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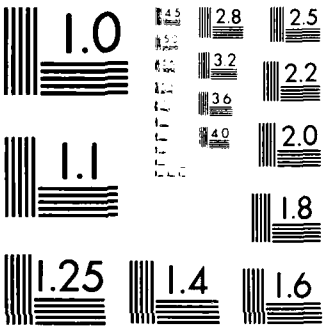

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TREATMENT OF ACTIVE DUTY VIETNAM VETERANS: SOME CLINICAL OBSERVATIONS

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TREATMENT OF ACTIVE DUTY VIETNAM VETERANS: SOME CLINICAL OBSERVATIONS

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SUMMARY

Background

Many groups of Vietnam veterans with post-traumatic stress disorder (PTSD) have been studied, including female veterans, medical personnel, minorities, POWs, etc. One group that has not been studied is active duty veterans.

Approach

Clinical observations from Navy psychiatrists and psychologists who concurrently conducted therapy groups at three separate military treatment facilities between 1981 and 1984 were recorded.

Results

The reasons many of these vets returned to active duty or remained in the service included: wanting to be in an environment where they would be accepted, having the same camaraderie they experienced in Vietnam, job security and advancement, and to rework or complete tasks that had failed in the past. Many expectations about service life were not met and as a result of new or continuing psychological problems they were referred to one of the three therapy groups.

Group and individual therapy were used extensively while hospitalization, family therapy and chemotherapy were used considerably less. New members were most concerned about being seen by themselves and others as mental patients and confidentiality. Treatment issues centered around futility, terror, grief, emotional isolation and numbing, fits of rage, guilt and distrust. One of the groups went to the Vietnam Memorial to help deal with unresolved grief.

Conclusions

A number of factors were felt to have influenced the successful outcome of these groups. Confidentiality was viewed as a critical pre-requisite to successful therapy. Another was the degree to which associations with mental health facilities could be de-emphasized. Where it was possible group meetings took place away from mental health centers. Finally, contact by members carried on outside group meetings not only helped individuals end their isolation but was a therapeutic resource. Further research in this area is needed to give military health care providers information on the prevalance, identification and treatment of active duty vets with PTSD.

...Oh Alexander
Is Peace not hell?
For Peace is a war
And its battlefield is the mind
We did not fit our times
Alexander
How lucky you were
To pass into the next life
At the end of the campaign
While we the legionary
Remained to fight
The war of peace
Without sword and shield
To defend ourselves
Against changing times

---Bill Douglas, SM1,USN
RVN 1968-1969

Background

Reports concerning delayed stress disorders and chronic readjustment problems among Vietnam veterans are visible in the professional literature. Fairbank, Langley, et al have compiled a bibliography of 171 articles on post-traumatic stress disorder (PTSD), 106 of which have been written within the last 10 years (1). One study has estimated that 40-60% of Vietnam veterans suffer from some form of PTSD (2). Attention has also focused on subgroups of Vietnam veterans who demonstrate chronic and delayed forms of PTSD (3-26). However very little research has been done on the active duty veteran population. The purpose of this paper was to record the observations of Navy psychiatrists and psychologists who concurrently conducted therapy groups at three separate military treatment facilities between 1981 and 1984. The reasons the clients attending these groups remained on active duty or returned, their work-related problems, and various issues about their group experience are presented.

Reasons for Re-entry or Continued Service

For those that left the service after the Vietnam War and rejoined, civilian employment was characterized by frequent job shifts or lateral job changes. Their reasons for returning varied but the following were considered to be typical. Some thought that by returning they would find an environment of acceptance and understanding. This was because they expected that military personnel would be much more empathetic about their attitudes about the war and thus be non-judgemental and possibly supportive. Some hoped to find the same intense camaraderie they had experienced in Vietnam. It was clear that others had experienced difficulties making a living as civilians, characterized by going from job to job without advancing in their careers. For them, the military service provided a structured situation requiring steady work and advancement.

Another reason for returning was the desire to regain the same peace of mind and calmness that they had periodically experienced in Vietnam. While life in Vietnam was extremely difficult with its physical deprivations, chaos and terror, group members reported the paradox of sometimes feeling serene and peaceful, even under the worst circumstances. This can be explained by realizing that while in Vietnam they frequently encountered dangerous situations that demanded intensely focused attention to survive. To do this they had to exclude from consciousness a myriad of issues and conflicts that might otherwise have confronted them, such as family relationships, mortgage payments, career decisions, etc. It was this focused, almost trance-like, attention that displaced other thoughts and allowed for tranquility. One veteran reflecting on the battlefield, said, "It's quiet out there."

Reexperiencing service life was also seen as a way to relive their youth, with its vitality and hardiness. Similarly, as opposed to the variety of people that might be encountered in civilian work settings, including the disabled, the military environment offered them the expectation of working solely with healthy and competent people. The feelings of competence, power, exhilaration and control had been enjoyed by many while in Vietnam, and it was thought that service life would offer these same things again. Being in charge of men, making life and death decisions, and operating expensive and powerful equipment was a pleasurable aspect of life in Vietnam. It was speculated that others returned as a way of gaining an opportunity to unconsciously rework or complete a task that had failed in the past. Finally, some wanted to return to better prepare themselves for another war. To avoid having to endure the stresses of transitioning from civilian to military life at a time or in a way that would be inconvenient and thus more stressful, some chose to return on their own initiative and on their own terms.

Work-related problems

Problems related to their work were noted; conflict with authority was especially prominent. Having survived arduous missions, many were impatient with the apparent triviality of peacetime military life and rituals. Conflicts ensued when they offered opinions on these matters and encountered opposition or rejection and found that they had no power to affect changes. The most intense authority conflicts were with superiors who were younger, female, or without combat experience. Relationships with peers were often poor because they were older and thus had different values and interests. When younger enlisted men expressed an eagerness to go to war, some veterans sought to disillusion and dissuade them with comments like, "You don't know what it's really like." Their combat experience sometimes worked against them, since they were asked uncomfortable questions, such as: what is it like to kill; did they kill any children; and, wasn't it a horrible experience, etc. To lessen the chance that they could be identified as combat veterans and thus asked these questions, some chose not to wear their combat ribbons.

Referral

Most of the clients were referred by specialists, although some came after hearing about the groups from another vet who was attending the group. Presentations included: nightmares after the bombing of Marine headquarters while on duty at the airport in Beruit; flashbacks starting after seeing a training film depicting the management of battlefield casualties; and distress over an inability to grieve following the death of a close relative.

Very few were self-referred. One of the difficulties was a lack of support or active discouragement by their command or co-workers to seek therapy, with the idea often insinuated that going into therapy was a sign of weakness. Junior enlisted personnel were sometimes seen as needing combat veterans to provide stable, problem-free role models. This made it more difficult for these vets to consider getting into therapy because then it would appear that they were not living up to this high ideal. Other Vietnam vets who were not having psychological problems or believed that there should not be a problem as a result of combat were often unsympathetic toward the distressed vet. Officers were reluctant to consider group therapy for themselves because of the prohibition against fraternizing with enlisted personnel. This was especially true of Marine Corps officers because they belong to a relatively small, intimate group.

Commencement of Group Therapy

All clients were screened prior to starting in one of the groups. Medical problems deemed to be incompatible with going into group therapy, such as alcohol or drug abuse, were dealt with first by referral to the appropriate treatment resource. In all cases PTSD was or could have been

diagnosed. Major psychiatric disorders were diagnosed infrequently, but the potential for establishing a diagnosis for character disorder, marital discord or drug or alcohol abuse was much more likely. Many came to the group with misconceptions or unwarranted fears, such as thinking that they would be alright after a few sessions, that their experiences were unique, or that they should be able to manage their problems themselves. Confidentiality was a major issue and clients expressed sensitivity about health record entries that might compromise their careers. They were extremely concerned that if their superiors knew they were in therapy, they would be seen as defective and that this would adversely affect their duty assignments and chances for promotion. Another related issue was the concern that they would have to reveal all of their Vietnam experiences, including secret missions and other classified information, which would result in legal prosecution. They were reassured that such disclosures were not required.

Treatment

Group therapy was the primary treatment mode, with brief hospitalization and chemotherapy used infrequently. Individual therapy and attendance at Veterans Outreach Centers concurrent with group therapy was common. Initially the clients often avoided civilian treatment settings. Many thought that civilian vets were "hippies" and radicals who had been against the war and currently held the military establishment in disfavor. Group members also thought that civilian vets typically were people who could not hold a job and had disfiguring war wounds. These negative identifications and expected incompatibilities made the idea of working together in a group setting seem impossible. However, this proved not to be the case. In several instances it was shown that when they did meet they had much more in common than they thought and that the need to share experiences and feelings and seek forgiveness was stronger than the need to remain apart.

The themes that developed in these groups were like those reported about similar veterans groups in the civilian setting, and included futility, terror, grief, emotional isolation and numbing, fits of rage, guilt, and distrust. Issues unique to the military setting were also discussed. A general distrust toward authority figures that started while in Vietnam was sometimes directed toward group facilities who were associated with uniformed officers. The group facilitators were often tested about their familiarity with combat veterans' experiences and issues. Additionally, they sometimes wanted to know what the facilitators had done during the war, and, if they had not directly participated, what their reasons were. Another topic included the clients' need to present a strong and masculine image, since as military men they didn't want to appear weak, especially as it related to Vietnam duty. They also discussed their concerns about public expressions of their longstanding bitterness and resentments for the lack of support or mistreatment by various anti-war and anti-military elements of society. The free expression of thoughts and

feelings, an essential pre-condition for movement and growth in therapy, was a difficult obstacle for some military personnel too long and too powerfully conditioned to automatic obedience and ritualized respect for superiors.

Group members were strongly encouraged to support each other. In one group home phone numbers were shared among members to encourage contact and support outside the sessions. Subsequently, the members helped each other with problems of daily living, and especially in periods of crisis. This supportive network was not unlike that seen in Alcoholics Anonymous. These informal contacts sometimes were the breakthrough from longstanding isolation to beginning socialization.

The clients were very sensitive to implications that they were sick. Consequently, where it was possible, meetings were held away from mental health clinics and hospitals, and the patient role was de-emphasized. The syndrome of post-traumatic stress disorder was characterized as a normal reaction to a grossly abnormal experience and did not necessarily result from personal shortcomings or character defects. Hospitalization was a last resort for the acutely suicidal or homocidal, and chemotherapy was reserved for specific target symptoms; e.g. neuroleptics for schizophrenia and phenelzine for major depression.

A novel treatment approach was taken by one of the groups. Eleven of its members visited the Vietnam Memorial in Washington, D.C., with the group facilitator to stimulate memories and encourage catharsis. Considerable time was spent at the memorial during three days of marathon group meetings. Lingering questions as to who had or had not survived the war were resolved as members read the names of former buddies on the wall of the memorial. This dispelled any doubts, broke down emotional barriers and made way for mourning which had long been avoided. Those with unresolved grief were helped the most as they were finally able to experience a profound affective discharge.

The facilitators noted the constancy of suicidal and homicidal potential among some of the group members. These feelings were often prominent, if not the primary issue. The ability to inflict injury or death upon others endures among a group of professionals whose military training and combat experience required it. However among the three groups there were rare instances of violence directed toward others. One suicide occurred during the three year period of this study.

Discussion

Since active duty veterans were constantly exposed to stimuli reminding them of their past experiences, and medical facilities were readily available, it would seem more likely that they would be identified and referred for treatment. However, in this seemingly encouraging climate vets did not come for therapy. Despite their difficulties, they did not readily go into therapy because this was incompatible with their self image of competent and self-reliant individuals. Three additional sources of resistance included lack of command support, and in some instances outright

denial, fear of exposure to peers and subordinates and the veterans' concerns about the impact of therapy on their careers. Supervisors and clients alike have accurately stated that many vets had outstanding service records since Vietnam, thus implying that therapy was not really needed. Unrecognized was the emotional cost of this success. The energy to control rage and deal with other symptoms was considerable, and it was at the expense of more productive pursuits. These vets typically were moral and religious and not given to act on impulses of rage, even though the pressures to do so were overwhelming. Therefore, if anything, they needed to be recognized for their accomplishments in the face of such difficulties. Promotion of adequate command liaison, widespread availability of treatment programs, increased awareness of the potential existence of PTSD in this population by military physicians are of major importance.

The therapists for these three groups faced the dilemma of conflicting therapeutic goals. Survival in combat requires that a special set of psychological defenses be learned and become ingrained. Combatants soon learn not to react emotionally, not to make friends, etc. But effective therapy for PTSD involves sensitivity to and timely expression of feelings. Therefore, the dilemma is in mitigating a psychological defense that will lessen the individual's ability to survive in future combat situations.

In conclusion, it is apparent that active duty Vietnam vets have characteristics which both link and distinguish them from their civilian counterparts. Further research into the prevalance, identification and treatment of PTSD in this group would enable health care providers important and needed information.

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The experiences of several Navy clinicians involved in the treatment of over 200 active duty Vietnam veterans at three separate military treatment facilities between 1981 and 1984 were presented. Their reasons for rejoining the service or remaining in and the social and psychological conflicts they faced were identified. Elements critical to the success of group therapy were: confidentiality, de-emphasis of associations with mental health facilities and the patient role, and promotion of inter-client support.

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