Marriage..												
Since Military	6	5	0	1	1	4	0	0	3	0	0	0
Since Combat	8	3	0	1	1	4	0	0	3	0	0	0
During Military	3	6	2	1	0	2	1	2	2	0	0	1
Lived With Partners	2	5	0	5	0	2	2	1	1	2	0	0
	(17-21)				(22-25)				(25-34)			

Key: S=Several
F=Few
O=One
N=None

Table 7

Combat's Effect on Relationship

	Gr.1 Yes	Gr.1 No	Gr.2 Yes	Gr.2 No	Gr.3 Yes	Gr.3 No
Did Relationships Break Up During Combat	4	8	0	5	0	3
Do You Think Combat Effected Relationships	11	1	5	0	3	0
Have Other Relationships Contributed Negatively	2	9	2	3	1	2
Has Your Sex Life Survived Your Experiences	9	3	4	1	2	1

Comments made on questions: involved themes of trust, anger, rage, disrespect, abuse, morality, Dear John letters, and derogatory comments about character of American women.

Summary and Implications

> The responsibility of the therapist, then, neither begins nor ends with the individual client; and the clients' responsibility neither begins nor ends with himself or herself. Both extend far outward, from the past into the future, into countless other lives. (Marin, 1981)

Over 40 million Americans, 20% of our population, have a distinct, direct personal link to a Vietnam era veteran (i.e., parents, wives, children, etc.) (DAV, 1987).

> Stress reactions are not limited to the few but are prevalent in the healthy majority. The stigma of abnormality, cowardice, and unconfirmed assumptions

> about normality and the effects of combat serves to cloud the real issue of post-combat reactions. Efforts to dismiss the post-combat recovery process and the private, residual effects in individual veterans do all veterans a disservice. Research efforts that illuminate this normal process and clarify appropriate interventions facilitating recovery will enrich us all, for the strength and moral character honed in this process have already begun to lead us from our national post-Vietnam malaise. (Smith, Parson, & Haley, 1983)

Research continues, but with a basically psychological focus. In addition to individual psychological treatment, this research indicates that the focus should be shifted to a more sociological orientation, for the problems of the veterans are also the problems of their society.

Family Therapy

What is missing for the Vietnam veteran and his family is a graduated process for integration of the traumatic events, first into the veteran's personal system, and then into the awareness of his significant relationships, including those with his children. It is incredibly insensitive to ignore the effect the Vietnam war will have on the wives and children of its veterans and future generations. The family needs to label and set goals that can be achieved in growing past the pain to healthier lifestyles.

Readjustment counseling for the veteran and his wife is basic. A couples group experience and parent peer support system (like a "Rap Group") will facilitate conflict resolution. The peer support system will encourage

independence and will further break down the social isolation of the veteran and his family. Education in stress management and the effects of trauma on relationships gives the couple knowledge and skills that can replace self-defeating behaviors.

Topical workshops based on information needed by the couples will build social and relationship skills. Career development issues need to be addressed to insure the economic security and survival of the veteran's family. Connections and channels must be developed (networking) to join the veteran, his family and the community. Churches and existing community services must be used as resources to avoid duplication of services and make resocialization efforts cost effective. Families can be stabilized by meeting the survival and security needs of the veteran within his family unit and in the community where he lives.

The therapeutic model must address the family as a system. Traditional diagnostic labels that are analytic should be avoided. Mental health professionals must be educated to the process and effects of trauma and impacted grief on the family as an interrelated unit. Coughlan and Parkin (1987) stress that involvement of the partner and family is a necessary and often overlooked treatment issue which directly affects isolation versus resocialization.

Career Development

Most of the research articles and books concerning the problems of Vietnam veterans mention "adjustment problems." Although this is a rather ambiguous term, unemployment and underemployment are almost always listed as criterion for it. Although lack of meaningful employment is usually recognized as a part of the problems these men are experiencing, very little has been done by these researchers to contribute to the solution of this part of their problems.

Upon their return home, Vietnam veterans found themselves isolated and unwelcomed, and plagued with a negative stereotype that they were unstable, dangerous, or at best, victims. This impeded their return to mainstream American life, and made it even more difficult for them to catch up on their careers and education with those who had not served.

Most Vietnam veterans, although relatively successful in the business world, tend to remain withdrawn and isolated from the society in which they live (Figley & Levantman, 1980). This means that most researchers are biased because they have based their research on the Vietnam veterans who have visited mental health facilities (U.S. Senate, 1980). They are not aware of the positive characteristics of the more successful veteran; they have continued to portray a negative image of Vietnam veterans; and they have

concentrated their efforts on describing the nature of PTSD instead of trying to "ameliorate" the symptoms (Catherall, 1986; Veterans Administration, 1978).

The counseling process should, therefore, use a holistic approach to take into consideration all aspects of the veteran's problem; when unemployment or underemployment is the focus, the therapist has to be aware of the reasons for lack of motivation, as well as the veteran's needs, perspectives, and aspirations. Special efforts may still be required to reach and provide services to the Vietnam veterans outside of a hospital setting. It is often postulated that the Vietnam veteran is reluctant to seek Veterans Administration assistance and/or treatment due to his perception that the V.A. does not understand nor is it sympathetic to his problems (Wilson, 1978). The establishment of Vet Centers and Veteran's Self-Help Programs in the community has provided needed assistance in reaching such veterans and eliminating the real or perceived resistances to dealing with the V.A. Continued (or perhaps increased) emphasis on vocational rehabilitation within these Vet Centers is recommended and may yield surprisingly good results (Parent and Magaziner, 1983).

The most significant contributions to the solution of the problems of Vietnam veterans has been through the efforts of various veteran's self-help groups. One such self-help group is the Vietnam Veterans of America. This

organization has published a book titled, "The Viet Vet Survival Guide" which, besides providing information and instructions on a multitude of other veterans' concerns, has chapters which provide excellent information and advice concerning employment, starting a business, education, and vocational rehabilitation. This organization can provide a vital link for resocialization and has chapters in every state in the Union.

Another national Vietnam veterans self-help group is Flower of the Dragon, Inc. This organization has prepared a basic manual for developing Vietnam veteran employment services by community-based organizations. This manual was written specifically for Vietnam veterans and for employment service problems, but can be adapted to other client groups and most social services. It is a "How to Do It" manual for Vietnam veterans and others who have little or no experience in developing and operating employment programs and necessary support services for Vietnam veterans. The basic approach, here, is client-centered, and the material and information in the manual is extensive and complex and is drawn form a variety of sources (U.S. Dept. of Labor, 1979).

There is another self-help program, the Vietnam Veterans' Leadership Program, which is designed to reach out and help those veterans who have had and are still having "adjustment problems." This program was personally approved by President Reagan on July 16, 1981, with a commitment to

provide federal resources as seed capitol to develop the Leadership Program across the country. The model process described in this manual is similar to the one developed by Flower of the Dragon, and it adds the dimension of social support systems to the spectrum of veterans' needs. Such support is needed by these veterans who have less than fully supportive families, friends and networks (Martin, 1984).

There is an existing proposal by VVLP (Vietnam Veterans Leadership Program) for a national computerized employment and training network. Under this proposed national job bank, a state or local office which cannot file a job locally can key in a national search command and be provided with a list of qualified applicants who are willing to relocate. The entire process will take about 30 seconds and will be very simple (if it is ever implemented).

One of the forms of PTSD is delayed, although chronic, so it does not surface until years after the trauma. This factor kept many veterans from seeking help or vocational assistance until it was too late to apply for Standard Government Assistance: G.I. Bill benefits for educational purposes expire 10 years from discharge and vocational rehabilitation assistance requires at least six months of unemployment and completion of a "treatment" program before consideration (Hendon and Haas, 1984). In general, a large number of studies were conducted in the late 1970's and early 1980's, including several done for the Veteran's

Administration, that examined a wide range of issues and problems related to veteran's readjustment. One of the general policy considerations that emerged from this research was a recognition of a basic need to give encouragement and support to Vietnam veterans.

Conclusions

After examining an extensive literature review, developing a questionnaire and using it, and conducting group sessions and personal interviews during this study, evidence collected seems to point towards a positive relationship between: (a) severity of stressors, (b) PTSD symptomology, and (c) subsequent alienation, withdrawn and isolation of Vietnam combat veterans from contemporary American society. Because of the relatively small number of subjects who participated in this study (20), statistical levels of significance were not used. The relationship indicated by this study progresses from a to b to c, but not directly from a to c. There are many variables to consider when assessing severity of stressors and PTSD symptomology on an individual level and there is a definite need for further research which would identify more of these variables and lead to more adequate treatment methods for PTSD. It also seems obvious that there is a need for more preventative efforts in the form of immediate therapy for

those who are exposed to extreme stressors such as those experienced in combat situations.

Upon their discharges beginning in the 1960's, Vietnam veterans should have been able to receive, at minimum or no cost, assistance in self-assessment and aptitude testing, career counseling, resume' preparation, interviewing techniques, and development of actual interviews with receptive employers. Help should have been given in starting up businesses. The cost to society would have been repaid many times over in terms of having improved the productivity and social contributions of nine million veterans.

Before their discharges veterans should have been "debriefed," as a purgative therapy to block development of PTSD symptoms. The bias of the American media and the corruption in our American government should have been exposed to educate the American people about the truths of the Vietnam war so that veterans could have been welcomed home and accepted into their society instead of blamed, rejected, and alienated (Banerian, 1985). American society should be ashamed of the way it has treated this veteran population.

During the war, American soldiers learned the value of teamwork. Their very survival depended upon the help and cooperation they extended to one another. The intensity of that experience created a powerful and unique bond among

them. They developed a respect and concern for comrades that is uncommon among the broader population in the same age group. It is this strong bond between them that has prompted Vietnam veterans to form various self-help groups to fulfill the needs that American society has ignored. Even the Vietnam Veterans Memorial in Washington was created by Vietnam veterans for themselves.

Essentially there has been a misconception about the people who served in Vietnam. They are strong people. They can and will take care of each other. What American society has done to them should never be allowed to happen again to a generation of American veterans. It is society itself which loses by neglecting such a valuable resource.

It may well be that many Vietnam veterans will be forced to live with certain kinds of pain and regret for the rest of their lives, though one can hope that they will be successful enough to turn the truths of the past to some use, becoming the keepers and bearers of those truths rather than the victims.

> Never before have so many questioned as much, as these veterans have, the essential rightness of what they were forced to do. These men have a sense of violated personal and social order, of fundamental break in human connection, which they relate to conditions imposed on them by the war in Vietnam. (Lifton, 1975)

Their psychic well-being will depend, in large part, upon their capacity to resolve the issues of mortality and conscience that haunt them. They need to find meaning in

their experiences, a purpose for their post-war lives. Whatever skills or comfort that they manage to salvage from traditional therapy, they will have to see through to the end, and largely on their own, the moral journey that began in Vietnam. There exists a strong and unique brotherhood among Vietnam combat veterans that has been created by their common suffering and alienation from American society. Most of the successful therapy that has been accomplished so far has been through the efforts of vets helping and supporting each other. Hopefully, the disciplines of the "healing professions" will someday develop more appropriate and adequate methods for treating PTSD than the ones which are in use now. Because of the damage that has been done and the prevailing attitude of American society, the healing process is necessary for these veterans, and for our society, will not likely occur during the lifespan of the generation involved.

From this dilemma, however, there are some lessons to be learned which would benefit future generations of veterans as well as other victims of post-traumatic stress disorder. The casualty list of post-ware suicide should serve notice that there is a definite need for further research of this potentially fatal problem.

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APPENDIXES

APPENDIX A

Statistics of Vietnam

STATISTICS OF VIETNAM

Longest war in U.S. history, August 4, 1964, to May 7, 1975.

Over 8.5 million served in the Armed Forces during the Vietnam era.

Approximately 4 million served in Vietnam.

500,000-1,500,000 saw active combat or were exposed to hostile situations.

58,156 KIA and MIA are listed on the Memorial in Washington, D.C.

303,000 were wounded.

150,000 required hospitalization.

75,000 sustained serious wounds resulting in permanent impairment.

300% higher rate of amputation.

18.4% sustained multiple amputations, compared with 5.7% in World War II.

2.5% mortality rate in Vietnam, compared with 4.5% in World War II.

It is estimated that 20%-60% of all who served in Indochina may be suffering emotional repercussions of their war experience (800,000 to 1.5 million people).

It is estimated that between 54,000 and 108,000 Veterans have committed suicide since the war. Estimates from 1978 to date.

Outreach Workers and Mental Health Professionals estimate that there are 35,000-45,000 Veterans living in ISOLATION.

Figures of All War KIA and MIA:

WORLD WAR I - 3,350 MIA's.

WORLD WAR II - 406,872 KIA's - 78,750 MIA's.

KOREAN WAR (CONFLICT) - 54, 235 KIA's - 8, 177 MIA's.

VIETNAM WAR - 57,685 KIA's - 2,459 MIA's.
As of to date there are 2,370 MIA's still missing.
TOTAL NUMBER of KIA's 518, 792 - MIA's 92,736.

KIA--Killed in Action
MIA--Missing in Action
POW--Prisoner of War.

All information compliments of : VIETNAM LEARNING CENTER
Phillip Hebert, Director
P.O. Box 3536
Alexandria, Virginia
22302

APPENDIX B

DSM III-R Diagnostic Criteria for PTSD

DSM III-R Diagnostic Criteria for PTSD, (p. 250)

309.89 Post-traumatic Stress Disorder

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives or friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:
   (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed).

   (2) recurrent distressing dreams of the event.

   (3) sudden acting or feeling as if the traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations, and dissociative (flashback) episodes, even those that occur upon wakening or when intoxicated).

   (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

   (1) efforts to avoid thoughts or feelings associated with the trauma.

   (2) efforts to avoid activities or situations that arouse recollections of the trauma.

(3) inability to recall an important aspect of the trauma (psychogenic amnesia).

(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills).

(5) feelings of detachment or estrangement from others.

(6) restricted range of affect, e.g., unable to have love feelings.

(7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep.

(2) irritability or outburst of anger.

(3) difficulty concentrating.

(4) hypervigilance.

(5) exaggerated startle response.

(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator).

E. Duration of the disturbance (symptoms B, C, & D) of at least one month.

F. Delayed onset of the symptoms was at least six months after the trauma.

APPENDIX C

Survey Questionnaire

SURVEY QUESTIONNAIRE

1. Of which era are you a veteran?___WWII ___Korea ___Vietnam

2. How old were you during your military experience? ___to___.

3. Were you involved in combat? ___frequently___seldom___never.

4. How old were you when you were involved in combat? ___to___.

5. How long were you involved in combat? ___months.

6. Did you see dead and/or wounded enemy soldiers? ___frequently___seldom___never.

7. Did you see dead and/or wounded American soldiers? ___frequently___seldom___never.

8. Did you ever kill anyone? ___frequently___seldom___never.

9. Were you ever wounded? ___yes___no.

10. Did you lose any close friends? ___yes___no.

11. Did you witness their death? ___yes___no.

12. Did you witness any "atrocities"? (torturing, killing of women and children, executions) ___yes___no.

13. Did you ever have to kill any of your friends/comrades? ___yes___no.

14. Were you married before entering military service? ___yes___no.

15. Were you married during military service? ___yes___no.

16. Have you been married since your discharge from military service? ___yes___no.

17. Have you ever been divorced? ___yes___no.
    a. more than once? ___no___.
    b. since your military experience? ___yes___no.
    c. since your combat experience? ___yes___no.

18. Have you had relationships other than marriage since your military experience? ___several___a few___one___none.

19. Have you had relationships other than marriage since your combat experience? ___several___a few___one___none.

20. Did you have relationships during your military experience? ___several___a few___one___none.

21. Have you lived with any of these partners? ___several___a few___one___none.

22. Have you talked about any of your combat experiences with any of your partners? ___extensively___a little___never.

* 23. Do you think that your combat experiences had any effect on your ability to get along with your partners? Please explain:

* 24. Did your relationship break up during your combat experience? ___yes___no.

* 25. If you had a relationship during your combat experience has your sex life survived that experience? ___yes___no.

* 26. If not, did other relationships during combat experience contribute to the decline of your sex life with your regular partner? ___yes___no.

* 27. Has your combat experience changed your opinion about women? ___yes___no.
Please explain:

* 28. Were you still a virgin before your combat experience? ___yes___no.

* Please answer the questions, even if your role in Vietnam was non-combative in nature.

APPENDIX D

Sources of Stressor Inventories to Assess PTSD and Vietnam Veterans

SOURCES OF STRESSOR INVENTORIES TO ASSESS PTSD & VIETNAM VETERANS

1. Vietnam Combat Veteran Survey
   Gary E. Berg, M.A., M. Div.
   Veterans Administration Medical Center
   St. Cloud, MN. 56303

2. Brentwood PTSD Scale (modified).

3. Revised D.I.S. PTSD Interview.

4. Figley Vietnam Veteran Survey

5. Figley and Stretch V.V.Q. Combat Exposure Scale
   Worksheet Etiological Factors in the Development of PTSD in Clinical Samples of Vietnam Combat Veterans.

6. David W. Foy, Edward M. Carroll, and Clyde P. Donahue, Jr.
   West Los Angeles Veterans Administration Medical Center
   Brentwood Division and
   School of Medicine, University of California,
   Los Angeles

7. Gallops Revised Combat Sheet

8. Keane Scale - Penk Scales

9. Lund Combat Exposure Worksheet

10. Symptom Patterns Associated With Post-traumatic Stress Disorder Among Vietnam Veterans Exposed to War Trauma
    Robert S. Laufer, Ph.D., Elizabeth Brett, Ph.D., and M.S. Gallops, M. Phil.
    Part of the Vietnam Veterans and Controls Study

11. Military Stress Experience Worksheet

12. Symptom Checklist and Combat-Activity Scale for Vietnam-Era Veterans
    Jeffry T. Mitchell, Ph.D.
    University of Maryland

13. Reaction Index Scale

14. Solomon Objective Military Stress Worksheet

15. Combat Experience Scale
Norman Solkoff, Phillip Gray, and Stuart Keill
State University of New York at Buffalo

16. PTSD Interview (PTSD-I)
Charles G. Watson, Ph.D.
Veterans Administration Medical Center
St. Cloud, MN. 56303