THE VIETNAM VETERAN AS A DISASTER VICTIM

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The introduction of the term post traumatic stress disorder in the DSM III has been one of the most important recent conceptual advances for clinicians working with victims of overwhelmingly stressful events. It has brought together a seemingly disparate collection of diagnostic entities including the post disaster syndrome, war neurosis, battle fatigue, K.Z. syndrome and P.O.W. syndrome and highlights the ubiquity of the emotional responses which individuals manifest when faced by such extraordinary traumas. Its main diagnostic points are the presence of a stress outside the range of normal experience, a subsequent psychic numbing and reduced involvement with the external world in parallel with a persistent re-experiencing of the trauma, and an associated cluster of dysphoric and autonomic symptoms.

Although the concept and clinical description grew out of work by Lifton, Shatan, Bourne, Horowitz and Figley on Vietnam veterans, it has direct relevence to survivors of natural disasters. I have been struck by the marked similarity of the symptomatology, emotional responses and coping skills employed by both the Vietnam veterans and Granville train crash survivors that I have had in therapy. From this perspective it could be argued that the 50,000 Australian Vietnam veterans constitute the survivors of the largest man made disaster in the past quarter century of our history. A disaster which took 494 lives, injured or maimed 2,398 and has left a steadily growing legacy of psychopathology.

Four commonly described features of a disaster are

a) a high level of psychological stress accompanied by a fear of death and annihilation

b) a sense of powerlessness

c) the arbitrary and inexplicable nature of the event which leaves the individual grasping for a meaning behind what has occurred and

d) a sense of guilt at surviving.

Each of these features can be applied directly to the experiences of Vietnam veterans. As well as the stress engendered by witnessing the horrendous injuries and deaths caused by mines, sniper fire and primitive booby traps, there was a constant and pervasive sense of threat in that the soldier could never feel entirely safe, not even in camp or while on leave nor could he ever be sure who the enemy was. In addition to these obvious threats, there were the more mundane stresses of a totally alien culture, a harsh and inhospitable climate and the risk of

debilitating tropical diseases. In terms of powerlessness, over one third of the Australian soldiers in Vietnam were conscripted National Servicemen rather than volunteers. Compounding this, the Vietnam conflict was essentially a guerilla operation, the enemy attacked without warning and disappeared into the native populace leaving no definable object to strike back at. This engendered a powerless rage and frustration which sometimes spilled over onto innocent civilians.

Soldiers would often find it hard to comprehend why they were in Vietnam and why they were being subjected to these dangers with few positive results to be seen other than body counts and "pacified" hamlets. These confusions and doubts were heightened by the fact many locals who were being "saved" would often view the soldiers with suspicions or as targets for sharp practices. In the large cities, they were confronted with rampant corruption, prostitution and drug addiction, while at the same time newspapers from home were full of reports of anti-Vietnam demonstrations. The culminating event for many veterans in convincing them of the futility of what they had been through was the fall of Saigon to the North Vietnamese in 1975, an event which left many with a stinging sense of rage, bewilderment and betrayal.

Survivor guilt, especially among men who had served in combat units and had lost close friends, continues to be a heavy and persisting legacy. An example is the patient who, as a conscientious and popular infantry corporal, had developed a paternal protectiveness to the younger and more inexperienced men in his platoon. While he was briefly hospitalised for a gastric complaint they stumbled into a mined area and suffered several casualties including two deaths. He came to feel directly responsible for the injuries and deaths and on his repatriation he unconsciously indulged in a whole cluster of self defeating and potentially self-destructive behaviours in a futile attempt at reparation and expiation.

It has been demonstrated in both disaster and military operations that group support and cohesion play a major protective role and when these break down the level of psychiatric dysfunction increases rapidly (Boman, 1979). Two contrasting examples from the disaster literature are Aberfan (Williams & Parkes, 1975) and Buffalo Creek (Titchener & Kapp, 1976). While on the whole Australian soldiers in Vietnam had a high level of morale and group cohesion, a number of factors tended to increase the alienation they experienced. Unlike earlier wars where the soldier went to battle and came home with his unit, a significant number travelled to Vietnam as individuals on commercial aircraft, joined an already existing unit for exactly twelve months and then returned by themselves. Base units especially tended to have people rotating through them without any opportunity for any *esprit de corps* to develop. Not surprisingly support troops had the highest rate of psychiatric

casualties, especially alcohol abuse and conduct disorders (Boman, 1982). In addition, on their return Vietnam veterans did not experience the same outpouring of community welcome and gratitude which their fathers had been accorded at the end of W.W.II. Not infrequently they were stigmatised by their peers as inhuman monsters who had enthusiastically participated in the slaughter of innocent women and children. Families often displayed a degree of ambivalence in their welcome, feeling that the soldier had abandoned them and it has often been reported that veterans' families neither wished, nor were able to comprehend the nature of what they had been through. One study has shown that in the six months following repatriation, 38% of veterans' marriages disintegrated (Wilson, 1979). Compounding this sense of alienation was the fact that the labour market had tightened considerably in their absence and many veterans reported that they were actively discriminated against by employers. In Totem and Taboo, Freud (1960) pointed out the vital importance of community prescribed rituals and support in removing the soldier's warrior status, sanctioning the aggressive acts he had indulged in and reintegrating him in the social matrix. Veterans in therapy describe the first few years after coming home as possessing an unreal, dreamlike and isolated quality; a time when they lacked a sense of direction, belonging or stability, and when the main task seemed to be to forget their Vietnam experiences. Physically in Australia, they were psychologically still in Vietnam. Perhaps Bettelheim (1979) best summarises the importance of social support at times of stress: "One cannot meet catastrophic events and survive when deprived of the feeling that somebody cares".

A defence commonly observed in the community when dealing with threatening events, is to blame the victim for his own misfortune. This has happened to Vietnam veterans in the U.S. where they have been discriminated against by the American Legion, and portrayed in movies and TV dramas as walking time bombs or depraved dope fiends, responsible for their country's first major military defeat.

Clinical Profile of Hospitalised Vietnam Veterans

To illustrate the kinds of clinical problems that are being experienced by Australian Vietnam veterans, the profiles of the last 25 hospitalised under my care in the psychiatric unit at the Concord Repatriation General Hospital in Sydney will be described. The data comes from standard, non-directive assessment interviews, information gathered from families and material that subsequently surfaced in therapy.

The average age of the patients was 34 years and their average length of stay was 22 days. The main presenting problems are listed in Table 1, their current social backgrounds in Table 2, details of Vietnam service in Table 3 and some major develop mental variables in Table 4.

As can be seen, quite a disconcerting picture emerges. Almost invariably the veteran's hospitalisation was associated with some behind a scene of domestic crisis and violence. form of impulsive "acting out" and he was often brought to hospital in a context of some drama, frequently escorted by police, very often under the influence of alcohol and in many cases leaving behind a scene of domestic crisis and violence.

TABLE 1

FREQUENCY OF PRESENTING COMPLAINTS AMONG HOSPITALISED VIETNAM VETERANS AND CURRENTLY SERVING MILITARY CONTROLS

PRESENTING PROBLEM	VIETNAM VETERAN %(N=25)	CURRENT MILITARY %(N=25)	(X^2) $p \leq .05$
DEPRESSION	88	52	SIG
ALCOHOL ABUSE	84	40	SIG
IMPULSIVE VIOLENCE	56	36	NOT SIG
SUICIDE ATTEMPT	40	36	NOT SIG
CHRONIC PAIN	44	-	
DRUG ABUSE	40	12	SIG
POST TRAUMATIC STRESS DISORDER	40	4	SIG

TABLE 2

CURRENT PSYCHOSOCIAL BACKGROUND VARIABLES
AMONG VIETNAM VETERANS AND MILITARY CONTROLS

SOCIAL DYSFUNCTION	VIETNAM VETERAN %(N=25)	CURRENT MILITARY %(N=25)	(X^2) $p \leq .05$
SIGNIFICANT MARITAL DYSHARMONY	44))84	36))52	SIG
DIVORCED - SEPARATED	40)	16)	
SEXUAL DYSFUNCTION	44	32	NOT SIG
UNEMPLOYED FOR LAST 3 MONTHS	48	-	
LEGAL PROBLEMS SINCE REPATRIATION OR LAST 10 YEARS	44	32	NOT SIG

TABLE 3

DETAILS OF VIETNAM SERVICE
(REGULAR ARMY 20, NATIONAL SERVICE 5)

	FREQUENCY % (N=25)
COMBAT ROLE, HIGH STRESS, EXPOSURE TO DEATH AND INJURY	44
SUPPORT ROLE, HIGH STRESS AND DANGER	24
SUPPORT ROLE, LOW STRESS AND DANGER	32
POST TRAUMATIC STRESS DISORDER	
ACUTE	16
CHRONIC	40
SERIOUS DISCIPLINARY INFRINGEMENTS	28

NOTE 36% of the currently serving comparison group had serious disciplinary infringements in the 18 months before hospital admission.

TABLE 4

FREQUENCY OF DEVELOPMENTAL VARIABLES

	VIETNAM VETERAN %(N=25)	CURRENT MILITARY %(N=25)	(X^2) $p \leq .05$
PARENTAL VIOLENCE AND CONFLICT	36	44	NOT SIG
PHYSICAL ABUSE	24	24	NOT SIG
PARENTAL SEPARATION OR BEREAVEMENT	24	44	SIG
PATERNAL ALCOHOLISM	44	36	NOT SIG
NEUROTIC, CONDUCT PROBLEMS	24	32	NOT SIG

The veteran's current level of psychosocial functioning was frequenly seriously impaired. In some 84% there was either marital disruption or break up, often linked with repeated violence directed towards the spouse or children. Almost half had been unemployed for the three months before their admission and a similar percentage had been convicted of offences since their repatriation. Crimes included murder, fraud, assault, possession of drugs and repeated driving under the influence charges. One of the sample has subsequently been murdered and one has suicided.

During their tour of duty in South Vietnam, two thirds were exposed to high levels of stress or danger, almost half were in combat and witnessed scenes of death and mutilating injury. Forty percent of the veterans manifested symptoms and signs diagnostic of a post traumatic stress disorder (PTSD) at the time of their hospitalisation. All the troops that had been in combat exhibited features of a PTSD; those with a PTSD who came from support units had all been exposed to considerable stress and danger. While serious disciplinary infringements were frequent in Vietnam, they were almost always confined to men in comparatively low stress support roles.

The problems of many men in the sample, however, date back to well before Vietnam. The fact that in the hospitalised sample the ratio of volunteers to National Servicemen (80% vs 20%) was greater than in the army in Vietnam (63% vs 37%) would suggest a bias toward psychopathology. Volunteers in both the Australian and American forces tended to become psychiatric casualties during their tour of duty more often than conscriptees (Boman, 1982). It often emerges in therapy that the decision to enlist in the first place was an attempt at coming to grips with adolescent crises around masculinity, independence and self esteem. These insecurities can be understood when it is realised that the veteran's early environment was often characterised by parental conflict, violence and separation, physical abuse and paternal alcoholism. Almost a quarter had manifested significant neurotic or conduct disturbances during their childhood years.

Clinical Profile of Hospitalised Currently Serving Military

The question that arises is how many of these presenting problems can be attributed to Vietnam and how many might be the expected psychopathology among a group of disturbed young adult males from a military background. In an attempt to answer this, the 25 currently serving, aged-matched, army members who had most recently been hospistalised under my care were compared on the same variables. The details are listed in tables 1,2 and 4.

It can be seen from Table 1 that while the same overall pattern of depression, alcohol abuse, violence and suicidal behaviours emerged, their frequency was less in the currently serving group. The most important clinical difference between the two groups was the almost total absence of post traumatic stress disorder among the non-Vietnam troops. The marked difference between the two groups in psychogenic pain disorder was an interesting and unexpected finding.

It might be suggested that those currently in the armed services, being in a structured and disciplined environment, might be less at risk for "acting out" behaviours, though one could also argue that it was the stress of the Vietnam experience, itself, that may have pushed the veterans in the direction of explosive violence, subsequent depressive reactions and the palliative use of alcohol. Likewise, one of the more frequently observed dynamics in psychogenic pain disorders is the inability to come to grips with feelings of guilt and anger, effects which were inevitably linked to the Vietnam experience.

It is also possible that the Vietnam veterans had a significantly more disturbed developmental milieu, predisposing them to psychopathology in later life. However, when the groups were compared on developmental variables, a similar pattern was found (Table 4).

The overall conclusion is that while a group of hospitalised Vietnam veterans display impulsive, "acting out" psychopathology similar to a hospitalised military group who had not been overseas, they do so with somewhat greater frequency and, in addition, 40% display features of a post traumatic stress disorder. Psychogenic pain disorder, often linked with drug abuse, occurred frequently among the veterans but not in the presently serving group. The excess of psychopathology among the veterans cannot be explained in terms of more disturbed early backgrounds.

Hospitalised Veterans Compared with Veterans at Large

Among hospitalised American Vietnam veterans, the same symptom cluster of anti social behaviours, alcohol abuse, somatization disorders, suicide attempts. aggressive outbursts and depressive reactions has been reported. They also have high levels of conflict in intimate relations and developmental backgrounds characterised by violence, separation and parental alcoholism (Strange and Brown, 1970; Braatz and Lumry, 1969). When compared with personnel currently in the military, hospitalised U.S. veterans had higher frequencies of psychopathology, especially stress related symptoms and somatization disorders (Strange and Brown, 1970). Is this level of violence and impulsivity in hospitalised veterans representative of the whole population of returnees?

There are few Australian studies directed to this question, however the highly publicised reports of increased suicide rates among Australian veterans have been shown to be unfounded. Sensational claims suggesting 470 have died at their own hands were not borne out either in figures presented to the recent Senate Standing Committee enquiry (Senate Standing Committee on Science and the Environment, 1983) or by a Repatriation Department survey among Victorian veterans. It is likely that the rate in Australia is no higher than expected from a matched group of adult males in their early thirties. In contrast, in the U.S., serving in the military during the years of the Vietnam conflict without going there (i.e. Vietnam era veteran) is associated with a 23% increased suicide rate (Presidential Review Memorandum on Vietnam-era Veterans, 1978).

American studies suggest that Vietnam veterans exhibit no higher levels of violence and criminal behaviour than Vietnam era veterans (who had no service in Indo China) (Presidential Review Memorandum on Vietnam-era Veterans, 1978), or currently-serving, non-combat military personnel (Strange and Brown, 1970) or young adult working class males (Starr, 1973) and that their rate of criminality is no greater than would be predicted from their premilitary behaviour and backgrounds (Nace et al., 1978).

Rates for alcoholism among Vietnam veterans have been demonstrated to be between 8 and 16% (Nace et al., 1978; Goodwin, Davis and Robins, 1975), not dissimilar to that for U.S. males in general (Cahalan and Room, 1974; Ewalt, 1981) and compare

favourably with those from Vietnam-era Veterans, (between 13% and 31%) (Presidential Review Memorandum on Vietnam-era Veterans, 1978; Ewalt, 1981) and currently serving U.S. military personnel (11%) (Burt, 1982). Likewise, while there was a slight tendency for Vietnam veterans who had seen heavy combat to abuse drugs more frequently, overall, there was no difference between veterans and controls (Ewalt, 1981).

Several American studies have demonstrated a clear relationship between combat stress and subsequent development of a post traumatic stress disorder. The relationship has little to do with the soldier's background but is associated with a number of social suport variables including the perception of the helpfulness of one's family on repatriation, the rapidity of discharge from the army and the level of support given by one's soldier friends (Egendorf, Kadushin and Laufer, 1981; Frye and Stockton, 1982; Martin, 1981). In one seemingly healthy and well functioning sample of veterans, 43% continued to display features of a post traumatic stress disorder (Frye and Stockton, 1982). A number of studies have also reported the ubiquity of depressive reactions among veterans (Strange and Brown, 1970) with a direct relationship to the degree of combat stress experienced in Vietnam (Helzer, Robins and Davis, 1976). There is the suggestion though, that depression is not such a persisting problem as post traumatic stress disorder (Helzer, Robins and Davis, 1976).

The Atypical Symptoms of Hospitalised Veterans and Current Serving Military

As a group, U.S. Vietnam veterans continue to suffer from depressive reactions and post traumatic stress disorder in rates greater than controls and in direct relationship to combat stress. However they are no more likely to be violent, alchoholic, drug dependent or convicted of criminal offences than others in their age group. If these American data can be transferred to Australian veterans, then it can be reasonably assumed that the impulsive violence, legal difficulties, alcohol and drug abuse and suicidal behaviours of the Vietnam group at Concord Repatriation General Hospital are not at all representative of Australian Vietnam veterans as a whole. In addition, this symptom cluster was observed both among our hospitalised veterans and our currently serving group. The prevalance of post traumatic stress disorder (40%) was very much like that described among a group of well functioning U.S. veterans (43%), and its absence in the controls reinforced the point that this is the main psychiatric disorder associated with service in Vietnam. Likewise, the high level of depression among the veteran group is consistent with U.S. findings that the condition is also linked with Vietnam service, and it is of note that the controls suffered from it some one third less frequently.

If hospitalised Vietnam veterans, both in this country and the U.S., are so atypical when compared with the rest of returnees, what are the diagnostic and psychotherapeutic implications? I wish to offer a highly impressionistic, clinical and decidely non scientific explanation:
The impulsivity and low frustration tolerance of the hospitalised veterans, their propensity for non-adaptive violence, frequent episodes of depression, difficulties with interpersonal relationships which have both highly unstable and deeply dependent qualities, and their abuse of alcohol and drugs are all suggestive of borderline personality functioning. In the ward milieu, they frequently demonstrate these features in their behaviour with staff and other patients, and are often surrounded by a highly charged ambience of *Sturm und Drang*. As with borderlines, they are very adept at stirring up conflicts among staff, half of whom come to see the veteran as a victim of government deception and horrendous war stresses, needing to be given extra amounts of TLC and protection; while the other half view him as a manipulative psychopath escaping his family responsibilities and malingering to obtain fraudulent compensation. Other borderline features which tend to emerge with time are a deep sense of entitlement and a chameleon like tendency to become part of whatever group they have contact with at the moment. A not uncommon phenomenon is that veterans with little or no combat experience indentify strongly with those who have, to the extent that they internalise all the details of enemy contacts, fire fights and dramatic "dust offs" and then relate them as if they were their own. It is my strong clinical impression that many of these patients latch on to the role of "Vietnam veteran" as if this were their only source of identity, self-esteem and purpose, and that without it, there would be little security in life for them to cling to. This is very reminiscent of Kernberg's description (Kernberg, 1975) of the borderline's constant search and need for external organisations and groups with which he coheres and identifies in an attempt to overcome his lack of an integrated self concept.

Conclusion

I have described here much that is common to victims of disasters and to Vietnam veterans and how significant numbers of veterans continue to have depressive reactions and stress related symptoms. Despite this, the great bulk of veterans have been able to reintegrate into society and lead lives which contain a measure of stability and satisfaction. There remains, though, a small group of highly visible, angry and chaotic individuals with many borderline traits, requiring frequent hospitalisations, and whose Vietnam experiences make up but one part of their deprived and disorganised lives. Clearly, to focus on this group's twelve months in Vietnam to the exclusion of all else would be to do them a grave therapeutic disservice, just as it is to say that all their personality difficulties, marital disruptions and psychosocial dysfunctions are due to chemical poisoning about which nothing can be done except to write them a cheque and send them on their way.

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