Vietnam Veterans Readjustment Problems

The Etiology of Combat-Related Post-Traumatic Stress Disorders

by Jim Goodwin, Psy.D.

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INTRODUCTION

Most Vietnam veterans have adjusted well to life back in the United States, following their wartime experiences. That's a tribute to these veterans who faced a difficult homecoming to say the least.

However, a very large number of veterans haven't made it all the way home from the war in Southeast Asia. By conservative estimates, at least half a million Vietnam veterans still lead lives plagued by serious, war-related readjustment problems. Such problems crop up in a number of ways, varying from veteran to veteran. Flashbacks to combat… feelings of alienation or anger… depression, loneliness and an inability to get close to others… sometimes drug or alcohol problems… perhaps even suicidal feelings. The litany goes on.

In its efforts to help these veterans, the 700,000-member Disabled American Veterans (DAV) funded the FORGOTTEN WARRIOR PROJECT research on Vietnam veterans by John P. Wilson, Ph.D. at Cleveland State University. That research resulted in formation of the DAV Vietnam Veterans Outreach Program to provide counseling to these veterans in 1978. With 70 outreach offices across the United States, this DAV program served as a model for the Veterans Administration (VA) Operation Outreach program for Vietnam era veterans, which was established approximately a year later.

Clinically, the readjustment problems these veterans suffer were designated as Post Traumatic Stress Disorders in the American Psychiatric Association's DIAGNOSTIC & STATISTICAL MANUAL III (DSM III). Counseling psychologists working with Vietnam veterans in the DAV and VA outreach programs emphasize that these disorders are not mental illnesses. Rather, they are delayed reactions to the stress these veterans–particularly combat veterans–underwent during the war in Southeast Asia.

The nature of post-traumatic stress disorders among Vietnam veterans is described in this paper by Jim Goodwin, Psy.D. Himself a Marine Corps veteran of Vietnam combat, Dr. Goodwin worked as a volunteer counselor in the DAV Vietnam Veterans Outreach Program while doing graduate work at the University of Denver's School of Professional Psychology. Following these studies, Dr. Goodwin rejoined the Armed Forces and is now a captain on active duty with the U.S. Army.

The material presented here is a condensation of Dr. Goodwin's chapter in POST-TRAUMATIC STRESS DISORDERS OF THE VIETNAM VETERAN: OBSERVATIONS AND RECOMMENDATIONS FOR THE PSYCHOLOGICAL TREATMENT OF THE VETERAN AND HIS FAMILY.

Edited by Tom Williams, Psy.D., this book was published by the nonprofit Disabled American Veterans as a guide to counseling professionals who are working with or interested in the problems of Vietnam veterans. Due to limited quantities, the complete book has been made available chiefly to psychiatrists, psychologists and other mental health counseling professionals. It is hoped that Dr. Goodwin's paper will provide all of the information on post-traumatic stress disorders needed by veterans, their families, and the general public.

A final note: Gerald R. Ford, when he was President of our country, asked the American public to put Vietnam behind them and forget it. I can think of no Presidential injunction that has been more effective. As a Vietnam War veteran, myself, I believe it's both healthful and necessary to put the bitterness and dissension of the war years behind us. But to forget the Vietnam War, its troubled veterans, and their families would be unforgivable. Sherman E. Roodzant National Commander Disabled American Veterans

RECOLLECTIONS

What price must the heart pay to live and love? Say you long hot days ahead without a kind word–days when fear will tear your insides apart – but one must go for duty calls… so very far away.

My heart is numb, my brain reels–yet no tears. Another friend is laid to rest. God rest his soul this brave man. Keep him safe for we'll meet again–at another time, in another place. Hot sun, endless hours grant me some respite from loneliness. Sharp rattle, orange streaks across the black sky–a sensation of torn steel, woven with hot flesh and blood beside me. God! God whatever God you be, speed my soul on its way but not in endless eternity. Thoughts of home come to me–don't let me go; please no–I'm afraid!

A cold refreshing wind penetrates my bones–what a strange place this be. I hear familiar voices that have long passed from existence–I see faces–faces of friends long since dead. I realize now what has happened and where I am, yet I am happy with those whose names are carved in stone amidst the grass of a place called Arlington.

Please don't weep for me for I no longer worry about what tomorrow brings… for me it brings a much needed rest… a rest forever. by: George L. Skypeck Captain, U.S.A. 12/71

THE ETIOLOGY OF COMBAT-RELATED POST-TRAUMATIC STRESS-DISORDERS

BY: Jim Goodwin, Psy.D.

"My marriage is falling apart. We just don't talk any more. Hell, I guess we've never really talked about anything, ever. I spend most of my time at home alone in the basement. She's upstairs and I'm downstairs. Sure we'll talk about the groceries and who will get gas for the car, but that's about it. She's tried to tell me she cares for me, but I get real uncomfortable talking about things like that, and I get up and leave. Sometimes I get real angry over the smallest thing. I used to hit her when this would happen, but lately I just punch out a hole in the wall, or leave and go for a long drive. Sometimes I spend more time on the road just driving aimlessly than I do at home.

"I really don't have any friends and I'm pretty particular about who I want as a friend. The world is pretty much dog eat dog, and no one seems to care much for anyone else. As far as I'm concerned, I'm really not a part of this messed up society. What I'd really like to do is have a home in the mountains, somewhere far away from everyone. Sometimes I get so angry with the way things are being run. I think about placing a few blocks of C-4 (military explosive) under some of the sons-of-bitches. A couple of times a year, I get into fights at bars. I usually pick the biggest guy. I don't know why. I usually get creamed. There are times when I drive real crazily, screaming and yelling at other drivers.

"I usually feel depressed. I've felt this way for years. There have been times I've been so depressed that I won't even leave the basement. I'll usually start drinking pretty heavily around these times. I've also thought about committing suicide when I've been depressed. I've got an old .38 that I snuck back from Nam. A couple of times I've sat with it loaded, once I even had the barrel in my mouth and the hammer pulled back. I couldn't do it. I see Smitty back in Nam with his brains smeared all over the bunker. Hell, I fought too hard then to make it back to the World (U.S.): I can't waste it now. How come I survived and he didn't? There has to be some reason.

"Sometimes, my head starts to replay some of my experiences in Nam. Regardless of what I'd like to think about, it comes creeping in. It's so hard to push back out again. It's old friends, their faces, the ambush, the screams, their faces (tears)… You know, every time I hear a chopper (helicopter) or see a clear unobstructed green treeline, a chill goes down my back; I remember. When I go hiking now, I avoid green areas. I usually stay above timber line. When I walk down the street, I get real uncomfortable with people behind me that I can't see. When I sit, I always try to find a chair with something big and solid directly behind me. I feel most comfortable in the corner of a room, with walls on both sides of me. Loud noises irritate me and sudden movement or noise will make me jump.

"Night is hardest for me. I go to sleep long after my wife has gone to bed. It seems like hours before I finally drop off. I think of so

many of my Nam experiences at night. Sometimes my wife awakens me with a wild look in her eye. I'm all sweaty and tense. Sometimes I grab for her neck before I realize where I am. Sometimes I remember the dream; sometimes it's Nam, other times it's just people after me, and I can't run anymore.

"I don't know, this has been going on for so long; it seems to be getting gradually worse. My wife is talking about leaving. I guess it's no big deal. But I'm lonely. I really don't have anyone else. Why am I the only one like this? What the hell is wrong with me?"

The above description of one Vietnam veteran's problematic lifestyle, more than ten years after the war in Southeast Asia, is unfortunately not an unusual phenomenon.

THE EVOLUTION OF POST-TRAUMATIC STRESS DISORDER

It was not until World War I that specific clinical syndromes came to be associated with combat duty. In prior wars, it was assumed that such casualties were merely manifestations of poor discipline and cowardice. However, with the protracted artillery barrages commonplace during "The Great War," the concept evolved that the high air pressure of the exploding shells caused actual physiological damage, precipitating the numerous symptoms that were subsequently labeled "shell shock." By the end of the war, further evolution accounted for the syndrome being labeled a "war neurosis" (Glass, 1969).

During the early years of World War II, psychiatric casualties had increased some 300 percent when compared with World War I, even though the preinduction psychiatric rejection rate was three to four times higher than World War I (Figley, 1978a). At one point in the war, the number of men being discharged from the service for psychiatric reasons exceeded the total number of men being newly drafted (Tiffany and Allerton, 1967).

During the Korean War, the approach to combat stress became even more pragmatic. Due to the work of Albert Glass (1945), individual breakdowns in combat effectiveness were dealt with in a very situational manner. Clinicians provided immediate onsite treatment to affected individuals, always with the expectation that the combatant would return to duty as soon as possible. The results were gratifying. During World War II, 23 percent of the evacuations were for psychiatric reasons. But in Korea, psychiatric evacuations dropped to only six percent (Bourne, 1970). It finally became clear that the situational stresses of the combatant were the primary factors leading to psychological casualty.

Surprisingly, with American involvement in the Vietnam War, psychological battlefield casualties evolved in a new direction. What was expected from past war experiences — and what was prepared for — did not materialize. Battlefield psychological breakdown was at an all-time low, 12 per one thousand (Bourne, 1970). It was decided that use of preventative measured learned in Korea and some added situational manipulation which will be discussed later had solved the age-old problem of psychological breakdown in combat.

As the war continued for a number of years, some interesting additional trends were noted. Although the behavior of some combatants in Vietnam undermined fighting efficiency, the symptoms presented rare but very well documented phenomenon of World War II began to be reobserved. After the end of World War II, some men suffering from acute combat reaction, as well as some of their peers with no such symptoms at war's end, began to complain of common symptoms. These included intense anxiety, battle dreams, depression, explosive aggressive behavior and problems with interpersonal relationships, to name a few. These were found in a five-year follow-up (Futterman and Pumpian- Mindlin, 1951) and in a 20-year follow-up (Archibald and Tuddenham, 1965).

A similar trend was once more observed in Vietnam veterans as the war wore on. Both those who experienced acute combat reaction and many who did not began to complain of the above symptoms long after their combatant role had ceased. What was so unusual was the large numbers of veterans being affected after Vietnam. The pattern of neuropsychiatric disorder for combatants of World War II and Korea was quite different than for Vietnam. For both World War II and the Korean War, the incidence of neuropsychiatric disorder among combatants increased as the intensity of the wars increased. As these wars wore down, there was a corresponding decrease in these disorders until the incidence closely resembled the particular prewar periods. The prolonged or delayed symptoms noticed during the postwar periods were noted to be somewhat obscure and few in numbers; therefore, no great significance was attached to them. However, the Vietnam experience proved different. As the war in Vietnam progressed in intensity, there was no corresponding increase in neuropsychiatric casualties among combatants. It was not until the early 1970s, when the war was winding down, that neuropsychiatric disorders began to increase. With the end of direct American troop involvement in Vietnam in 1973, the number of veterans presenting neuropsychiatric disorders began to increase tremendously (President's Commission on Mental Health 1978).

During the same period in the 1970s, many other people were experiencing varying traumatic episodes other than combat. There were large numbers of plane crashes, natural disasters, fires, acts of terrorism on civilian populations and other catastrophic events. The picture presented to many mental health professionals working with victims of these events, helping them adjust after traumatic experiences, was quite similar to the phenomenon of the troubled Vietnam veteran. The symptoms were almost identical. Finally, after much research (Figley, 1978a) by various veterans' task forces and recommendations by those involved in treatment of civilian post-trauma clients, the DSM III (1980) was published with a new category: post-traumatic stress disorder, acute, chronic and/or delayed.

HOW THE VIETNAM EXPERIENCE DIFFERED FROM PREVIOUS WARS AND SUBSEQUENTLY PREDISPOSED THE COMBATANT TO THE POST-TRAUMATIC STRESS DISORDER: DELAYED AND/OR CHRONIC TYPE

When direct American troop involvement in Vietnam became a reality, military planners looked to previous war experiences to help alleviate the problem of psychological disorder in combat. By then it was an understood fact that those combatants with the most combat exposure suffered the highest incidence of breakdown. In Korea this knowledge resulted in use, to some extent, of a "point system." After accumulating so many points, an individual was rotated home, regardless of the progress of the war. This was further refined in Vietnam, the outcome being the DEROS (date of expected return from overseas) system. Every individual serving in Vietnam, except general officers, knew before leaving the United States when he or she was scheduled to return. The tour lasted 12 months for everyone except the Marines who, known for their one-upmanship, did a 13-month tour. DEROS promised the combatant a way out of the war other than as a physical or psychological casualty (Kormos, 1978).

The advantages were clear: there would not be an endless period of protracted combat with the prospect of becoming a psychological casualty as the only hope for return to the United States without wounds. Rather, if a combatant could just hold together for the 12 or 13 months, he would be rotated to the United States; and, once home, he would leave the war far behind.

The disadvantages to DEROS were not as clear, and some time elapsed before they were noticed. DEROS was a very personal thing; each individual was rotated on his own with his own specific date. This meant that tours in Vietnam were solitary, individual episodes. It was rare, after the first few years of the war, that whole units were sent to the war zone simultaneously. Bourne said it best: "The war becomes a highly individualized and encapsulated event for each man. His war begins the day he arrives in the country, and ends the day he leaves" (p. 12, 1970). Bourne further states, "He feels no continuity with those who precede or follow him: He even feels apart from those who are with him but rotating on a different schedule" (p. 42, 1970).

Because of this very individual aspect of the war, unit morale, unit cohesion and unit identification suffered tremendously (Kormos, 1978). Many studies from past wars (Grinker and Spiegel, 1945) point to the concept of how unit integrity acts as a buffer for the individual against the overwhelming stresses of combat. Many of the veterans of World War II spent weeks or months with their units returning on ships from all over the world. During the long trip home, these men had the closeness and emotional support of one another to rework the especially traumatic episodes they had experienced together. The epitaph for the Vietnam veteran, however, was a solitary plane ride home with complete strangers and a head full of grief, conflict, confusion and joy.

For every Vietnam combatant, the DEROS date became a fantasy that on a specific day all problems would cease as he flew swiftly back to the United States. The combatants believed that neither they as individuals nor the United States as a society had changed in their absence. Hundreds of thousands of men lived this fantasy from day to day. The universal popularity of short- timer calendars is evidence of this. A short-timer was a GI who was finishing his tour overseas. The calendars intricately marked off the days remaining of his overseas tour in all manner of designs with 365 spaces to fill in to complete the final design and mark that final day. The GIs overtly displayed these calendars to one another. Those with the shortest time left in the country were praised by others and would lead their peers on a fantasy excursion of how wonderful and carefree life would be as soon as they returned home. For many, this became an almost daily ritual. For those who may have been struggling with a psychological breakdown due to the stresses of combat, the DEROS fantasy served as a major prophylactic to actual overt symptoms of acute combat reaction. For these veterans, it was a hard- fought struggle to hold on until their time came due.

The vast majority of veterans did hold on as evidenced by the low neuropsychiatric casualty rates during the war (The President's Commission on Mental Health, 1978). Rates of acute combat reaction or acute post-traumatic stress disorder were significantly lowered relative to the two previous wars. As a result, many combatants, who in previous wars might have become psychological statistics, held on somewhat tenuously until the end of their tours in Vietnam.

The struggle for most was an uphill battle. Those motivators that keep the combatant fighting — unit ESPIRIT DE CORPS, small group solidarity and an ideological belief that this was the good fight (Moskos, 1975) — were not present in Vietnam. Unit ESPIRIT was effectively slashed by the DEROS system. Complete strangers, often GIs who were strangers even to a specific unit's specialty, were transferred into units whenever individual rotations were completed. Veterans who had finally reached a level of proficiency had also reached their DEROS date and were rotated. Green troops or "fucking new guys" with almost no experience in combat were thrown into their places. These FNGs were essentially avoided by the unit, at least until after a few months of experience; "short timers" did not want to get themselves killed by relying on inexperienced replacements. Needles to say, the unit culture or ESPIRIT was often lost in the lack of communication with the endless leavings and arrivals.

There were other unique aspects of group dynamics in Vietnam. Seasoned troops would stick together, often forming very close small groups for short periods, a normal combat experience noted in previous wars (Grinker and Spiegel, 1945). Some groups formed along racial lines due to lack of unit cohesion within combat outfits. As a seasoned veteran got down to his last two months in Vietnam, he was struck by a strange malady known as the "short timer's syndrome." He would be withdrawn from the field and, if logistically possible, would be settled into a comparatively safe setting for the rest of his tour. His buddies would be left behind in the field without his skills, and he would be left with mixed feelings of joy and guilt. Interestingly, it was rare that a veteran ever wrote to his buddies still in Vietnam once he returned home (Howard, 1975). It has been an even rarer experience for two or more to get together following the war. This is a strong contrast to the endless reunions of World War II veterans. Feelings of guilt about leaving one's buddies to whatever unknown fate in Vietnam apparently proved so strong that many veterans were often too

frightened to attempt to find out what happened to those left behind.

Another factor unique to the Vietnam War was that the ideological basis for the war was very difficult to grasp. In World War II, the United States was very clearly threatened by a uniformed and easily recognizable foe. In Vietnam, it was quite the opposite. It appeared that the whole country was hostile to American forces. The enemy was rarely uniformed, and American troops were often forced to kill women and children combatants. There were no real lines of demarcation, and just about any area was subject to attack. Most American forces had been trained to fight in conventional warfare, in which other human beings are confronted and a block of land is either acquired or lost in the fray. However, in Vietnam, surprise firing devices such as booby traps accounted for a large number of casualties with the human foe rarely sighted. A block of land might be secured but not held. A unit would pull out to another conflict in the vicinity; and, if it wished to return to the same block of land, it would once again have to fight to take that land. It was an endless war with rarely seen foes and no ground gains, just a constant flow of troops in and out of the country. The only observable outcome was an interminable production of maimed, crippled bodies and countless corpses. Some were so disfigured it was hard to tell if they were Vietnamese or American, but they were all dead. The rage that such conditions generated was widespread among American troops. It manifested itself in violence and mistrust toward the Vietnamese (DeFazio, 1978), toward the authorities, and toward the society that sent these men to Vietnam and then would not support them. Rather than a war with a just ideological basis, Vietnam became a private war of survival for every American individual involved.

What was especially problematic was that this was America's first teenage war (Williams, 1979). The age of the average combatant was close to 20 (Wilson, 1979). According to Wilson (1978), this period for most adolescents involves a psychosocial moratorium (Erickson, 1968), during which the individual takes some time to establish a more stable and enduring personality structure and sense of self. Unfortunately for the adolescents who fought the war, the role of combatant versus survivor, as well as the many ambiguous and conflicting values associated with these roles, let to a clear disruption of this moratorium and to the many subsequent problems that followed for the young veterans.

Many men, who had either used drugs to deal with the overwhelming stresses of combat or developed other behavioral symptoms of similar stress-related etiology, were not recognized as struggling with acute combat reaction or post-traumatic stress disorder, acute subtype. Rather, their immediate behavior had proven to be problematic to the military, and they were offered an immediate resolution in the form of administrative discharges, often with diagnoses of character disorders (Kormos, 1978).

The administrative discharge proved to be another method to temporarily repress any further overt symptoms. It provided yet another means of ending the stress without becoming an actual physical or psychological casualty. It, therefore, served to lower the actual incidence of psychological breakdown, as did the DEROS. Eventually, this widely used practice came to be questioned, and it was recognized that it had been used as a convenient way to eliminate many individuals who had major psychological problems dating from their combat service (Kormos, 1978).

When the veteran finally returned home, his fantasy about his DEROS date was replaced by a rather harsh reality. As previously stated, World War II vets took weeks, sometimes months, to return home with their buddies. Vietnam vets returned home alone. Many made the transition from rice paddy to Southern California in less than 36 hours. The civilian population of the World War II era had been treated to movies about the struggles of readjustment for veterans (i.e. The Man In The Grey Flannel Suit, The Best Years of Our Lives, Pride of The Marines) to prepare them to help the veteran (DeFazio, 1978). The civilian population of the Vietnam era was treated to the horrors of the war on the six o'clock news. They were tired and numb to the whole experience. Some were even fighting mad, and many veterans came home to witness this fact. Some World War II veterans came home to victory parades. Vietnam veterans returned in defeat and witnessed antiwar marches and protests. For World War II veterans, resort hotels were taken over and made into redistribution stations to which veterans could bring their wives and devote two weeks to the initial homecoming (Boros, 1973). For Vietnam veterans, there were screaming antiwar crowds and locked military bases where they were processed back into civilian life in two or three days.

Those veterans who were struggling to make it back home finally did. However, they had drastically changed, and their world would never seem the same. Their fantasies were just that: fantasy. What they had experienced in Vietnam and on their return to their homes in the United States would leave an indelible mark that many may never erase.

THE CATALYSTS OF POST-TRAUMATIC STRESS DISORDERS FOR VIETNAM COMBAT VETERANS

More than 8.5 million individuals served in the U.S. Armed Forces during the Vietnam era, 1964-1973. Approximately 2.8 million served in Southeast Asia. Of the latter number, almost one million saw active combat or were exposed to hostile, life- threatening situations (President's Commission on Mental Health, 1978). It is this writer's opinion that the vast majority of Vietnam era veterans have had a much more problematic readjustment to civilian life than did their World War II and Korean War counterparts. This was due to the issues already discussed in this chapter, as well as to the state of the economy and the inadequacy of the GI Bill in the early 1970s. In addition, the combat veterans of Vietnam, many of whom immediately tried to become assimilated back into the peacetime culture, discovered that their outlook and feelings about their relationships and future life experiences had changed immensely. According to the fantasy, all was to be well again when they returned from Vietnam. The reality for many was quite different.

A number of studies point out that those veterans subjected to more extensive combat show more problematic symptoms during the

period of readjustment (Wilson, 1978; Strayer & Ellenhorn, 1975; Kormos, 1978; Shatan, 1978; Figley, 1978b). The usual pattern has been that of a combat veteran in Vietnam who held on until his DEROS date. He was largely asymptomatic at the point of his rotation back to the U.S. for the reasons previously discussed; on his return home, the joy of surviving continued to suppress any problematic symptoms. However, after a year or more, the veteran would begin to notice some changes in his outlook (Shatan, 1978). But, because there was a time limit of one year after which the Veterans Administration would not recognize neuropsychiatric problems as service-connected, the veteran was unable to get service-connected disability compensation. Treatment from the VA was very difficult to obtain. The veteran began to feel depressed, mistrustful, cynical and restless. He experienced problems with sleep and with his temper. Strangely, he became somewhat obsessed with his combat experiences in Vietnam. He would also begin to question why he survived when others did not.

For approximately 500,000 veterans (Wilson, 1978) of the combat in Southeast Asia, this problematic outlook has become a chronic lifestyle affecting not only the veterans but countless millions of persons who are in contact with these veterans. The symptoms described below are experienced by all Vietnam combat veterans to varying degrees. However, for some with the most extensive combat histories and other variables which have yet to be enumerated, Vietnam-related problems have persisted in disrupting all areas of life experience. According to Wilson (1978), the number of veterans experiencing these symptoms will climb until 1985, based on his belief of Erickson's psychosocial developmental stages and how far along in these stages most combat veterans will be by 1985. Furthermore, without any intervention, what was once a reaction to a traumatic episode may for many become an almost unchangeable personality characteristic.

DEPRESSION

The vast majority of the Vietnam combat veterans I have interviewed are depressed. Many have been continually depressed since their experiences in Vietnam. They have the classic symptoms (DSM III, 1980) of sleep disturbance, psychomotor retardation, feelings of worthlessness, difficulty in concentrating, etc. Many of these veterans have weapons in their possession, and they are no strangers to death. In treatment, it is especially important to find out if the veteran keeps a weapon in close proximity, because the possibility of suicide is always present.

When recalling various combat episodes during an interview, the veteran with a post-traumatic stress disorder almost invariably cries. He usually has had one or more episodes in which one of his buddies was killed. When asked how he handled these death when in Vietnam, he will often answer, "in the shortest amount of time possible" (Howard, 1975). Due to circumstances of war, extended grieving on the battlefield is very unproductive and could become a liability. Hence, grief was handled as quickly as possible, allowing little or no time for the grieving process. Many men reported feeling numb when this happened. When asked how they are now dealing with the deaths of their buddies in Vietnam, they invariable answer that they are not. They feel depressed; "How can I tell my wife, she'd never understand?" they ask. "How can anyone who hasn't been there understand?" (Howard, 1975).

Accompanying the depression is a very well developed sense of helplessness about one's condition. Vietnam-style combat held no final resolution of conflict for anyone. Regardless of how one might respond,t he overall outcome seemed to be just an endless production of casualties with no perceivable goals attained. Regardless of how well one worked, sweated, bled and even died, the outcome was the same. Our GIs gained no ground; they were constantly rocketed or mortared. They found little support from their "friends and neighbors" back home, the people in whose name so many were drafted into military service. They felt helpless. They returned to the United States, trying to put together some positive resolution of this episode in their lives, but the atmosphere at home was hopeless. They were still helpless. Why even bother anymore?

Many veterans report becoming extremely isolated when they are especially depressed. Substance abuse is often exaggerated during depressive periods. Self medication was an easily learned coping response in Vietnam; alcohol appears to be the drug of choice.

ISOLATION

Combat veterans have few friends. Many veterans who witnessed traumatic experiences complain of feeling like old men in young men's bodies. They feel isolated and distant from their peers. The veterans feel that most of their non-veteran peers would rather not hear what the combat experience was like; therefore, they feel rejected. Much of what many of these veterans had done during the war would seem like horrible crimes to their civilian peers. But, in the reality faced by Vietnam combatants, such actions were frequently the only means of survival.

Many veterans find it difficult to forget the lack of positive support they received from the American public during the war. This was especially brought home to them on the return from the combat zone to the United States. Many were met by screaming crowds and the media calling them "depraved fiends" and "psychopathic killers" (DeFazio, 1978). Many personally confronted hostility from friends and family, as well as strangers. After their return home, some veterans found that the only defense was to search for a safe place. These veterans found themselves crisscrossing the continent, always searching for that place where they might feel accepted. Many veterans cling to the hope that they can move away from their problems. It is not unusual to interview a veteran who, either alone or with his family, has effectively isolated himself from others by repeatedly moving from one geographical location to another. The stress on his family is immense.

The fantasy of living the life of a hermit plays a central role in many veterans' daydreams. Many admit to extended periods of isolation in the mountains, on the road, or just behind a closed door in the city. Some veterans have actually taken a weapon and attempted to live off the land.

It is not rare to find a combat veteran who has not had a social contact with a woman for years — other than with a prostitute, which is an accepted military procedure in the combat setting. If the veteran does marry, his wife will often complain about the isolation he imposes on the marital situation. The veteran will often stay in the house and avoid any interactions with others. He also resents any interactions that his spouse may initiate. Many times, the wife is the source of financial stability.

RAGE

The veterans' rage is frightening to them and to others around them. For no apparent reason, many will strike out at whomever is near. Frequently, this includes their wives and children. Some of these veterans can be quite violent. This behavior generally frightens the veterans, apparently leading many to question their sanity; they are horrified at their behavior. However, regardless of their afterthoughts, the rage reactions occur with frightening frequency.

Often veterans will recount episodes in which they became inebriated and had fantasies that they were surrounded or confronted by enemy Vietnamese. This can prove to be an especially frightening situation when others confront the veteran forcibly. For many combat veterans, it is once again a life-and- death struggle, a fight for survival.

Some veterans have been able to sublimate their rage, breaking inanimate objects or putting fists through walls. Many of them display bruises and cuts on their hands. Often, when these veterans feel the rage emerging, they will immediately leave the scene before somebody or something gets hurt; subsequently, they drive about aimlessly. Quite often, their behavior behind the wheel reflects their mood. A number of veterans have described to me the verbal catharsis they've achieved in explosions of expletives directed at any other drivers who may wrong them.

There are many reasons for the rage. Military training equated rage with masculine identity in the performance of military duty (Eisenhart, 1975). Whether one was in combat or not, the military experience stirred up more resentment and rage than most had ever felt (Egendorf, 1975). Finally, when combat in Vietnam was experienced, the combatants were often left with wild, violent impulses and no one upon whom to level them. The nature of guerrilla warfare — with its use of such tactics as booby trap land mines and surprise ambushes with the enemy's quick retreat — left the combatants feeling like time bombs; the veterans wanted to fight back, but their antagonists had long since disappeared. Often they unleashed their rage at indiscriminate targets for want of more suitable targets (Shatan, 1978).

On return from Vietnam, the rage that had been tapped in combat was displaced against those in authority. It was directed against those the veterans felt were responsible for getting them involved in the war in the first place — and against those who would not support the veterans while they were in Vietnam or when they returned home (Howard, 1975). Fantasies of retaliation against political leaders, the military services, the Veterans Administration and antiwar protesters were present in the minds of many of these Vietnam combat veterans. These fantasies are still alive and generalized to many in the present era.

Along with the rage at authority figures from the Vietnam era, these veterans today often feel a generalized mistrust of anyone in authority and the "system" in the present era. Many combat veterans with stress disorders have a long history of constantly changing their jobs. It is not unusual to interview a veteran who has had 30 to 40 jobs during the past 10 years. One veteran I interview had nearly 80 jobs in a 10-year span. The rationale quite often given by the veterans is that they became bored or the work was beneath them. However, after I made some extended searched into their work backgrounds, it became apparent that they felt deep mistrust for their employers and coworkers; they felt used and exploited; at times, such was the case. Many have had some uncomfortable confrontations with their employers and job peers, and many have been fired or have resigned on their own.

AVOIDANCE OF FEELINGS: ALIENATION

The spouses of many of the veterans I have interviewed complain that the men are cold, uncaring individuals. Indeed the veterans themselves will recount episodes in which they did not feel anything when they witnessed the death of a buddy in combat or the more recent death of a close family relative. They are often somewhat troubled by these responses to tragedy; but, on the whole, they would rather deal with tragedy in their own detached way. What becomes especially problematic for these veterans, however, is an inability to experience the joys of life. They often describe themselves as being emotionally dead (Shatan, 1973).

The evolution of this emotional deadness began for Vietnam veterans when they first entered military boot camp (Shatan, 1973). There they learned that the Vietnamese were not to be labeled as people but as "gooks, dinks, slopes, zipperheads and slants." When the veterans finally arrived in the battle zone, it was much easier to kill a "gook" or "dink" than another human being. This dehumanization gradually generalized to the whole Vietnam experience. The American combatants themselves became "grunts," the Viet Cong became "Victor Charlie," and both groups were either "KIA" (killed in action) or "WIA" (wounded in action). Often, many "slopes" would get "zapped" (killed) by a "Cobra" (gunship), and the "grunts" would retreat by "Shithook" (evacuation by a Chinook helicopter); the jungle would be sown by "Puff the Magic Dragon" (a C-47 gunship with rapid-firing mini- gattling guns).

The pseudonyms served to blunt the anguish and the horror of the reality of combat (DeFazio, 1978). In conjunction with this almost surreal aspect of the fighting, psychic numbing furthered the coping and survival ability of the combatants by effectively knocking the aspect of feelings out of their cognitive abilities (Lifton, 1976). This defense mechanism of survivors of traumatic experiences dulls an individual's awareness of the death and destruction about him. It is a dynamic survival mechanism, helping one to pass through a period of trauma without becoming caught up in its tendrils. Psychic numbing only becomes nonproductive when the period of trauma is passed, and the individual is still numb to the affect around him.

Many veterans find it extremely uncomfortable to feel love and compassion for others. To do this, they would have to thaw their numb reactions to the death and horror that surrounded them in Vietnam. Some veterans I've interview actually believe that if they once again allow themselves to feel, they may never stop crying or may completely lose control of themselves; what they mean by this is unknown to them. Therefore, many of these veterans go through life with an impaired capacity to love and care for others. they have no feeling of direction or purpose in life. They are not sure why they even exist.

SURVIVAL GUILT

When others have died and some have not, the survivors often ask, "How is it that I survived when others more worthy than I did not?" (Lifton, 1973). Survival guilt is an especially guilt- invoking symptom. It is not based on anything hypothetical. Rather, it is based on the harshest of realities, the actual death of comrades and the struggle of the survivor to live. Often the survivor has had to compromise himself or the life of someone else in order to live. The guilt that such an act invokes or guilt over simply surviving may eventually end in self-destructive behavior by the survivor.

Many veterans, who have survived when comrades were lost in surprise ambushes, protracted battles or even normal battlefield attrition, exhibit self-destructive behavior. It is common for them to recount the combat death of someone they held in esteem; and, invariably, the questions comes up, "Why wasn't it me?" It is not unusual for these men to set themselves up for hopeless physical fights with insurmountable odds. "I don't know why, but I always pick the biggest guy," said the veteran in the transcript at the beginning of this chapter. Shatan (1973) notes that some of these men become involved in repeated single-car accidents. This writer interviewed one surviving veteran, whose company suffered over 80% casualties in one ambush. The veteran had had three single-car accidents during the previous week, two the day before he came in for the interview. He was wondering if he were trying to kill himself.

I have also found that those veterans who suffer the most painful survival guilt are primarily those who served as corpsmen or medics. These unfortunate veterans were trained for a few months to render first aid on the actual field of battle. The services they individually performed were heroic. With a bare amount of medical knowledge and large amounts of courage and determination, they saved countless lives. However, many of the men they tried to save died. Many of these casualties were beyond all medical help, yet many corpsmen and medics suffer extremely painful memories to this day, blaming their "incompetence" for these deaths. Listening to these veterans describe their anguish and torment… seeing the heroin tracks up and down their arms or the bones that have been broken in numerous barroom fights… is, in itself, a very painful experience.

Another less destructive trend that I have noticed exists among a small number of Vietnam combat veterans who have become compulsive blood donors. One very isolated and alienated individual I interviewed actually drives some 80 miles round-trip once every other month to make his donation. His military history reveals that he was one of 13 men out of a 60-man platoon who survived the battle of Hue. He was the only survivor who was not wounded. this veteran and similar vets talk openly about their guilt, and they find some relief today in giving their blood that others may live.

ANXIETY REACTIONS

Many Vietnam veterans describe themselves as very vigilant human beings; their autonomic senses are tuned to anything out of the ordinary. A loud discharge will cause many of them to start. A few will actually take such evasive action as falling to their knees or to the ground. Many veterans become very uncomfortable when people walk closely behind them. One veteran described his discomfort when people drive directly behind him. He would pull off the road, letting others pass, when they got within a few car lengths of him.

Some veterans are uncomfortable when standing out in the open. Many are uneasy when sitting with others behind them, often opting to sit up against something solid, such as a wall. The bigger the object is, the better. Many combat veterans are most comfortable when sitting in the corner in a room, where they can see everyone about them. Needless to say, all of these behaviors are learned survival techniques. If a veteran feels continuously threatened, it is difficult for him to give such behavior up.

A large number of veterans possess weapons. This also is a learned survival technique. Many still sleep with weapons in easy reach. The uneasy feeling of being caught asleep is apparently very difficult to master once having left the combat zone.

SLEEP DISTURBANCE AND NIGHTMARES

Few veterans struggling with post-traumatic stress disorders find the hours immediately before sleep very comfortable. In fact,

many will stay awake as long as possible. They will often have a drink or smoke some cannabis to dull any uncomfortable cognition that may enter during this vulnerable time period. Many report that they have nothing to occupy their minds at the end of the day's activities, and their thoughts wander. For many of them, it is a trip back to the battle zone. Very often they will watch TV late into the mornings.

Finally, with sleep, many veterans report having dreams about being shot at or being pursued and left with an empty weapon,, unable to run anymore. Recurrent dreams of specific traumatic episodes are frequently reported. It is not unusual for a veteran to reexperience, night after night, the death of a close friend or a death that he caused as a combatant. Dreams of everyday, common experiences in Vietnam are also frequently reported. For many, just the fear that they might actually be back in Vietnam is very disquieting.

Some veterans report being unable to remember their specific dreams, yet they feel dread about them. Wives and partners report that the men sleep fitfully, and some call out in agitation. A very few actually grab their partners and attempt to do them harm before they have fully awakened. Finally, maintaining sleep has proven to be a problem for many of these veterans. They report waking up often during the night for no apparent reason. Many rise quite early in the morning, still feeling very tired.

INTRUSIVE THOUGHTS

Traumatic memories of the battlefield and other less affect- laden combat experiences often play a role in the daytime cognitions of combat veterans. Frequently, these veterans report replaying especially problematic combat experiences over and over again. Many search for possible alternative outcomes to what actually happened in Vietnam. Many castigate themselves for what they might have done to change the situation, suffering subsequent guilt feelings today because they were unable to do so in combat. The vast majority report that these thoughts are very uncomfortable, yet they are unable to put them to rest.

Many of the obsessive episodes are triggered by common, everyday experiences that remind the veteran of the war zone: helicopters flying overhead, the smell of urine (corpses have no muscle tone, and the bladder evacuates at the moment of death), the smell of diesel fuel (the commodes and latrines contained diesel fuel and were burned when filled with human excrement), green tree lines (these were searched for any irregularity which often meant the presence of enemy movement), the sound of popcorn popping (the sound is very close to that of small arms gunfire in the distance), any loud discharge, a rainy day (it rains for months during the monsoons in Vietnam) and finally the sight of Vietnamese refugees.

A few combat veterans find the memories invoked by some of these and other stimuli so uncomfortable that they will actually go out of their way to avoid them. When exposed to one of the above or similar stimuli, a very small number of combat veterans undergo a short period of time in a dissociative-like state in which they actually reexperience past events in Vietnam. These flashbacks can last anywhere from a few seconds to a few hours. One veteran described an episode to me in which he had seen some armed men and felt he was back in Vietnam. The armed men were police officers. Not having a weapon to protect himself and others, he grabbed a passerby and forcefully sheltered this person in his home to protect him from what he felt were the "gooks." He was medicated and hospitalized for a week.

Such experiences among Vietnam veterans are rare, but not as uncommon as many may believe. Many veterans report flashback episodes that last only a few seconds. For many, the sound of a helicopter flying overhead is a cue to forget reality for a few seconds and remember Vietnam, reexperiencing feelings they had there. It is especially troublesome for those veterans who are still "numb" and specifically attempting to avoid these feelings. For others, it is just a constant reminder of their time in Vietnam, something they will never forget.

REFERRALS FOR HELP

As already discussed, post-traumatic stress disorders result in widely varying degrees of impairment. When a single veteran (whether bachelor or divorced) with the disorder requests help, I refer him to a group of other combat veterans. The reasons are twofold. First, the veteran is usually quite isolated and has lost many of his social skills. He has few contacts with other human beings. The group provides a microcosm in which he can again learn how to interact with other people. It also helps remove the fear, prevalent among these veterans, that each individual veteran is the only individual with these symptoms. In addition, many of the veterans form close support groups of their own outside the therapy sessions; they telephone each other and help each other through particularly problematic episodes.

Second, the most basic rationale for group treatment of these veterans is that it finally provides the veteran with that "long boat ride home" with other veterans who have had similar experiences. It provides a forum in which veterans troubled by their combat experiences can work their feelings through with other veterans who have had similar conflicts. In addition, the present symptoms of the disorder are all quite similar, and there is more reinforcement in working through these symptoms with one's peers than in doing it alone.

The group situation is appropriate for most degrees of the symptoms presented. The especially isolated individuals will often be quite frightened of the initial group session. When challenged by questioning the strength that brought them to the initial interview,

however, they will usually respond by following through with the group. Those with severely homicidal or suicidal symptoms are best handled in a more crisis-oriented, one-to-one setting until the crisis is resolved. I refer these veterans to an appropriate emergency team, with the expectation directly shared with the veteran that he will join the group as soon as the crisis has abated.

Veterans who are presently married or living with a partner present a somewhat different picture. Their relationships with their partners are almost invariable problematic. Frequently, a violent, explosive episode at home created the crisis that brought the veteran in for counseling in the first place. When such is the case or there is a history of battering of the partner, it is extremely important to refer the veteran and his partner to a family disturbance counseling center. The consequences of this continued behavior are obvious. In addition, a referral for the veteran to a group with other combat veterans is appropriate. The partner of the veteran may find some understanding of her plight and additional support from a woman's group created specifically for partners of Vietnam combat veterans.

Other veterans who are married or living with a partner may not be experiencing so serious a problem. However, the partners are often detached from one another; they just seem to live under the same roof, period. Referral of the veteran to a combat veterans group and referral of the partner to a partners of Vietnam veterans group is important.

Some veterans and their partners will jointly attend the screening session. Both are troubled by what has been happening and often want to enter marital therapy together immediately. In my experience, the veteran finds it extremely difficult in the beginning of therapy to deal with interactional aspects with his partner when other past interactions with traumatic overtones overshadow the present. When these traumatic experiences do surface, the partner is often unable to relate. Therefore, it is much more beneficial, in my opinion, to allow the veteran time with other combat veterans in a group. In the meantime, suggest a woman's support group for partners of Vietnam veterans for the spouse. Here she would receive additional support as well as an understanding of post-traumatic stress disorders. Sometime thereafter, marital therapy, couples group therapy or family therapy may be appropriate.

Many veterans with post-traumatic stress disorders, in addition to the symptoms already described, also have significant problems due to multiple substance abuse. In my experience, those veterans who have habitually medicated themselves have compounded the problem. Not only do they experience many of the symptoms already described, but the additional symptoms of chronic multiple substance abuse and alcoholism may mask the underlying reasons for self-medication as well. Therefore, these chronic syndromes, which perpetuate themselves through addictive behavior, must be dealt with first. Then a more accurate picture of the underlying problem will result, and an appropriate referral can be made.

Except for some help with an immediate crisis upon being first interviewed during the screening session, the combat veteran struggling with the symptoms of post-traumatic stress disorder, chronic and/or delayed, benefits most from group interaction with his combat peers. Throughout this paper I have emphasized the individual, solitary aspect of the war for each veteran. The aftermath of the war has followed in kind. Now, with the help from the DAV Vietnam Veterans Outreach Program and the VA's Operation Outreach (Vet Center) program, models have been established for reintegrating troubled Vietnam veterans with themselves and their society. Helping the community to recognize the problem and directing the veteran to the specialized services of the community have given the veteran struggling with this disorder a means of "coming home."

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