COMBAT RELATED PSYCHOPATHOLOGY: ETIOLOGY, SYMPTOMS AND TREATMENT CONSIDERATIONS

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COMBAT RELATED PSYCHOPATHOLOGY: ETIOLOGY, SYMPTOMS AND TREATMENT CONSIDERATIONS

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by

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To the Graduate Council:

I am submitting herewith a Research Paper written by John Parry Graham entitled "Combat Related Psychopathology: Etiology, Symptoms and Treatment Considerations." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Psychology.

Linda Rudolph
Major Professor

Accepted for the

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THE YOUNG DEAD SOLDIERS

The young dead soldiers do not speak.

Nevertheless, they are heard in the still houses: who has not heard them?

They have a silence that speaks for them at night and when the clock counts.

They say: We were young. We have died. Remember us.

They say: We have done what we could but until it is finished it is not done.

They say: We have given our lives but until it is finished no one can know what our lives gave.

They say: Our deaths are not ours; they are yours; they will mean what you make them.

They say: Whether our lives and our deaths were for peace and new hope or for nothing we cannot say; it is you who must say this.

They say: We leave you our deaths. Give them their meaning.

We were young, they say. We have died. Remember us.

Archibald MacLeish, 1976

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Chapter 1

INTRODUCTION

The purpose of this project is to present information consolidated from the writings of notable therapists experienced in the provision of psychotherapy for casualties of combat. Most of the material reflects contemporary theory with the exception of the historical development of combat stress presented in the second chapter.

The treatment approach as well as the etiological theories suggested evolved from the clinical experience of the writers. The therapeutic suggestions offered do not represent dogma, merely a compatibility of approaches among involved professionals.

Vietnam was selected as a focal point for practical reasons. The vast majority of current research and literature is focused on Vietnam veterans. Also, the majority of individuals currently in need of psychotherapeutic assistance come from this twenty- to thirty-year old population.

Chapter 2, as previously mentioned, attempts to trace the evolution of the etiological theories surrounding the psychological impact of combat. The period which surrounds the first world war brought the inception of serious professional attention to the phenomenon of combat psychopathology. The period of time during and since Vietnam is characterized as the most conceptually productive.

Chapter 3 addresses the issues of symptomatology and etiology. Two unique issues evolved from the readings which compared Vietnam

veterans with veterans of previous wars. First, Vietnam veterans often display a pattern of delayed symptomatology which frequently is manifested more than a year following military discharge. Second, American society contributed unwittingly to the veteran's psychological adjustment difficulties through its opposition to the conflict. The latter portion of Chapter 3 contains a brief theoretical explanation of combat psychopathology. The basis for the explanation stems from Dr. John Wilson's application of Erikson's personality theory (Wilson, 1980) to the traumatic and interruptive experiences of war. Wilson's conception is not inexorable; it is simply the most ambitious work available.

The fourth chapter explores the primary psychotherapeutic issues gleaned from recent literature. Factors such as the therapeutic philosophy and the substantive qualities of the therapeutic relationship are found to be uniquely applicable to the treatment of Vietnam veterans. Various group therapy techniques are briefly presented.

Chapter 2

COMBAT PSYCHOPATHOLOGY: THEORETICAL DEVELOPMENT

The behavioral sciences have devoted increasingly greater amounts of energy to the conceptualization of the phenomenon surrounding stress reactions to combat situations. Understanding the historical development of the etiological theories enhances the professional's therapeutic competency.

The first attempt to categorize the emotional reaction to combat occurred during the United States Civil War when the term "nostalgia" was applied (Bourne, 1970). Further attempts to understand the phenomenon of combat psychopathology can be observed trhough a succession of classifications initiated at the time of the first world war. A variety of etiological theories are reflected in these classifications. Kormos (1978) provides an excellent variety of theoretical views from which to examine the evolving etiological issues. These views will be referred to throughout the chapter.

The earliest theory preceded the first world war and held that adverse combat reactions were a result of cowardice, moral weakness and poor military discipline. Needless to say, soldiers suffering from psychopathology during this era were offered little support and understanding. Reports of the management of psychiatric war casualties by the French and Germans reveal prevalent use of physical threat such as electrical shock--even death (Bourne, 1970).

The familiar term "shell shock" originated in the first world war;

it supports an organic theory of etiology. The symptomatology was thought to result from brain concussions sustained when the soldiers were subjected to conditions of persistent artillery bombardment (Figley, 1978). Observation soon revealed a lack of correlation between the symptoms and exposure to the shelling. Consequently, psychiatrists were forced to revert to the previously accepted theory of character weakness or provide a fresh concept. Psychoanalytic theory, which was growing in popularity during this period, provided the alternative concept. What Kormos (1978) describes as an illness theory is in essence the predispositionally oriented psychoanalytic theory which had gained much acceptance during the later part of the first world war. This theory continued to be accepted through much of the 1940's. Thus, the etiological theory had shifted from character weakness to organicity; discarding both, the theory was now clearly psychological.

As the first world war progressed psychiatrists, through a process of trial and error and observation of the practices of our allies, began to focus their attention on the therapeutic application of rest, food, and persuasion. These measures were effective when applied in forward combat areas (Glass, 1954). As a result approximately 65 percent of those soldiers presenting symptoms at the division or forward level were returned to their units (Bourne, 1970).

Following the first world war many of the presumably transient conditions became chronic and were termed "war neuroses." These were believed to be a result of predisposing personality characteristics (Glass, 1954). This concept served to minimize the stress of the combat experience itself as a potential contributing factor (Glass, 1954). During this post-war period some evidence exists of combat-like stress

occurring in individuals not displaying symptomatology during their combat experience (Glass, 1954).

As indicated the experience of the first world war led to viable concepts of psychological response to combat, effective therapeutic intervention, and evidence of a possible delayed reaction to combat.

The second world war provides the next setting for further concentration on the phenomenon of combat-related psychopathology. Despite the achievement of military psychiatry in the first world war the United States entered the war poorly prepared to cope with psychiatric casualties. The well documented lessons learned previously had to be relearned. As a result the early psychiatric casualty rate at times exceeded 100 casualties per 1000 soldiers per year (Bourne, 1970). Psychiatric care was not provided in the forward combat areas until the spring of 1944 (Bourne, 1970). Glass (1954) reports the first major combat by American forces resulted in a large number of casualties which had to be evacuated to rear facilities. This major evacuation to the rear commonly resulted in chronic symptomatology and poor recovery for further combat (Glass, 1954). The principle of immediate intervention in forward areas had been neglected. The concept of predispositional etiology was not neglected as there was rigorous screening of potential recruits. As a result the pre-service rejection rate was high as was the medical psychiatric discharge rate. At times during the 1940's the psychiatric discharge rate exceeded one and a half percent (Tiffany and Allerton, 1967).

Since the etiological theory held to the concept of a predispositional personality intervention strategies were aimed at identifying subconscious conflicts and correlating them with various stressors of

combat duty (Glass, 1954). This approach, while therapeutically valid and often helpful to the patient, resulted in the accumulation of a variety of viable reasons for not returning the soldier to the combat environment. These reasons were accepted most readily by the soldiers and resulted in placing the psychiatrist in a conflictual position. Not only were psychiatrists responsible for treating casualties but they were also responsible to the military services for maintaining the fighting strength of the units. Bey and Chapman (1974) provide an excellent discussion of this incompatibility.

As the war progressed military psychiatry rediscovered that higher return-to-combat rates could be maintained if the role of predispositional features and the process of searching for intrapsychic conflicts were minimized. Meeting the troubled soldier's needs for food and rest and maintaining him in the supportive environment of his unit were more effective in gaining rapid recovery. Remaining in the unit also prevented the guilt which often occurred as the result of leaving comrades during combat. This preferred psychiatric treatment increased comfort and self-esteem and strengthened defense mechanisms (Glass, 1954). The emphasis on early intervention in forward areas grew; the rates which indicated successful restoration to combat status grew as well.

One of the primary functions of the psychiatrists and general medical officers was to determine the severity of the soldier's condition and to diagnose appropriately. Nosology during the second world war reflected a lack of concensus and a reluctance to apply traditional psychiatric classifications to the soldier (Brill, 1967). Terms such as "combat fatigue" or "combat exhaustion" were more benign

than the traditional illness-oriented neurotic and psychotic classifications and were used frequently. Their extensive use represented another shift in the etiological concept of this confusing pathology. The illness concept was modified resulting in an endurance/environmental theory (Kormos, 1978). This theory allows for the notion that all is not predispositional and that even the healthiest of soldiers can potentially react adversely when subjected to a severely traumatic environment.

Terms such as "combat exhaustion" were utilized primarily for the classification of acute conditions. These usually responded quickly and positively to the provision of food and rest (Brill, 1967). More familiar diagnoses such as neuroses or psychoses were applied when symptoms were chronic.

While the majority of casualties improved after a brief period of time some were chronically affected as in the first world war. For others symptoms were delayed and did not develop until years after the war (Flutterman and Pumpain-Mindlin, 1951).

The Korean conflict of the early 1950's found military psychiatry ill-prepared as in the second world war. Within a matter of months, however, psychiatric intervention was again established in the forward areas with the expected success (Bourne, 1970). The approximate psychiatric casualty rate for this conflict was 37 casualties per 1000 soldiers per year (Bourne, 1970).

According to Glass (1954) a valuable concept of combat psychiatry was employed during the Korean conflict. A psychiatrist's effectiveness and depth of understanding were determined to be enhanced considerably by a process of rotating psychiatrists to forward combat positions. The

experience of the combat environment improved the psychiatrist's ability to separate the incapacitating symptoms from those less severe. It also allowed the psychiatrist to appreciate the needs of the unit as well as the experiences of the soldier (Glass, 1954). In addition the Korean conflict found specially trained general practitioners providing early psychological assessment and intervention in some combat areas, thus freeing the psychiatrists for additional responsibilities (Glass, 1954).

In Korea more success was achieved in returning to combat those evacuated to the larger, rear treatment facilities. Psychological reorganization in these cases was enhanced not by traditional psychotherapy but by enhancing self-esteem and pride by requiring the casualties to function in productive noncombat roles. Approximately 40 percent of these casualties were returned to combat (Glass, 1954).

With the Korean conflict also came the sophistication of the system of diagnosis. A reference entitled the Diagnostic and Statistical Manual of Mental Disorders (DSM I) was published by the American Psychiatric Association (Figley, 1978). The manual classified combat-related psychopathology as a gross stress reaction if it was transient and due to unquestionable or obvious stress (Figley, 1978). Thus, psychiatry's conceptualization of man's psychological reaction to combat was composed of two significant elements: (1) his predispositional features, and (2) environmental stress which varies in severity. Implicit in the diagnostic process was the growing acceptance of the role that stress played in producing psychopathology.

Military medicine's experiences with combat psychiatry were by this point well documented and available for future application. That

application occurred in the early 1960's during the escalation of the United States involvement in Vietnam.

The United States entered the conflict in Vietnam with certain anticipation of psychiatric casualties (Bourne, 1970). Each military division was assigned a psychiatrist, a social worker, and several mental health technicians (Bey and Smith, 1974). From the very beginning psychiatric care was available in forward combat areas (Colbach and Parrish, 1970).

Bloch (1969) reports that by the time of Vietnam military psychiatry had formalized an effective model of practice which was characterized by the application of the following principles: (1) immediacy--treatment should occur as soon as possible following symptomatology; (2) proximity--treatment should occur as close to the soldier's unit as possible; (3) expectancy--the mental health professionals involved in intervention should always convey the expectation of an eventual return to combat duty, thus thwarting the potential for secondary gain.

Early mental health statistics of the Vietnam conflict, when compared with those of previous wars, were impressive. Rates reflecting 12 psychiatric casualties per 1000 soldiers per year were a significant improvement over those achieved in Korea and vastly superior to those of the second world war (Bourne, 1970).

Recent literature (Bourne, 1970; Colback and Parrish, 1970; DeFazio, 1978; Figley, 1978; Goodwin, 1980; Kormos, 1978) is replete with discussion of the various factors which were likely to have contributed to the seemingly improved mental health status of the soldiers. Most of the factors were a product of design such as the 12-month maximum tour in Vietnam, forward psychiatric treatment, and provisions for rest

and recreation. Other positive factors such as the brief episodes of enemy engagement and the absence of sustained artillery attacks were simply characteristic of the guerilla war waged by the Viet Cong.

The hypothesis is that the limited duration and less frequent combat in Vietnam, when compared to previous wars, may have altered previously observed stress patterns and resulted in fewer casualties. Yet, there were new stressors present, those not experienced previously by United States forces. This was a guerilla war of unsuspected sniper attacks and undetectable enemy sympathizers. Many innocent civilians were undoubtedly killed because of their suspected role as enemy assassins. Land or territory was not the prize. The prize was the number of enemy killed, and this became the focal point of the war (Shatan, 1978). It is certainly probable that military psychiatry was prepared to cope with the results of heretofore conventional warfare but less well prepared to assist with the stress experienced by soldiers fighting a guerilla war, one which became increasingly unpopular. Early psychiatric casualty statistics might not reflect this weakness; in fact, these statistics might be representative of those of noncombat units in the United States (Bourne, 1970). Nevertheless, as the length of the unsuccessful confrontation grew so did the casualty rate for psychopathology (Goodwin, 1980). Caputo (1977) describes some personal changes during his tour in Vietnam:

> I did not go crazy, not in the clinical sense, but others did. The war was beginning to take a psychological toll. Malaria and gunshot and shrapnel wounds continued to account for most of our losses, but in the late summer the phrases "acute anxiety reaction" and "acute depressive

> reaction" started to appear on the sick-and-injured reports sent out each morning by the division hospital. To some degree, many of us began to suffer "anxiety" and "depressive" reactions. I noticed, in myself and in other men, a tendency to fall into black, gloomy moods and then to explode out of them in fits of bitterness and rage. It was partly caused by grief, grief over the death of friends. (pp. 190 - 191)

Morale began to decline significantly and other forms of pathology reached levels never before attained (Kormos, 1978). In the later stages of the conflict drug abuse was pervasive, insubordination common, and "fragging" or attacks on officers occurred with alarming frequency (Kormos, 1978).

Not only was symptomatic behavior increasing within the theater of conflict but reports also emerged that Vietnam veterans were encountering problems in their attempts to adapt and assimilate into a society which in general viewed the war and its participants with contempt (Bourne, 1970). The soldiers were rotated out of their combat units individually after completing their 12-month tours and were promptly flown from a combat environment to units in the United States. They gladly left the combat zone but with mixed emotions as there would be no sense of victory, only survival (Goodwin, 1980). There was no grand welcome as in previous wars; rather, the soldiers were confronted with a society indifferent to their sacrifices. Formal transition programs designed to prepare the veterans for the shift in societal attitudes were not available (Wilson, 1978). The veterans were bewildered and bitter at finding themselves unexpectedly alienated.

Santoli (1981) cites Brian Delate in the following post-war experience:

> I tried to explain to people. I'm a verbal person, so I really wanted people to understand what I had gone through. My parents gave me a cocktail party. They didn't know what else to do. They gave me a cocktail party like it was a graduation party. And they realized in the middle of the party, they both did and I guess that's why I love them so much, that they really had made a mistake.
>
> I was starting to get loaded, and this lady friend of my mother's said to me, "Well did you kill anybody?" She's got a martini and a cigarette. She had no idea what she was asking. She was somebody who I'd looked up to for years as a kid. I said, "You have no idea of the dimension of your question. You just threw that out like, 'Did you ever deliver newspapers as a kid?'" I started staring her right in the eyes: "Do you realize what your asking? Do you have any idea of the nature of your question?" And I left, I just split and I thought, "Oh, man." (p. 132)

At the close of the Vietnam conflict the clinical picture of combat psychopathology had shifted from acute symptomatology to the growing tendency for problems to center on reintegration following a return to society. While it is difficult to specify all of the variables contributing to the etiology of combat psychopathology it is well accepted since Vietnam that environmental stress and predisposition are the primary contributors.

In 1980 a third edition of the Diagnostic and Statistical Manual

(DSM III) was published. This edition classifies psychological reactions to combat as anxiety disorders, acute, chronic, or delayed.

Chapter 3

THE CLINICAL PICTURE

Post-traumatic stress disorder is the most recently adopted diagnostic term (DSM III, 1980) used to describe the symptom pattern resulting from an individual's psychopathological reaction to a traumatic event. War is considered such an event as are tragedies such as plane crashes, earthquakes, and fires.

The most productive contemporary view from which to focus attention on this phenomenon surrounds the veterans of the Vietnam conflict. These veterans, most of whom are between the ages of 28-35, have been the subject of considerable attention and concern since the escalation of the Vietnam conflict in the mid 1960's.

In general Vietnam veterans are reported to be adjusting adequately (Center for Policy Research, 1981; Wilson, 1978), but for some there has been considerable hardship, especially those exposed to heavy combat (Center for Policy Research, 1981; Wilson, 1978). These veterans are overrepresented in unemployment and drug and alcohol abuse statistics (Center for Policy Research, 1981).

As indicated in the previous chapter the stress of combat combined with predispositional factors such as pre-military achievement levels, general coping patterns, and family stability, frequently results in severe and deeply entrenched symptomatology (Coleman, Butcher and Carson, 1980). It should be noted that while stress and predisposition most often combine to produce the pathological result severe stress

alone will take its toll even when a healthy predispositional picture is displayed. Thus, positive predispositional personality features provide a reserve strength and allow greater tolerance of severe stress, but they do not assure complete immunity (Center for Policy Research, 1981).

The adverse symptoms and behavior patterns may manifest themselves in close association to the traumatic event(s), or in the months or years which follow (DSM III, 1980). The delayed onset of symptoms occurred with many of the veterans and is the primary focus of our attention. Because of the potential problems involved in attempting to establish a definite correlation between currently evolving symptoms and a previous trauma little service-connected assistance was offered through the Veterans Administration. Due largely to the delayed onset many veterans had no formal mechanism for mental health care.

Those diagnosed as suffering from post-traumatic stress disorder typically experience frequent nightmares, anxiety, depression, guilt, irritability, numbed emotions, and difficulty forming satisfying interpersonal relations (Goodwin, 1980). The reduced levels of sensitivity or emotional responsiveness are common and individuals frequently complain of not being able to love as they had previously (DSM III, 1980). Anxiety is a common denominator and the typical defense pattern is denial, repression and withdrawal.

DeFazio (1978) cites two primary sources of symptomatology. The first is the exposure to tragic death experiences, both of friends and enemies. The second is the traumatic impact of an unsupportive and often rejecting society experienced upon return to the United States. Caputo (1977) discusses both of these experiences in the following passage from

So much was lost with you, so much talent and intelligence and decency. You were the first from our class of 1964 to die. There were others, but you were the first and more: you embodied the best that was in us. You were a part of us, and a part of us died with you, the small part that was still young, that had not yet grown cynical, grown bitter and old with death. Your courage was an example to us, and whatever the rights or wrongs of the war, nothing can diminish the rightness of what you tried to do. Yours was the greater love. You died for the man you tried to save and you died pro patria. It was not altogether sweet and fitting, your death, but I'm sure you died believing it was pro patria. You were faithful. Your country is not. As I write this eleven years after your death, the country for which you died wishes to forget the war in which you died. Its very name is a curse. There are no monuments to its heroes, no statues in small-town squares and city parks, no plaques, nor public wreaths, nor memorials. For plaques and wreaths and memorials are reminders, and they would make it harder for your country to sink into the amnesia for which it longs. It wishes to forget and it has forgotten. But there are a few of us who do remember because of the small things that made us love you--your gestures, the words you spoke, and the way you looked. We loved you for what you were and for what you stood for. (pp. 212-213)

The observation of the death of friends and fellow soldiers frequently results in a gnawing sense of guilt in those remaining alive

and unwounded. This reaction is appropriately termed "survivor guilt" (Goodwin, 1980). It is frequently characterized by chronic rumination over alternative actions which might have saved a life. Survivors are prone also to particularly severe self-assessment and to patterns of increased self-defeating behavior (Shatan, 1978).

Guilt which arises from the act of killing is no less severe. This act which frequently resulted in the death of women, children and the aged may have traumatized severely the developing ideological system of the young soldier (Wilson, 1980). The growing condemnation of the conflict by American society led to further exacerbation of the guilt upon the veterans' return to their hometowns. They were commonly rejected and criticized because of the tactics used for survival in counterguerilla warfare. Empathy was rare in the American public as few people have witnessed the death of friends at the unlikely hands of women and children. Depression is often the final outcome and a sense of hopelessness centers on the seemingly unresolvable nature of the experience.

Coping strategies were necessary especially for those exposed to combat. One such strategy was refraining from the luxury of intimate friendships (DeFazio, 1978). Soldiers quickly learn that friends are frequently killed, and that the circumstances of war infrequently lend themselves to healthy grief responses (Shatan, 1973). This strategy (numbing) often became a chronic pattern and, while appropriate for survival in combat, did not allow for healthy adjustment upon return to the United States. As a result the most severely troubled veterans have frequently been described as loners, alienated from society and seemingly unable to locate their previous abilities to form warm,

intimate relationships (Goodwin, 1980; Shatan, 1978).

The returning veterans displayed a common preference to detach themselves quickly from their unpopular roles as soldiers and to inconspicuously assimilate into society. The assimilation was complicated by constant reminders of their war experiences. Veterans returning to academic settings found student sympathy in direct conflict with the beliefs and values they had established just a few years prior. Employers were skeptical of the veterans' character due in part to the stereotypes developed and perpetuated by the news media. The post-war adjustment period was clearly posing stresses of its own.

Anger, frequently difficult to control, is also a common complaint of disturbed veterans (Goodwin, 1980). The combat veteran had experienced the repeated frustration of unsuccessful attempts to locate and defeat the elusive enemy forces. Often the only tangible result of his effort was the death of his comrads. Upon his return the society which he had hoped would support his credibility as a valuable, patriotic human being was at best indifferent. The veteran in a state of alienation and with few acceptable outlets for his emotional energy most frequently vented his frustrations on those close to him such as family members (Goodwin, 1980), thus undermining his best resource. His anger found another release as he grew cynical and tended to resent authority figures and government agencies (Goodwin, 1980). These agencies were representatives of bureaucracy and were viewed as ultimately responsible for the suffering the veterans were experiencing. Animosity developed between the veterans and the Veterans Administration, with progress toward resolution occurring only in more recent years.

Relaxation was difficult to achieve without drugs or alcohol and uncomfortable levels of anxiety had to be tolerated. Many objects and events of daily life in the United States reminded the veterans of their combat experience and resulted in intense fear and survival behavior. For others there was always the sense of being overly suspicious of surroundings.

A convenient theoretical explanation of the psychological impact of war is offered by Wilson (1980), who employs Erikson's developmental frame of reference. According to Wilson (1980) war most heavily impacts upon individuals in their early twenties while they are submerged in the process of forming identities and values. This is termed the state of "identity versus role confusion." Successfully accomplishing the tasks of this stage is likely the most critical developmental achievement, and like the achievements of other stages is necessary in an epigenetic sense before other life tasks are confronted (Wilson, 1980).

War disrupts the normal process of growth and development by temporarily unbalancing the age-stage relationship. The normal psychosocial moratorium which usually extends to the late twenties consequently is disrupted by the war experience forcing either delayed or often premature acceptance of self-concepts.

The potential for distorted self-concepts is increased and so is the likelihood that individuals will be unsure of their own attributes and weaknesses. Uncertainty encourages weakened interpersonal relationships and inappropriate selection of career and educational goals. Anxiety results from comparisons to others more developmentally on course and the sense that progress is less than optimal. Long-term choices and commitments such as career and marriage also arouse discomfort as the

sense of self may be diffused (Wilson, 1980).

War also provides a challenge to the ideological make-up of the young person engrossed in the process of crystallizing values and beliefs. The soldier finds himself removed from the normal environment and surroundings of his peers and is thrust into life-threatening situations in which his values and moral principles are challenged by his instinct to survive. Confusion and ambiguity may now define the developing ideology and the trauma experienced may alter severely developmental progress. When the moral controversy of Vietnam is added to the dilemma greater disruptive potential is present (Wilson, 1980).

Wilson (1980) suggests three common psychodynamic reactions to such trauma. The most severe response is one of ego-retrogression in which a regressive adaptation results in earlier modes of resolution such as shame, guilt, and mistrust. Wilson (1980) defines the picture this way:

> When retrogression occurs as a part of a traumatic war neurosis, the individual typically reports several of the following symptoms: anger, apathy, anxiety, alienation, cynicism, denial, depression, defensiveness, emotional numbness (psychic numbing), fear, "flashbacks," guilt, impatience, insomnia, inability to concentrate, lethargy, mistrust, repression, regression, recurring dreams and nightmares, repetition compulsion or repetitive tendencies, psychological stasis, sleep disorders, social introversion and withdrawal. (p. 142)

In the regressive reaction the ego and sense of self are not merely bruised but are profoundly altered requiring extensive restoration (Wilson, 1980).

A second response, one typical of the majority of Vietnam veterans, is not characterized by regressive qualities but is focused on the stage-appropriate task of ideological development. These individuals are largely asymptomatic but struggle within to resolve the ideological conflicts resulting from participation in a controversial war (Wilson, 1980).

The most unusual developmental response to stress of war occurs in those individuals who rapidly progress to more mature developmental stages. They possess well defined identities and clear ideologies with a strong flavor of altruistic motivation. For these individuals the stress of war had an accelerating impact. The events were placed in proper perspective with little cognitive disruption and their advanced ideological perspectives allowed them to interpret their experiences in a manner typical of the self-actualized person (Maslow, 1954). The war was viewed in a realistic manner; the discomforts concentrated on existential incongruities or breaches of authenticity, not on developmental achievements (Wilson, 1980).

From these views of psychological adjustment the mental health professional is provided some foundation from which to build an understanding of appropriate avenues for therapeutic assistance.

Chapter 4

PSYCHOTHERAPEUTIC INTERVENTION

Many well versed authors have contributed to the understanding of the veteran's war experience and to the issues which surround the repertoire of applicable psychotherapeutic strategies. Features of the therapeutic process such as the therapist-client relationship, transparency of the therapist, and the therapist's attitudinal resolution toward killing and atrocity are considered by many professionals to be the most important issues (Egendorf, 1978; Fuentes, 1980; Haley, 1974; Howard, 1976; Shatan, 1973; Williams, T., 1980). The group format in different variations is most often presented as the intervention strategy of choice (Howard, 1976; Lifton, 1978; Marafiote, 1980; Williams, C., 1980; Williams, T., 1980).

The cynical nature of the veteran is cited as the primary barrier to the formation of positive therapist-client relationships (Haley, 1974; Howard, 1976; Williams, T., 1980). Consequently the professional's authenticity will be challenged as will his/her posture on the Vietnam war, a subject of extreme sensitivity to combat veterans. Male therapists will be confronted about their activities during the Vietnam era. Some professionals, Vietnam veterans themselves, feel veteran therapists have a distinct advantage, making them the professionals of choice in treatment settings (Howard, 1976; Williams, T., 1980). Understandably, combat-experienced therapists are imbued with a level of appreciation and empathy impossible for the non-veteran therapist to

achieve. Howard (1976) succinctly discusses this phenomenon in the following description of a veteran therapy experience:

> The veteran feels that here at last the phenomenology of his experience can be appreciated directly rather than intellectually or vicariously. He quickly feels that he is not being judged or evaluated, but related to. (pp. 133-134)

While some therapists seem to find the combat-experienced therapist essential to effective therapy (Williams, T., 1980) others are less adamant (Howard, 1976). Certainly without this inherent authenticity the establishment of a trusting and facilitative environment is more challenging.

The therapist's ability to acheive the optimal milieu is, again, a function of his/her authenticity. Several authors (Egendorf, 1978; Fuentes, 1980; Haley, 1974; Howard, 1976; Shatan, 1973; Yalom, 1975) suggest that this quality is displayed in no better way than the professional's willingness to avail himself/herself to the veterans in an open, sharing, and transparent manner. Shatan (1973) recommends an "emotional comradeship." Haley (1974) suggests the ability to "be there." Howard (1976) posits the willingness to "experience with." These elements are considered essential to successful professional relationships with veterans of Vietnam combat. Only by this extension of the self will the therapist encourage the veteran's relaxation of defenses and the subsequent cathartic and abreactive value of re-experiencing the trauma and anguish.

Shatan (1973) suggests the value and challenge of openness in the following statement:

> To be of aid, we must become as emotionally connected with the veterans as if we were ourselves war survivors. But we should be forwarned: we, too, may have nightmares; we, too, may be unable to sleep, unable to talk normally to other people for a few days or weeks. (p. 651)

Howard (1976) acknowledges the strength of his convictions in this manner:

> It is impossible to exaggerate the importance of the sharing relationship with the therapist, which requires not only a nonjudgmental attitude in the classical sense, but the ability and willingness to "experience-with," and often to be a real nonrole-playing person. (p. 132)

This approach is not unique to therapeutic efforts with Vietnam veterans though; there is evidence that therapist transparency, aside from its clinically proven appropriateness in the above environment, has gained acceptability in the broader community. Yalom (1975), in discussing the trend, notes:

> All of these approaches argue that therapy is a rational explicable process. They espouse a humanistic attitude to therapy in which the patient is considered a full collaborator in the therapeutic procedure; aside from the ameliorative effects stemming from expectations of help from a magical being, there is little to be lost and perhaps much to be gained through the demystification of the therapy process. (p. 207)

Thus, the role of the professional as an objective, unattached leader finds little recommendation. A role with different demands is

espoused, one which requires an emotional involvement and a commitment in the true sense of relationship.

This role described by Shatan (1973) will not be an easy one to assume successfully. The anguish which must be shared with these men of combat is based not in the illogical fantasy of the classical neurotic but in the unfortunate life and death reality of war. Combat veterans were so heavily traumatized by occurrences of death and mutilation that many have never before revealed their experiences, possibly fearing repugnance and rejection. As Haley (1974) suggests, they have been their own judge and jury. The therapist must be prepared to completely share the anguish, and as Shatan (1973) recommends, facilitate a previously repressed grief response.

For a therapist to achieve a genuinely non-judgmental attitude toward those individuals once involved in the horrors of aggressive combat behavior is difficult. The requirement runs deeper than a superficial examination of his/her own potential responses in a similar environment. Howard (1976) states it very frankly:

> In particular, the ability and even desire to kill, of which I have spoken, must be recognized by the therapist. An affective as well as intellectual recognition is essential; and this must occur not only in terms of the client, but in terms of the therapist's capacity for similar acts under similar conditions. If the therapist is unwilling to do this, then the "good" therapist is set against the "bad" patient, and the former will be ineffective or destructive in the treatment of Vietnam combat veterans. (pp. 132-133)

Two authors (Haley, 1974; Howard, 1976) suggest that the

therapeutic relationship and the professional's ability to share the veteran's anguish actually is the treatment. It is likely that in a Rogerian (Rogers, 1961) sense a combination of unconditional acceptance and empathic understanding serve to diffuse the veteran's sense of alienation and shame and restore dignity and acceptability to his self-perception.

Haley (1974) suggests the knowledge that war and atrocity have existed since the beginnings of mankind itself, while not a comforting idea, helps to place the events of the Vietnam conflict in a realistic perspective. To enhance this knowledge supplementary reading is recommended, literature on the Vietnam conflict in particular. For the nonveteran therapist, self examination and reading will never provide the experiential knowledge and understanding possessed by the veteran and acknowledging this fact to the veterans enhances professional credibility (Haley, 1974; Williams, T., 1980). The use of veteran therapist consultants is also highly recommended (Williams, T., 1980).

In addition to the therapeutic effects of the professional relationship other features of the encounter are vital. The intellectual process feeds the need to understand and to place events in proper perspective. Additionally, the veteran's ability to generalize the therapeutic experience to community life is also facilitated (Yalom, 1975). Haley (1974) offers a valid warning concerning intellectualization. She suggests that the intellectual process may be overstimulated, resulting in excessive attention to determining casual factors. Egendorf (1978) parallels this contention by suggesting that the discovery of pertinent material does not necessarily beget a therapeutic

result. Obviously, the therapist must assume responsibility for carefully monitoring the conceptual process.

While a variety of therapy methods including individual and family approaches are considered applicable to the treatment of combat veterans the group process has gained recognition as the primary choice (Williams, T., 1980). Howard (1976) recommends an environment composed of veterans with similar difficulties, peers if you will, as the most appropriate. As indicated earlier many veterans have not shared their experiences of combat with others. For most the initial disclosure is painful and more easily accomplished in the company of those whith similar backgrounds. Here the probability of acceptance is optimal and understanding is likely.

Yalom (1975) supports this position in the following statement:

> On the basis of our present state of knowledge, therefore, I propose that cohesiveness be our primary guideline in the composition of therapy groups. The hoped for dissonance will unfold in the group, provided the therapist functions effectively in the pre-therapy orientation of patients and during the early group meetings. Group integrity should be a primary concern, and we must select patients with the lowest possible likelihood of premature termination. (p. 271)

Tom Williams's (1980) advice has a less restrictive flavor. Persons with psychotic and character disorders are viewed as inappropriate candidates for the group milieu as are individuals in immediate crisis. Further consideration of veteran composition is not considered essential. Additionally, Tom Williams (1980) recommends the veteran's group as a

most effective setting in which to counter survival guilt and the stigmatization common to those in service during the Vietnam era.

Structure of the group context is also a focal point. Some of the more recent authors (Marafiote, 1980; Williams, T., 1980) advocate closed groups with time limitations and individual goals viewed as essential. Earlier authors (Lifton, 1978; Shatan, 1973), the acknowledged pioneers in the field, function from the more fluid, open-ended group concept sometimes referred to as the "rap" group. In consideration of the potential advantages of either position the deciding factors in implementation should be the skills of the professional(s) and the needs of the veterans.

Marafiote (1980) advocates the use of behavioral techniques and strategies such as relaxation training, role playing, assertiveness training and thought stopping. These techniques are valuable when employed for symptom reduction and skill building. Marafiote (1980) is careful to note the importance of receiving adequate professional training prior to attempting such techniques.

Regardless of the group approach used the professional is cautioned against restricting opportunities to clarify values and beliefs as such a restriction would profoundly hinder ideological developemnt considered so vital to this population (Wilson, 1980).

The final treatment concept included for discussion in this chapter is the family therapy model. This model offers diversity both in assigning precipitating factors and in avenues for intervention and remediation. One author (Williams, C., 1980) expands the concept of family through systems theory to include the entire primary social network (family, organizations, and groups) of the veterans. The

advocates of this expanded approach convincingly suggest that a direct relationship exists between the emotional temperaments of the veteran and individuals with whom he/she interacts. Therapeutic involvement with the veteran in a context isolated from his/her family would negate the reciprocal nature of their influence. This influence is clarified in the following statement by Candice Williams (1980):

> Most of the women felt they had been nurturing, caring, and supportive of their veteran partners. But they felt this had not been very successful in terms of the relationship, nor in terms of their own self-esteem and identity. Like the men, many felt helpless and demoralized. (p. 80)

The course of intervention suggested begins with partners in separate group settings with the eventual goal being a mutual experience (Williams, C., 1980). The initial group for the female partners is a support group designed to facilitate emotional sharing and improved self-esteem. As confidence is gained and problem issues are drawn into clearer focus the potential for successful couple therapy is enhanced.

Candice Williams (1980) discusses some logical considerations for the female partners of the Vietnam veterans. One of primary concern is the conflict in which women are often placed within the context of their partner relationships. The woman's attempts to fulfill her needs for a sound identity and self confidence are often undermined by the veteran's insistance that her attention be directed toward him. She is thus unwittingly placed in a no-win situation with minimal opportunity for personal growth. Also, if the female partner is not careful to balance her attentions, the resulting stress may precipitate maladaptive behavior and the veteran's symptomatology is likely to increase.

Madanes (1981) alludes to this phenomenon in the following comment:

> Symptomatic behavior in one spouse can organize the other spouse's behavior in many different ways. How free time will be spent, how money should be used, how to relate to the extended family--these are just a few examples of areas that can be dominated by the helplessness of the symptomatic spouse. (p. 30)

Another important consideration supports a hypothesis that mutual change is facilitated optimally be mutual involvement. From this perspective, unless the therapeutic focus is expanded to include the veteran's social network, a significant opportunity for problem resolution will escape attention.

Chapter 5

CONCLUSION

The material in this paper has resulted from the investigation of current behavioral science literature. The inquiry was conducted to illuminate the issues surrounding the treatment of "post-traumatic stress disorder."

The etiological theory of the phenomenon in question progressed from an organic supposition to one of predispositional factors. Certain variables of mental health care during times of combat also are seen to have a significant effect upon psychiatric casualty rates. Currently, combat psychiatry functions by a model of care comprised of the principles of immediate treatment, treatment provided in close proximity to battle, and treatment emphasizing an expectation of return to duty. These principles undoubtedly influenced the soldier's mental health resulting in the significantly lower percentage of psychopathology during the early years in Vietnam. However, other unique elements of this conflict such as insidious enemy forces, civilian assassins, and a disillusioned American public had a significant impact, one often not evident for years after the veteran's return from Vietnam. Many veterans have eventually become troubled by nightmares, superficial interpersonal relationships, numbed emotions, and guilt. Experiences of alienation also have produced resentment toward society.

The lack of therapeutic intervention supported by the federal government signified the failure of the United States to anticipate and

meet the needs of its returning soldiers. Mental health clinicians have become increasingly aware of the veterans' predicament. Therapeutic intervention was initiated on an experimental basis and from this the clinical picture and relevant intervention strategies have gradually evolved. The third edition of the Diagnostic and Statistical Manual of Mental Disorders (1980) reflects the early clinical work with the veterans. It includes the category of "post-traumatic stress disorder" associated with combat, a category not included in the second edition.

Recent literature indicates that most professionals agree on the subject of psychotherapeutic strategy. A therapeutic relationship characterized by reciprocal openness and trust is critical as transparency is considered an essential trust-building element in overcoming the veteran's cautious nature. Another critical factor focuses on the importance of the therapist's resolution of disapproving attitudes toward killing and the brutality of war. Often difficult factors to resolve, these ingrained attitudes are a primary factor leading to the suggestion that veteran therapists are the optimal professionals for the roles in intervention.

A group process with other veterans is the recommended intervention modality in either a structured or unstructured format. The group milieu provides a setting in which to relearn social skills, reexperience authentic relationships, and freely share the common and often tragic experiences of war. Behavioral groups are also recommended as they are effective in helping veterans overcome disturbing symptoms. Expansion of the group format to include family members and others of significance to the veteran is strongly recommended.

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