Post-traumatic stress reactions in Vietnam combat veterans: the role of social supports in symptom development

John C. Smith

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POST-TRAUMATIC STRESS REACTIONS IN VIETNAM COMBAT VETERANS:
THE ROLE OF SOCIAL SUPPORTS IN SYMPTOM DEVELOPMENT

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
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THE DEGREE OF MASTER OF SOCIAL WORK

BY
JOHN C. SMITH

SCHOOL OF SOCIAL WORK

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ABSTRACT
SOCIAL WORK

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POST-TRAUMATIC STRESS REACTIONS IN VIETNAM COMBAT VETERANS:
THE ROLE OF SOCIAL SUPPORTS IN SYMPTOM DEVELOPMENT

Advisor: Dr. Amos Ajo
Thesis dated: May, 1990

This study explored the role of social supports as a factor which may be associated with symptomatology of combat related stress problems in Vietnam veterans. It attempted to determine if there is a significant relationship between the dependent variable, stress reactions, and the four independent variables, combat experience, current life stresses/supports, life stresses and supports at time of treatment, and life stresses/supports at time of return from Vietnam. A convenience sampling of 35 male Vietnam veterans was conducted in studying the relationship.

The major findings in the study revealed that there is a significant relationship between stress reactions and combat experience, current life stresses/supports, life stresses/supports at time of treatment, and life stresses/supports at time of return from Vietnam.
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CHAPTER I
INTRODUCTION

War appears to be one of the constants of history. Man's history is one of an unending chains of endless struggles between warring hordes, tribes, and nations. Durant notes, that "in the last 3,421 years of recorded history, only 268 have seen no war."

War is the most tragic disaster that humanity inflicts upon itself. It brings about the utmost physical, psychological and societal destruction known to humanity and results in multiple loss of life and gross environmental changes. The Vietnam conflict is the most recent war experienced by the United States.

The war in Vietnam was over for American combat troops in 1975; however, for many veterans the war continues today on a daily basis. Their war, fought in homes, business places, hospitals, and prisons, is a constant personal and psychological battle with their combat experiences. Of the 1.6 million Americans who served, over 57,000 were killed, 300,000 were wounded, and 1,000 remain missing (Egendorf, 1986). It is estimated
that as many as 800,000 veterans suffer psychological and interpersonal problems associated with their combat experiences (Parson, 1984). Vietnam era veterans are 65 percent more likely to die from suicide and 49 percent more likely to die from motor-vehicle accidents than non-veterans of the same era and age group (Hearst, 1986). Total mortality among Vietnam veterans is 17 percent higher than other veterans (Center for Disease Control, 1987).

The purpose of this study is to explore the role of social supports as a factor which may be associated with symptomatology of combat related stress problems in Vietnam veterans. This research tests the proposition that social supports function to help maintain the combat veteran in a healthy and productive life and that a decrease in those supports may contribute to an increase in symptomatology.

An initial review of the literature on the development and etiologies of post-traumatic stress symptomatology reveals little agreement among the theorists and researchers in the field (Triana, 1985). In fact, it was not until 1980 with the
publication of the third revision of the Diagnostic and Statistical Manual (SDM III) that a separate category for stress disorders was defined for diagnostic purposes.

Numerous aspects of the Vietnam War combined to produce a combat setting abroad and a political environment at home unlike that experienced by any other American soldiers. Many of these unique circumstances became ingredients which contributed to the delayed stress reactions seen in many Vietnam veterans.

A review of the unique characteristics of the Vietnam war provides useful background to the study of post-traumatic stress disorders (PTSD) in combat Vietnam veterans. Some of those characteristics, for example, the limited tour of duty and periods of rest and retreat from the combat zone, though they may have had some deleterious effects, were conscious attempts on the part of the American military to alleviate the psychological trauma of war. Other characteristics, such as the anti-war sentiment in America and the young age of American GIs, were traits specific to the conflict in Vietnam and the political climate in America during
the Vietnam era. The anti-war sentiment in America had a significant impact on the returning GIs' intrapsychic adaptation and interpersonal relationships.

**Combat Trauma in the Vietnam War**

Analysis of the combat experience and clinical observations of American GIs and veterans in previous wars, led the United States military to institute numerous modifications of the combat experience in an effort to ameliorate the deleterious psychological effects of combat, specifically the stress of combat. Ironically, it was in many instances exactly these changes which would later contribute to the delayed combat stress reactions often seen in Vietnam veterans.

A low incidence of psychiatric casualties predominated in Vietnam until early 1970 when a sharp rise was noted. For purposes of the American military, a psychiatric casualty was defined as occurring when a soldier was absent from combat for more than 24 hours for problems which were emotionally derived which for all practical purposes included in psychiatric hospitalization
(Colbach and Parrish, 1970). In 1965, the incidents of psychiatric casualties were reported at a rate of 10.8 per 1000 troops in Vietnam as compared with 9.1 per 1000 troops at the same time in the United States. In 1967, similar reports in Vietnam were 9.8 per 1000 as compared to 91.9 per 1000 in the United States. In 1969, a slight increase was reported with 15.0 per 1000 in Vietnam while the level in the United States was 10.4 per 1000 (Colbach and Parrish, 1970). The literature presents conflicting views regarding the increase in psychiatric casualties later reported toward the end of the Vietnam war (Colbach and Parrish, 1970; Kormos, 1978).

The lower rates of psychiatric casualties in Vietnam compared with those of the Korean War which averaged 37 per 1000. World War II produced rates which ranged from a high of 101 per 1000 in one part of Europe to a low of 28 per 1000 in another part of Europe (Colbach and Parrish, 1970). Although similar statistics are unavailable for the Southwestern Pacific Front, Figley (1978, p. xvi) points out that the psychiatric casualty rate there appears to have been greater than 25%. The higher
percent was attributed to the environmental conditions including the heat, the jungle environment, tropical diseases, isolation and excessive physical demands, all, of course, similar to the conditions experienced in Vietnam.

Psychiatric casualties in Vietnam were reported under five broad diagnoses including: psychosis, psychoneurosis, combat exhaustion, personality disorder, and 'other'. Personality disorder encompassed the largest percent of casualties at 30%, 'other' at 28%, and combat exhaustion, surprisingly with the lowest, 7% (Colbach and Parrish, 1970).

Another early report of psychiatric casualties, divided psychiatric casualties into enlisted and draftees. It was reported that only 11% were found to be draftees. It was thought that their limited tour of duty protected them from some of the psychological trauma experienced by enlisted GIs (Huffman, 1969).

Modifications implemented by the American military to ameliorate the deleterious effects of combat included: field psychiatric care, DEROS (Date of Expected Return from Overseas), and
frequent periods of rest and relaxation (R and R). It was to these changes that the Surgeon General's Office attributed the improved statistics in the psychiatric casualty reports (Colbach and Parrish, 1970). However, it later became apparent that it was exactly these modifications as well as other unique characteristics of the Vietnam war which led to the delayed and chronic forms of PTSD commonly seen in Vietnam veterans. Those other characteristics included: the adolescent age of the average GI in Vietnam, the ambiguity of the enemy and total emersion into the was environment, and GI's homecoming (Goodwin, 1980; Kormos, 1978; Parson, 1984).

Field Psychiatric Care

Among technical implementations instituted in the Vietnam War was field psychiatric care. Three psychiatrists, two psychiatric social workers and 12 enlisted non-professionals per 50,000 troops were provided (Colbach and Parrish, 1970). "Real emergency cases" were treated at small division hospitals and usually returned to duty within short
periods of time. When necessary, evacuation to larger hospitals in the country was possible.

The phenomenon of secondary gain was considered a strong motivating force among the military health providers. Colbach described their attitude in his report:

...the military health worker is first and foremost a guardian of reality. And the reality is that we are fighting in Vietnam, and somebody has to carry a gun there, even though very few men actually choose to do so. If one soldier is relieved of this duty, another will have to replace him. And the soldier replaced by another will have to live a long time with the realization that he was so 'sick', so weak, that somebody else had to take over for him when the chips were really down (Colbach, 970, p. 341).

Thus, the emphasis was on the maintenance of the troops' combat force, rather than on the mental health of the individual soldier.

**DEROS**

The limited tour of duty, coined DEROS (date of expected return from overseas), provided the soldier with his exact date of departure from Vietnam ("in country") or 365 days from his arrival. Thought to be an advantage, the limited tour of duty proved to have many detrimental effects. The advantage was that there no longer
would be an unknown, protracted length of combat
duty. If he could survive 12 months, each soldier
knew not only that he would be going home, but also
exactly when he would be going home. (The
exception to this was the Marine Corps whose length
of stay was 13 months.) Thus, survival became the
crucial issue.

DEROS created a highly individualistic war.
Each soldier arrived in country alone. He joined a
platoon that had already been formed. New GIs were
referred to as FNGs (Fucking New Guys) for the
first few months in their assigned platoons. FNGs
were to be avoided since their inexperience could
prove fatal not only to themselves but to others
around them as well (Goodwin 1980).

At the other end of the tour were the "short
timers" who were often pulled away from active duty
to areas of relative safety as the day of their
departure drew near. For many, this was a time
characterized by feelings of guilt and concern for
their platoon buddies they were leaving, as they
were usually the most experienced by that time
since they had been there the longest. It has been
noted that Vietnam veterans almost never remain in
touch with their fellow soldiers. Ridden with feelings of guilt about having left their buddies behind, many are afraid to look up those buddies (Goodwin, 1980). It is imaginable that it is with anxiety, if it is done at all, that they scan the wall of the Vietnam War Memorial for the names of their buddies left behind.

The final ceremony of isolation was the GIs lonely plane ride home; often from rice paddies to the streets of his hometown within 36 hours. In retrospect, it has been suggested that advantages were rendered to the World War II veteran through his membership in a company. Not only did they share common experiences, but, perhaps more importantly, they shared a deprocessing time together. The boat ride home to the United States took several weeks and provided a relaxed atmosphere to talk about the work through some of their traumatic experiences. Interestingly, World War II veterans are known for their company reunions and it is not uncommon for soldiers who served together to remain in contact with each other years later (Goodwin, 1980).
Finally, DEROS helped construct a psychological state of functioning required for survival which was in itself deleterious because it was time-limited to the 12-month tour of duty. The goal of the GI was, thus, survival for 12 months. It was thought that if he survived, he could go home and simply pick up where he left off. This psychological state of functioning was compounded by the chaotic and turbulent war environment where there was no stability or safety. Parsons (1984) refers to their psychological state as a "partial adaptation," where,

...inner-outer harmony is comprised in the form of a psychic split, so that the essential integrations of war experiences into the ongoing personality structure of the combatant are severely hampered. In the absence of such essential integrations, psychic numbing takes over as a necessary defense in the war situation (Parson, 1984, p. 11).

R and R

Another factor which encouraged a partial psychological adaptation to the war environment was frequent retreats away from combat, sometimes to various Asian cities for R and R. These frequent retreats to safety allowed the soldier to enter and remain in the psychological denial and numbing
phases of traumatic stress reactions (Horowitz, 1975). Thus, R and R served to maintain the psychic numbing by disallowing the integration of the war reality and the reality of all else outside of "the Nam."

**Adolescent War**

American GIs in Vietnam were the youngest soldiers ever sent into combat by the United States. The average age of the GI entering combat was 19 as compared to 25 for the World War II soldier (Parson, 1984).

In terms of psychological development, their identities were not yet crystallized, rather they were still in a period of "psychological moratorium" (Erikson, 1968). During this period, it is generally an accepted notion in our society that roles and identities are experimented with and the boundaries of families and of the society are tested. Adolescents are generally maintained by the reciprocity of the family and society until their true psychological identities are formed.

However, the American GI was taken away from those accepted forms of passage into adulthood.
His family became the military, and in that family he was required to perform duties which went against all that he had learned in his previous life. Sometimes, he even performed atrocities which he had never before imagined (Haley, 1973; Hendin and Pollinger, 1984). One veteran described it:

Most of all, we learned about death at an age when it is common to think of oneself as immortal. Everyone loses that illusion eventually, but in civilian life it is in installments over the years. We lost it all at once and, in the span of months, passed from boyhood through manhood to a premature middle age. The knowledge of death, of the implacable limits placed on a man's existence, severed us from our youth as irrevocably as a surgeon's scissors had once severed us from the womb. And yet, few of us were past the age of twenty-five. We left Vietnam peculiar creatures, with young shoulders that bore rather old heads (Caputo, 1977, pp. xv).

Some authors suggest that after the American GI performed the task to the completion of the goal, survival, he may have felt abandoned by his military family (Parson, 1984). Sometimes he learned after his return home that he had been abandoned by friends and even his natural family as well. He may have felt estranged from family and
friends and found that life did not seem the same, and indeed it was not and would never be again.

In one study, it was found that men who later developed post-traumatic stress disorder were more likely to have been adolescents during their combat experiences (van der Kolk, 1985). Van der Kolk also found that they had often formed intense attachments to another man in their unit, but suffered the death of that combat buddy. The loss was often followed by a period of intense rage and acts of revenge. In his study, van der Kolk explains:

Adolescents use their peer group as an intermediary stage between dependency on their family and emotional maturity, and the army, particularly under battlefield conditions, maximizes the impact of peer group cohesion. For these younger men, the death of a friend was experienced as the dissolution of the once omnipotent group and as a narcissistic injury (van der Kolk, 1985, p. 365).

Ambiguity Regarding the Enemy

In previous wars, the enemy was usually well defined. In Vietnam, the whole environment was at war. The entire countryside was at war. There was no place to escape to safety. Even Saigon, where GIs often went for R and R was not completely safe.
"Those nights there was a serious tiger lady going around on a Honda shooting American officers on the street with a .45. I think she'd killed over a dozen in three months; the Saigon papers described her as 'beautiful,' but I don't know how anybody knew that" (Herr, 1977, p. 42-3).

Vietnam, a land of rice paddies and jungles, was filled with alien threats and dangers. The jungles were filled with leeches, mosquitoes, ticks, poisonous snakes, and even tigers (Moore, 1986). Diseases were numerous including typhus, typhoid, cholera, malaria, bubonic plague, encephalitis, tuberculosis, and rabies. The climate was one of intense heat, often reaching 110 degrees, and periods of torrential rainfall.

The enemy was everywhere and at the same time the enemy was nowhere to be seen. The Viet Cong wore black so that it was difficult to see them, especially at night. Firefights were often conducted without ever seeing the enemy, but rather shooting into the blackness at the arms fire that was returned. Often, the only awareness the GI had of the enemy was when a bullet from a sniper found its target and left a dead GI. One of the most
constant threats to the GI was the boredom he experienced between the sniper’s fire. The sniper was an ever present reminder that at no time could the GI relax. The jungles were filled with booby traps including violent projectiles, land mines and ambushes. Even children, whom GIs were known to befriend, were strapped with explosives that would kill the GI as well as the child when exploded. "Many veterans today bear the psychic scars related to having killed a young child who persistently approached in spite of warnings to stop" (Parson, 1984, p. 8).

The goals of the war were uncertain. In previous wars, primary objectives usually included gaining territory. Thus, the actual acquisition of territory was a yardstick of accomplishment. However, in Vietnam, the mission was never clear. As a result, the primary goal became the acquisition of dead bodies. Emphasis on Viet Cong killed rather than territory obtained, has obvious psychological implications:

Our mission was not to win terrain or seize positions, but simply to kill: to kill Communists and to kill as many of them as possible. Stack ‘em like cordwood. Victory was a high body-count, defeat a low kill-ratio, war a matter of
arithmetic. The pressure on unit commanders to produce enemy corpses was intense, and they in turn communicated it to their troops. This led to such practices as counting civilians as Viet Cong. ‘If it’s dead and Vietnamese, it’s VC,’ was a rule of thumb in the bush. It is not surprising, therefore that some men acquired a contempt for human life and a predilection for taking it (Herr, 1977, p. xix).

In previous wars, American ideology seemed to justify the GIs presence in the war. In Vietnam, the American military seemed plagued with doubts and confusion. Even the physical aspects of the war itself were confusing.

Demoralization in the war zone was another problem for many. Low morale was a response to chronic frustration, anger, and confusion regarding seemingly irrational and erratic policies, tactics, and strategies implemented in the war. Soldiers felt deprived of a sense of progress or even lack of it. In conventional warfare, policies and strategies usually evolved logically from military objectives; success was measured in terms of actual land gained, occupied, and controlled. In Vietnam, however, a territory would be occupied by our troops after a ‘successful’ battle, only to be fought for again at a later tie. Since military officials needed some yardstick against which to measure battle, they focused on the ‘body count’ as the sole criterion for movement toward victory (Parson, 1985, p. 9)
Homecoming

Many who went to Vietnam did not wholeheartedly support the war but went because they were drafted. Once there, they found the goals of the war, at the least, ambiguous and obscure. Their personal goal became that of survival rather than the pursuit of some ideological politics. In 1970, Colbach and Parrish reported that the American GI did not seem "...overly concerned with the justification for the war" (p. 338). Once they achieved their goal of survival and returned home, they found that they were not treated as returning war heroes. There were no parades and no hero's welcome. In fact, it was quite the opposite. Returning GIs found antiwar demonstrations and marches. Vietnam veterans were often called "baby killers."

It has been said that a country has a moral obligation to honor its returning war heroes. In this manner, the United States failed miserably. In fact, it has only been with massive amounts of defensive denial, projection, repression, and splitting that this country has been able to deal with its feelings of anxiety and depression
regarding our experience in Vietnam (Parson, 1984). Only in recent years have there been indications of the nation's willingness to deal with its emotions about Vietnam, through parades for Vietnam veterans and most recently the popularity of the intensely provocative film, "Platoon."

Parson (1984) describes the "disreception" of the American GI as an extreme narcissistic injury. In accord with psychology of adolescence, those GIs serving in Vietnam were so young that their identities were not yet firmly intact. Parson suggests that they transferred their need for an "idealized parent imago" (Kohut, 1977) onto their country and the military. Thus, they idealize America, the American military and all that it symbolized. However, when they returned from war, the American military quickly disposed of them, processing most soldiers in two or three days, and America failed to celebrate them, or "mirror" them positively, thus potentially creating the narcissistic injury.

According to Parson's model the narcissistic injury experienced by returning GIs served to further isolate them not only from the mainstream
of American society, but also from other veterans. It also may have served to exacerbate feelings of anger and betrayal. The Vietnam veteran is often portrayed as angry and hostile, and certainly many are:

All we gave him was military hardware, but no emotional or ideological support. Now he feels he has been duped, taken advantage of, or to use the common phrase of Vietnam veterans—he has been 'fucked over.' The Vietnam veteran is full of rage; he is mistrustful and guilt-ridden... The Vietnam was veterans are often depressed, unable to enjoy life, undergoing existential crisis, questioning the meaning of life, etc. Frequently they express cynical attitudes, but when one scratches the surface one finds a great deal of sensitivity and vulnerability (Tanay, 1985, p. 34).

Shatan (1978) suggests that their anger is secondary to their underlying need to grieve:

The 'post-Vietnam syndrome' confronts us with the unconsummated grief of soldiers—'impacted grief' in which an unending, encapsulated past robs the present of meaning. Their sorrow is unspent, the grief of their wounds is untold, their guilt is unexpiated. Much of what civilians view as cynical disillusionment is really the veterans' numbed apathy from an excess of death and bereavement. The welcome with which the soldiers are met is equivocal: They may be regarded as those who 'lost the war,' as well as trained killers. This absence of social acceptance, this defensive rejection of their needs, aggravates their failure to mourn even more. Experiences whose horror they can barely convey set them
apart from the rest of the population (Shatan, 1978, p. 51).

In a study involving 114 combat veterans, Wilson (1985) found a significant correlation between the veteran’s experience at homecoming and the later development of post-traumatic stress reactions. Wilson defined the homecoming as constituting the first six months after the veteran returned from the war. He found that what was significant during that time was the "relative degree of support from significant others and a meaningful community, the opportunity to talk freely about the traumatic experiences of the war and the social and institutional mechanisms that facilitate a rapid return to normal psychosocial functioning" (Wilson, 1985, p. 113).

Summary

The Vietnam War was a unique war fought under unique circumstances. It is thus understandable that the psychological stress reactions would also have unique qualities. This chapter has defined some of the unique characteristics which may have contributed to the development of delayed and
chronic stress reactions seen in combat Vietnam veterans.

This research was based on the belief that PTSD is characterized by a numbing or denial phase which is followed by a reexperiencing phase. It suggests further that individuals who are adaptively defended in the denial phase with a functioning reservoir of social supports, may be prompted into the reexperiencing phase if those supports are decreased. These propositions were tested by talking with combat Vietnam veterans about their experiences, stress reaction, and social supports.

The following chapter addresses the literature articulating the etiologies and symptomatology of combat stress reactions in Vietnam veterans. It provides an overview of the historical and current theoretical perspectives with a final emphasis on how social support can play a role in the development of PTSD symptomatology.
CHAPTER II
LITERATURE REVIEW

The most commonly reoccurring theme in the literature on PTSD is that of disagreement. Little agreement is found on the etiologies, the nature and even the existence of the disorder in combat Vietnam veterans (La Guardia, 1983). In 1980 the Diagnostic and Statistical Manual (DSM III) defined a diagnostic nosology for PTSD. Prior to its publication, the criteria was nebulous and obscured by the languages of numerous theoretical approaches, each attempting to define it in their own terms. With the publication of the revised third edition of the Diagnostic and Statistical Manual (DSM III-R) in May, 1987, further clarification of the diagnostic criteria of PTSD has been achieved, however, there still remains disagreements regarding its nature, etiologies and treatment implications. This chapter reviews the current literature on the diagnostic criteria, symptomatology, and etiologies of PTSD in Vietnam veterans. Also included is a review of the literature on social supports as a factor associated with PTSD in Vietnam veteran.
Diagnostic Criteria

Although diagnosing PTSD among Vietnam veterans should be a straightforward task, it has often become a complicated and controversial task (Arnold, 1985; Walker, 1982). By considering the constellation of the symptomatology, the traumatic history, the developmental history, the treatment history, and the current status of the veteran, the process is simplified. This section reviews the current criteria for diagnosing PTSD, the constellation of PTSD symptomatology commonly seen in Vietnam veterans, and the problems of misdiagnosis of PTSD in Vietnam veterans.

DSM III-R Criteria

Since the onset of the Vietnam War, much has been written on combat stress reactions with an increasing amount of research on the etiologies of the symptomatology. The recent literature focuses on the aspects of stress reactions peculiar to Vietnam veterans, particularly the delayed and chronic forms. These symptomatic forms were defined in the publication of the DSM III in 1980
under the category of Post-traumatic Stress Disorder, Acute/Chronic or Delayed, and have proven to directly resemble those stress reaction symptoms found in Vietnam veterans (Boulanger, 1985). The DSM III-R omits the classifications of acute or chronic but rather denotes that the disturbance must have a duration of at least one month and delayed onset is to be specified if the onset of symptoms was more than six months after the trauma.

Diagnostic criteria include:

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

B. The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
(2) recurrent distressing dreams of the event

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

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

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

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

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

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

(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
(5) feeling of detachment or estrangement from others

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

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

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

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response
(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

D. Duration of the disturbance (symptoms in B, C, and D) of at least one month. Specify delayed onset if the onset of symptoms was at least six months after the trauma (American Psychiatric Association, 1987, pp. 250-251).

By omitting the differential between chronic versus acute forms of PTSD, the DSM III-R reflects
the literature on PTSD in combat Vietnam veterans which emphasized the delayed and chronic forms commonly seen in those veterans today. The other significant change offered in the DSM III-R is that it further describes the overt symptomatology of the numbing responses to the traumatic experience.

Symptomatology: Overt and Covert

The symptomatology of PTSD can basically be divided into two categories: overt and covert symptomatology. Horowitz and Solomon (1975) first described these two main aspects of stress response as: "an intrusive-repetitive tendency and a denial-numbing tendency" (1975, p. 68). The intrusive-repetitive symptoms are the overtly expressed symptoms and the denial-numbing symptoms are those which are covertly expressed. Horowitz and Solomon suggests, "The intrusive-repetitive symptoms usually lead to the diagnosis of stress response syndrome; the signs of denial and numbing may go unobserved" (1975, p, 69). Thus, if the veteran presents with denial and numbing symptomatology, it may be unlikely that a correct diagnosis of PTSD will be made.
Overt symptomatology consists of those symptoms which are intrusive and lead to a repetitive tendency secondary to the need to work through the traumatic event (Arnold, 1985; Walker, 1982). These symptoms include those which are most readily observed: nightmares or dreams of the event, intrusive or recurrent thoughts of the traumatic event, sudden acting or feeling like the event was going to occur again because of exposure to a triggering stimulus (sometimes referred to as flashbacks), feeling excessively edgy or jumpy, other sleep disturbances, guilt about having survived when others did not, and memory impairment.

Covert symptoms include the aspects of denial and numbing tendency. These include feelings of detachment from others, diminished interest in significant activities, diminished ability to trust others and constricted affect. Although these are noted in the DSM III-R to be characteristic of PTSD, if they are primary symptoms exhibited, they usually go unnoticed and thus are often not diagnosed as PTSD (Waid, 1987). The numbing and denial aspects are defenses employed by the ego to
defend against the pain of reexperiencing, working through, or abverting the traumatic experience (Arnold, 1985; Hendin, et al., 1980; Horowitz, 1975; Walker, 1982). Their presence prevents the assimilation of the event as well as the development of an adaptation response. When the ego is no longer able to repress and deny the impact of the traumatic experience in the numbing phase, the ego may further employ more regressive defenses such as projective identification (Parson, 1984) in order to maintain the denial phase. Horowitz and Solomon (1975) suggest that, given a period of prolonged safety, the denial phase will give way to the reexperiencing phase.

The affective expression of overt symptomatology is, in itself, a phase of the therapeutic process.

Thus traumatized individuals who present complaints of depression, anxiety, fear, irritability, anger, "flashbacks" to the event, problems in concentration, sleep disturbances, paranoid preoccupations, "bad" dreams, interpersonal isolation, etc. may be manifesting not the disorder per se, but a normal stress-recovery process (Parson, 1984, p. 12).
It is thought that the denial and numbing aspects are a phase which would present prior to the more overt symptomatology (Arnold, 1985; Boulanger, 1985). Later, avoidance alternates with reexperiencing of the trauma in accordance with the degree of reexperiencing that can be tolerated. Waid (1987) suggests that thorough clinical exploration of the combat experience with the veteran will encourage the elimination of denial of the veterans' combat experiences.

Differential Diagnosis

Despite the increasing literature clarifying the diagnostic category of PTSD and the specific symptomatology of those stress reaction in Vietnam veterans, reports suggest that differential diagnosis remains a difficult task (Parson, 1984; Waid, 1987; Walker & Cavenar, 1992). The problem of diagnosis is compounded by a lack of a thorough combat history (Waid, 1987; Walker & Cavenar, 1982) but also by the overlapping symptomatology of PTSD and other disorders including schizophrenia and character disorders.
PTSD is often misdiagnosed as schizophrenia (Parson, 1984; Walker & Cavenar, 1982). Parson describes the diagnostic dilemma:

It seems that the florid symptoms of repetitive anxiety attacks, panic states, dissociative paranoid rage states, and other dissociative phenomena such as "flashbacks," often lead to the diagnosis of schizophrenia rather than PTSD. Despite dissociative phenomena observed in these veterans, reality testing and other ego functions known to be severely impaired in schizophrenic disturbances, remain intact (Parson, 1984, p. 17).

A complete combat history with a thorough family and personal history as well as additional psychological testing are the essential components for a differential diagnosis (Parson, 1985; Walker & Cavenar, 1982).

Another common misdiagnosis of PTSD is that of character disorder. Parson suggests that the affective symptoms displayed by combat veterans and commonly mistaken as character disorder symptomatology actually represent "...ineffectual defense(s) against the return of the repressed, split-off traumatic affects, memories, and ideas" (Parson, 1985, p. 18). He maintains that the clinical presentation of these symptoms which appear similar to character disorders,
"...developed by psychic necessity to protect the veteran, rather than subject him to the emotional trouble and inner chaos that characterizes PTSD pathology" (p. 19). Walker and Cavenar (1982) also suggest the importance of a thorough history to differentiate between PTSD and antisocial personality, a common diagnosis for Vietnam veterans. They differentiate the diagnosis by noting a history of maladaptive behavior prior to the age of 15.

Diagnosis of PTSD is thus greatly complicated by the similarity of the symptomatology to other diagnostic categories. A thorough understanding of the combat experience and personal and family histories help the diagnostician to differentiate PTSD from these other similar diagnoses. It is further complicated by the lack of agreement in the theoretical etiologies of PTSD. These theories can basically be viewed as representing two separate etiological perspectives; the predispositional perspective and the enviromental perspective. Each have coexisted throughout the literature on combat stress reactions and may contribute to the confusion in the current literature regarding PTSD.
in Vietnam veterans. The next section reviews the historical evolution of those etiological perspectives.

**Etiologies of Combat Stress Reactions:**

**Historical Perspectives**

The literature on combat stress reactions has been greatly influenced by the nature of the military conflicts with which this country has been involved. Interest has tended to peak during and shortly after the conflicts and wane during peacetime. Varying views and attitudes have affected the prevailing theories on the etiologies of stress reactions according to the times. However, the Vietnam War brought about a set of unusual circumstances which led to the development of delayed stress reactions in combat veterans, many of which are still being newly diagnosed and others which are, as of yet, undiagnosed. Therefore, the interest in the etiologies, nature, and treatment of stress reactions has not waned with the passing of time since that was, but, rather, has endured. However, clarity and agreement in these issues has not yet been
achieved. Thus, an historical perspective on these issues is critical to understanding the literature today. This section reviews the development of the theoretical perspectives on understanding combat stress reactions by presenting the clinical research and literature from this country's recent armed conflicts.

**World War I**

Before and after World War I, soldiers experiencing psychological problems secondary to combat experience were considered to be either weak or lacking in self and/or military discipline. These weaknesses were considered to be predispositional and secondary to personal or family histories of mental disorders.

Although fear was considered a normal reaction to combat stress, one's behavioral reaction to fear was as critical element in understanding psychological adaptation. Cowardice was considered the pathological result of fear without self-control (Smith, 1981).

By 1916, it was thought that trauma brought on by the shock to the brain from loud explosions of
the shells and mortar could bring on behavioral and psychological disturbances (Figley, 1978). In 1919, F.W. Mott coined the term "shell shock" in his paper entitled, "War Neuroses and Shell Shock." He suggested that the condition was brought on by a reaction to physical brain lesions and by either carbon monoxide or changes in the atmospheric pressure (Trimble, 1985).

At that time, a distinction was made in the literature between 'commotional' shell shock and emotional shell shock (Smith, 1981). The commotional shell shock referred to those reactions which had an organic and, thus, understandable or forgivable origin. The emotional shell shock referred to reactions which were purely psychological in origin. Psychological reactions were considered to be under conscious and willful control, thus indicating a failure in self-control.

In 1917, Freud presented his paper on war neuroses. He described traumatic neuroses as,

...an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in permanent disturbances of the manner in which the energy operates (Freud, 1963b, p. 275).
In his paper, "The Common Neurotic State" (1963a), he more clearly defined the defensive nature of the ego:

Thus in traumatic neuroses, and particularly in those brought about by the horrors of war, we are unmistakably presented with a self-interested motive on the part of the ego, seeking protective and advantage a motive which cannot, perhaps, create the illness by itself but which assents to it and maintains it when it has come about. This motive tries to preserve the ego from the dangers the threat of which was precipitating cause of the illness and it will not allow recovery to occur until a repetition of these dangers seems no longer possible or until compensation has been received from the danger that has been endured (Freud, 1963b, 382).

The prevailing opinion at that time stated that the defensive nature of the ego was a reaction to the traumatic experience, secondary to a premorbid ego structure flaw, exposing itself only under the strenuous conditions of combat. This argument remains at the core of the disagreement in the literature on the development of post-traumatic stress reactions.

**World War II**

World War II began with the notion that the predisposition of personal deficits was the primary
cause of stress reactions. Thus, pre-service screening attempted to eliminate from induction those recruits with a predisposing character. However, despite these attempts, psychiatric casualties were high from the onset of the war.

As a result of experiences in World War I, it was thought that immediate treatment of psychiatric casualties with prompt return to the battlefield was the most effective course. Psychiatrists were then afforded a firsthand view of the battle experience as they were moved to the battlefront in World War II. It was from that vantage point that they began to view the effect of the actual combat experience in the development of symptomatology and the relevance of physical stamina of the soldier.

The term "exhaustion" was popularized by the frontline psychiatrists who found this to be a relief from having to define so many soldiers as having predisposing character deficit. However, it did not answer why soldiers who had not recently been exposed to physical fatigue developed legitimate reactions; or why others who were exposed for long periods of time to physical fatigue and hardships did not develop reactions.
Reluctant to define stress reactions in terms of predisposing factors, psychiatrists were forced to make decisions regarding the legitimacy of the stress reactions in terms of the degree of the conditions under which the reactions occurred.

Also common in the literature at that time and henceforth was the concept of secondary gain. This notion derived out of the belief that psychological reactions were conscious and willfully self-controlled. Kardiner (1941) notes that the soldier leaving combat for psychological disturbances benefited financially as well as by the legitimate escape from duty. He suggests that the compensation factor does not create the neurosis but, rather, is more a source of resistance in treatment and rehabilitation. The possibility of secondary gain remains a factor in contributing to the complications of appropriate diagnosis today and will always remain a factor as long as secondary gain is a reality (Fleming, 1985; Sparr and Pankratz, 1983).
Korean War

Following close on the heels of World War II, the Korean War found few changes in the theoretical orientations of the etiologies of stress reactions (Smith, 1981). The term 'combat fatigue' was introduced by the Marines and the Navy to refer to that condition that the Army still referred to as combat exhaustion. Underneath still raged the debate concerning casualty: predisposition versus physical and psychological weariness.

After the Korean War, interest in the development of post-traumatic stress reactions was renewed. In 1952, the original Diagnostic and Statistical Manual was published and contained a category for stress reactions, including combat stress reactions. However, to qualify for this diagnosis there could be no history of personal or social maladjustment, there must be a satisfactory military record and there must also be prolonged exposure to combat (Smith, 1981). This diagnosis was designed to eliminate those with predisposing character deficits who then would be diagnosed with personality disorders. One of the onsets of this diagnostic definition was that prognosis for
someone without a predisposing deficit was considerably better than those considered to be personality disordered. The implication for treatment at Veteran Administration Hospitals was significant, since those with predisposed deficits (or non-service related injuries) were not eligible for treatment.

With the publication of the revised Diagnostic and Statistical Manual (DSM II) in 1968, the stress category was replaced with a broader "(Transient) Adjustment Reactions of Adult Life" (American Psychiatric Association, 1968, p. 48). Although the criteria were broader to include reactions to any overwhelming stress, distinctions were made between those patients who recovered quickly and those who did not. The quickly recovering patients were thought to have 'good adaptive capacity' while others should be considered for diagnosis of another mental disorder. Thus, the chronic or prolonged reactions still were viewed as being more pathologic and predisposed.
Vietnam War

As mentioned in the introduction to this paper, numerous measures were taken at the onset of the Vietnam war to prevent psychiatric casualties. It was, thus, with some pride that the military initially reported low rates of psychiatric casualties. However, the latter years began to show higher rates of casualties as well as indications that the widespread use of drugs among troops were attempts at self-medicating their psychological turmoil.

Diagnostic frameworks were still based on the notion of predisposition and good versus bad reactions. Three basic categories were noted: 1) genuine combat fatigue, reserved for those individuals with good pre-military adjustment, successful combat histories and prolonged exposure to stress; 2) pseudo-combat fatigue, designating those with similar symptoms as those with genuine combat fatigue, but who seemed to break under a lesser degree of stress; and 3) combat neurosis, which included the development of symptomatology in predisposed individuals, distinguishable by the presence of neurotic traits (Smith, 1981).
In an attempt to frame the models of stress trauma mostly commonly found in the literature, Kormos (1978) defined six theoretical models for conceptualizing stress trauma, or the "Acute Combat Reaction" (p. 8). The first, the illness model, conceptualizes the combat experiences as triggering or activating an already existing intrapsychic conflict. Psychopathology is the etiology of the stress reaction and the term "traumatic neurosis" is most often used to describe it. Similar to this model is the experimental neurosis model which also involves a conflict factor but is based on Pavlov's "experimental neurosis". The endurance model was popularized by the terms "combat exhaustion" or "battle fatigue" and refer to the theory that everyone has their breaking point. The voluntaristic model refers to the model proposed by Kardiner (1941) who upholds the view that secondary motivations are intrinsic to the development of combat reactions. Environmental theories propose that external factors play a significant role. The judgment model suggests that combat reactions are failures in moral and ethical standards. Kormos goes on to propose the Acute combat Reaction model
which, "...consists of behavior by a soldier under conditions of combat, invariably interpreted by those around him as signaling that the soldier, although expected to be a combatant, has ceased to function as such" (Kormos, 1978, p. 8). He was satisfied that this definition was able to incorporate all of the theoretical positions, however, it did not address the basis of the controversies of predisposition.

Prior to the publication of the DSM III, much of the early literature on PTSD in the Vietnam veteran focused on clarification of the diagnostic criteria, specifically how the stress reactions in Vietnam veterans were similar to other traumatic stress reactions. After the publication of the DSM III, research turned more efforts to the unique characteristics of stress reactions in Vietnam veterans and its etiologies. Theoretical perspectives governing the early literature and research on PTSD in Vietnam veterans could be basically separated into the predispositional and the environmental perspectives. Some of the more recent research is examining an interplay of both
perspectives. The next section reviews the current status of that literature.

Etiologies of Stress Reactions:

Current Perspectives

The inclusion of post-traumatic stress disorder in the DSM III provided a diagnostic description of symptoms for clinicians and validated the reality of stress reactions for financial reimbursement purposes. However, again, it did not address the controversies surrounding the etiologies of stress reactions. The basis of the theoretical controversy remains over the interplay between predispositional versus environmental factors contributing to the development of combat stress reactions (DeFazio, 1978; Triana, 1986). In the Vietnam literature, these views became the "stress evaporation perspective" and the "residual stress perspective" (Figley, 1978, p. 59) respectively. Smith (1981) believes that both of these theories make an inherent moral judgment, assigning blame and responsibility either to the individual or to the war event in an attempt to explain the adverse
reactions of Vietnam veterans. Some of the more recent literature considers both the environmental nature of the combat experience as well as the pre-military functioning of the veteran as contributing to the development of stress reactions (Wilson, 1985).

**Predispositional Perspective**

The predispositional or the stress evaporation theory holds that veterans may experience stress reactions after returning from combat; however, with time the symptomatology will dissipate. This theory maintains that few combat veterans suffered from adjustment problems compared to noncombat veterans and the differences in adjustments between the two are insignificant (Borus, 1973; Borus, 1974; Panzarella et al., 1978; Worthington, 1977). Maladjustment is considered to be secondary to predisposing character deficits (Borus, 1973; Huffman, 1969; Worthington, 1978;). Little consideration, if any, is given to the actual combat experience.

Borus (1974) found in another study involving 577 Vietnam veterans and 172 nonveterans, only
twenty-three percent of the veterans showed evidence of maladjustment as indicated by disciplinary-legal difficulties and/or emotional problems. This was not significantly different from the maladjustment evidenced in the nonveterans. However, neither the 1973 nor the 1974 study distinguished between combat and noncombat soldiers, both were composed only of soldiers who were still in active duty and finally, the 'nonveterans' were actually military personnel who had not served in Vietnam.

Panzarella, Mantell, and Bridenbaugh (1978) questioned 143 active duty military personnel who reported to a mental health clinic between October, 1973 and May, 1974. Of course, 34 had served in Vietnam; however, quite significantly, they failed to include a variable for combat exposure in the study. They conclude, "the incidence of psychiatric problems among Vietnam veterans is about the same as the incidence among nonveterans in the same population" (Panzarella, mantell, and Bridenbaugh, 1978, p. 162).
Environmental Perspective

Increasingly, the literature has considered the nature of the Vietnam combat experience essential to the understanding of delayed stress reactions seen in those veterans (Figley, 1978). The environmental or residual stress perspective maintains that the combat experience has made a significant impact and had long-lasting effects on the lives and functioning of these veterans (Card, 1983, DeFazio, 1975; Egendorf, 1981; Foy, 1984; Friedman; 1986). It has even been suggested that after a period of prolonged safety, it is predictable that the overt symptoms of stress reactions will appear (Horowitz & Solomon, 1975).

In one of the first studies to compare combat veterans with non-combat veterans, DeFazio (1975) found significant differences in the mean number of symptoms experienced by those groups. Symptoms reported more frequently by the combat veterans included frequent diarrhea, disturbed sleep, feeling blue, something wrong with one's mind, smoking marijuana, describing oneself as a hothead, unable to relax and finding it hard to get close to others. His study consisted of 207 veterans who
were attending a community college. It is noted that because these veterans were attending college, they likely represent a portion of better adjusted veterans. Of those, 144 reported having some combat experience while 63 reported having no combat experience. DeFazio noted that sometimes there was a relationship between the symptom and the actual traumatic experience, such as the veteran who experienced increased nightmares whenever the room temperature (in the room in which he was sleeping) rose above 80 degrees. He concludes that not only does "...prolonged exposure to situations which engender fear and anxiety produce disturbances in ego functioning..." (p. 162) but also those symptoms are persistent and "...reflect disturbances in the autonomy of certain ego functions which are altered to reflect an adaptation to the new (traumatic) situation" (p. 163).

Strayer and Ellenhorn (1975) conducted a study of adjustment patterns and attitudes among Vietnam veterans by using a random sample of 40 recently discharged veterans. Each veteran rated his combat experience on a scale ranging from no combat
experience to heavy combat experience. The light, moderate and heavy combat categories were fairly evenly distributed with 10 percent of the sample reporting no combat experience. The results indicated a significant relation between severity of combat experience and severity of adjustment problems.

The veteran's perception of the extent and intensity of his combat involvement is closely related to his mode of adjusting to civilian life. Feelings of hostility, depression, and guilt, and a negative attitude toward the war were all significantly associated with reported "severe" combat experience as were self-perceived severe adjustment problems (Strayer & Ellenhorn, 1975, p. 85).

In one of the most ambitious projects to date, Egendorf, Kadushin, Laufer, Rothbart and Sloan (1981) conducted a study of 1380 veterans including Vietnam veterans as well as Vietnam-era veterans. They found that the combat experience had a significant impact on postwar adjustment. Exposure to combat increased feelings of alienation which were compounded by the lack of a hero's welcome home. They found that the incidence of stress symptoms during and immediately following the combat experience increased with the intensity of the combat exposure but that it was more confined
to veterans serving after 1968. Vietnam veterans were found to be three times as likely to feel stressed as Vietnam-era veterans; Vietnam-era veterans were twice as likely to feel stressed as nonveterans. It is significant to note that although their "stress scale" was based on symptoms reported by traumatically stressed populations but includes items which may or may not be directly combat related, such as, headaches, feeling numb, memory difficulties, irritability, sleep disturbances, etc.

Card (1983) was able to study a sample of 1471 men including: 481 Vietnam veterans, 502 non-Vietnam veterans (Vietnam-era veterans) and 487 nonveterans. Her study had the advantage of drawing from a sample of a study, Project TALENT, started in 1960 designed to study factors effecting America's youth in their transition to adulthood. Thus, Card's study was prospective with available information collected at three intervals in the subjects' lives: first when they were in the ninth grade and the last time when they were thirty-six years old, or more than one decade after the veteran's return from war. Using the pre-service
data they were able to match the men in their three categories according to demographic and psychological characteristics, thus enabling them to rule out certain pre-military variables which in previous studies remained questionable. Although this study was limited to subjects of the same age, their average age was a half a year older than the average Vietnam veteran. Card was able to document that the more severe the combat experience, the greater the number of PTSD-related problems as a civilian more than a decade later. Card’s study confirmed the residual-stress model proposed by Figley in that Vietnam veterans were found to have significantly higher occurrences of PTSD and with greater severity than the non-Vietnam veterans and the nonveterans. Also, those problems were found to have persisted for more than a decade, contrary to the stress-evaporation model. Card concludes,

...evidence shows that postservice social and psychological problems flow from service in a war zone, not from the military experience itself. Those experiencing heavy combat are especially vulnerable to long-term psychological consequences...the primary antecedent of PTSD is the severity of the combat experience, not the background characteristics of the individual soldier or his general military behavior and adjustment. Twenty-seven percent of
Vietnam veterans who experienced heavy combat manifest PTSD-related symptoms at age thirty six (Card, 1983, p. 113).

Neither the predispositional nor the environmental perspective adequately addresses the nature of the PTSD syndrome which appears to plague the Vietnam veteran. The work of Egendorf and Card have come closer to addressing the difficulty of solely assigning either the predispositional or the environmental models to these stress reactions, by addressing the interplay of both perspectives on the development of the symptomatology.

Social Support

In support of Green, Wilson, and Lindy's proposed need for a supportive recovery environment, Catherall (1986) states, "Dealing with the effects of trauma is largely a social process and occurs in the natural social groups in which people live" (Catherall, 1986, p. 472). He proposes that those natural social groups can constitute the family, the therapeutic process or other groups which provide a sense of community or belonging for the individual and may or may not be mutually exclusive. He maintains that the primary
dynamic of PTSD is the survivor's need to control the intrusive and repetitive thoughts related to the trauma but that a supportive social environment is essential to the self-examination required to gain control of those thoughts. The social support system of the individual serves in an emotionally supportive role, helping to allay the survivor's anxiety, but also in a cognitive role by reinforcing the individual's self-concept.

Self-examination requires some kind of social context—we define ourselves according to how we compare with others.... This is true in terms of our most basic beliefs and values, including right and wrong; they only acquire meaning within a social context (Catherall, p. 473).

As mentioned in the description of Parson's model, the military can be seen as an idealized parental imago which positively mirrored the GI's combat identity. It provided a social context for the American GI to carry out his combat obligation by Justifying and condoning killing and violence. However, the American public can be seen as having failed to provide the recovery environment necessary for self-examination.

In order to facilitate veterans', transition to a civilian identity, the social context at home needed to provide
a similar environment in which veterans could continue to justify their combat behaviors while accepting a new set of values for civilian or peacetime behavior. If the social context at home did not condone the behaviors, then the veteran could not safely engage in self-examination. And if the veteran could not reexamine his combat behaviors, then he could not effectively assimilate his combat identity (Catherall, 1986, p. 473).

In Support of this theory, Catherall points out there is some evidence that those who went beyond the boundaries of the defined combat social context by committing atrocities seem to have an increased susceptibility to PTSD (Hendin and Haas, 1984; Hendin, Haas, Singer, Gold, and Trigos, 1983).

As previously reviewed, the Vietnam veteran experienced, generally, a dysreception by the American public. Individual receptions and support systems varied and recently are being increasingly viewed as significant in predicting whether or not a veteran later developed delayed stress reactions (Wilson, 1985).

To facilitate a review of the literature pertaining to social support and the development of symptomatology in PTSD, a common frame for defining social support is essential. The next section
presents an update on the most current definitions of social support found in the literature.

**Definitions of Social Support**

The term social support is a broad term which has become popular in the literature in recent years; however, it is problematic due to a lack of clarity and agreement concerning its definition. As House (1985) points out, there is no agreed upon definition of social support and often literature and research pertaining to the subject fails to make any definition of the term. Much of the research pertaining to social support and PTSD fails to define the term but rather incorporates a working definition into the research.

Generally, social support is agreed to constitute a flow of information between people; although, some writers have been so vague as to say that social support is any support which is social (House, 1985). House suggests that, "...social support involves the flow between people of emotional concern, instrumental aid, information, or appraisal" (House, 1986a, p. 255). He suggests that emotional concern consists of empathy and
caring, instrumental aid consists of acts such as the giving of money or assistance, information aid consists of suggestions and advice, and appraisal consists of feedback or social comparison (House, 1985). House (1985) makes the important distinction that social support can be either subjective or objective: that is, either based on the observations of the individual, or based on observations made by another party. This idea of objective versus subjective observations leads to the difficulty in understanding social support through perceptions. He suggests that greater understanding of individuals' objective relationships, experiences, and interactions as related to the subjective perception of those is necessary.

Cobb addresses this problem. He defines social support as "...information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations" (Cobb, 1976, p. 300). He goes on to say that information leading one to believe that he is cared for and loved is most often received through intimate, dyadic relationships involving
mutual trust. He refers to this as emotional support. The second, he refers to as esteem support, is most effectively derived out of a public context and leads the individual to feel a sense of self-worth and value. Cobb's final aspect of social support frames the individual in a network where everyone has common knowledge about goods and services available in the network. Cobb suggests that this common knowledge answers three questions: "...What is going on and how did it begin? What is the relationship between us? How and when did we get here?" (Cobb, 1976, p. 301).

For purposes of this research, Cobb's conception of social support was adopted because to understand the veterans' plight it is essential to understand it through the veteran's perceptions, rather than by observations made by others. Thus, Cobb's definition of social support most readily accommodates itself to studying the veteran through his own perceptions because Cobb clearly adds the element of the subjects' perception of the social support.

Although the term remains broad in its scope, it is generally agreed that social support may be
received from various people in the environment (Billings and Moos, 1982; Cobb, 1976; House, 1986a). The family is usually a primary source of support, (Billings & Moos, 1982) however, certainly not an exclusive source of support. Interpersonal relationships in the work setting have also been shown to provide a measure of support (Billings & Moos, 1982). Studies in gender differences indicate that employed men are more likely to receive support from work sources and unemployed women are more likely to receive support from family sources (Billings & Moos, 1982). Other sources of support can include friends and acquaintances (Froland, Brodsky, Olson & Stewart, 1979) and psychotherapists or other helping professions (Froland, Brodsky, Olson, and Stewart, 1979; House, 1985).

Not only is there disagreement regarding the definition of social support there is also some disagreement about its effectiveness (House, 1985). Critics of the research are increasingly suggesting variables for interpretations of data, such as the often argued factor of predisposition (House, 1985). Despite disagreements regarding the
interpretation of data, and lack of clarity in terminology, there do seem to be some indications that social support can have a positive effect on ameliorating stress and coping with crisis (Cobb, 1976; House, 1985, 1986).

Social Support and PTSD

In the only study designed solely to examine social support in Vietnam veterans with PTSD to date, Keane, Scott, Chavoya, Lamparski and Fairbank (1985) interviewed 45 Vietnam era veterans to examine the degree to which the Vietnam veteran perceived changes in the levels of social support over a period of time. Specifically, they examined pre-military, post-military, and current levels of social support. They examined social support in five dimensions: material aid; physical assistance; sharing thoughts and feelings through conversation; advice and guidance; and positive social contact. Their study consisted of three groups of 15 veterans each: the first group (PTSD) consisted of veterans who were currently diagnosed as having PTSD and under treatment for such; the second group (WAV) consisted of combat veterans who
were deemed to be well adjusted by their reported absence of PTSD symptomatology or other psychological disturbances; the final group (MSV) consisted of Vietnam era veterans who were medical service in-patients at a Veteran’s Administration Hospital and who did not report PTSD symptomatology. Keane et al. found significant differences in social support network size as reported by the three groups of Vietnam veterans as a function of three different times: one to three months after entering the service, one to three months after discharge from the service, and currently. No significant differences were noted at the pre-military time. Specifically, all three groups reported decreases in social support network at the post-military time as compared to the pre-military time, with the PTSD group reporting a significantly lower level of social support network than the WAV and MSV groups. Although the WAV and MSV groups then began to experience increase in their social support networks up until the present, the PTSD group reported continued decreases.

Keane et al. also found significant differences in the qualitative dimensions of social
support for the PTSD group. That is, in material support, physical support, sharing support, advice support, and positive social contact support, they found significantly lower levels for the PTSD groups as compared with both the WAV and MSV groups. The WAV and MSV groups reported relatively intact support over time or sometimes reported strengthened support.

Keane et al. found the homecoming period to be marked by a significant decrease in social support. Although they cite this as being a function of the anti-war sentiment at home and the resulting inability of combat veterans to discuss their experiences, they add that it did result in social alienation, depression and guilt which are all hallmarks of the PTSD symptomatology seen in Vietnam combat veterans. The significance of social support at homecoming was also support by Wilson and Krauss (1985). They suggest that "psychological isolation" (p. 141) at homecoming is the single best predictor of PTSD. They go on to suggest that "...psychological isolation meant the network of
bonding, support, trust, and mutuality with the larger corpus of society was no longer functional" (p. 141).

The study conducted by Keane et al. (1985) has contributed greatly to our understanding of the development of PTSD symptomatology in combat Vietnam veterans by examining the levels of social support at three different times in the veterans' lives. Their work suggests that some combat veterans experience a linear reduction over time in social supports. As in most previous studies, this study does not determine a causality effect but does imply a reciprocal effect. Although their findings suggest that symptom severity of PTSD is related to degree of combat exposure rather than to premilitary factors, they acknowledge the need for further research on "...the characteristics of individuals vulnerable to developing PTSD under the stressors of combat" (Keane et al., 1985, p. 100).

One of the first studies to address social support as related to the combat Vietnam veteran was the comprehensive Legacies of Vietnam (Egendorf et al., 1981). Since the publication of that work, other writers have considered social supports as a
factor in symptomatology development of PTSD and some attempts have been made to define which, if any, social supports are beneficial to the veteran.

**Types of Social Support**

The literature examining social supports identify several types of support. These include marriage versus psychological isolation, peer relationships, community factors, cultural and racial factors, education, income and employment, and church, social, civic, and professional organizations.

**Marriage versus psychological isolation.**

Kadushin, Boulanger and Martin (1981) interviewed 1,380 Vietnam and Vietnam-era veterans. They controlled their study for stress, combat, class, spouse support and measurements of the interpersonal environment. They found that, "...married veterans, especially Vietnam veterans are better off than unmarried men; it is positive social support that counts, not merely being married" (Kadushin, Boulanger, and Martin, 1981, p. ii). However, their measurement of "...spouse support was used as a rough indicator of the
presence or absence of intimate social support" (p. 86). They found that married men tended to be better psychologically adjusted and found this effect to be heightened for Vietnam, non-white veterans. They also found that not being married had a preserving effect on previously experienced psychological conditions. Men who reported lesser degrees of spouse support were found to be at greater risk for having psychological problems than with unmarried men. Significantly, they found that combat exposure increased the probability of experiencing psychological problems only for unmarried men and married men who receive little spouse support. They maintain that "...this effect is very strong, indicating that the characteristics of the intimate interpersonal environment are extremely important for men who have undergone the traumatic stress of war" (p. 91). Kadushin concludes that spouses, if they so desire, are effective supports but that unsupportive spouses are less helpful than not being married at all.

Although Card's (1983) study was not defined as examining social supports, it examined the significance of marital status on PTSD in Vietnam
veterans. She found that being divorced, separated, living alone, or having a single marital status are significantly associated with PTSD among Vietnam veterans; that is, married Vietnam veterans or those living with a girl friend had lower rates of PTSD than unmarried Vietnam veterans or those not living with a girl friend. Card's study, however, did not measure the quality of the relationship as did the Kadushin study nor was it able to determine causality. In fact, Card suggests a reciprocal causality between PTSD and its correlates. Thus, problems in one's personal life may exacerbate PTSD which in turn, would exacerbate further personal problems.

Peer support. The Kadushin (1981) study found that social support from peers was related to reduced levels of stress reactions among veterans, particularly stress reactions associated with combat. However, they found that well-meaning friends may not be helpful and can even be detrimental to the veteran. Under the right circumstances, they found that other veterans can be helpful.
Community: rural versus urban. Kudushin et al. (1981) found that the kinds of social support which were associated with reduced stress reactions was dependent on the kind of environment in which the veteran lived, varying in urban and rural areas and among racial and cultural cohorts. For veterans who live in an interpersonal environment consisting of other Vietnam veterans and also live in a metropolitan area, there seems to be a positive association with decreased stress reactions. However, for a veteran living in an interpersonal environment of other Vietnam veterans and living in a smaller community, there seems to be a negative association or an increase in stress reactions. They speculate that in large cities, the communities of Vietnam veterans were formed randomly and composed of members with varying degrees of mental health and experiences. In the small cities, the communities of Vietnam veterans were formed by the more stressed veterans seeking out other veterans and was less likely to include varying degrees of mental health.
In large cities, whether or not one has Viet Nam veteran friends is largely a matter of accident. In smaller towns and perhaps among men with parental supports in larger cities, a veteran with problems seeks out others like himself. The men with problems reinforce one another and perhaps become "professional veterans." A cosmopolitan circle of Viet Nam veterans, on the other hand, contains veterans with many interests other than being a veteran. This kind of circle can be helpful to the veteran with problems (Kadushin, 1985, p. 65).

They conclude that communities of Vietnam veterans are helpful to each other and should be encouraged but should include healthy Vietnam veterans as well as those requiring help. They further suggest that the groups should not be racially or otherwise homogenous, as some more naturally occurring groups might be, but rather include a diversified group of veterans. In the only other study to examine the size of the veterans' home town community as a variable, Card (1983) found no association with variables relating to community size.

Cultural/racial factors. Kadushin (1981) found significant differences in the percent of stress reactions found in various racial groups supporting the notion that race is both a generator and particularly a preserver of stress reactions. They found that Black and Chicano veterans were
more likely to be stressed than white veterans. Also, that simply being in Vietnam was as stressful for Blacks as being in combat for whites. Seventy percent of the Black combat veterans in their study today experience some form of stress reactions. Forty percent of all Vietnam veterans as compared with twenty percent of all white Vietnam veterans remain stressed today. Finally, Kadushin notes that Black veterans who experienced stress reactions immediately after the war are more likely than white veterans to still be experiencing stress reactions today.

**Education.** Kadushin et al. (1981) suggest possible explanations which contribute to an understanding of differences in the findings of higher stress reactions in Blacks and Chicanos. First, they suggest a relationship between the degree of combat, one’s level of education and the degree of stress reaction experiences. Specifically, the more combat one experiences and the less education one has acquired, the greater the stress reaction. In support of this idea, they found a higher percent of white veterans with college degrees than black veterans. “This point,
where combat interacts with high educational attainment levels to reduce the percentage of stress reaction, appears to put blacks at a disadvantage, and might account in part for the higher rate of stress reactions among blacks" (Kadushin, Boulanger, and Martin, 1981, p. 56).

Rothbart, Sloan and Joyce (1981) found lower current educational attainment also associated with increased levels of stress among Vietnam veterans, particularly combat veterans. They also found lower income and irregular or unsatisfying employment associated with increased levels of stress. They concluded that the occupational differences between non-veterans and Vietnam-era veterans, and Vietnam-era veterans and combat veterans, are secondary to educational differences.

Income/employment. Kadushin et al. (1981) found a significant association between income and stress reactions. Their study suggests that annual incomes of less than $10,000 seem to have a significant interaction effect. Almost half of the combat veterans who income was less than $10,000 per year, were experiencing stress reactions. More than one third of the Black and Chicano veterans
fell into this category while less than one quarter of the white veterans did. Also, veterans whose income were greater than $20,000 were less likely to have stress reactions and the racial differences were even greater in the area of income. One quarter of the white veterans earned more than $20,000 while only eleven percent of the Black and Chicano veterans fell into this earning category.

Kadushin et al. (1981) conclude that these findings do not support a causality effect between combat experience, education, and income. Rather, they suggest that stress reactions can develop as a result of heavy combat experience and, thus, interfere with one's ability to complete his education to his own satisfaction, therefore interfering with his successful pursuit of his career. They conclude, "...there are current environmental conditions that can, under circumstances which are not determined, interact with heavy combat to reduce or to maintain stress reactions dependent on the nature of the condition" (Kadushin, Boulanger, and Martin, 1981, p. 62).

Card (1983) also found higher unemployment, lower job prestige and lower income for Vietnam era
veterans, particularly, combat Vietnam veterans. They found the income deficit to remain as late as 15 years after return to civilian life, even when educational, racial and other differences were controlled. However, Card found neither a significant association with occupational achievement in terms of job prestige and hourly or yearly pay and PTSD nor a significant association between the intensity of the combat experience and subsequent occupational achievement. Card concludes, "...a person can be troubled by combat stress disorders and yet function competitively on the job. The strains become evident in nonwork-related areas of human functioning" (Card, 1983, p. 114).

Church/social, civic, and professional organizations. Card's study was the only study to examine variables for other social network supports including: church, social and civic organizations, and professional and charitable organizations. Of these, they found only participation in church activities to be associated with reduced incidence and severity of PTSD. They found no association with variables relating to community size.
Help Seeking Factor

*Increased symptomatolog*... In terms of help seeking, Kadushin, (1981) found that talking to just anyone may not be helpful to the veteran and is not associated with lower rates of stress reactions. However, talking with a Vietnam veteran about Vietnam can be very helpful. They found that the more PTSD symptoms a veteran had, the more likely that he had sought help. However, seeking help with a therapist who was not specially trained in work with Vietnam veterans, did nor reduce the rate of stress reactions. Thus, they conclude that therapists in general may not always be helpful to veterans.

If we look only at men who reported PTSD symptoms during or in the first year after the war and who are combat veterans, then men who subsequently sought help for these symptoms are more likely than other men to have symptoms today. At the very least, there is no evidence in our data that seeing a professional who is not specifically trained in work with Vietnam veterans reduces the level of symptoms. However, this is not the case for Veterans who talked to Vietnam veterans friends. Men who reported symptoms during or a year after the war were less likely to report them today if, in the meantime, they had talked with veteran friends (Kadushin, 1985, p. 66).
Summary

In summary, PTSD follows a significant traumatic stressor and is characterized by a numbing period and a working through period. The numbing period is characterized by the more covert symptomatology of denial and avoidance. The working through period is characterized by the more overt intrusive repetitive symptoms such as nightmares or dreams of the event, flashbacks, intrusive thoughts of the event, and guilt about having survived.

The intensity of the combat experience is a critical factor contributing to the development of PTSD in combat Vietnam veterans. However, another critical issue is the characteristics of the individual in terms of his perceptions of his combat experience and how he interprets those into his functioning in civilian life. Further, it is individual as well as environmental characteristics which determine the final effects of the combat experience and the veteran’s ability to successfully work through the traumatic experience.

Any general kind of social support may or may not be helpful to a veteran; the crucial element in determining whether or not it is helpful is the circumstances in which the help was offered. Thus, the
mere presence of spouses, friends, or therapists did not in itself constitute support, but rather, the quality of the relationship constituted whether or not it was supportive.

The environmental characteristics contributing to the successful working through of the traumatic experience consist of various social supports, leading the veteran to believe that he is cared for, valued, and a member of supportive network. The primary supports identified in the literature were relationships with spouses and other close relationships, education, income, and occupation.

The Vietnam veteran may not have experienced a supportive cultural environment in which to work through his combat experience. Personal experiences based on levels of support, occurring both at the time of homecoming and since his return from combat, have also affected the veteran's ability to work through the combat experience.

This exploratory study was designed to examine the relationship between the Vietnam veterans' perception of level of various social supports at homecoming, the time of initiating treatment, and currently and the degree of symptomatology experienced at these points. The
following chapter discusses the methods used to implement this study.
CHAPTER III
METHODS AND PROCEDURES

RESEARCH DESIGN

The research design employed is a correlational design. Correlational studies include "all those research projects in which an attempt is made to discover or clarify relationships through the use of correlational coefficients (which express in mathematical terms the degree of relationship between any two variables)." The design reveals the extent to which the dependent variable is affected by the independent variable.

SAMPLING

The sample in this study is comprised of 35 make Vietnam veterans that received services from VET CENTERS located in Atlanta, Georgia; Orlando, Florida; and Chicago, Illinois. The VET CENTER is designed to provide the Vietnam veteran with an opportunity to receive professional services and referrals through non-traditional approaches. The goal of the VET CENTER is to identify Vietnam-era veterans residing in the Atlanta area through
outreach into his/her community and to link them with all available resources. Permission to use the facility was granted by Mr. Del Perkins, Director of the Atlanta VET CENTER, and Mr. Willie Chappell, therapist at the VET CENTER. Survey questionnaires were mailed to VET CENTER team leaders in Orlando, Florida and Chicago, Illinois. These team leaders administered, collected and returned the surveys to the researcher.

The participants were selected by using convenience sampling. This involves taking whichever elements are readily available to the researcher. This style of sampling was chosen due to the fact that it was nearly impossible to identify all persons of the Vietnam veteran population. Nonetheless, the researcher acknowledged the possible limitations of generalizability, for it tends to reduce the utility of findings based on the availability of samples. Moreover, this sampling style proved to be most economical.

As the Vietnam era veteran came into the VET CENTER, the staff informed the veteran of the
survey and requested that he complete the questionnaire. The respondents were insured that the confidentiality of the veterans would be preserved and the results of the study would be made available to all participants. After the Vietnam veteran completed the questionnaire, it was returned to the VET CENTER staff.

INSTRUMENTATION

The instruments used to collect the data were: Family Relations Index, Psychosocial Adjustment Index, and Demographic Variables Index by Hudson and Nehemkis, Macari, and Lettieri. The survey was then distributed to a group of male Vietnam veterans at the VET CENTER. Mr. Del Perkins, Mr. Willie Chappell, and other staff members assisted in the distribution and collection of the questionnaire. Similar instrumentation occurred in VET CENTERS in Orlando, Florida and Chicago, Illinois.

STATISTICAL ANALYSIS

There will be no significant increase in stress reactions of male Vietnam veterans with
post-traumatic stress disorder based on increased levels of social support.

The appropriate statistical tests to be used are correlational coefficient. The correlational coefficient is "an index of the relationship between two variables." It indicates both the strength and the direction of a relationship. The level of measurement required for using the correlation coefficient is the interval or ration scale. There is one important limitation to using this statistic that must be acknowledged. The correlation between variables does not necessarily mean causality. "Just because one variable is labeled independent and another dependent, and a relationship is found between them, does not prove that changes in one variable cause changes in another. However, valid and reliable conclusions may be drawn. Chi square, a statistic used to test the independence of two factors, and Cramer's V, a statistic used to determine the relationship between variables, will also be presented."
CHAPTER IV

FINDINGS

This study sought to explore the proposition that lack of social supports and the experiences of combat are associated with the development of PTSD symptomatology. Through the use of survey questionnaires, data was collected on thirty five Vietnam combat veterans. The following descriptive report of these thirty five veterans, their combat experiences, their PTSD symptoms and their social supports may be useful in understanding PTSD.

We attempted to show through the use of cross-tabulation tables, Chi-Square, levels of significance and Cramer's V a relationship between the dependent variable, stress reactions, and the independent variables, combat experience, current life stresses/supports, life stresses/supports at time of treatment, and life stresses/supports the time of return from Vietnam.
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TABLE 2

THE CONTINGENCY TABLE ANALYSIS OF STRESS REACTIONS AND THE INDEPENDENT VARIABLES

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## TABLE 3

**CURRENT SYMPTOMS**

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<th>Occ</th>
<th>O</th>
<th>VO</th>
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<td>Being startled by noises that remind you of Vietnam:</td>
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<td>11</td>
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<td>6</td>
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<td>Verbally abusing others when angry:</td>
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<td>12</td>
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### TABLE 4

**CURRENT SOCIAL SUPPORTS**

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SUBJECTS' CHARACTERISTICS

The thirty five respondents ranged in ages from 35 to 53 years at the time of the survey. At the time they entered the service, their ages ranged from 17 to 28 years and at the time they entered combat their ages ranged from 17 to 30 years.

Twenty-eight subjects (80%) were white males; Five (14.3%) were black males; one (2.9%) American Indian; and one (2.9) respondent identified himself as Cajun.

Twenty-one (60%) of the respondents were married; four (11.4%) subjects were separated; eight (22.8%) were divorced; and two (5.7%) never married.

Educationally, 48% of the subjects reported having completed high school prior to entering the service. 31% reported they had completed some grade/high school. Fourteen of the subjects reported having completed college after leaving the service. Of this group, one reported completing graduate school. Nine subjects reported completing
some college after service while seven subjects reported they had completed some high school.

Twenty-six (74.3%) of the subjects reported being employed full time, two part-time, and seven (20%) were unemployed.

Table 1, Demographics, reports the ages of each veteran when he entered the service as well as when he entered combat. It reports current marital status, either single (S), separated (SP), or divorced (D). The veteran's educational attainment prior to his military experience is reported as well as his current educational attainment. The educational categories include: some high school (S/HS); completed high school (HS); some college (SC); completed college (C); and completed graduate school (GS). It reports present employment status with "unem" referring to unemployed, and "E/FT" referring to employed, full-time. Additionally, it reports whether or not the veteran is presently receiving treatment (P) and how long he has been in treatment; if he has completed treatment (C) for PTSD symptoms and how long he received treatment; or if he has never received treatment (N/A).
COMBAT EXPERIENCES

Fifteen of the subjects were drafted into the service and twenty voluntarily enlisted. Thirty-three subjects never considered evading the draft and two did consider it. Twenty-two subjects reported being strong supporters of the war, ten supported it, two reported not having an opinion, and one reported not supporting the war.

Intensity of the Combat Experience

The subjects were asked to evaluate the degree of their combat experience by answering three questions on the survey questionnaire. Those questions were: "How often did you kill the enemy?", "How often did you see dead enemy?"; and "How often did you see dead GIs?". To the question, "How often did you kill the enemy?", six reported killing the enemy "very often" or "on a daily basis". Eight veterans responded "often", ten reported they killed the enemy "occasionally", while seven responded "rarely" and the remaining four reports they "never" killed the enemy.

To the question, "How often did you see dead enemy?", fifteen veterans reported "very often" or
"on a daily basis". Ten responded "often". Eight responded "occasionally", and defined that as "once a week". The final two veterans responded "rarely".

One of those defined rarely as being only "three or four time the whole time I was in Vietnam" but added that he "saw a lot of dead civilians".

Responding to the question, "How often did you see dead GIs?", Eight responded "very often" or "daily". Seven responded "often", or "two or three times per week". Fifteen reported "occasionally". Three responded "rarely" and three reported never seeing any dead GIs.

**PTSD SYMPTOMS**

PTSD symptoms were evaluated by the veterans' recollections of those at homecoming and currently. Because of the number of symptoms reported, the following discussion will examine the aggregate data, rather than the individual data.

Table 3, Current Symptoms, shows the frequency of the aggregate reported symptoms. Of particular interest is the finding that 37% of these veterans rarely that they do not hit others when angry. 51%
have tried to injure themselves, and 73% felt as if they "died in Vietnam". Two of these veterans report "never" feeling empty inside. Two report they "never" have difficulty controlling their anger. Fifteen of these veterans have difficulty expressing their feelings. Thirty four of these veterans reported some difficulty trusting others: ten reported "occasionally", twelve "often", and twelve "very often".

The results of the findings can be stated as follows:

**HYPOTHESIS 1**: There will be no significant increase in stress reactions based on combat experience.

The results of the contingency table analysis showed \( X^2 = 30.5, \text{df} = 2, \text{level of significance} = P<.0000 \) and Cramer's \( V = .933 \). With these results, we reject the null hypothesis and accept the research hypothesis that there is a significant relationship between stress reactions and combat experience.
HYPOTHESIS 2: There will be no significant relationship between stress reactions and current life stresses/supports.

The results of the contingency table analysis showed $X^2 = 43.0$, $df = 4$, $P < .0000$, and Cramer's $V = .784$. With these results, we reject the null hypothesis and accept the research hypothesis that there is a significant relationship between stress reactions and current life stresses/supports.

HYPOTHESIS 3: There is no significant relationship between stress reactions and life stresses/supports at the time treatment is initiated.

The result of the contingency table showed $X^2 = 21.0$, $df = 4$, $P < .0003$, and Cramer's $V = .547$. With these results, we reject the null hypothesis and accept the research hypothesis that there is a significant relationship between stress reactions and life stresses/supports at the time treatment is initiated.

HYPOTHESIS 4: There is no significant relationship between stress reactions and life stresses/supports at the time of return from Vietnam.
The results showed $X^2 = 31.6$, df = 4, $P < .0000 =$, and Cramer's $V = .672$. With these results, we reject the null hypothesis and accept the research hypothesis that there is a significant relationship between stress reactions and life stresses/supports at the time of return from Vietnam.
CHAPTER V

DISCUSSION

This study sought to explore the association between social support, combat, and PTSD symptomatology through the use of survey questionnaires with 35 combat Vietnam veterans. Generally, this study found an association between combat and PTSD symptomatology and, to a lesser extent, an association between social supports and PTSD symptomatology.

The most significant finding of this study was the high correlation between the intensity of combat and PTSD symptomatology as reported by the 35 veterans in this sample. That is, higher levels of reported combat experience are associated with higher levels of reported PTSD symptomatology. This finding supports the environmental perspective which maintains that the combat experience has a significant and long-lasting effect on the lives of these veterans (Card, 1983; DeFazio, 1975; Engendorf, 1981; Foy, 1984; Friedman, 1986). However, it should be noted that this study does not rule out either the predispositional theory which argues that predisposing personality deficits
are the primary factors associated with the development of PTSD (Borus, 1973; Figley, 1978; Panzarella et al., 1978; Worthington, 1977) nor does it rule out newer alternative theories which suggests that both predisposing personality characteristics and the experience of combat combine as factors in the development of PTSD (Green, Wilson, and Lindy, 1985; Parson, 1984; Hendin, Pollinger, singer, and Ulman, 1981). This study was not designed to evaluate and compare these various theories. Rather than supporting or disproving theoretical underpinnings, the intent of this study was to examine the association between combat experience, social supports, and the development of PTSD.

The 35 veterans included in this study reported higher levels of PTSD symptomatology at homecoming than currently. The veterans who reported the highest levels of PTSD symptomatology at homecoming also reported the lowest levels of social support at homecoming. This finding is consistent with the literature which suggests that psychological isolation at homecoming is the single best predictor of PTSD (Wilson & Krauss, 1985).
Taken one step further, the data reveal that those veterans who reported the highest levels of PTSD symptomatology and the lowest levels of social support at homecoming were also the veterans who later sought treatment for PTSD. This provides further evidence for the suggestion that the lack of support experienced by the veteran is associated with the development of PTSD.

The association between current PTSD symptomatology and current social supports were less clearly related in this sample. Specifically, low levels of reported current social support were not always associated with high levels of current PTSD symptomatology; and high levels of current social support were not always associated with low levels of current PTSD symptomatology. However, the data do suggest that as time went on, social supports were reported as being increasingly helpful to these veterans. This could be a function of the veterans' increased capacity to utilize the supports in their environments, or it could be a function of the environment becoming more receptive to the needs of the veterans. It seems highly possible that these two phenomena were
occurring simultaneously. That is, the veterans may have become more able to utilize supports in their environments and at the same time, their environments became increasingly aware of and receptive to the needs of these Vietnam veterans.

FINDINGS RELATED TO THE LITERATURE

The findings of this study support some of the previous findings documented in the literature. The intent of this study was to explore the associations of combat, social support, and PTSD symptomatology. However, it also explored other factors including: the age at the time the veteran entered combat; the period of the war in which the veteran engaged in combat; his education; and his marital status. The following section will review the findings and the pertinent literature related to these findings.

Combat and PTSD Symptomatology

The association between the combat experience and the ages of these five veterans at the time that they entered combat supports the literature indicating the increased vulnerability of adolescents to PTSD as a result of combat (Parson,
1984; van der Kolk, 1985). That is, the younger the GI at the time that he entered combat, the greater the likelihood that he would later suffer from PTSD symptoms. In this sample, the veterans who were the youngest at the time they entered combat reported the greatest amount of PTSD symptomatology at homecoming. The veteran who was the oldest when he entered combat later reported the least amount of PTSD symptomatology both at homecoming as well as currently and never sought treatment for PTSD symptoms.

The period of the war in which the veteran entered combat was not associated with the severity of PTSD in these 35 veterans, contrary to what is suggested in the literature. Egendorf, Kadushin, Laufer, Rothbart, and Sloan (1981) found an association between the severity of PTSD symptoms and the intensity of the combat exposure, and that this association was even more pronounced in veterans serving after 1968. In this study, the veterans who entered combat prior to 1968 reported equally high levels of PTSD symptomatology as those who entered during 1968, regardless of their reported intensity of the combat experience. The
veteran who entered combat in 1969, reported intense combat, but surprisingly, reported the least amount of PTSD symptomatology both at homecoming and currently. Therefore, age at the time the veteran entered combat may be a more salient variable in predicting PTSD than the period of the war in which combat occurred.

Social Support and PTSD Symptomatology

Twenty-one veterans were married, four were separated, eight were divorced and two had never married. The four divorced veterans reported the highest levels of current symptomatology. Kadushin, Boulanger, and Martin (1981) suggest that PTSD is higher in unmarried men who had combat experience. They also suggest that men who received little spouse support are more likely to report higher levels of PTSD. They conclude that not being married is more helpful to combat veterans than to be married to an unsupportive spouse. The finding that the two veterans in this study who have never been married but report the lowest levels of current symptomatology coincides with Kadushin's conclusion that not being married
at all may be more beneficial than being married to an unsupportive spouse.

Educationally, these 35 veterans follow the patterns suggested in the literature that, the more combat the veteran has experienced and the less education he has acquired, the more likely he is to later exhibit PTSD symptomatology (Kadushin, Boulanger & Martin, 1981). Of these 35 veterans, those who had some college before going to Vietnam reported the least symptomatology at homecoming. However, these veterans were also the oldest at the time they entered combat. If a GI entering combat had already had some college it is highly likely that he also would be older than those GIs who had only completed high school. Therefore, it is difficult to know whether age or education is the more critical variable in determining the predictability of PTSD among Vietnam veterans.

Kadushin et al. (1981) suggests that PTSD reactions interfere with the veteran's ability to complete a desired level of educational attainment, thereby interfering with his successful pursuit of career. Twenty of these veterans were able to acquire higher levels of education after the
military. Three of the veterans completed graduate school and six completed college. Since 25 of them exhibited stress symptoms, this finding does not support Kadushin's proposition that stress reactions interfered with the pursuit of education. Again, other factors may have contributed to their successful pursuit of education.

The data reveal some association between educational achievement and social supports. Two of the veterans who completed graduate school reported the highest levels of current social support. All 20 veterans who completed further education reported higher levels of social support currently than at homecoming. The one veteran who reported no change in the level of social support since homecoming was also the veteran who did not pursue further education. It should be added that this veteran is the veteran who does not work and prefers not to work. It may be that, because he is not interested in pursuing a career, he may simply not be interested in pursuing a higher education or that he is too stressed to pursue goals and ambitions in any arena.
LIMITATIONS OF THE RESEARCH

This study is limited in its applicability to all combat Vietnam veterans because it is a small, homogenous sample. The majority of the veterans in this sample were white. A more representative sample would have included more ethnic minority veterans.

By using a predominantly structured format, the subjects were less able to provide subjective information. A more open-ended format would allow for more opportunity for the subject to qualitatively describe his experiences. Also, it would be desirable to conduct in-person interviews for qualitative purposes rather than resorting to the use of survey questionnaires.

IMPLICATIONS FOR FUTURE RESEARCH

Further research would take into consideration some of the limitations of this study, previously described. Specifically, further research would include a more heterogeneous sample including more minorities and more veterans with lesser education achievements.
The Black GI made up an important part of the American combat force in Vietnam. The literature suggests that Blacks and Chicanos are more likely to suffer from stress reactions than whites (Kadushin et al., 1981). A good understanding of how social supports are associated with PTSD symptom development would not be complete without further knowledge of the experiences of the Black veterans. Further research would explore levels of social support in various ethnic minorities.

Of interest to the findings of this study was that although PTSD symptoms did not interfere with the educational achievements of most of these veterans, perhaps it did have a negative effect on their employment experiences. Of the 21 veterans who are currently employed full-time, one was disbarred (although the circumstances of this event are unknown) and another reported a history of fighting with employers. Of the eight who were not currently employed, seven preferred to be employed and the others preferred not to be employed. Because this study did not seek to explore the details of employment or educational histories, further information regarding those experiences
would be necessary before conclusions could be
drawn. Further research regarding social support
might include more detailed, qualitative
exploration of employment and educational
achievements with their association with social
supports.

The literature suggests that Vietnam veterans
benefit from relationships with one another
(Kadushin, 1985). Of the 35 veterans in this
sample, only six reported having relationships with
other Vietnam veterans. Without further
understanding of why these veterans did not have
relationships with other veterans, it is difficult
to understand the meaning of that finding and to
draw any conclusions about the helpfulness of
Vietnam veterans to one another from this sample.
Further research might explore the meaning of the
presence or absence of such relationships.

Findings regarding the age of the veteran at
the time he entered combat, corresponded with the
literature (Parson, 1984; van der Kolk, 1985)
indicating that the younger the GI, the greater the
likelihood that he would later experience PTSD
symptoms. However, the findings were less clear
about the association between the time of the war in which the veteran entered combat and later development of PTSD symptoms. Future research might wish to control for both variables and examine these associations in a larger sample.

The present knowledge base and clinical understanding of predicting PTSD is still in its earliest stages. This study attempted to explore lack of social supports as a factor associated with symptom development. If it could be determined that lack of social supports were a factor in symptom development, one could hypothesize that maintaining positive and qualitative social supports would reduce the likelihood of PTSD. Information such as this would be helpful in contributing to a growing body of knowledge regarding the constituents of a healing environment which leads to recovery.

Green, Wilson, and Lindy (1985) stress the importance of a supportive healing environment producing favorable conditions for the veteran to examine his experiences and work through his feelings. They go on to suggest that if the veteran’s general environment is adequately
supportive, then it alone may constitute a healing environment and the veteran may be able to work through his combat experience without entering into therapy. However, if the general environment is not adequately supportive, psychotherapy may provide the bridge between the general environment and the support needed to work through the combat experience.

The findings from this study indicate that there is some correlation between the veteran's lack of social support and symptomatology. Thus, if the veteran does enter psychotherapy, the clinician might encourage the development of such a supportive environment in the veteran's life. Further research might explore in greater detail the relationship between the lack social supports and the development of PTSD symptomatology, by incorporating some of the aspects described in this section.

**CLINICAL IMPLICATIONS**

The findings from this study confirm the importance of a thorough combat history in the diagnostic assessment, especially when the veteran
presents with covert symptoms (as defined in the DSM III-R) which are not easily recognizable as part of the PTSD constellation. Often the veteran is unaware that his combat experiences may have an effect on his current personal problems. Clinicians are often remiss in identifying the subtleties of the covert symptoms and in connecting them with the correct diagnosis. Without a thorough combat history, these symptoms are easily confused with other diagnostic categories including character disorders and sometimes schizophrenia. The DSM III-R has included an elaboration of the covert symptoms of PTSD which will hopefully make clinicians more acutely aware of the true meaning of those symptoms and prompt clinicians to further explore the combat histories from the link to correct diagnosis.

A final aspect of critical importance for clinicians is their countertransference about American combat veterans. Regardless of age, all Americans have been affected by the war in Vietnam on some level. Vietnam has had a great emotional impact on this country. All clinicians need to closely examine their own countertransference
around these significant issues, since they may incorrectly assess and diagnose a Vietnam veteran based on their own denial or unresolved emotional reactions to this trouble time in our collective history.

**SUMMARY**

Clinicians must be acutely aware of the complexities in assessing and diagnosing PTSD. It is essential to go beyond the possibly repressed feelings which may both be a part of the veteran's presentation and be a part of the clinician's countertransference. The clinician must be attuned to the necessary constituents of a healing environment, which may vary according to the individual veteran, just as the dynamics in the psychotherapeutic process may vary.

Finally, the clinician must be sensitive to the veteran who continues to deny the significance which Vietnam may hold on his life today, even though his personal and professional life may be fraught with turmoil and instability. For it may be these defenses which have allowed functioning to be as adequate as it is, even though the clinician may feel that functioning could be improved by
successfully working through some of the unresolved feelings about the combat experience. These defences may still be extremely important for the veteran in warding off the anxiety of working through the trouble past. However, when therapeutic relationship provides enough support for continued or enhanced ego functioning, the veteran may be able to relinquish his defenses enough to work through the trauma of his Vietnam experiences.

It is time that America heal itself and its warriors. Now, more than a decade after the Vietnam war ended, there are some indications that this country is ready to begin to deal with its own PTSD. It seems that we as a country are beginning to feel that it is collectively safe to come out of the denial phase that we have been in and to begin to deal with our own guilt and shame about Vietnam.

It is the moral obligation of all Americans, as well as clinicians, to accept Vietnam veterans so that they may accept themselves. As clinicians, we should encourage and facilitate this process by beginning to provide a healing environment for veterans as well as non-veterans.
Healing is inclusive, whereas whatever we battle against we exclude and despise. And so from a healing perspective, it is self-defeating to try to reject what we see as unworthy or threatening in ourselves or others. Healing occurs as we develop openness, care, and vision to cast in a worthy light whatever appears before us. Healing asks us not to banish, domesticate, or pacify the warriors, but to honor and cherish him; not to exclude him from healing, but to welcome him to create and play his own unique role (Egendorf, 1985, p. 250).

Without healing first ourselves, we cannot expect that veterans too will be healed.

As J. Edwin Smith (1987) so eloquently illustrates in his article, "Coming to Terms with the Guilt," even those of us who did not go to Vietnam may suffer secondary to our guilt about Vietnam. Although Smith did not go to Vietnam, he suffered from many PTSD symptoms as a reaction to the loss of his brother who died there. He eloquently describes the anguish and the pain that he suffered and a moment of healing when he visited the Vietnam war memorial in Washington, D.C.

For a brief moment, the sobs erupted, and he shook uncontrollably. He heard a jet pass overhead. Later, the quiet of the night was broken by the thumping of a helicopter. And then, almost miraculously, the tears stopped, and that stranger -- the animal that he had become -- disappeared. The beast just got up and
walked away. It slithered away and died. I returned to the monument the next day, feeling alive for the first time in years. Something I had allowed to be taken away from me had been miraculously restored. Call it healing, if you like (Smith, 1987, p. 18).

CASE ILLUSTRATIONS

To further understand the meaning of the statistical data presented and to portray the recounted experiences of these veterans, three case illustrations will be presented. The first will represent a veteran in treatment for PTSD whose scores suggest that he is currently symptomatic, the second will represent a veteran who has never been in treatment for PTSD and whose scores suggest that he is asymptomatic, and the final case will illustrate a veteran who has completed treatment for PTSD and whose scores suggest that he is currently asymptomatic.

Veteran: Calvin

Calvin is a 38-year-old, white Vietnam veteran who is currently in treatment for PTSD. He is divorced, has had one marriage and two children by that marriage. Prior to entering the service,
Calvin had completed some high school and, since being discharged, has completed college. Calvin is unemployed because of disabilities resulting from combat injuries but would prefer to be employed full time. He receives between 75 and 100 percent Veteran's disability compensation for combat injuries. He does volunteer work on a full-time basis.

Calvin enlisted into the Army when he was 18 years old and entered combat in Vietnam when he was 19 years old. He states that he was a strong supporter of the war when he enlisted and never considered evading the draft. His tour of duty in Vietnam lasted from February, 1968 until December, 1968, when he was injured. While in Vietnam he served as a fire team leader and his rank was Spec 4. He was involved in direct combat arms. He reported firing his weapon at the enemy, killing enemy, seeing dead enemy, and seeing dead GIs on a daily basis. Of all of the veterans in this sample, he reported the greatest degree of combat. Calvin regularly currently experiences the same symptoms that he did at homecoming. Those symptoms include sleep disturbances, nightmares about
Vietnam, intrusive thoughts about Vietnam, flashbacks about Vietnam, being startled by noises that remind him of Vietnam, feeling depressed, having difficulty trusting others, having difficulty expressing feelings, and feeling jumpy.

At the time that Calvin returned from Vietnam, he had no relationships with people that he considered as supportive with the exception of his parents. Even that relationship was sometimes problematic. He considered his religious beliefs to be the only positive support in his life.

Calvin initiated treatment for PTSD more than 10 years after discharge from the Army when he separated from his wife. He describes his difficulties with his wife as being "the problem which aggravated my condition." However, when asked why he sought treatment he said, "I got tired of living. I was living like I was continually in combat. I knew it (the reason for seeking treatment) was combat related." Although Calvin has been in treatment for 3 years, he reports no changes in his ability to cope with his combat experience since his return from Vietnam. This seems to be an accurate assessment since his
reported symptoms and their frequency have remained the same. However, the realm of Calvin’s social supports have expanded considerably since his return from Vietnam and again since he initiated treatment 3 years ago. His support network has increased in size to include children, parents, friends, a therapist and other Vietnam veterans. At homecoming he reported only his parents and religious beliefs as consisting of his support network.

When asked for any comments in general, Calvin somewhat solemnly reflected, "It was a silent war when we came home. A war between the vets and the anti-war people. It was all a mental game. I tried to keep it beneficial for me. It’s not a silent war for me now."

The seeming paradox of Calvin is that although his social supports have increased, he shows no changes in the degree of reported PTSD symptomatology. However, it is important to note that it is not unusual for someone in therapy to remain in pain and to remain symptomatic. In fact, that may be part of the therapeutic process.
Veteran: Martin

Martin is a 40-year-old, white combat Vietnam veteran who has never received treatment for PTSD and whose scored indicate that he is relatively asymptomatic. He did enter couple’s therapy with his wife for a year prior to their divorce. Martin has had one marriage and has two children from that marriage. Prior to his military experience, Martin had completed some college. After the service, he completed law school, however, he was later disbarred and no longer practices law. (It is unclear what the circumstances of his being disbarred are and whether that is secondary to PTSD reactions.) He is full-time employed in a family business. He receives between 10 and 25 percent Veterans' disability compensation for injuries received in combat.

Although Martin enlisted in the Army when he was 19 years old, he states that he did not support the war. He added that he thought that he enlisted as a rebellious act toward his parents who expected him to complete college. He was a first lieutenant and served in the Green Beret and was 21 years old when he entered combat. He explained that as a
member of the Green Beret, he was not a member of a platoon, but rather was trained to go into combat either along or perhaps with one other soldier. Most of his combat missions involved spending many days in the jungle with only one other American soldier and many Vietnamese, it was generally considered that at least 25 percent were thought to have been Viet Cong.

Upon return from Vietnam, Martin experienced some sleep disturbances but quickly adds that it was only because things were too quiet for him in the hospital where he was recovering from his wounds. More recently he reports that on rare occasions he experiences intrusive thoughts about Vietnam, feels depressed, or feels jumpy or nervous. He admits to occasionally experiencing an inability to control his anger and when asked if he ever hits people when he is angry he stated, "No, they would be dead if I did." When asked if he ever felt if he had "died in Vietnam" he responded, "My innocence died in Vietnam."

Martin reports that his relationships with his parents and children are very helpful. He also reports his support group as being very helpful,
but then adds that he is his "own support group." He has no relationships with other Vietnam veterans. Having recently divorced, he reported that his relationship with his ex-spouse is very problematic. The impression that he portrays is that he is very self-sufficient, as the Green Beret trained him to be, and that he prefers to do things himself rather than to depend on others. He does, in fact, very often have difficulty in expressing his feelings and in trusting others. When asked if he had any comments in general about his experiences in Vietnam he responded, "I played the game well and I am not proud of it either."

The seeming paradox of Martin is his firm stance that Vietnam is behind him and has nothing to do with his life now; however, he does seem to have difficulties which are not inconsistent with similar problems of other veterans suffering from PTSD, i.e. problems with relationships and in employment. It may be that his difficulties are secondary to predisposed personality characteristics or it could be a combination of both, as is often the case. The decision to seek treatment may come (if at all) only after his
problems become so painful that relief can only be found in therapy. On the other hand, he may continue to function in much the same way that he has since Vietnam, and this may remain satisfactory to him, as it seems to have been for these years since Vietnam.

**Veteran: Earl**

Earl is a 37-year-old white, Vietnam veteran who sought treatment for PTSD symptoms within the first five years after he returned from Vietnam. When he initiated treatment, he did not consider his difficulties to be related to his combat experiences. "I didn’t like my life style. I was moving from job to job and getting into fights at work. I was an angry person and didn’t know what I wanted to do."

Earl stayed in treatment for three years. Since then he has completed graduate school and works as a psychologist with combat Vietnam veterans. He has never been married and has no children but says that he hopes one day to be married and is currently involved in a serious relationship.
Because Earl thought he was about to be drafted, he joined the Army when he was 17 years old. He entered combat when he was 18. He served in Vietnam from November, 1976 to November, 1968 and his rank was E5. As an interpreter for special forces in Laos, he lived in Vietnamese villages and although he carried a weapon, he was not routinely involved in combat. He normally fired his weapon at the enemy a couple of times each month and thought he may have killed enemy three times. He rarely saw dead enemy or dead GIs but often saw dead Vietnamese civilians.

When Earl returned from Vietnam, he was very often plagued with overt symptoms of PTSD. He was constantly startled by noises that reminded him of Vietnam. He frequently suffered from sleep disturbances, nightmares, intrusive thoughts, and flashbacks about Vietnam. He has difficulty controlling his anger and often would hit others or verbally abuse others when angry. He was depressed, jumpy, and nervous. He felt empty inside and felt like he had "died in Vietnam." He had a lot of difficulty trusting others and expressing his feelings. Although sports, hobbies,
and his relationship with his parents were helpful to him at that time, he had few other supports. He did not have a relationship with a significant other. He had no religious convictions or ties, and he had no relationships with other Vietnam veterans. Relationships with friends, including sexual relationships, and relationships at work were really a major problem for him.

Now, 20 years after Earl first arrived in Vietnam, he is almost completely asymptomatic; however, Vietnam remains an integral part of his life and of who he is. On rare occasions, he still loses his temper, but no longer has to physically act out that anger by striking others. Occasionally he still has nightmares, sleep disturbances, and intrusive thoughts about Vietnam. He often still has difficulty trusting others.

Earl’s struggle to recover has included three years of his own therapy as well as the sublimation of his energies into his life work of continuing the process by working with others including Vietnam veterans. He reports that his relationships with his parents, friends, "significant other", and support group are very
helpful to him. He reports his relationships with other Vietnam veterans, relationships with his boss, hobbies, and sports are helpful to him.

Through the use of his own personal strengths and the use of the environment around him, Earl has managed to successfully achieve a much more adaptive style of life than he reported at the time he returned from Vietnam. It seems evident that he was able to capitalize on his own internal resources as well as the external resources in his environment.

Summary

This chapter has reported on demographic data and qualitative measures in the areas of combat experiences, PTSD symptoms, and social supports. In addition, qualitative data were presented through the use of case illustration.
BIBLIOGRAPHY


APPENDIXES

APPENDIX A..........................Consent Form
APPENDIX B..........................Questionnaire
APPENDIX A

Informed Consent Form:

Factors Associated with Combat Related Stress in Vietnam Veterans

The purpose of this study is to explore with Vietnam veterans factors associated with combat related stress problems.

I understand that participation in this study will involve completing a uniform questionnaire for Clinical Social Work Intern, John C. Smith, who will ask me questions about:

1. My age, education, family and occupation.
2. My military background.
3. Any stress reactions I may have had.
4. My current and past life stresses and supports.
5. Treatment I might have received for these problems.

I understand that participation in this study may not directly benefit me but that the information obtained from me may lead to a better understanding of the problems of combat Vietnam veterans.

I understand that the information obtained from this study will be confidential. I understand that the information obtained from me will be used only in terms of anonymity and without revealing my identity. I consent to the publication of the study results as long as the information is anonymous and disguised so that no identification can be made.

I understand that there is a strong possibility that some of the questions may arouse or remind me of important emotional experiences. I understand that I may decline to answer any question that I prefer not to answer, and that I may withdraw from the study at any time without prejudice to my future care.

I have read and understand the above explanation and voluntarily consent to participate in this study.

Date ___________________________ Signature of Participant

I certify that I have presented the above information to the participant and have secured his consent.

Date ___________________________ Signature of the Investigator
APPENDIX B
INTERVIEW QUESTIONNAIRE

Part I: Demographic Information

1. Present Age: ________________________
   Date of Birth: ________________________
   Dates of Service in Vietnam: __________

2. Sex: 
   (1) Male
   (2) Female

3. Race or Ethnicity:
   (1) American Indian or Alaskan Native
   (2) Asian or Pacific-Island American
   (3) Mexican American
   (4) Black
   (5) White
   (6) Other: ____________________________

4. Education:
   (1) Completed grade school or less
   (2) Some high school
   (3) Completed high school
   (4) Some college/trade school
   (5) Completed college
   (6) Completed graduate school

4a. Education Prior to Military Experience:
   (1) Completed grade school or less
   (2) Some high school
   (3) Completed high school
   (4) Some college/trade school
   (5) Completed college
   (6) Completed graduate school

5. Marital Status:
   (1) Married
   (2) Separated
   (3) Divorced
   (4) Single

5a. Number of Marriages: ________________

6. Employment Status:
   (1) Employed full-time
   (2) Employed part-time (and like it this way)
   (3) Employed part-time (but don't like it this way)
   (4) Unemployed (and like it this way)
   (5) Unemployed (but don't like it this way)

6a. Are you currently receiving VA disability benefits and if so what percent of compensation?
   (1) Not disabled or not getting compensation
   (2) 0-10 percent
   (3) 11-25 percent
   (4) 26-50 percent
   (5) 51-75 percent
   (6) 76-100 percent

6a. Is any percent of this disability compensation for Post-Traumatic Stress Disorder?
Part II: Military Background

9. What branch of the service did you serve in?
   (1) Marines
   (2) Army
   (3) Air Force
   (4) Navy
   (5) Coast Guard

10. What rank were you?
10a. What position did you serve in your platoon?

11. How old were you when you entered the service?
11a. Entered combat?

12. How did you enter the service?
   (1) Enlisted
   (2) Enlisted after the draft notice
   (3) Drafted
   (4) Activated from reserve unit

13. Did you ever consider evading the draft?

14. What did you think of the Vietnam war when you entered the service?
   (1) I was a strong supporter.
   (2) I supported it.
   (3) Didn't really have an opinion.
   (4) I did not support it.
   (5) I was strongly opposed to it.

15. Were you injured (which required hospitalization) during the military?
   (1) Yes, it was combat-related.
   (2) Yes, it was not combat-related.
   (3) No.

16. What was your primary assignment in Vietnam?
   (1) Combat arms: either field, navy or air duty.
   (2) Direct combat support.
   (3) Support: rear echelon.

17. How often did you fire your weapon at the enemy?
   (1) Very often
   (2) Often
   (3) Occasionally
   (4) Rarely
   (5) Never

18. How often did you kill the enemy?
   (1) Very often
   (2) Often
   (3) Occasionally
   (4) Rarely
   (5) Never

19. How often did you see dead enemy?
   (1) Very often
   (2) Often
   (3) Occasionally
   (4) Rarely
   (5) Never

19a. How often did you see dead GIs?
   (1) Very often
   (2) Often
   (3) Occasionally
   (4) Rarely
   (5) Never
Part III: Stress Reactions

Please consider whether you presently experience any of the following and the frequency of them.

20. Sleep disturbances?

21. Nightmares about Vietnam?

22. Intrusive thoughts about Vietnam?

23. Flashbacks about Vietnam?

24. Being startled by noises that remind you of Vietnam?

25. Inability to control your anger?

26. Do you hit other people when you are angry?

27. Do you verbally abuse others when you are angry?

28. Have you ever tried to injure yourself?

29. Do you ever feel depressed?

30. Do you feel empty inside?

31. Do you ever feel that you died in Vietnam?

32. Do you have difficulty trusting others?

33. Do you have difficulty in expressing feelings?

34. Do you feel nervous or jumpy?
Part IV: Stress Reactions

Please consider whether you had any of the following experiences in the first year after you returned from Vietnam and the frequency of them:

<table>
<thead>
<tr>
<th>Experience</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>35. Sleep disturbances?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>36. Nightmares about Vietnam?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>37. Intrusive thoughts about Vietnam?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>38. Flashbacks about Vietnam?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>39. Being startled by noises that remind you of Vietnam?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>40. Inability to control your anger?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>41. Do you hit other people when you are angry?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>42. Do you verbally abuse others when you are angry?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>43. Have you ever tried to injure yourself?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>44. Do you ever feel depressed?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>45. Do you feel empty inside?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>46. Do you ever feel that you died in Vietnam?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>47. Do you have difficulty trusting others?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>48. Do you have difficulty in expressing feelings?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>49. Do you feel nervous or jumpy?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>
Part V: Current Life Stresses and Supports

Please consider each of the following items to determine whether they present problems for you or if they are helpful for you and rate them accordingly:

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship with your spouse:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>Relationship with your children:</td>
<td>(3) (4) (5)</td>
</tr>
<tr>
<td>Relationship with your parents:</td>
<td>(6)</td>
</tr>
<tr>
<td>Friends:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>Support Group:</td>
<td>(4) (5) (6)</td>
</tr>
<tr>
<td>Relationship with your therapist:</td>
<td>(6)</td>
</tr>
<tr>
<td>Relationships at work:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>(4) (5) (6)</td>
<td></td>
</tr>
<tr>
<td>Sexual activities with your significant other:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>Sexual activities with others (excluding your significant other):</td>
<td>(4) (5) (6)</td>
</tr>
<tr>
<td>Use of alcohol:</td>
<td>(6)</td>
</tr>
<tr>
<td>Use of drugs:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>(4) (5) (6)</td>
<td></td>
</tr>
<tr>
<td>Relationships with other Vietnam veterans:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>(4) (5) (6)</td>
<td></td>
</tr>
<tr>
<td>Hobbies:</td>
<td>(6)</td>
</tr>
<tr>
<td>Sports in which you participate:</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>(4) (5) (6)</td>
<td></td>
</tr>
<tr>
<td>Relationship with your boss:</td>
<td>(6)</td>
</tr>
<tr>
<td>Religious Beliefs or Affiliations</td>
<td>(1) (2) (3)</td>
</tr>
<tr>
<td>(4) (5) (6)</td>
<td></td>
</tr>
</tbody>
</table>
Part VI Life Stresses and Supports at the Time that Treatment was Initiated

Please consider each of the following items in terms of your life situation at the time you began treatment and evaluate whether they were helpful or problematic for you at that time. If you have never been in treatment for Post-traumatic stress reactions, you may go on to Part VI.

<table>
<thead>
<tr>
<th>Item</th>
<th>Very Helpful</th>
<th>Helpul</th>
<th>not a Problem but also not helpful</th>
<th>Sometimes a Problem</th>
<th>Really a Problem</th>
<th>Does not apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>66. Relationship with your spouse:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>67. Relationship with your children:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>68. Relationship with your parents:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>69. Friends:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>70. Support Group:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>71. Relationship with your therapist:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>72. Relationships at work:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>73. Sexual activities with your significant other:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>74. Sexual activities with others (excluding your significant other):</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>75. Use of alcohol:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>76. Use of drugs:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>77. Relationships with other Vietnam veterans:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>78. Hobbies:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>79. Sports in which you participate:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>80. Relationships with your boss:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>81. Religious Beliefs or Affiliations:</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
</tbody>
</table>
Part VII: Life Stresses and Supports at the Time of Return from Vietnam

Please consider each of the following items in terms of your life situation at the time that you returned from Vietnam and evaluate whether they were problematic or helpful for you at that time.

<table>
<thead>
<tr>
<th>Item</th>
<th>Very Helpful</th>
<th>Not Helpful</th>
<th>Sometimes a Problem</th>
<th>Really a Problem</th>
<th>Does not apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>82. Relationship with your spouse:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>83. Relationship with your children:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>84. Relationship with your parents:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85. Friends:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86. Support Group:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>87. Relationship with your therapist:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88. Relationships at work:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>89. Sexual activities with your significant other:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90. Sexual activities with others (excluding your significant other):</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>91. Use of alcohol:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92. Use of drugs:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93. Relationships with other Vietnam veterans:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>94. Hobbies:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95. Sports in which you participate:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96. Relationships with your boss:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97. Religious beliefs or Affiliations:</td>
<td>(1) (2)</td>
<td>(3) (4)</td>
<td>(5) (6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Part VIII: Therapy

The final section deals with any treatment you may have received for combat related stress reactions and the reasons for seeking treatment.

98. Have you ever received treatment for combat related stress reactions?
   (1) Yes
   (2) No

99. Are you currently receiving treatment?
   (1) Yes
   (2) No

100. How long did you receive treatment, or if presently in treatment, how long have you been in treatment?
   (1) Less than 3 weeks
   (2) 3 weeks-3 months
   (3) 3 months-1 year
   (4) 1-2 years
   (5) 2-5 years
   (6) more than 5 years

101. How long after discharge from the service did you wait before initiating treatment?
   (1) within the first 3 months after discharge
   (2) within the first year after discharge
   (3) within the first 5 years after discharge
   (4) 5-10 years after discharge
   (5) more than 10 years after discharge
   (6) never initiated treatment

102. Did you initiate treatment voluntarily?
   (1) Yes
   (2) No

103. Were you encouraged by family or friends to initiate treatment?
   (1) Yes
   (2) No

104. What do you see as the reasons for which you initiated treatment?

105. Have you noticed any differences since your discharge from the service in your ability to cope with your combat experience?

Thank you for participating in this study. Even though it may not benefit you directly, it is hoped that the information learned from this study will contribute to a better understanding of the problems of combat Vietnam veterans.

Is there anything which you feel is important to the understanding of combat Vietnam veterans and their stress reactions which was not covered in this questionnaire?

Any other comments in general?

How did you feel while you were responding to these questions?

Do you think you need to talk with anyone about this experience?

Thank you again.