# PTSD and the Vietnam Veteran: THE BATTLE FOR TREATMENT

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Willie enlisted at 17 and was corpsman in Vietnam for 2 years. Although he experienced guilt and grief about some combat triage decisions that resulted in death, he was decorated for bravery under fire and saved many lives on the battlefield. During his second year, Willie witnessed the death of a close friend in a village; he became enraged and crushed the skull of the young boy who had thrown the grenade.

Willie returned home without being wounded. But on his second night home, he was stabbed in a bar fight by anti-war patrons who called him an "Uncle Tom" for "fighting the white man's war."

Willie found himself emotionally numb, bitter, without support, unable to hold a job, and in continual conflict with authority. Worse, every night the murdered Vietnamese boy and his family and Willie's dead friends visited him.

Willie's fear of sleeping, the flashbacks, and the nightmares made his life intolerable, and the only way he could sleep was to drink wine until sedated. He entered an acute psychiatry unit while awaiting admission to a post-traumatic stress disorder (PTSD) program. There, the staff identified him as noncompliant and demanding and were in constant conflict with him about unit structure. They set limits to stop his restless pacing at night and Willie became angry and resistive. He was finally restricted to the unit after an angry outburst when confronted about his demanding medication to sleep.

When time arrived for his PTSD support group, the cotherapist offered to escort Willie off the unit. The RN replied, "Well, we don't think that he has PTSD, anyway. The team feels that the group is complicating his treatment; he's just splitting. He's restricted and can't leave the unit." A male nurse stated, "My dad's unit fought for three years in World War II and they never had problems. Willie wasn't even wounded!"

Despite a plethora of literature concerning post-traumatic stress disorder in general, and Vietnam veterans in particular, the above situation occurs all too frequently. It is apparent that not only the public, but also many health-care professionals doubt the legitimacy and realities of PTSD symptomatology. The intensity of resistance and anger toward these patients by professionals can be most startling. Programs and plans of care are fraught with personal control issues, bias, and issues of pathological staff group dynamics.

The misunderstandings and resistance of treaters to PTSD is a result of ignorance rather than indifference. A knowledge of the extenuating circumstances, the predisposing factors, and the etiology of PTSD can enable clinicians to treat veterans and other sufferers of post-traumatic symptoms more appropriately and with compassion. It is crucial that professionals come to recognize PTSD for what it is, and to overcome preconceived beliefs and assumptions about the symptoms and those who suffer them.

Sirois and Swift (1987) point out that movies and television features about the Vietnam experience have heightened awareness and sensitivity to the issues of PTSD and Vietnam veterans; the grassroot support for Operation Desert Storm (ODS) has also helped improve this situation. However, the problems of adequate treatment still exist for the Vietnam veteran, and some authors (Brende, 1985) suggest that it is imperative that clinicians seek support for their personal struggles with these issues from other therapists, supervisors, and the literature concerning PTSD.

## Post-Traumatic Stress Disorder and Diagnostic Confusion

Post-traumatic stress disorder is a psychological reaction to overwhelming traumatic events or stress that is far beyond normal human experiences. The disorder has two common features that can occur separately or concurrently. The first is a general emotional numbing and loss of normal affective responsiveness to life situations and to interpersonal relations. The second is that victims re-experience the event in a number of ways, in the form of painful and fearful recollections, intrusive thoughts, recurrent dreams and nightmares, chronic anxiety states, and dissociative episodes.

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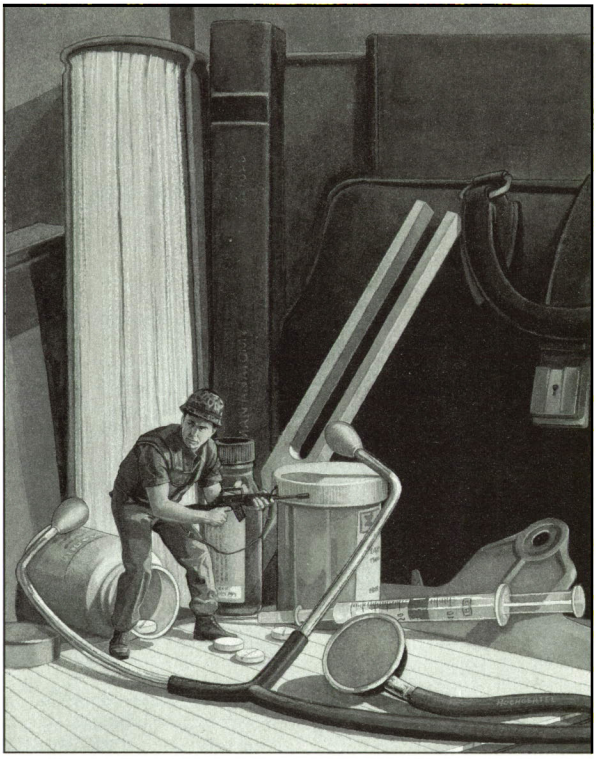

Many believe that post-traumatic symptoms are normal responses to horrible events, are prolonged, and cause serious dysfunction (Norman, 1989). These ideas are derived from a wide variety of trauma victims—survivors of disasters, personal violence, sexual abuse, and combat. Estimates of the incidence of PTSD from the Vietnam conflict range from 500,000 to 750,000 (Walker, 1982). The Veterans Administration estimates that as many as 25% of the men and women who served in Southeast Asia suffer some symptoms of PTSD, which would indicate an estimated 750,000 cases (Blank, 1982). Others estimate a rate of at least 18% and possibly as high as 54%, or 1.5 million cases (Ingraham, 1986).

The unique problems of the Vietnam veteran began to be recognized in the late 1970s. In 1980, the American Psychiatric Association officially recognized the disorder and included the new diagnostic category "PTSD" in the *Diagnostic and Statistical Manual (DSM-III)*, which listed five diagnostic criteria for PTSD (APA, 1980). The *DSM-III-R* (1987) clarified and redefined the *DSM-III* criteria and included the following:

- the exposure to a traumatic event that is outside the range of normal human experience;
- the re-experiencing of the traumatic event in various ways;
- the persistent avoidance of stimuli associated with the trauma;
- the persistent symptoms of increased arousal; and
- the duration of symptoms of at least 1 month and that occur at least 6 months after the traumatic event.

These criteria describe typical experiences that are common to PTSD sufferers. Ursano and Holloway (1985) point out that the nature and severity of the trauma, the metaphorical significance of the event to the individual, the biological vulnerability to psychological pathology, and the psychosocial context before, during, and after the trauma are important predisposing factors. The most serious symptom is depression and a drastic increase in risk of suicide (Hickman, 1987). Another common symptom is antisocial behavior, including violence (Collins, 1990; Egendorf, 1981). Ursano (1981) identifies adjustment disorders as a post-traumatic symptom; it often is a component of PTSD. Many sufferers have difficulty holding a job and have a history of multiple employments over the years (Bailey, 1990). Many complain of attention and concentration deficits (Van Putten, 1984); impaired memory is also problematic (Horowitz, 1980). Other common symptoms are hyperalertness, chronic anxiety states, and survival guilt (Laufer, 1985).

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The most devastating and complicating treatment factor of PTSD is substance abuse (Jelinek, 1984). This factor was even more problematic for the Vietnam veteran, because drugs were used officially by the US military. Amphetamines were used to promote wakefulness. Alcohol was used extensively, and was commonly provided to units following actions or deployment. Phenothiazines and other tranquilizers were also used for the first time in combat (Jones, 1975). The widespread use of marijuana served a purpose in that it muted the stress of combat and repressed fear, guilt, and grief (Horowitz, 1975). It is not surprising that substance abuse upon return would become problematic—made more so by the double standard that drugs were acceptable in combat for stress, but illegal and shameful for stresses revisited in civilian life.

Because substance abuse is a common symptom in PTSD, it often becomes the focus of treatment, leaving other symptoms and issues overlooked (Wedding, 1987). Agosta and McHugh (1987) studied rape victims, battered women, and incest victims and found that self-medication for anxiety using alcohol or other drugs is very common. Newman (1987) observes that PTSD patients from Vietnam often self-medicate for severe sleep disturbances, intrusive thoughts, and chronic anxiety states.

Finally, these patients exhibit a lack of trust, have difficulties with authority (Van Putten, 1984), and often have a chip-on-the-shoulder attitude. Vietnam veterans experienced authority—their own officers—who continually placed them in a position to be killed. After the troop reductions began, being killed in a losing effort was even more difficult to deal with. This message was, of course, reinforced upon their return to the US, where they faced ridicule and avoidance by those in authority and years of struggle to receive appropriate treatment.

These conditions make for emotional distancing, an aggressive interpersonal style, and a tendency to antagonize and alienate others. Interpersonal distancing and affective blunting exacerbate this personality style. These patients have great difficulty trusting "outsiders" (Hickman, 1987) and will often test caregivers by questioning motives, knowledge, and sincerity.

More confusing is the problem of misdiagnosis. The Veterans Affairs' Operation Outreach, designed to contact those veterans who experienced post-traumatic symptoms, discovered that patients suffering moderate to severe post-traumatic symptoms had gone for years without an accurate diagnosis (Clark, 1987); that is, from war's end until 1980, these 500,000 to 1.5 million individuals were misdiagnosed. The most frequent misdiagnosis of PTSD is personality disorder (Newman, 1987). The second most common diagnosis of PTSD is psychosis (Domash, 1982); severe cases of PTSD are often diagnosed as paranoid schizophrenia. Some veterans developed reactive psychoses, and severe cases of PTSD can present clinically as a psychotic disorder. The symptoms for PTSD sufferers are distinctive, however, and include severe anxiety, internal imagery, and dissociative states that all connect to the traumatic event.

Because so many veterans obtained a diagnosis prior to 1980, and because PTSD may mimic other diagnoses, PTSD often becomes a secondary diagnosis, that is, not the disorder of primary treatment focus. Many believe that when PTSD is a secondary diagnosis, failing to address PTSD issues leads to treatment failure (Agosta, 1987; Newman, 1987).

Aside from the issue of diagnostic confusion, PTSD often simply goes unrecognized (Atkinson, 1982; Van Putten, 1984). The adverse interactional style of Vietnam veterans, the provocative nature of their interpersonal relations, their aggressiveness, and their difficulties talking about the traumatic experiences all contribute to either misdiagnosis, or to post-traumatic symptoms not being recognized for what they are. Consequently, many PTSD patients continue to carry a primary diagnosis that is not PTSD. This misdiagnosis has negatively influenced treatment plans, therapies, and medications.

Of people exposed to severe trauma, only some will develop symptoms that correspond to *DSM-III-R* criteria for PTSD. Others will develop serious symptoms that are post-traumatic symptoms, but that are not diagnosed as PTSD. Professionals must recognize that these, too, are legitimate psychiatric symptoms and therefore need to be addressed in treatment. Shore (1986) identifies depression as the most common single post-traumatic symptom, with an extremely high risk of suicide. Substance abuse is also a single post-traumatic symptom (Davidson, 1985; Laufer, 1985). Other single symptoms are anti-social behavior, including violence, and emotional distancing (Collins, 1990). Since 1980, much has been learned about PTSD by the VA and through public, forensic, and private practices. In October 1980, the VA authorized compensation and other benefits for PTSD patients, but does not yet compensate for post-traumatic symptoms that do not meet all the *DSM-III-R* criteria.

**Combat psychological breakdown results in conditions that inflict terrible suffering on patients and from which many never recover.**

### American Naiveté and the Roots of Professional Prejudice

Many report that a professional disagreement exists against the diagnosis of PTSD itself (Atkinson, 1982). Some believe that these patients suffer from a pre-existing problem, perhaps exacerbated by the trauma or civilian stressors. Others doubt the validity of PTSD and believe it to be rare, and thus resist appropriate treatment (Van Putten, 1984). These notions are unsupported by the literature and may represent denial, personal resistance, or other issues (Kadashin, 1991).

Much of the bias of professionals, and of Americans in general, is due to a lack of basic understanding of the ex-

**PTSD is not unique to socioeconomic class or ethnicity, but adaptation, coping skills, and support systems affect the severity of post-traumatic symptoms.**

tent to which combat produces psychological casualties. This contributes to the denial of the widespread existence of combat-related symptoms.

Gabriel (1987) refers to many references of psychological casualties in the Greek and Roman armies, and points out that combat-related psychiatric casualties are well known throughout history. Modern armies have had considerable experience since 1905 with psychiatric breakdown during combat. Once called "shell shock" or "war neurosis," the acute psychological reactions to combat were well-documented in World War I (Rundell, 1989). In 1922, the prolonged, chronic symptoms were recognized and labeled "post-combat psychiatric disorder" (Sargent, 1940).

In World War I, of the 2 million men sent overseas, 153,994, or about 8%, were lost to the war effort due to psychological problems (Strecker, 1944). In World War II, 1.39 million men suffered some psychiatric symptoms, and 504,000, or 37.5%, of those who saw combat were permanently lost to the war effort (Ginsberg, 1950). In the first year of the Korean War, 250 per 1,000 men were lost to psychological symptoms—almost 7 times that of World War II. As the war became more stabilized, the rate fell to an average 32 per 1,000 men, or slightly lower than in World War II (Gabriel, 1987). This means that the chance of becoming a psychiatric casualty was 143% greater than that of being killed.

In modern warfare, the rates have been higher. In 1982, when Israel invaded Lebanon, psychological casualties were twice the number of those killed, and accounted for 27% of those wounded (Belensky, 1983). The greatest risk to the modern soldier is the threat of being psychologically debilitated. In Vietnam, approximately 16% of those involved in combat were killed, and loss due to psychiatric reasons was 12.6% (Gabriel, 1987).

Although the special circumstances of the Vietnam conflict served to reduce psychological symptoms during combat, they produced delayed and prolonged symptoms on a scale that was totally unexpected. More than 3 million men served in Vietnam, and more than 58,000 were killed. More than 60,000 (almost 17%) have committed suicide since returning home (Peterson, 1990).

The roots of cultural naiveté about war and its consequences go further than simple ignorance of these statistics. There is a widespread belief that combat-induced psychological breakdown is, at worst, only transitory and easily cured. The truth is the opposite: combat psychological breakdown results in conditions that inflict terrible suffering on patients and from which many never recover.

### Etiological Issues of the Vietnam Conflict

There are two characteristics of the Vietnam conflict that contribute to the etiology of PTSD. The first is the personal differences of those who served in Vietnam. The average age of the World War II combat soldier was 23; in Vietnam it was 19. Adolescents were sent to fight at a point in their psychosocial development that Erikson calls identity versus identity diffusion (Miller, 1983). This is a stage at which the integration of various identifications occurs to produce a complete adult identity. If integration does not occur, a state of identity diffusion occurs and the personality becomes fragmented—killing can become a pleasure in its own right. Chronic problems upon returning home can become difficulties in adjustment and identity. The average age of women who served as medical personnel in Vietnam was 25 (Schwartz, 1987), the developmental stage of intimacy versus isolation (Miller, 1983). Predictably, these female veterans often later suffer an inability to form intimate relationships with others and experienc isolation, denial, and adjustment problems related to conflicting roles (Schwartz, 1987).

The ideology and influences from the peer group are very powerful, and when young people are taught that the enemy is inhuman—"gooks"—it is understandable that atrocities and hideous violence can become commonplace. Evidence indicates that the diffusion of identity is exacerbated by minority group status (Miller, 1983) and it has been found that black and Hispanic veterans suffer PTSD at a higher rate (Allen, 1986).

Allen (1986) states that racism in the military and conflicts over civil rights issues in the US during the war also limited the minority veteran's support system. Blacks and Hispanics had conflicting emotions and more difficulty than whites in accepting the brutality and atrocities of the war. They had more affinity for and identification with Vietnamese nationals (Goff, 1982; Parson, 1984) and were less able to dehumanize the Vietnamese than were their white counterparts (Yager, 1984).

Many Vietnam veterans came from underprivileged and poorer minority cultures, which more often had dysfunctional family and social support systems. This contributed to a susceptibility to which teenaged soldiers were exposed. PTSD is not unique to socioeconomic class or ethnicity, but adapta-

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tion, coping skills, and support systems affect the severity of post-traumatic symptoms (Lund, 1984). Tanaka (1988) indicates that the lack of such support creates a personal vulnerability to most traumatic symptomology. Norman (1988) studied military nurses, and found that due to more supportive social networks, these female veterans fared better psychologically than their male counterparts. Of thousands of nurses who served in Vietnam, eight were killed, and as many as 90% are estimated to have suffered post-traumatic symptoms. About 22% were severe enough to necessitate therapy. Their symptoms mirrored those of combat veterans. After 15 years, almost 25% of these nurses still report having high levels of anxiety and painful, intrusive thoughts. Others (Schnair, 1986) report that as many as 50% of these women report having these symptoms and 20% describe them as "significantly disruptive."

The second issue is the characteristics of the war itself. Unlike other American combat experiences, Vietnam was largely a guerrilla war. An important difference was the enemy. In Vietnam, the enemy was often the very civilians that our soldiers were sent to defend. The enemy was often children, women, or the elderly—those whom American men are taught to defend from early childhood. The danger was chronic and pervasive. There were no secure areas in Vietnam; death or injury could occur anywhere at any time. Soldiers were continually at risk from snipers, mines, booby traps, and civilians. Karnow (1983) reports that some celebrated US Marine units in World War II fought no longer than 6 to 8 weeks during all of the war. The Vietnam veteran was endangered every day of his 12-month tour of duty.

There were also many more wounded in Vietnam, due primarily to the efficient and rapid evacuation by helicopter. In World War II, 1 in 4 Marine casualties died, whereas in Vietnam, 1 in 7 died. This produced a far greater percentage of survivors who were wounded, handicapped, or disabled (Karnow, 1983). For instance, the incidence of paraplegia was 1000% higher in Vietnam than in World War II and 50% higher than in Korea (Schwartz, 1987).

There was no standard by which to measure success or failure of military operations in Vietnam; fierce battles were fought many times over the same geography. The US military invented the "body count" to measure success—the number of enemy slaughtered. As a result, returning veterans were often denounced and berated for brutality.

Another issue was the date of expected return from overseas. This system assigned a soldier a fixed length of stay overseas, unlike previous wars in which soldiers stayed with a single unit throughout the conflict. The advantage of the system was that it encouraged coping for that period, and it was expected that fewer psychological casualties would occur. The disadvantages were that the horror, grief, and guilt were put on hold or suppressed, to be dealt with at a later time. There was no time in which to process or decompress.

Worse, toward the end of his tour, a soldier was often moved to safer duty in the rear to wait out his time. This produced much guilt in the Vietnam veteran (Howard, 1976) and took experienced soldiers off the line where they could have been a support to newer replacements. The replacements were avoided by more seasoned soldiers until they acquired combat experience. Cohesiveness and morale of units were lost in this parade of endless, solitary arrivals and departures (Kormos, 1978).

In World War II, the veteran's reentry to civilian life took weeks or months and provided time for processing the events of combat, grieving, and receiving the support of others who had served alongside the soldier. In Vietnam, the veteran's return was done alone, in the company of strangers; in some cases, the trip from rice paddy to Southern California took less than 36 hours (Sirois, 1987).

## Conclusion

Veterans who suffer post-traumatic symptoms must overcome a multitude of obstacles for appropriate treatment: public attitudes concerning mental illness in general, professional resistance, diagnostic confusion, and a cultural bias concerning the nature of psychiatric casualties from warfare. Vietnam veterans must battle even harder for treatment, acceptance, and compensation. Women veterans are still denied treatment or compensation for PTSD, having not officially been exposed to combat (Schwartz, 1987). Every aspect of the Vietnam conflict, and the characteristics of those who served there, set up these veterans for serious psychological adjustments and psychiatric disturbances.

**Those who served in Vietnam were victims of the particular situation, the conditions of the era, and of the conflict itself.**

Veterans of Operation Desert Storm should fare much better than their Vietnam counterparts. They were deployed along with their established units, served for the duration, and returned home with their comrades. The support from their families, their communities, the mass media, and politicians was drastically different from that which was offered to Vietnam veterans. The numbers of psychiatric casualties from ODS remain to be counted, but the circumstances indicate that these may be few. Yet legitimate PTSD sufferers may encounter the attitude that "the war lasted only 100 hours and very few were killed or wounded," and these patients may also face a battle for appropriate treatment.

Those who served in Vietnam were victims of the particular situation, the conditions of the era, and of the conflict itself. They do not deserve to be victimized again by resistant or unresponsive health professionals. They cannot be compared with soldiers of other times, or stereotyped by unrealistic bias produced by ignorance or by the media. Psychiatric professionals must respond with compassion, empathy, and understanding to these challenging patients. Resentment, denial, and resistance cre-

## PTSD KEY POINTS

**PTSD and the Vietnam Veteran: The Battle for Treatment. Blair, D.T., Hildreth, N.A. *Journal of Psychosocial Nursing and Mental Health Services* 1991; 29(10):15-20.**

1. Patients with post-traumatic stress disorder (PTSD) often encounter treatment that is complicated by professional bias, personal issues, countertransference, and pathological staff dynamics.

2. Treatment is further complicated by diagnostic confusion, the dual diagnoses of substance abuse or depression, and symptoms that mimic personality disorders or psychosis.

3. The special circumstances of the Vietnam conflict that contributed to the susuceptibility and etiology of PTSD are the individual characteristics of those who served, the special nature of the war itself and the military strategies used, and the psychosocial and cultural milieu in which it occurred.

ate strong conflicts, disruptive disagreements, and splits within treatment settings. However, clinicians who are unwilling or unable to overcome personal issues have the duty of treating these patients with dignity, respect, and professionalism. Anything less is abusive, and has no place in modern psychiatric treatment settings. Vietnam is long over, and the time for healing is long overdue.

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