

AN ABSTRACT OF THE THESIS OF

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Title: A PROPOSED SUBTYPE OF POST TRAUMATIC STRESS

DISORDER: COMBAT TRAUMA SYNDROME

Abstract approved:

A handwritten signature in cursive script, appearing to read "Philip J. Whitt", written over a horizontal line.

This paper proposes a subtype, Combat Trauma Syndrome, to the diagnostic category of Post Traumatic Stress Disorder (PTSD) as included in the Diagnostic and Statistical Manual, Third Edition, 1980 (DSM III, 1980), by the American Psychiatric Association. Combat Trauma Syndrome is hypothesized to be a specific type of PTSD. This paper delineates the factors inherent to the acquisition of this particular subtype.

The proposed Combat Trauma Syndrome incorporates components of Eriksonian, Existential, and Psychoanalytic concepts of ego and identity. These concepts of ego and identity are seen to be the foundation of Combat Trauma Syndrome subtype of PTSD.

This paper addresses two specific levels of response to trauma and details the outcome of both. Concepts of guilt and shame are dealt with as the result of the behavioral response to the trauma of combat. The concept of layering of feelings and emotions is addressed as well as a new theoretical concept, Momentary Psychosis. The Momentary Psychosis concept is defined and differentiated from the Brief Reactive Psychosis, as defined and cited in DSM III, 1980.

Implications for treatment of PTSD, Combat Trauma Syndrome, are provided. These include specific issues of grief and spirituality.

Suggestions for research are also included in this paper. Five subtypes of PTSD are hypothesized for further clarification. Finally, four levels of anger are suggested and explanations of each are provided.

A PROPOSED SUBTYPE OF POST TRAUMATIC
STRESS DISORDER: COMBAT TRAUMA SYNDROME

WOUNDS THAT DON'T BLEED

by

Robert W. Hayes

A thesis

submitted in partial fulfillment

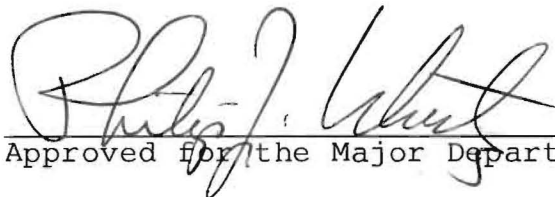
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Most of all, to Dr. Ron Karst, the one who believed in me from the very beginning: believed that I could do with others what I was not sure of in myself. Thank You.

Finally, to my Lord, for bringing me all the way Home.

DEDICATION

To my children, that they may never know the horror of war, that war's legacy will spare them this dreaded knowledge of the dark side of man . . .

War is the tragedy of error, bias, and lack of understanding in man--the reactions of man come too soon before he's stepped up in bias and hate. Leaders dismiss the educational process of universal levels. Perhaps greed is the cornerstone of war and many times man has stumbled on its tragedy. The most profitable image in man is that which education creates; the most destructible quality of any change that man creates is in the war he makes in his fellow man.

Lord, let my words be education to my children that they will not destroy their fellow man as . . .

FOREWARD

Thoughts By A Young Veteran

The years others knew as youth, I spent learning the meaning of Death. The times others spent learning to love, I passed hoping to live through endless nights. The moments others remember as laughs in classrooms, I remember as terror in the jungle. The instants of pleasure taken for granted by others, I remember as forgotten hopes--long ago crushed by the reality of war.

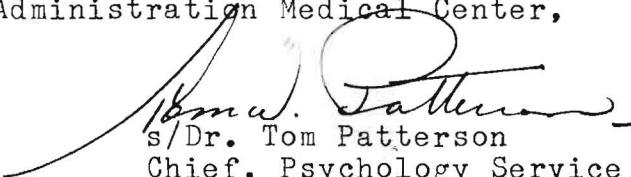
The unfulfilled dreams of others are yet to be thought by me since I am in search of my elusive youth, looking for years lost in combat, which are no more--and never will be.

(George L. "Sky" Skypeck)

About The Author

Mr. Hayes began employment with the VA system with the opening of a new inpatient treatment unit for Vietnam veterans suffering from Post Traumatic Stress Disorder in July, 1982. A Vietnam combat veteran himself, Mr. Hayes has brought a blend of his own understanding of the effects of war, his academic training in psychology, and his unique humaneness in working with non-veteran staff members and with the combat patients. He has developed approaches to treatment that blend these factors together. His ability to risk, to confront, and to support has provided new treatment approaches and motivation

to improve for the Vietnam veterans on the unit. His compassion has aided many in dealing with long denied feelings of grief. He recognizes the unspoken, hidden emotional needs of the veterans and responds in ways that bring them to consciousness in order to resolve them in a beneficial way. He offers his strength and his compassion to those in need and in fear. He has accompanied veterans to legal hearings, taken depressed patients on outings, relieved combat fears with some in the countryside, dealt with grief in cemeteries, in hospital groups, and in his arms. Although Mr. Hayes suffers a life-threatening disease himself, he provides others with the will to live and serves as a model for those finally coming home from Vietnam. (Text which accompanied Veteran's Administration Administrator's Hands and Heart Award, 1984, presented January, 1985, at Colmery O'Neil Veteran's Administration Medical Center, Topeka, Ks.)


s/Dr. Tom Patterson
Chief, Psychology Service

STATEMENT OF THEORETICAL
PROBLEM AND OBJECTIVE

With the advent of diagnostic and Statistical Manual III (DSM III) in 1980 came the diagnostic classification of Post Traumatic Stress Disorder (PTSD), under the broader diagnostic category of Anxiety Disorder. The essential feature of the disorder, as stated in DSM III, 1980, is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

DSM III, 1980, indicates that the stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). DSM III, 1980, further states the disorder is apparently more severe and longer lasting when the stressor is of human design.

DSM III, 1980, addresses course and subtype in its text. Subtypes are divided into separate categories by length of time from trauma to onset of symptoms. When the symptoms begin within six months of the trauma and have not lasted more than six months after the trauma or last six months or more, the chronic subtype is diagnosed. No prognosis is given.

Predispositional factors are addressed by DSM III, 1980, as "Preexisting psychopathology apparently disposes to the development of the disorder." There is no clarity to predispositional factors.

The objective of this paper is to focus on the diagnosis of PTSD as defined in DSM III, 1980. This paper will speak to the failure of this diagnosis, as defined and cited, to address the specific and sustained stressors of combat from the generic Post Traumatic Stress Disorder diagnosis.

Furthermore, this paper will address the key issue of sustained life threat and will point out the theoretical stages leading to the acquisition of what is herein labeled Post Traumatic Stress Disorder (PTSD), subtype Combat Trauma Syndrome.

For definitional purposes, DSM III, 1980, refers to "the essential feature....being the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience." Also stated in DSM III, 1980, is "the disorder is apparently more severe and longer lasting when the stressor is of human design." DSM III, 1980, makes no mention of sustained life threatening stressors that are unique yet common place in combat. In summary, neither the definition nor its qualifier of severity or duration, as cited in DSM III, 1980, address in any fashion the sustained and life threatening trauma of combat as being different in makeup or severity from generic PTSD.

Among topics addressed in this paper but not in DSM III, 1980, are specific grief and spiritual issues. These are hypothesized, in the context in which they will be used, to be content specific to PTSD, Combat Trauma Syndrome.

Additionally, this paper will address predispositional factors which DSM III, 1980, states "apparently disposes to the development of the disorder." PTSD, Combat Trauma Syndrome, is believed to have its roots deep in ones ability to assimilate and integrate life events into "self." Issues of self and pre-military identity become very important as predispositional factors leading to abrupt change in morals and values of the individual.

Other subtypes will not be addressed in detail, but will be hypothesized for future research. The focus of this paper will be pointing out the failure of DSM III, 1980, to address the anomalies which necessitates needs for inclusion in DSM III, 1980, of at least one additional subtype, Post Traumatic Stress Disorder, Combat Trauma Syndrome.

In summary, this paper is presented on the thesis that the continual exposure to the life threat of combat contains sufficient, distinctive elements which warrant a subtype of diagnosis specific to combat exposure; Post Traumatic Stress Disorder, Combat Trauma Syndrome.

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CHAPTER 1

Introduction: Concept of Self and Identity

Ego and Identity

In order to deal effectively with the conceptual theoretical framework of Post Traumatic Stress Disorder (PTSD) Combat Trauma Syndrome, it is necessary to address the concepts of ego and identity. It is hypothesized that Combat Trauma Syndrome (CTS) has distinctive differences from generic PTSD as cited in Diagnostic and Statistical Manual, Third Edition, 1980 (DSM III, American Psychiatric Association, 1980), due in large part to sustained life threat. Further, it is hypothesized that cultural fragmentation, the breakdown of societal norms, morals, values, and belief systems, itself a symptom of the rapid change and progression in society, had tremendous impact and influence on youth who served in combat. Identity and self concepts, based on this premise, are of prime import.

Fragmentation of culture during the late 1950's and 1960's was a symptom of emotional, psychological and spiritual disintegration, resulting in compartmentalization of these particular areas. Compartmentalization, as defined by J. P. Chaplin, 1975, speaks to "the isolation and blocking off of ideas, feelings, values and attitudes (p. 102)." This compartmentalization feeds the disintegration of each of the areas from their integrated role into society and resulting identity.

This compartmentalization, it is stated, resulted in strained concepts of ego and identity, and aided predisposition to anxiety neurosis, specifically PTSD, Combat Trauma Syndrome.

Erikson (1968) states that the process of identity formation begins at birth and progresses in increasing differentiation until death. Erikson states there is universal sequence of human development that is epigenetic in nature. The epigenetic sequence means that there is a constant interplay between genetically based aspects of personality and the motivational attributes of the person. This organismically based ground plan, together with socializing influences combine to form a series of psychosocial crises. In essence, a psychosocial crisis refers to a critical period of development that will contribute to the final form of identity structure. What gets contributed to the mature, adult identity is a function of how well a particular crisis is resolved.

In his theory, Erikson details eight psychosocial crises or "stages" of human development (Figure 2.). Most important in these eight stages is the fifth psychosocial crisis, Identity versus Role confusion, which usually occurs in late adolescence and young adulthood. This developmental period has as its "task" the need to form a more stable and enduring personality structure and sense of self in order to assume the various roles of adulthood and to meet adequately the demands that accompany them. This crisis is especially important since the doubts, uncertainties, insecurities as well as personal and social competencies of a person must be integrated into a

more coherent and enduring sense of self that links the historical past in continuity with the present. It is a time of emancipation from parents, increased responsibilities, career choice, early attempts at mutual intimacy and the recognition of one's abilities and limitations.

Erikson (1964) in Insight and Responsibility states, "Young people must become whole people in their own right, and this, during a developmental stage characterized by a diversity of changes in physical growth, in genital maturation, and in social awareness. The wholeness to be achieved at this stage I have called 'a sense of inner identity.' The young person, in order to experience wholeness, must feel a progressive continuity between that which he promises to become in the anticipated future; between that which he conceives himself to be and that which he perceived others to see in him and expect of him.

Individually speaking, identity includes, but is more than the sum of, all successive identifications of those earlier years when the child wanted to be, and was often forced to become, like the people he depended on. Identity is a unique product, which now meets a crisis to be solved only in new identifications with age-mates and with leader figures outside the family.

The adolescent search for a new and yet reliable identity can perhaps best be seen in the persistent endeavor to define, to overdefine, and to redefine oneself and each other in often ruthless comparison; while the search for reliable alignments

can be seen in the restless testing of the newest in possibilities and the oldest in values. Where the resulting self-definition, for personal or collective reasons, becomes too difficult, a sense of role confusion results. The youth counterpoints rather than synthesizes his sexual, ethnic, occupational and typological alternatives and is often driven to decide definitely and totally for one side or another (p. 91-92)."

Synthesizing issues of identity and role confusion with compartmentalization and the symptomatic fragmentation, understanding of the "self" becomes an extremely important, but largely incomplete stage for the youth who experiences combat in this highly complex developmental stage. The personality of the individual is theorized to be not yet crystalized at this crucial stage. Identity is but what one believes oneself to be, as stated above. However, the self, not being well integrated, is tenuous, at best.

Existential View of Self

Edwards (1982) addresses the issue of existential self process by stating, "Existential process is the process of being toward-the-future. Not that I have a future to live out that is inexorably predetermined, but one that is yet-to-happen depending on the choices that I make (p. 38)." Kierkegaard (1948) spoke to five possible conditions of life purpose, among which were the discoveries of self identity which owes its existence to a relationship that paradoxically redeems the meaning of aesthetic, and ethical experience (social duty).

Clearly, the existential view of self is focused toward the be-ing of the self. Edwards (1982) goes on to state, "Personality--persona--is the product of language and logic. It is the mask of self. Behind the mask, the be-ing is the word for that no-thing which cannot be represented by any other. Be-ing is not a property that can be added on to an object at hand, such as "the sky is blue." Be-ing is the is which makes possible the process of being me, as in the familiar saying: Be your self. In the process of be-ing me I have (possess) psychic images (objects) but I am in dread, despair, love, ecstasy. I am guilty, ashamed, penitent. These are existential processes not psychic processes. The existential process only occurs in the presence of another human being from whom I seek a caring response. In this moment of contact the vision of change is revealed (p. 38)."

To further tie together the important concepts of ego and identity with the pre-combat youth, it is necessary to address and define issues of assimilation and accommodation.

Assimilation and Accommodation

Hilgard and Bower (1975) deal with the issues of assimilation and accommodation. They note that the concept of assimilation is very similar to that of Herbart (1776-1841). That is, knowledge derived from the environment is not a mere passive registration through perception but depends on the prior experience fits.

This previous background is called an apperceptive mass, and Piaget calls it the child's schemes or structures. Piaget (19

uses the term assimilation for this process of "fitting in" or becoming a part of existing cognitive organization. Such assimilation is then the first part of the two part process of interaction between external reality and the child's own attained cognitive structure. The second part of the process consists of the child changing his scheme or structure somewhat so as to conform to the new external reality. This, then, is the process of accommodation.

Assimilation of ego and identity into the scheme of the individual's environmental experience, the self or be-ing, is the single most basic issue concerning the identity versus role confusion stage hypothesized by Erikson (1968) (Figure 2). Assimilation of this identity at this particular age (13-19) is inherent to each person and must be successfully completed to maturationally deal with future life experiences in a socially acceptable manner; in short to physically assimilate trauma as well as everyday situations into one's scheme, or self.

Attachment Theory

As an adjunct to Erikson and Edward's identity postulations, the attachment theory of cognitive dysfunction is addressed to further elucidate the importance of acquisition of self-identity and the concept of self, as well as to deal with messages given to the youth by cultural variables. Guidano and Liotti (1983) address three main arguments for explaining the etiology of cognitive dysfunction according to attachment theory. The first argument concerns the self knowledge the individual gains from the presence and behavior of other people

significant to the individual. Re-stated, the self image is structured through interactions with people who are in their environment. This serves to orient and coordinate the self perception until the individual is capable to perceive themselves accomplishing this task behaviorally. Second, the attachment of the individual to the domestic environment will probably not change their own cognitive style very much due to the identity gained from those close to them. Guidano and Liotti (1983) note, however, that the cognitive structure and resulting self identity "can be partially modified by the intervention of the following variables:

- *The kind of cultural stimulation provided by the family's social network.

- *The availability of alternative identification models in the social network.

- *The life events (illnesses, bereavement, financial changes, geographical moving, etc.) that occur during the course of development (p. 104)."

Third, if the individual has distorted self conceptions regarding basic aspects of his identity, this view of self will not only determine attitudes toward reality, but influence cognitive and emotional processes in their course. The subsequent interaction between the structures of personal identity and perception of reality will inevitably elicit a rigid and defensive attitude of oneself, expressed behaviorally as insecurity and inadequacy.

Guidano and Liotti (1983) speak to the theme of Erikson's identity versus role confusion resolution by stating, "After a slow gradual development, the adolescent seems well endowed

with the necessary abilities for an autonomous relationship with outside reality and for a formal organization of self-knowledge. Nevertheless, although the cognitive repertoire seems almost complete, its full use is usually delayed until early adulthood. Perhaps because of social influences that delay economic autonomy, but more likely because of repercussions of the very novel transformations that have taken place, adolescents seem much more prone to analyzing and observing the new cognitive and somatic endowments than to finding a practical use for them (p. 48)."

It is precisely this delay in the "cognitive repertoire" that is addressed in the foundational aspects of Post Traumatic Stress Disorder, Combat Trauma Syndrome. The focus of this introductory chapter and discussion chapter on Concept of Self and Identity is to bring to the forefront the issues which speak to late adolescence period of human development as the crucial point in which the healthy maturation of identity and ego is arrested for the youth as he enters combat.

Assimilation and Integration of Cultural Variables--Premilitary

In the previous discussion of ego and identity, a foundation speaking to the need for assimilation and integration of life events into the identity has been developed. In this section, issues of ego and identity will once again be addressed. However, the focus of this particular section of the paper will address the issues of identity and ego as they pertain to the relationship between the individual and his pre-military

environment. It is stated that this relationship with one's environment, specifically the cultural aspects of one's environment contains core issues of the predispositional factors not addressed by DSM III, 1980 in the generic diagnostic category of PTSD.

In discussion of the environment of the individual prior to his military service, one must consider the chemistry of that environment and its culture. Several issues are believed to be key in import with respect to cultural variables. Addressed herein are issues concerning the very makeup of the society the combat-bound youth grew up in and the messages he received from that society, comprised chiefly of family, friends and his community.

Cultural Variables--Post World War Two Society

The prevalent environment of America during the 1950's and 1960's was by and large influenced by a Post World War II society. Mothers-to-be had served their country working in war-related industry and factories. Fathers-to-be had entered the military for World War II and not only did their cultural "duty" but added passion to the performance of their duty, spurred on by national referendum and overwhelming support. The end result of this tremendous collective effort was a victorious nation in the largest global war ever undertaken. Patriotism became the watchword. Communism and all it stood for was the ultimate evil, the monster, threatening a patriotic God and His chosen country.

Korea came and went, addressed chiefly as a "conflict" with apparently no one understanding much of where it was and seemingly less regarding what it was about. Veterans of the Korean conflict returned home to much less than the ticker tape parades of World War II veterans.

Card (1983) addresses the issue of the returning veteran in terms of illuminating the differences between veterans of World War I, World War II, Korea, and the war in Vietnam. She points to the unpopularity of the Vietnam war as being the largest variable differentiating the Vietnam conflict from its predecessors.

Upon their successful return home, as addressed above by Card (1983), the World War II veteran typically found himself a respected and valued part of the community. As time wore on, patriotic expectations stemming directly from the victory in World War II dominated the American culture. The youth in the post World War II culture was the recipient of the resulting patriotic expectations.

Issues of Importance--1960's

Other cultural issues layered over the Post World War II messages from parents, friends and community, that were even more difficult to comprehend. Among these issues were the racial confrontations in the southern United States; the promise of birth and shock of death in the Camelot of John F. Kennedy; the threat to world peace brought home by the Bay of Pigs fiasco: but perhaps most intimidating of all to deal with was the threat of thermonuclear war.

One particular popular song of the 1960's speaks with clarity to the issues facing the youth of America in Post World War II society; Barry McGuire's "Eve of Destruction."

"The Eastern world, it is explodin'--
Violence flarin', bullets loadin'
You're old enough to kill, but not for votin'
And even the Jordan River has bodies floatin'.
Don't you understand what I'm trying to say--
Can't you feel the fears that I'm feelin' today?
If the button is pushed--there's no runnin' away
There'll be no one to save with the whole world
in a grave.

Take a look around you boy, it's bound to scare
you boy. . .
Yea my blood's so mad, feels like coagulatin'
I'm just sittin' here comtemplatin'
Can't twist the truth--it knows no regulatin'
Hand full of senators don't pass legislation
And marches alone can't bring integration
When human respect is disintegratin'
This whole crazy world is just too frustratin'. . ."

The culture of the 1960's was a time of controlled chaos. Almost anything was acceptable if it was dealing with the counterculture movement. However, contrasting this was the youth from rural America; the "All-American" youth. White makes right and do what your country says is your duty.

Vietnam, pre-1968, was largely supported by middle-class America. Southeast Asia had not yet been exposed to deeper probing by media and news coverage. There was at least some sense of pride to be detected early on in the war, 1965-1968. This pride is reflected by a verse from a song entitled "Ballad of the Green Beret" by Staff Sergeant Barry Sadler, United States Army, in 1965:

"Back at home, a young wife waits,
Her Green Beret has met his fate,
He has died for those oppressed
Leaving her his last request:

'Put silver wings on my son's chest--
Make him one of America's best.
He'll be a man they'll test one day;
Have him win the Green Beret.'

This theme was taken a step further by American hero John Wayne in the movie "The Green Berets", the story of the Special Forces, United States Army, in the Republic of Vietnam. The movie was a big hit and conveyed a message of duty, responsibility and the acquisition of manhood for age appropriate youth.

The acquisition of manhood coupled with the "duty to country" concept is perhaps the most powerful force in shaping the youth for military service. Although the draft was utilized, many young men enlisted in the Marine Corps and Army, which provided the bulk of the fighting forces in Vietnam. As previously noted, many parents, relatives, and communities passed on messages of expectation to the youth concerning his availability and duty for military service. Uncles who had been in World War II or Korea were always handy to "assist" the youth with assorted tales of glory or manhood to be attained by going "overseas." In short, the youth had received many messages of expectation given to him during the valuable, formative stages of Identity.

Summary

In summarizing the ego and identity issues coupled with the cultural variables of the pre-military identity it is necessary to recapitulate certain basic tenets.

First, the youth who was to serve in Vietnam struggled with the inherent needs to assimilate and integrate a sense of identity from the world around him.

Second, he had to complete, in some fashion, certain maturational tasks that would enable him to satisfactorily complete the age appropriate "Eight Stages of Man" as defined by Erikson, (1968) (Figure 2). Specifically, he had to tie together role identities he assumed willingly as well as dealing with role expectations placed upon him by the homogeneous community.

Third, he had to undergo physical changes in growth and awareness and to integrate these into his social world. This further speaks to the importance of the ego and identity issues as he changed, in some way, his ego-identity as he grew physically.

Fourth, he had to make very important identity decisions concerning his life based upon his understanding of his nubile and uncertain values, principles, and beliefs. As addressed, the youth had many ego identity issues to cull through and to subsequently combine with societal and parental expectations of him.

Theoretical Model of
Cognitive Processing--Combat
Trauma Syndrome

In the previous section of this paper, ego and identity issues have been discussed at length. The acquisition of morals and values, assimilated through life events and struggles with questions of identity has been addressed through discussion of pre-military cultural variables.

Due to the focus of this paper on Post Traumatic Stress Disorder (PTSD), 1980, and the hypothesized subtype Combat Trauma Syndrome (CTS), these previously addressed issues of ego and identity are carried into the combat arena itself for further explanation and study.

As indicated in Figure 1, it is stated that there are two levels of response to traumatic events available to the individual undergoing the trauma. A basic precept of this paper is that the youth who endured the trauma did not have a firm identity base upon which he could foundationally support the impact of psychic trauma in the form of sustained life threat and combat trauma itself.

The two levels of response seen being available to the soldier are identified as the Integrated Level of Response and the Pathological Level of Response. For purpose of definition, the Integrated Level of Response speaks to the successful integration and assimilation of life events both mundane and traumatic in nature, into the concept of identity of the individual. As depicted on Figure 1, the task of the individual

is seen as being to assimilate and integrate life events and resulting feelings and emotions into one's concept of self and the identity of self. The Integrated Level of Response then is seen as the mechanism by which one may achieve homeostasis in relation to his concept of ego-identity.

CHAPTER 2

Integrated Level of Response:
Psychic Assimilation

The integration and assimilation of life events is highly determinant on the ability of the individual to establish and maintain interpersonal relationships. If the individual can maintain stasis during the crisis event or events, or at the very least to only bend rather than break under the strain, he stands greater opportunity to achieve a more positive and mature sense of self. With this more positive and mature sense of self goes a more healthy self identity which is the interactional key to satisfying and rewarding interpersonal relationships.

The assimilation and integration of combat trauma into the ongoing identity of the individual is viewed by this author as something of an enigma. It is possible many combat participants who endured sustained life threat as well as severe trauma had stronger egos and their ego-identities were quite similar in nature with their sense of ego-ideal. It is this ability to maintain touch with who he is and who he believes himself to be that allows the individual to escape the trauma and move on to Healthy Coping, escaping the Pathological Level of Response and its resulting relative phases.

Stress Syndrome Response Pattern of Adaptation

This phase of response to trauma, because it is common to both the Integrated Level of Response as well as the Pathological Level of Response, is covered in detail in the section on Pathological Level of Response, specifically on Page 40. The Horowitz Model, Figure 3, details this phase.

Healthy Coping

Healthy Coping speaks to the ability of the individual who has undergone the trauma of combat to find his own methods of dealing with what he has seen and done. With the Healthy Coping, the veteran is aware he has specific memories as well as an altered perception of who he is, however, he has been able to integrate the war and its trauma into his daily life. The key to the coping mechanism is seen to be the successful Psychic Assimilation of trauma. This assimilation speaks to its roots in a stronger sense of ego-identity prior to the trauma of war. It is resultingly possible that this more complete sense of identity prevented this individual from stepping outside the boundaries of his ego-ideal. This more complete sense of self, with parameters of self-conduct, within the individual serves to achieve a greater sense of accomplishment without the ego splitting, schizoid problem seen in the individual who has less ego-ideal strength.

Healthy Coping, as alluded to in the Psychic Assimilation Phase, is seen to integrate healthy interpersonal relationship skills which allow the individual the freedom to

enjoy close contact with others without fear of death or personal injury. Long term relationships are fostered and closure is accomplished on war trauma as the individual completes assimilation and integration of the trauma into his sense of self.

It must be emphasized that although the trauma of combat cannot ever be erased from the memory, the ability of the individual to simply cope with these memories is of prime import. The trauma of death and loss in Vietnam speaks to the relevancy of the grief issues addressed in the "Treatment Implications: Grief" section of this paper. Further, that the integration of spiritual issues into the trauma, also addressed in the "Treatment Implications: Spiritual Issues" section of this paper, must occur to effect Healthy Coping.

CHAPTER 3

Pathological Level of Response

The Pathological Level of Response speaks to the presence of unprocessed and incomplete integration and assimilation of events and situational trauma. As illustrated in the theoretical model (Figure 1) this level of response is seen to deal with the layering effect of emotions and feelings, which if not dealt with integrationally, binds the individual into the Pathological Outcome.

Other specific phases to the Pathological Level of Response are the:

1. Layering Effect of Feelings and Emotions.
2. The Traumatic Event.
3. The Schizoid Problem; Ego Splitting.
4. Psychic Overload.
5. The Momentary Psychosis.
6. Response to Momentary Psychosis.
7. Stress Syndrome Response Pattern of Adaptation; as well as the Pathological Outcome.

The Layering Effect

Previous mention has been made of pre-military culture variables where the young soldier gathered the roots of his yet tentative identity. Upon completion of basic military training and later, his presence in Vietnam, the average age of the American combatant was nineteen years. With the

completion of basic training, the soldier found himself with the fresh and awesome identity of a soldier. Having been trained in the art of combat and survival, he became aware that he had, by virtue of his training and uniform, been given both the license and expectation to kill; not to mention the training and the instruments with which to inflict death and awesome destruction. The young soldier also came to realize that along with these skills and tools was deployment to a combat zone, if not a certainty, at the very least a distinct possibility.

With this new and yet tenuous identity of being a soldier more or less firmly in hand, the threat of orders for Vietnam was one of the first foundational pieces that was not processed for the soldier. On top of this component was added other significant emotional layering. Specifically, emotions of dread, excitement, anxiety, fear, trepidation, insecurity, alienation and vulnerability, among others were thrown unaddressed into the pool of unprocessed feelings. The turbulence of the emotional whirlwind with what was perhaps the soldier's last time to see his family, former high school friends, girlfriend or wife, and community only added more impact to his heightened emotional state.

Upon embarkation for Vietnam, the young soldier generally went through a staging area with many other young soldiers, also bound for combat. Shared, spoken and unspoken, feelings of fear and anxiety, termed "negative anticipation" were thrown into the already swelling pile of unassimilated emotions.

Arriving in Vietnam, the sights, smells, and sounds may have quickly justified and exacerbated the anxiety instead of having the psychologically desirable time to process and comprehend this tremendous input on an already stressed mind. For example, the ambient temperature in Vietnam, from the author's experience, was generally close to 100° F; further it was common practice to burn human excrement as a means to dispose of it (diesel fuel was used as a means to burn it). Also from personal experience, the airfield being flown into upon arrival in Vietnam would also be found under attack, leaving the aircraft and soldiers-to-be circling above, watching what could seem to be a bad movie. These factors, individually or thrown together, could have real impact on the youth and significantly escalate fear and anxiety. As a result, the young soldier may have quickly added significant quantities of fear, hatred, disgust, shock, and other strong emotions, singularly or as a combination of emotion to the still growing pile, further complicating the Layering Effect.

Surely but swiftly, events of loss began to take place, layering on top of unassimilated events. Fear mounts on anxiety as death is seen and experienced. Trauma begins its earnest "stacking", leaving the young soldier no time for assimilation; the ever present, sustained threat of death begins to wear down the psychic stamina. Fear again mounts on top of fear already present. Terror, sheer and stark, becomes an explanation for fear and a cause for hatred, as well as being an ever present companion. Once again the whirlpool of

emotions builds and the result is little chance for healthy assimilation.

Menninger (1946) clearly believed that the accumulation of various stressors during combat were adequate to provoke symptoms in World War II combatants: "---The cumulative effect is a major factor, so that whenever the specific traumatic event does occur, it may in some cases appear trivial--- the soldier may or may not be able to describe certain events which may have been the final straw---the death of a comrade, the hopelessness of a particular assignment---a broken promise (p. 206)."

These unprocessed, unassimilated, and for the most part, unknown feelings were building one on top of another, creating the "Layering Effect" (Figure 1). Suddenly, as Menninger alludes to above, a traumatic event may occur, causing a breakdown in the soldier's ability to maintain control of the potential to psychically assimilate the trauma. As indicated in Figure 1, the feelings may be singular or combined into more complex emotions which unassimilated, continue layering until, with the mounting pressure, the single traumatic event may trigger an explosive response. This layering process feeds directly on through the Traumatic Event Phase into the Psychic Overload Phase due to the nature of the overload qualities of the layering of trauma on the individual.

In summary, the "Layering Effect" is seen as being the mechanism in which the lack of assimilated emotions creates a situation that sets up the individual for explosive response to further trauma.

The Traumatic Event

With this layering process, addressed in the previous section already operating the individual may then endure a traumatic event of usual or unusual import. However, it is strongly stated that the presence of sustained life threat, characteristically common to combat, is the variable which escalates the event from "just another thing" to "the straw that broke the camel's back."

Whether the traumatic event is of usual or unusual import is, once again, not an issue. Clearly, the issue is the presence of sustained life threat, coupled with the layering effect of unassimilated and unintegrated thoughts and emotions as a response to traumatic events.

The resulting psychic force of this event on the unassimilated and unintegrated layering of emotions serves to drop one to the point of detachment from oneself: this ego split is termed "the schizoid problem" (Guntrip, 1973) and is addressed in detail in the following section.

The Schizoid Problem

As the result of the layering effect and the traumatic event, the ego splitting, schizoid problem occurs. This ego splitting is seen as the direct result of both fighting and fleeing at the same time, resulting in depersonalization. For example, the expectation one may have of oneself in combat is to fight honorably without any trace of cowardice; a matter of instilled duty. However, the intensity of the

situation demands detachment, which is translated as ego flight. Ego splitting becomes the only manner in which the traumatic event can be endured while leaving the self basically intact.

Digressing, as previously noted this particular stage is quite relative and highly individual. It is also concomitant on the ability of the individual to integrate and assimilate life events.

The split of the ego plunges the detached self into the psychic overload phase of the Pathological Level of Response, (Figure 1) if the event itself cannot be assimilated, given time and appropriate circumstances.

The concept of experiencing an event or stressor in life may be somewhat misleading and incomplete for the scope and focus of this paper. While it is true that we undoubtedly "endure" or in some way "experience" these particular events, the event is not truly experienced until one deals with it cognitively. It can be said that one "does" an act or deed. How one does it and perceives it at the very moment of action determines the quality and depth of the "experiencing" and interfaces with reality, as possible.

If the event is so traumatic or stressful that it threatens the emotional stability of the individual undergoing the event, one may detach oneself from the event and in fact, fail to "experience" the act or event. If the event is not processed cognitively, the retouching of the event will have significant avoidance attached to it. One may fear the event, just as one fears bad dreams. The fear of touching the event

in memory is that one may not return from the reality of the unprocessed event; just as the fear of being inextricably caught in and unable to return from a bad dream is certainly powerful. The conscious fear of the bad dream, or traumatic event, is seen as being highly magnetic in drawing one back to the event one consciously chooses and wishes to avoid. Horowitz, (1976) under "Fear of Repetition" states, "Any event that occurs may recur. Anticipation of repetition of painful stress events conflicts with the wish to avoid displeasure. Persons fear a real repetition and they also fear a repetition in thought (p. 22)." The magnetic quality is postulated as the mind's inherent work and desire to return time and time again to the stress event in an attempt to achieve integration of the event.

This again serves to elucidate the fight or flight problem the ego experiences. In choosing to avoid, to flee, it is helplessly drawn back to the experience by the sheer force of the trauma upon the psyche of the individual. Raw, sheer, power; the type the mind finds abhorrent but yet is somehow addicted to.

Delving further into the issue of the schizoid split and the individual himself, the schizoid condition of ego splitting concerns a relationship with oneself. It constantly emerges in the chronic uncertainty as to whether the individual is or has a self, owing to feelings of emptiness, non-entity, and dereliction. This may be due to an individual's not having assimilated an assured sense of self, such that he

is unable to make satisfactory relationships with other people, so commonly noted among Vietnam veterans (Wilson, 1983). The schizoid person conspicuously can neither do with nor do without the human relationships he so desperately needs and desires. The schizoid problem can be without relief because the individual believes himself to be devoid of feelings but continually finds himself tripping over his emotions.

The schizoid knows--through painful experience, that although he desperately needs human relationships, he cannot enter into it nakedly--vulnerable--because his fears do not allow him to sufficiently trust or love, and he feels so weak that he expects the mental proximity of another person to overwhelm him. The ego splitting, schizoid reaction is a fear product. It is then perhaps more useful to recognize this hard core of the schizoid mentality and then use the term to denote a psychopathological trend to be found to be mixed up with all sorts of other trends; psychosomatic and hysteric; obsessional and depressive; anxious and so on.

The fight or flight mechanism of the schizoid problem is in direct response to the influx of trauma that is so threatening to the individual, he may not be able to assimilate it in the extremely short duration of time in which it occurs. The schizoid split itself is of response to trauma; it is the precursor total sensory overload. It is likened to the home electrical system in a thunderstorm. If a significantly large bolt of lightning strikes the electrical system, the main breaker is thrown upon this serious overload. Smaller

bolts of lightning may throw only a single breaker. However, a truly massive bolt of lightning may not only destroy the breaker system, it may devastate the total home. The momentary psychosis, as the result of this schizoid split, fits well into this metaphor as it represents the stage of non-reality--which is one of inconceivable powerload. Reality--electrical power to run the home--no longer exists. Reality in the mind is stretched, distorted as the reaction to the trauma, cognitive processing, continues to be attempted.

Here, in this complex pattern of ego splitting, or loss of primary psychic unity, with all the weaknesses and internal conflicts it involves, is seen to be perhaps the root cause of personality disorders, including Post Traumatic Stress Disorder, Combat Trauma Syndrome. The most vulnerable part of the self is the most hidden part, the schizoid ego, cut off from all relationships in the depths of the unconscious.

Psychic Overload

The Psychic Overload phase of the Pathological Level of Response speaks specifically to the inability of the mind to deal with the aftermath of, in sequence, the layering effect, the traumatic event, and the ego split. This phase represents the moment in time when the mind can no longer bear the weight of previous layered emotions as well as the trauma at hand. It is the moment directly after the split of the human ego into its fight or flight component and the overwhelming stimulus overload gives permission for the ego to respond in its

most basic form, the shutting down of feelings and utilization of all senses for self-protection.

The moment of Psychic Overload incorporates into it the process of "stretching the fabric of time." The mind, actually racing at fantastic speed, selects a singular portion of the event to focus or obsess upon to avoid the threat, psychically, of the traumatic event. This singular focusing is seen as forming a barrier to other possible emotions--or absolute mental breakdown--and provides a window by which one slides into the momentary psychosis phase which then dominates the individual's cognitive processing.

Momentary Psychosis

Momentary Psychosis is introduced in the context of this paper addressing Post Traumatic Stress Disorder, Combat Trauma Syndrome subtype, to be a transient situational reaction to the severe, sustained life threat of combat. It is characterized by disorganization of thought processes, disturbances in emotionality and disorientation as to time, place, person, and is manifested behaviorally as well as cognitively.

Momentary Psychosis differs clearly from Brief Reactive Psychosis, as defined by DSM III, 1980. In the definition, DSM III, 1980, states "The essential feature is the sudden onset of a psychotic disorder of at least a few hours but no more than two weeks duration, with eventual return to pre-morbid level of functioning. The psychotic symptoms appear immediately following a recognizable psychosocial stressor

that would evoke significant symptoms of distress in almost anyone. The precipitating event may be any major stress, such as the loss of a loved one or psychological trauma of combat. Invariably there is emotional turmoil, manifested by rapid shifts from one dysphoric affect to another without the persistence of any one affect."

DSM III, 1980, further states under Diagnostic criteria for Brief Reactive Psychosis, subsection C--"The symptoms last more than a few hours but less than two weeks, and there is an eventual return to the premorbid level of functioning. (Note: The diagnosis can be made soon after the onset of psychotic symptoms without waiting for the expected recovery. If the psychotic symptoms last more than two weeks, the diagnosis should be changed.) (p. 200-202)."

While DSM III, 1980, does address the fact that the precipitating event may be an event such as the psychological trauma of combat, it does not speak to the fullness of the event or the reexperiencing of the event, which is seen by this author to be commonly termed "fugue", "dissociative", and colloquially speaking, "flashbacks." The time limited parameters of Brief Reactive Psychosis preclude the availability of dealing with the component mechanisms of PTSD in any fashion other than as a full psychotic disorder, which is felt to be highly inaccurate, at best.

However, the term Momentary Psychosis has implications of allowing for less diagnostically severe, but as potentially handicapping, diagnoses of Personality Disorders. These

Personality Disorders potentially fit the pathological outcome of PTSD, Combat Trauma Syndrome, in a much more tailored fashion without diagnosis of Psychosis, which is seen as a misnomer.

Further, the term psychosis itself must be spoken to. Psychosis, in itself, speaks to the loss of contact with reality. In the momentary psychosis, one may find the overwhelming stressor occurring again and again, if not in memory, then in a reality situation as combat stresses are seen to occur throughout one's combat assignment. The experience of the momentary psychosis may be, in itself, the more frightening experience in comparison to the event. The knowledge of the experience of the psychosis may stimulate overwhelming fears of re-experiencing the psychosis event as well as touching the memory and fear of the psychosis; of not being able to let go of it, with the fear of being stuck in this state of non-being and non-reality forever.

Guntrip, (1973), states "The profoundest effect of the schizoid ego split concerns the existence of the lost center of a superficially organized self,--leaving the individual with no conscious capacity to feel understanding, warmth and personal concern for others but only being aware of a dreadful sense of isolation and nonentity within (p. 151)."

The Momentary Psychosis is the ego's method of establishing control of the mind amid the total disorder and of avoiding nothingness--the product of maximum stimulus overload--existentially speaking. The identity of self is threatened

so totally and violently that control is maintained at all costs. In this instance, it is felt that the psychic overload and momentary psychosis phases deal specifically with the threat to one's ego-identity. This may be so strong that the individual enduring the event may in fact feel as if he does not exist any longer and, as a result, he becomes the identity he lives in the behavioral component to the momentary psychosis; that of no longer simply a soldier doing his duty, but of a crazed killer who laughs as he stands over his kill and expectantly seeks more--for the enjoyment of killing.

The behavioral component to the momentary psychosis may be quite physical in nature. As a result of severe combat stressors in the layering effect and of the traumatic event itself, furied raping, mass or singular killing, mutilation, torture, and swift, deadly retaliation become acceptable, immediate responses. Decapitation of the enemy soldiers, another response, is seen as the most difficult behavioral component to deal with in the Response to Momentary Psychosis Phase (Figure 1).

In summary, the young soldier, primed as he was in his beliefs, faced tremendous pressures and had at least some sense of identity, however tenuous, to deal with this pressure of war. Combat--the war--excites his needs of completion of duty and performance and then fails or refuses to satisfy them: he can fulfill the role of combatant but cannot accept the resulting identity received--having gone beyond what a soldier is "supposed" to do. He is faced with both

existing and yet rejecting bad objects--the enjoyment of
furious killing--and his ego splits under the strain. We are
then faced with a human being who has lost psychic unity, who
develops conflicting and incompatible reactions to his own
needs and to the people and situations he meets.

Response to Momentary Psychosis

The response of the individual to the traumatic event on
through the Pathological Level of Response is seen to be the
phase in which the individual who has endured the trauma in
some way, evaluates himself and his actions. He is seen to
begin, at this juncture, to pass judgment upon what he has
done in response to the trauma he has undergone. The indi-
vidual, especially in the combat situation as a result of the
behavioral component of the momentary psychosis, had ample
motive and opportunity to exercise the extreme power he had
at his disposal. The resulting guilt and shame, along with
the incorporation of these into his newfound sense of identity
will be addressed in this section.

As spoken to at length in the section on identity and
concept of self, the individual has an ego-ideal--a belief of
who self should be. He has beliefs of what and who his iden-
tity is and what this identity is about. These beliefs are
the result of the assimilation, integration, and cognitive
understanding of life events. In the specific case of the
combat soldier and the trauma of combat, it is stated that he
cognitively and behaviorally alters his self-identity. This

alteration: self-identity is seen to result from the pathological identifications with both the "executioner" and "victim", from which the individual in combat found himself unable to escape.

The bind of situationally being both "executioner" and "victim" is extremely important to conceptualize.

Victims of traumatic events have long been observed to become self destructive toward their own bodies. Menninger, Mayman, and Pruyser, (1963) described the phenomenon as follows:

"It was an empirical fact of common knowledge long before Freud that many individuals regularly, and all individuals occasionally, take out their rage and guilt feelings upon themselves. . . . Regardless of its symbolic meaning and regardless of its means of physiological accomplishment and regardless of its subjective painfulness, somatization carries with it an unconscious intention to hurt someone which has been partly deflected in its aim so that to some extent the wrong person suffers. Somatization may be looked upon from the economic standpoint as a sacrificial compromise. . . ."

Victimization began with the dehumanization of the Vietnamese people by soldiers who utilized such terms as "Gook", "Slants", and others, thus allowing for conscience-free degradation and frequent indiscriminate killing. This "numbing" of basic human sensitivity became necessary: as killing became acceptable, it also became impossible to distinguish from victimization.

Directly in contrast to the "victim" is the "aggressor" or "executioner" role identity. The attempt by many American soldiers to pull together an idealized mental construct of

"being a man" during military training led to the idealizing of an identity of a killer as being an inherent and integral part of the identity of a soldier. However, this "killer" identity was at this point only an imagined one.

Once combat was experienced and the trauma continued to mount, the assimilation of the identity of a soldier became more and more difficult to keep clean. Specifically, the behavioral component to the momentary psychosis (furious killing, raping, and mutilation) left the young soldier with a real crisis: crisis speaking to "How could the me I know do that?" Springing directly from this issue was a new identity to assimilate. An identity that, having done deeds and acts he could find no experience in his past with which to equate, the young soldier felt stuck but yet strangely at peace with. Peace due to the awesome power he had just tapped and suddenly, the identity was in place, with only minor twitches and twinges of discomfort over continued killing of enemy and civilians alike. The concept of guilt and shame was beginning to creep in.

Hayes, (1983) unpublished, wrote, "In Vietnam we were so helpless: totally at the mercy of whatever was thrown at us. To survive a fire fight was simply that. Devoid of control over the event, we could but strike back in rage and fury, built to unfathomable intensity when (the enemy) killed your people and you couldn't find him to kill. The easy targets for salving the helplessness were the villagers and civilians. Looking for a reason, no matter how small, to

kill, to waste, to blow them away. A dead Vietnamese was a V.C. It was so difficult to tell friendly civilians from the enemy. After seeing buddies blown to bits so many times, the fury became the jelly for the bread and butter of life. The inability to control or to have life play by the rules gave reason to treat every gook as an enemy. Killing became fun: we were no longer helpless. Within the fury we were able to find control. We decided who lived and who died--and how they died: easy or hard, fast or slow."

This traumatic identity did not come cheap. As addressed, the shame and guilt issues began to respond to the specific behavior of the soldier. The fury, a term used to maximize the expression, behaviorally, of anger speaks to a willingness to forego dealing with issues of right or wrong. Fury dictated its own rules and the ego-identity became an item of totally useless baggage. Nothing existed but insanity. Any previous identity, including its morals, values, principles, and feelings were certain to get the soldier killed; he could not afford to allow himself to feel. To feel was to make oneself vulnerable: vulnerability was certain death. Once again, as the soldier fought to avoid the feelings of shame, guilt, and wrongdoing, the issues remained a spectre. Moral pain would be the price to be paid for the shame.

Shame and Guilt

Piers, (1953) states, "1) Shame arises out of a tension between the ego and the Ego-Ideal, not between Ego and

Super-ego as in guilt. 2) Whereas guilt is generated whenever a boundary (set by the super-ego) is touched or transgressed, shame occurs when a goal (presented by the ego-ideal) is not being reached. It thus indicates a real "shortcoming." Guilt anxiety accompanies transgressions; shame, failure (p. 11)."

As stated, shame speaks to the failure of the individual to live up to the Ego-Ideal: a disappointment by the self to maintain meaningful and important (to the ego-ideal) standards. Hypothetically speaking, the bind occurs if the soldier believes himself to be killing only as a sacred duty and trust, but then suddenly discovers the killing to be exciting, fun, and addictive. The soldier discovers it becomes difficult to quiet the inner voices (the ego-ideal and super-ego) feeding "bad messages" regarding the change in reasoning for killing. Duty and country take a secondary role as the fury feeds itself.

This behavioral bind has other implications besides making life difficult for the ego-ideal. The soldier is well aware that if he stops to decide, if he hesitates to react instantaneously to any threat, perceived or real, he is facing certain death. The inner conflict over morality and justifiable killing he knows is dangerous to his health and ultimately, his survival. And yet he cannot escape the doubt and shame, at whatever level his subconscious may be able to relegate it.

Lynd, (1958) writes, "Through all the root meanings of guilt runs something that corresponds closely to Piers, (1953) conception. Guilt is certainly a transgression, a crime, the violation of a specific taboo, boundary, or legal code by a

definite voluntary act. Through the various shadings of meaning there is the sense of the committing of a specific offense, the state of being justifiably liable to penalty. In the usual definitions, there is no self-reference as there is in shame (p. 23)."

This particular reference speaks directly to the criminality of the guilt; guilt over the active, action phase of the momentary psychosis. The guilt and shame over transgressions again brings into clear relief the societal message that not only was the war in Vietnam wrong at a social level but that the Vietnam combat veteran was wrong for whatever he did, as he came to interpret it. This interpretation, though irrational, was affectively smack on target. He knew his guilt as society in general perceived their guilt in the promulgation of the war: both were guilty but attempted to ignore the guilt in the hope that no one would bring it to their attention.

This shame and guilt that the soldier dealt with, at whatever level he could suppress it, fed the identity change that had already begun. Then dealing not only with the difficulty of trauma but inner pain as well, it was not too surprising to have the soldier give in to the ego-identity which was rapidly evolving. He became able, and quite willing, to see himself as bad, unworthy, and definitely not deserving of continued life or anything remotely resembling good things.

Lynd, (1958) goes on to say, "Guilt, in contrast to shame, is more related to specific acts, going against specific

taboos. Basic trust in one's world and especially in the persons who are its interpreters is crucial to one's sense of identity. In shame there is a questioning of trust. It is for such reasons as these that shame may be said to go deeper than guilt; it is worse to be inferior and isolated than to be wrong, to be outcast in one's own eyes than to be condemned by society (p. 207)."

Once again, the specific acts done beyond simple combat are seen as the basis for shame. Combat, in itself, is relatively simple: the soldier succeeds or attempts to succeed in killing the enemy before the enemy can kill him. However, the soldier becomes significantly more vulnerable to shame when the action is of mutilation--severing fingers, ears, or limbs--or decapitation, the ultimate vanquishing of the enemy. There is honor in combat in killing or destroying another combatant in a clean, righteous manner. As stated, the problems arise at the point of breaking those societal, religious taboos of childhood. "Real soldiers" don't decapitate people just to leave a warning or prevent the superstitious enemy from going to his heaven; they don't leave unit insignae attached to the forehead of the dead enemy. Nor do "real soldiers" carve their initials on the bodies of live prisoners.

It is specifically for these issues, again the behavioral response component of the momentary psychosis phase, that leaves the guilty and deeply shamed individual to reinterpret his identity. An identity so hideous and unhuman that, once recognized, casts out and ostracizes oneself in one's own

eyes even before a societal response can be forthcoming.

Summary

In summary, this Response to the Momentary Psychosis Phase of the Pathological Level of Response is seen as the assimilation and integration of a changed and terrifying identity. The soldier has seen the work of his hands and brain; indeed, of himself. He has had to acknowledge, at some level, his responsibility for his actions. He, in turn, condemns himself with his shame and resulting guilt and anger to a life of inner self torture. Job 36: 13-14 sums it up nicely: "Yes, the stubborn who cherish anger, and when He shackles them, do not ask for help: they die in their youth, or lead a life despised by all (Jerusalem Bible, 1966)."

Stress Syndrome Response Pattern of Adaptation

Common to both Integrated Level of Response as well as to the Pathological Level of Response is the Stress Syndrome Response Pattern of Adaptation.

Horowitz, (1976) (Figure 3) proposed a model which speaks to the individual's response to a life trauma situation. This model states that due to the event of trauma, "Outcry is an almost reflexive emotional expression upon first impact of unexpected new information. The expression may take the form of weeping, panic, moaning, screaming, or fainting (p. 56)."

The Outcry Phase is the phase in which the individual, at some level, becomes cognizant that a stress event has occurred.

Horowitz goes on to define the next phase, Denial, as "the term given a phase relevant to the implications of the stressful event in which there is some combination of emotional numbing, ideational avoidance, and behavioral constriction. Denial usually describes a defense mechanism in which there is avoidance of awareness of some painful aspect of reality. . ."

The third stage of this model Horowitz terms "Intrusion" and defines it as "the period of unbidden ideas and pangs of feeling which are difficult to dispel, and of direct or symbolic behavioral reenactments of the stress event complex; a complex which is an amalgam of internal and external components of meaning. Intrusions include nightmares of the stress event, recurrent unbidden images, and startle reactions with perceptual or associational reminders." This period denotes a mixed phase of denial and intrusive repetition in thought, emotion and/or behavior.

Horowitz completes his model with the phases of "Working Through" and "Completion" and says this in summation: it is "the phase of further ideational and emotional processing through and acceptance (or stable defensive distortion) with loss of peremptory quality of either the denial or recollection of the stress event (p. 82).

In the Pathological Level of Response (Figure 1) this Stress Syndrome Response Pattern of Adaptation has the same potentiality of outcome as does the Integrated Level of Response. However, due to the pathological nature of the

Response to Momentary Psychosis phase, there is seen to be very little real possibility that the individual undergoing the stress can be able to do more than Horowitz (above) alludes to in a "stable defensive distortion." This state of stable defensive distortion enables the soldier, post combat, to use rationalization, justification, and projected guilt to ease the moral pain and difficulty the stressors left with him. Aware of the awesome power he had utilized in his response to his combat environment, he could not bring himself to return to the fullness of the traumatic event for fear of being "stuck" there. The inability of the individual to return to the event itself and to process the events prior leaves the individual unable to complete the "Working Through" stage, thoroughly entrenched in the "denial" and "outcry" phases of response to trauma.

In the Integrated Level of Response, the individual is able to complete the tasks of assimilating and integrating the trauma; essentially having completed the Psychic Assimilation Phase (Figure 1). Once having this completed phase behind him, the individual is able to move through the trauma, deal with it either in terms of "sealing it over" or cognitively retouching and reexperiencing the event and its precipitators, and, in result, moving on to the Healthy Coping Phase.

Pathological Outcome

The Pathological Outcome speaks to the effect non-assimilation of trauma and resulting behavioral actions has

on the individual. While Post Traumatic Stress Disorder is not the only mental disorder that will spring from combat trauma, discussion will be limited to the pathology of PTSD, Combat Trauma Syndrome.

Symptoms of PTSD include reexperiencing the traumatic event or events through flashbacks, nightmares, and dreams. Victims also often lose interest in activities they once enjoyed; fishing, hunting, sports, and work, for example. In instances such as these, the veteran may feel detached from people; experience difficulty in establishing and maintaining interpersonal and social relationships. Indeed, the external relationship with others is but an indicator to the depth of the real difficulty existing internally in the battle of and with self. With the knowledge the veteran has of what he has done and participated in willingly or given silent consent to, the shame issues couple with the knowledge of self-identity. He came to realize he had done more than those who, left behind at home, did not know what he had come to know.

Costilow, (1984) unpublished, wrote---"So you say you understand, but I fear you never can. You were not with us there, for you chose to stay behind. We do not fault you for that. But you could have been more kind when some came back to join you with that Hell instilled in mind. No, we do not fault you brothers, but you hurt us deep--severe, when you say you understand, man. But we still live there."

As illustrated above, betrayal by one's country as well as one's God is an inseparable portion of PTSD, Combat Trauma

Syndrome. However, the other side to the pathological outcome dealing with betrayal is the betrayal of self. This betrayal of self, the willing rejection of one's pre-combat identity remains the single most difficult issue for the individual to put to rest.

The individual, having undergone war and its unique brand of insanity, may use some of what he considers to be effective coping mechanisms. In an effort to protect themselves and others from unpleasant memories of the war, the veteran may attempt to deny his involvement in the war with hopes that by "stuffing it down" it will not resurface nor cause any problems. Therefore, they may adopt a stance of silence. In doing so, however, they send messages to family and friends that they should leave the veteran alone and as a result, co-conspire with the veteran to pretend the war did not happen. In his encouragement of family and friends to be silent regarding his participation in the unpopular war, he is seen to be avoiding reminders of not only his actions, but that they, his family, would not understand. Further, that those he cared about would condemn him if he should talk to them about his personal experiences and role in the war. This significant interpersonal relationship impairment once again mirrors the internal conflict.

Summary

In summary, the internal conflict directly impacts the Pathological Outcome of PTSD. The actions of the individual

in combat are so removed from the realm of normal life trauma, the individual must set aside, with help, his fears and horrible expectations and return through the unworked, unprocessed trauma, or fully expect severe and distressing pathological behavior for the remainder of his life.

CHAPTER 4

Treatment Implications

The veterans of the Vietnam conflict seek to "justify" their actions. Actions which occurred either in the line of duty or spontaneous, furiated acts, which would most likely never have been perpetrated by this individual were it not for the circumstances of war. This justification can never come. "Justify" is a legal term, derived from the word justice, or to "make right" or "fair."

For the "typical" Vietnam veteran dealing with moral pain over the things he did, he can never "justify" the totality of the situation in the first place, let alone his resulting responses.

It is believed that in order to safely reexperience the trauma of Vietnam, specifically in dealing with what was done by the individual, the Vietnam veteran must give up his quest for justification. He must then move toward understanding, assimilation, of why he did the specific things he did in response to the layering effect and resulting trauma. Justification, in its legality, is but an intellectualism and permits one to avoid the real issues. Further, the intellectual understanding, justification, or righteousness can never salve the moral pain.

Elements of this moral pain left over from the trauma of combat are seen to include grief and spiritual issues. These are addressed herein as a part of this paper.

Spiritual Issues

For most American servicemen who went to war in Vietnam, John Wayne and Jesus Christ ran hand in hand. The culture of the day had John Wayne as the symbol of patriotism and held him up as the model each and every soldier should aspire to be like.

Jesus Christ, on the other hand, was also a culture hero. The Bible teaches that "Jesus loves me" and since America's theme or motto is "In God We Trust", it must somehow mean that Jesus loves me when and only when I do what my country asks me to do.

However, Vietnam stretched the link between John Wayne and Jesus Christ to the point of breaking. As Mahedy, (1983) says, "We believe America has a divine mandate to evangelize the world to its own political and economic systems. War is the sacred instrument, the great cultic activity whereby this mission is achieved. Jesus Christ and John Wayne must be linked again after their brief separation by Vietnam."

Both sides of the American influence in Vietnam--those who went and those who stayed at home--were in many ways profoundly affected. Those who sent those who went became an inseparable part of the massive evil. Innocence stayed behind, refused to partake in the barbarous acts of war. Mutilation, killing, and wholesale slaughter could not be separated from the mass and collective consciousness of America, combatant or not. America had been raped by her own lust for righteousness. Power and innocence were shattered: no

longer attributable to a self-proclaimed righteous nation.

As Mahedy (1983) once again states: "The warriors, their nation, and their god were shown to be powerless. The taboos had been broken. We had sinned and the wages of sin was death. Only in this context can the pervasive loss of faith among the Vietnam veterans be understood."

The purpose and message remains clear: still awaiting the magical touch of forgiveness from a forgiving God they can no longer look upon. They cannot accept a penance, for to do so would be to admit that God does exist and in His existence, forgiveness would be a reality. But for most Vietnam veterans, forgiveness cannot be accepted because the knowledge exists that "I cannot forgive myself," creating a bind for the existence of God.

For many other Vietnam veterans the real question is not "Will God forgive me?", but rather, "How can I possibly forgive God for what He allowed to happen to me, as well as what He allowed me to do?"

Having overstepped the power of God and finding the "just, king, and loving God" who promised to always be there did, in fact, not exist in combat. God, at best, died for most veterans in Vietnam. He was not to be found when the killing began. The doubting of God became strong agnosticism, if not outright defiant atheism. God could not exist in the slaughter and murder of babies and children.

Hayes (1983) unpublished, wrote ". . . we lived life and death in a few short years; eighteen, give or take a year

or so. Having done such non-God like things--the utter abhorrence, unfathomable fatigue, and self rejection concerning acts and deeds done. 'He never comes home again and his house knows him no more (Job 8: 10).'

'Since I have lost all taste for life, I will give free reign to my complaints; I shall let my embittered soul speak out (Job 10: 1).'

Am I worthy to deserve life? The very question of existentialism is raised. From "Jesus Love Me" to "Kill 'cause they deserve it and it's fun." Am I not worth less than an animal? At least an animal eats most of its kill. I stood and laughed. I was invincible. Immortality touched me. I WAS GOD!

Coming home, no one, leastwise ourselves, knew us. We wore our pain in silence. Killed ourselves in silence. Begged in silence for others to kill us.

As time wore on, it became more and more necessary to scream my pain, like Job. It's not my fault God put that load on me. I was just doing my job. I was a nice kid, 'till they told me to kill women, children and babies--and then paid me to do it."

Separation Issues

Another issue specific to the inner pain of the Vietnam veteran is the spiritual separation issue that Christ dealt with upon the cross. When Christ drank of the cup, he took on the sins of the whole of mankind in their entirety. This

act of taking on the sins of mankind meant that the Father could no longer look upon Him. The scriptures are plain that God the Father cannot look upon sin. Thus, the terrible moral pain Christ felt with the weight of these sins upon Him and the resulting separation from the Father caused Him to cry out, "My God, My God, Why have you deserted me (Jerusalem Bible, Matthew 27: 47)?"

These same separation issues confront the Vietnam veteran who has partaken in the "sin" of his transgressions. These transgressions separated the no longer innocent soldier from his father in Heaven, creating in the soldier the knowledge that not only has he sinned in his own eyes, but through cultural and religious upbringing, he has become separated from God. The separation from God, as with Christ on His cross, meant that God had deserted him just when He was needed most, and at a point when, just like Christ, he was only doing his job.

The resulting anger for the Vietnam veteran, who was not released from his pain by death, unlike Christ, could only serve to widen the chasm between the Father and His soldier-son. Further, the veteran continued to endure the crucifixion of his morals and beliefs by the massive evil of his own actions--replayed constantly by his conscience. Each successive death and killing served only to wound him deeper in his pain. Unable to find God in the horror of innocents being mutilated, killed, and burned beyond recognition, the anguish of the soul could only cry, 'My God My God, why have you deserted me?'

Upon return to America, the search for God was almost non-existent, due to the strong sense of betrayal the veteran felt from God. With no sense of love or gentleness from the supposedly kind and loving God, the veteran may have struck out blindly at religion and all those who professed to know Him: the ultimate betrayal was of the God who sent the youth to war being unavailable to the veteran in his deepest hour of need.

Reintegration of Spirituality

The reintegration of spirituality is seen to take place only when the veteran can come to the realization that the true God had no part in the choices of man in war. Further, that like Job, the Vietnam veteran must come to realize that the God who created him is the same God who created the earth; God's answer to a righteously indignant Job was, "Where were you when I created the foundation of the earth (Job 38:4)?"

Not only must the Vietnam veteran come to accept that God offers blanket forgiveness for all sins, but he must also give up the irrational notion that he must first of all forgive himself. The desire to forgive oneself is admirable, if not inaccurate. However, only those who know the depth of their sin and transgressions can truly know the need to forgive the "self" who could do what was done. The individual must, in the final scene of recompense, bend the knee and accept the forgiveness of the Father, finally washing away the blood stains and the ongoing identity of "killer." Not until this confession, whether it is done in the confines

of a church confessional or in the expressive psychotherapy construct of a psychiatric institution, is offered openly and finally, can the veteran break down the walls of separation between himself and the Father.

Grief

Grief is addressed in this paper as the single most important issue besides the Spiritual Separation. Post Traumatic Stress Disorder, Combat Trauma Syndrome, is seen to be made up chiefly of unprocessed grief issues and unrecognized identity and innocence losses. Pathological grief, the state of being stuck in one of the stages of grief, is seen as being common to the veteran with Combat Trauma Syndrome subtype of PTSD.

In treating a veteran dealing with the trauma of Vietnam and the losses therein, it is necessary to assist the veteran in understanding that all losses to be mourned are not specifically death oriented in nature. Another critical aspect of treatment of Combat Trauma Syndrome, PTSD is helping the returned veteran to understand the process of grief.

The grief process is held to be a very important aspect of treatment due to many factors. Among these factors is the lack of closure afforded to the soldier while in combat regarding the sudden death of friends and buddies. Often, intense fire fights would result in single or multiple deaths from squads or fire teams. On occasion, surviving squad members would have to carry the bodies of dead friends to the

nearest extraction point where the bodies could be ferried before they could be removed. Further, when buddies were severely injured, helicopters were used to extract them, with the soldier remaining in the field having little or no information as to the condition of his friend, allowing him no closure on the relationship.

These examples serve to illustrate the above mentioned lack of closure on death and loss--grief--issues in Vietnam.

However, other significant losses occurred. The loss of one's innocence and youth went largely unaddressed. He may or may not have been aware of the change or loss in self, but had little time and no permission to address these issues.

The grief over loss of individual friends, innocence of self, and coupled with the day to day grind of trauma and combat, impacted many combatants to such a degree that they turned to self-medication with drugs, legal and illegal, as well as alcohol to numb the pain of these losses. This coping mechanism, self-medication, was utilized in Vietnam as well as upon return to America.

Grief became a very private, little touched or discussed emotion. As previously referred to in the Layering Effect (Figure 1) this loss of death stacked on other losses, with anger, hatred, fury, fear, and other strong emotions continuing to swirl and stir deep inside the individual. This overwhelmed state of emotionality pushed the combatant back into the schizoid split of depersonalization: he could not afford to feel the pain nor deal with the emotions of what he had

been through, thus the resulting need for the "fight or flight" operation, once again, of the ego.

This "replay" continues long after combat and is an integral part of the symptomatology of PTSD, Combat Trauma Syndrome. This situation also speaks to the fear the veteran has in reexperiencing the event in therapy: he knows he will get "stuck" and never return to reality or sanity.

In order to assist veterans in dealing with the issues of grief, this author has developed a grief manual, specific to PTSD, Combat Trauma Syndrome, which is utilized in treatment of Vietnam veterans in an inpatient psychiatric setting for the past two and one-half years. It is herein presented as an effective model for treating pathological grief in a module concept.

Initially, the veterans are asked to take pencil and paper, answering the eight major questions on the Grief Awareness Inventory. These are read to the veteran, one question at a time on an incomplete sentence basis: the veteran must complete the sentence-question. Upon completion of the Awareness Inventory, the veterans are asked to pass their answers to the group leader for safekeeping until the final session, when they will once again answer the same eight major questions with, at this time, the modifier questions listed. In this manner, the veteran may become either 1) aware of a change of focus on grief issues through the module; or 2) that his initial responses were, in reality, what he really does need to deal with.

Upon completion of the Awareness Inventory and collection of papers, the veterans are given an overview of the module and the expectations of them. The manual is then given to them for use and study. The manual contains a statement of what Grief work is as well as what symptomatology is intended to be reduced by the module.

A quotation from The Bible (Job 30: 16-23) is provided to assist the veteran in becoming more in touch with his feelings regarding death. Emotions are stressed in this particular session.

Much of the work involved at this point is "homework" with the brunt of the module, in the future, being solely used for group exploration of feelings regarding death and loss issues, using the manual as a guideline.

Indicators of Pathological Grief

The veterans are asked to put a mark beside each statement that speaks to where he has been since his return from Vietnam. This is done to reinforce for the veteran both the seriousness of the situation and the hope for the future through recognition of the problems to be dealt with. Flexible time is utilized to allow verbalization of feelings over information gained.

Phases of Grief

Phases of Grief session focuses on the explanation, in basic and clear terms, what emotions individuals deal with in response to the trauma of death and other loss issues. The

development of this manual utilized the Kubler-Ross phases of grief as she dealt specifically with the terminally ill, which is the generalized feeling of Vietnam veterans.

Identity Loss: Pre-military

The section of the grief module dealing with pre-Vietnam issues attempts to assist the veteran in getting back in touch with who he was prior to his entry in the military. It touches, in-depth, the topics of morals, values, and beliefs; asking the veteran to become aware that his feelings of joy, peace, and innocence are not dead but merely put far out of mind. This is accomplished by inquiring of them the music of the day as well as the kind of car they had and the activities they were involved with before the military.

Identity Loss: Military

The loss of identity in the military, specifically basic training, is also spoken to in the pre-military section of the grief module. However, one very big important step is added prior to Vietnam issues. An attempt is made, therapeutically, to look at, process, and then to understand the changes in feeling and layering of emotion as the youth completed basic training and departed for Vietnam. This is done specifically by having the veteran, again as homework, write out a detailed description of his memories of leaving home; arrival at the debarkation point; and of the flight or ride to Vietnam. The veterans are then asked to share this with the other members of the group and it is this process that

feeds the recall as well as comprehension by the veteran of the layering effect, specifically the layering of anxiety and fear even prior to arrival in Vietnam.

Many veterans arrived in Vietnam, as did the author, to find the landing field under attack. The veteran is pushed to describe his feelings as he recalls departing the aircraft and finding other soldiers, standing in the heat and stench, awaiting his deplaning so they might return home. They are asked to recall their feelings as they looked into the eyes of the soldiers going "home", finding terror, dread, and death readily apparent.

Sudden Death

The section on Sudden Death speaks directly to the process of aiding the veteran in identification of his initial contact with sudden death, whether it was of him killing or of witnessing a friend get killed. Emphasis is placed on the veteran sharing specific details of what was happening; what was the method of death (booby trap, mortar or rocket round, small arms fire, friendly fire, etc.); and most importantly, what were the feelings and resulting behavioral responses utilized in response to this trauma. This is done to assist their comprehension of why and how the identity change from innocent soldier to killer and murderer came about. Emphasis is placed upon the veteran taking these newly explored feelings and reexperienced actions back to other Vietnam-specific phases of treatment.

Grief Issues: Post Vietnam

Post Vietnam issues are dealt with initially by having the veteran recall and share his return from Vietnam. This usually includes the recantation of the protestations of the war that was occurring at the points where the veterans returned home. Further, the veteran is encouraged to become aware of his behavior in regard to family and friends and the blocks to successful grieving which, in his eyes, protected him. The pathological, and in many regards characterological patterns of life style, are illuminated, and as a result, he is forced to admit to and become responsible for his behavior and actions.

Spirituality and Grief

As addressed in the Sudden Death portion of Grief, often times God receives the blame for the helplessness of sudden death. It then becomes extremely important to allow the veteran the opportunity to work back through the issues involving the "Death of God" and to explore the utter helplessness with him. It also becomes important to assist the veteran with closure of the death issue by offering a funeral service for the deceased object or person. This funeral service allows the veteran not only the opportunity to say goodbye, but allows him to turn painful anguish into memory. Needless to say, the Vietnam veteran requires close support and comfort throughout grief therapy.

Grief therapy with the Vietnam veteran speaks to the specific issueing of Republic of Vietnam trauma and walking

with the veteran, hand in hand if necessary, as he uncovers and exposes and subsequently heals the pathological grief issues.

Spirituality and grief issues dovetail in their need for processing with the veteran. He cannot and will not turn from the Pathological Outcome of the Pathological Level of Response (Figure 1) until he is able to go back through the issues, pre-trauma, and cognitively restructure both the spiritual and grief issues not previously assimilated and integrated into the self.

CHAPTER 5

Concerning the Counselor

In the treatment of Post Traumatic Stress Disorder, specifically Combat Trauma Syndrome, issues concerning the therapist are seen as being of paramount importance. The role of the therapist has great impact on how the client/patient approaches and utilizes therapy. Since the therapist may be a woman, a man, a veteran, or a non-veteran, issues of transference and countertransference are addressed as an adjunct to this paper.

However, prior to dealing with transference--countertransference issues, the issue of therapist adequacy must be breached.

Adequacy versus Inadequacy

Prior to attempting therapy with patients/clients, specifically Vietnam veterans, it would be critically important for the counselor to address the issue of his own adequacy as a person. Although this would appear to be an elementary, basic issue that would seemingly already have been dealt with in any counselor, the issue becomes especially dramatic when attempting to deal with the aftermath of combat trauma. Bordering on but seemingly separated from countertransferential issues, adequacy concerns who the counselor is before interaction with his client and subject matter.

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Concerning Combat Trauma Syndrome, the counselor must become aware of his own experiential interactions with anger and the impact, behaviorally, it has on other human beings. If the counselor can become aware of this entity, he will most likely be able to address cognitively the transference and countertransference issues which arise in regard to the taking of human life. If the therapist has never dealt with his own possibilities of response to extreme anger, he will be unable to accept the potentiality of outcome of therapy with the Vietnam veteran. Should he not see himself as adequate, he will seek to have his client/patient fulfill his needs of adequacy by collaboration rather than counselor/therapist patient relationship. His need to be needed will place the patient in a no-win situation. The patient ideally fights to be free of the therapist, but feeling the need of the therapist for the patient, he is faced with the dilemma of staying sick or acting out. If he stays sick, he assists the therapist by showing him he is a good therapist because his patient needs him. The other route, acting out, becomes the patient's only way to break out of this anti-therapeutic bind. He forces the therapist to give up on him, proving to the therapist, as well as to himself, that he really is hopelessly sick.

Adequacy issues also speak to the ability of the therapist to address his own feelings to himself or to others. If he cannot effectively confront or constructively criticize others because he fears return criticism, he takes to the

patient/therapist relationship latent hostility and anger, which the patient is forced to deal with in terms of passive-aggressive or other inappropriate treatment modalities.

In summary, although this, by no means, is a comprehensive overview of the adequacy versus inadequacy issue, it does address the very most basic issue concerning the therapist/counselor as a human being.

Transference and Countertransference

Transference

Transference must be dealt with by all mental health professionals in one fashion or another. Transference refers to the wish of the patient that the therapist (parent) would give him power and knowledge that would alleviate the discomfort, pain, or suffering of the patient. Further, the patient often adds to this with, "If you really care about me, you would give me everything I need without my having to ask for it, and you will love me unconditionally in spite of how bad a person I really may be."

The therapist with Vietnam veterans will be dared by the veteran to get close enough to trust, to care. The transference wish is seen to say, "If you really care, you will make it all okay and Vietnam will be only a bad dream."

Suffice it to say, the therapist must be aware of the wish for magical "cure" by the therapist who evidently doesn't care enough for the patient to "cure" him.

Countertransference

It must be noted that all therapists, no matter their sex role, personal belief system regarding the Vietnam war as right or wrong, or therapeutic disciplinary background will have varying outlook and reactions to the Vietnam veteran population. Countertransference, which speaks to the therapist's emotional attachment and response to the patient is seen to exist in all therapists who deal with Vietnam veterans in a therapeutic relationship.

Female Therapist

The female therapist may have to work through her own personal feelings of dealing, firsthand, with a "babykiller"; one who has tortured, mutilated, or killed children with or without regrets for his actions. The woman therapist may also have to deal with a patient who has raped female civilians in the course of his time in Vietnam.

As a therapist, the woman may experience strong feelings of empathy and understanding for the conflict she sees in the veteran, which causes her internal conflict between her feelings as a woman, therapist, and "mother". As the patient begins to move into the intense moral pain of reexperiencing the trauma he was involved in, she will have to seek and adopt a professional stance that will allow the patient the release of his feelings, rather than respond by blocking on the resulting painful affect the disclosures elicit. In short, the female therapist must become aware of the countertransferential potentialities for her in dealing with the Vietnam veteran.

Newberry, (1985) states, "Many of those realities that occurred in Vietnam elicit intense feelings in the therapist of disgust, revulsion, horror, and hate, frequently followed by fear. We all, at one time or another, experience fears of annihilation or destruction by our patients, but in working with Vietnam veterans that fear may be enormously increased because of knowledge about these patient's past actions in combat."

Veteran Therapist

Being a Vietnam veteran and a mental health professional has its advantages as well as disadvantages in dealing with Vietnam veterans. The most obvious advantage is that relationship and trust are quickly established. However, the dredging up of the therapists own war experiences are a part of the price to be paid. Many Vietnam veterans refuse to work with a non-veteran therapist. This added pressure, perhaps similar to the Messiah-complex, the only One who can help, is a liability for the veteran-therapist as well as an asset for the patient. He may find himself to overextend both personally and professionally to help his fellow "brothers." It is extremely important for the veteran-therapist to develop a strong peer support system in conjunction with his work with Vietnam veterans.

As the female therapist must address her motivation and emotional parameters with the Vietnam veteran patient, so must the Vietnam veteran therapist. Survivor guilt, wishes of making up for what was done, or making up for

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what was done, or making up for what was not done, he must be aware of his reasons for working with this population.

Non-Veteran Therapists

Many non-veterans have worked extremely well with the combat veteran. However, it is of crucial importance for the therapist to tell the veteran "up front" that he, the therapist, has not been in combat and may not experientially understand, but that he does care and is willing to listen. Further, the non-veteran therapist should consciously avoid saying "I understand" for this will more often than not "shut down" the veteran very quickly. The veteran knows that no one who has not endured the ultimate terror of war can possibly understand and will "write off" the therapist instantly.

The non-veteran therapist must have some sense of why he chooses to work with this special population. He must consider guilt of not having gone as well as the voyeuristic stance of gratifying his own vicarious wishes of war. He must also know that he may begin to exhibit symptomatology of PTSD himself: self-isolation, dreams, nightmares, anxiety attacks and overreaction to war-related stimuli (helicopters, loud noises, etc.).

Summary

Newberry, (1985) writes of countertransference with Vietnam veterans: "The most profoundly intense times of treatment, in a treatment setting that is relentlessly intense throughout its course, are those times when the patient must

relieve the utter horror and stark terror of events that profoundly altered his psychic structure. . . perhaps the most intense countertransference also occurs at this point. The therapist may feel extreme guilt for "subjecting" the patient to this brutal endeavor. Guilt and fears of harming the patient or making him worse are engendered. Fears of literally driving the patient insane are evoked, as are fears that the therapist himself will be overwhelmed and engulfed. The therapist's deepest fear is that he will destroy or annihilate the patient."

CHAPTER 6

Conclusions: Summary

The focus of this paper has been to illustrate the lack of specificity currently existing in diagnosis and subsequent treatment of Post Traumatic Stress Disorder, as defined by Diagnostic and Statistical Manual, Third Edition, 1980, as published by the American Psychiatric Association.

This paper has addressed a proposed subtype of Post Traumatic Stress Disorder, specifically Combat Trauma Syndrome. This subtype is characterized as having major components of sustained life threat, significant identity alteration due to lack of integrated and assimilated sense of identity prior to insertion into combat. Further, this paper has addressed new theoretical concepts concerning the cognitive processing of combat trauma. These concepts of cognitive processing include the Momentary Psychosis--a state of loss of touch with reality--which is quite different from Brief Reactive Psychosis, as defined by DSM III, 1980; the subsequent Response to Momentary Psychosis Phase and its resulting behavioral component; as well as guilt and shame and the resulting loss of spirituality. Grief issues are addressed in detail as they are seen to be neglected in the individual's processing of trauma of combat.

Two levels of response to life trauma are presented in this paper; 1) the Integrated Level of Response; 2) the

Pathological Level of Response. Each Level of Response is detailed in its specific response to trauma. The Pathological Outcome to unintegrated and unassimilated trauma is provided to provide an understanding of the outcome of incomplete cognitive processing of the trauma of combat.

This model steps beyond detailing of trauma and response to trauma and proposes specific areas of treatment implications. Treatment implications addressed specifically are grief and spiritual issues which are, for the most part, either generally ignored in psychiatric and psychological forays into the realm of PTSD or unaddressed in treatment of PTSD.

The material presented herein is provided to provide a basis for in-depth understanding and treatment of Combat Trauma Syndrome, PTSD, and to stimulate research to clinically evaluate enclosed theories for therapists in the field. This model suggests that other subtypes can substantially differ from Combat Trauma Syndrome. Other subtypes are proposed for research purposes as well as to improve clinical practice.

Suggestions for Research:
Other Potential Subtypes

With the culmination of this paper on Post Traumatic Stress Disorder, subtype Combat Trauma Syndrome, the diagnostic door is ajar for the suggestion of other subtypes of PTSD. While inclusion of other subtypes and subsequent detailed issueing of these goes far beyond the scope of this paper, some suggestions for further research is presented.

PTSD, as seen by this writer, specifically Combat Trauma Syndrome, is at one end of a continuum in terms of victimization. The author proposes the following levels of PTSD (Figure 4).

First, the Passive Level of PTSD speaks to an example situation of the wife who watches her husband commit suicide; such as a shotgun blast to the head. Although she is in no direct life threat, the trauma is substantial to impact her with intrusive memories, isolation, and unresolved guilt feelings that at some level, she may be responsible.

The Second Level is the Passive-Victim. An example of this is the Hyatt-Regency Disaster in Kansas City in 1981. The victims were all not expecting the trauma, indeed they were safe and expecting a night of peace and enjoyment. The aftermath for the survivors was the realization of severe life threat as attested to by the dead from the collapse of the skywalks.

The Third Level is postulated to be one of potential life threat without action by the self in response. An example of this would be action in Vietnam but at a safer proximity from combat where incoming rounds are experienced, but there is no resulting behavior by the individual in returning fire.

Level Four is Postulated to be Rape Trauma Syndrome in which the person is violated physically and may, perhaps, strike back, but is without sustained life threat. This is a victim subtype.

Level Five is Combat Trauma Syndrome, containing sustained life threat as well as the victimization of the individual. What is seen as more stressful and eventually more pathological in outcome is the victim-aggressor element of this subtype. This speaks to a deeper level of ego alteration; being victimized--mentally raped--and responsively turning aggressor with fury.

One other research suggestion that stems from this paper is the understanding of the layering of forms of anger. It is believed that anger is an emotion comprised of many other emotions. However, at the base of the foundation of anger is seen to be helplessness.

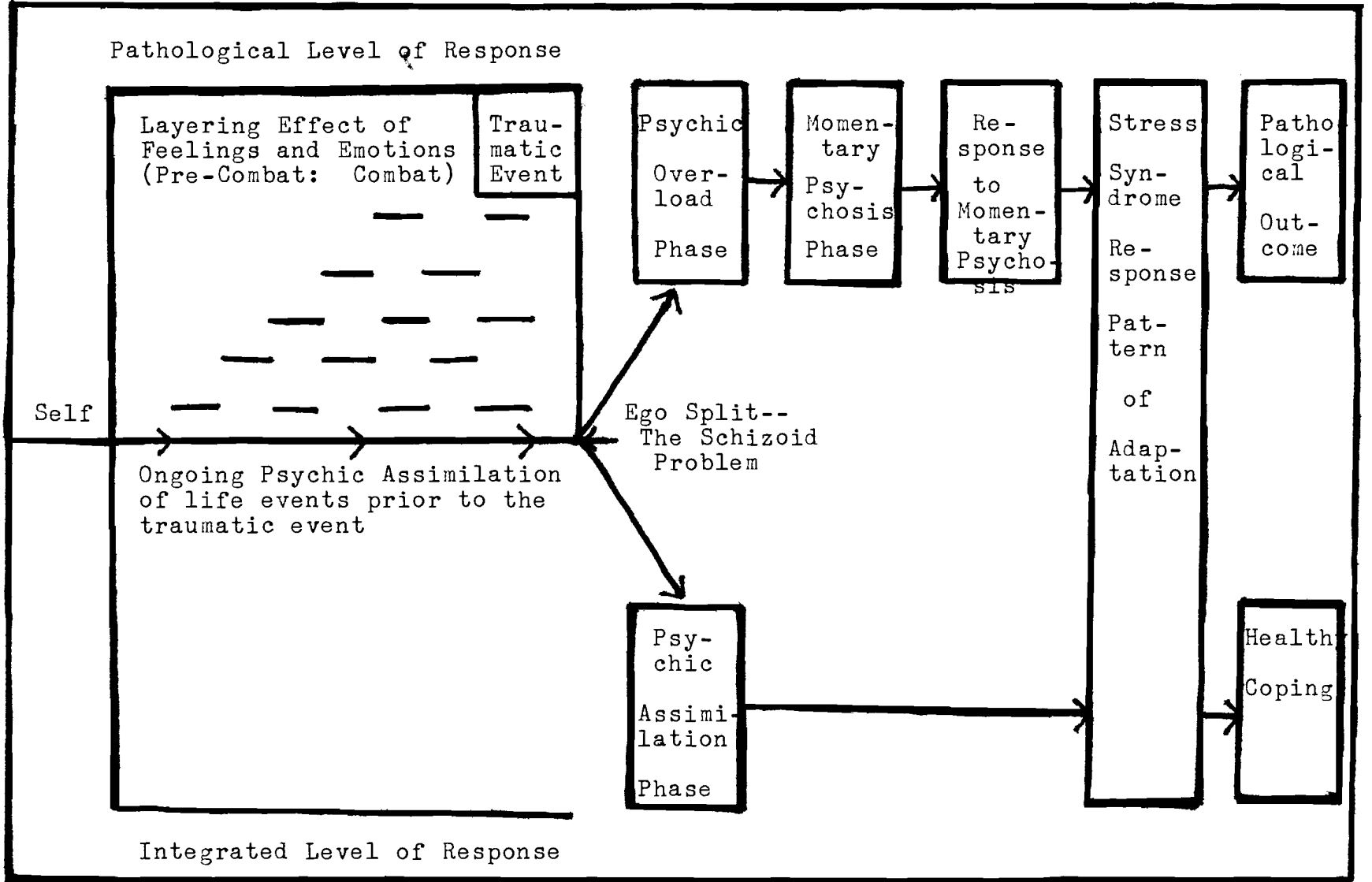
Anger, then, is seen to have four levels (Figure 5). The first and most basic of these levels is seen as the state of being "mad". This is postulated as the state where the individual is first aware of overt feelings toward a subject, object, or person.

The Second Level of anger is the initial behavioral stage of anger. "Angry" implies a stronger sense of helplessness which the individual responds to by striking out (kicking, crying, throwing objects.)

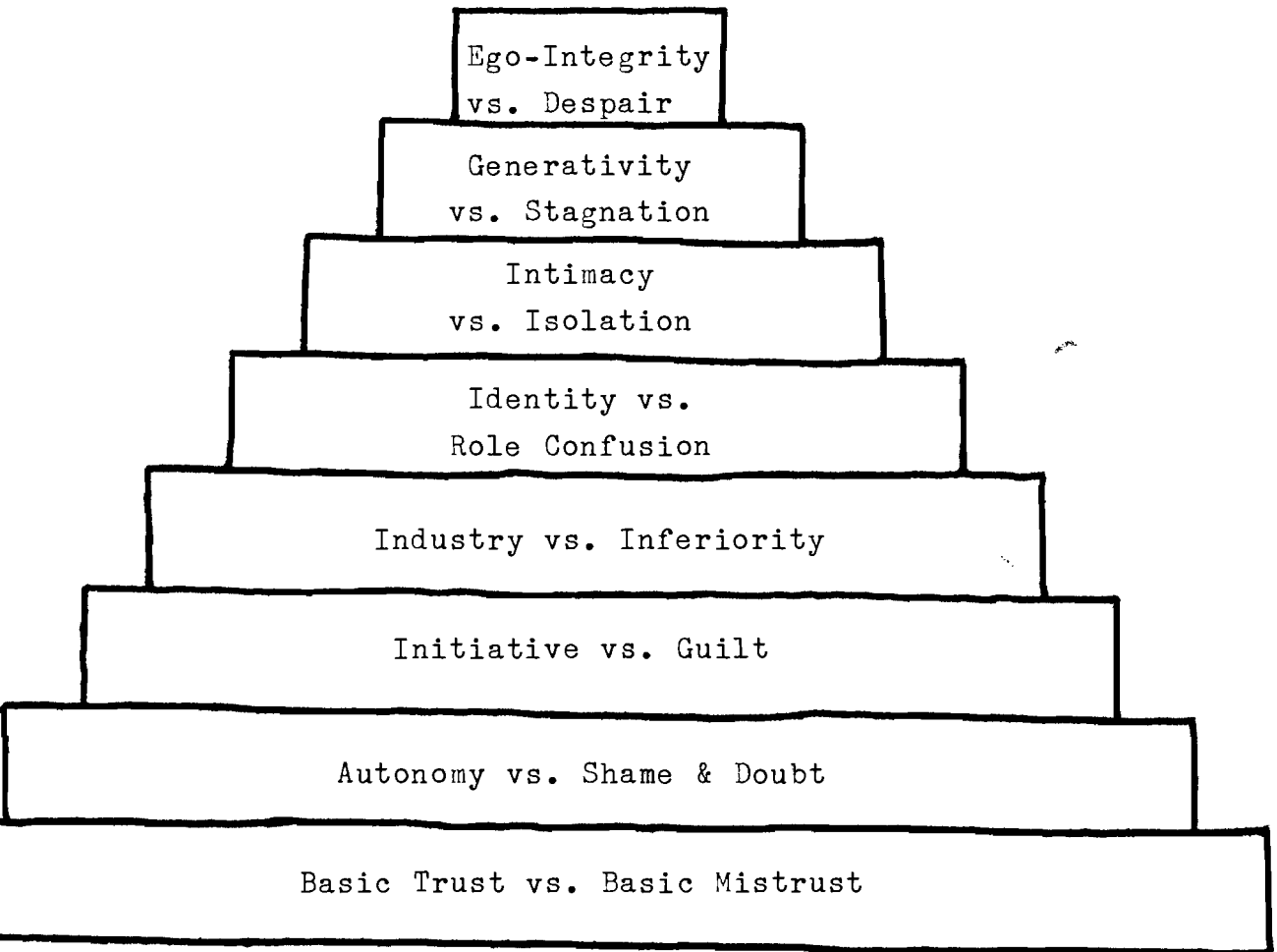
The Third Level of Anger is "Rage" in which the individual strikes out passionately and possibly for an extended period of time. Behaviorally, the "Rage" may take the form of striking another with the intent to inflict injury or harm. Subsequent superego action has regrets in regards to this heated behavior.

The Fourth Level, "The Fury", is cold and cruel. It is best described as revenge and manifested in a very calculating, pre-meditated fashion. The individual may have few, if any, regrets for some time, if ever. The Fury at combat speaks to the retaliatory nature for victimization of the individual. In combat, for instance, the soldier may become addicted to the adrenaline/fear high that accompanies the Fury.

As previously stated, this by no means, covers the potentiality of research possibilities, but offers some viable beginnings for interested individuals.



(Figure 2)

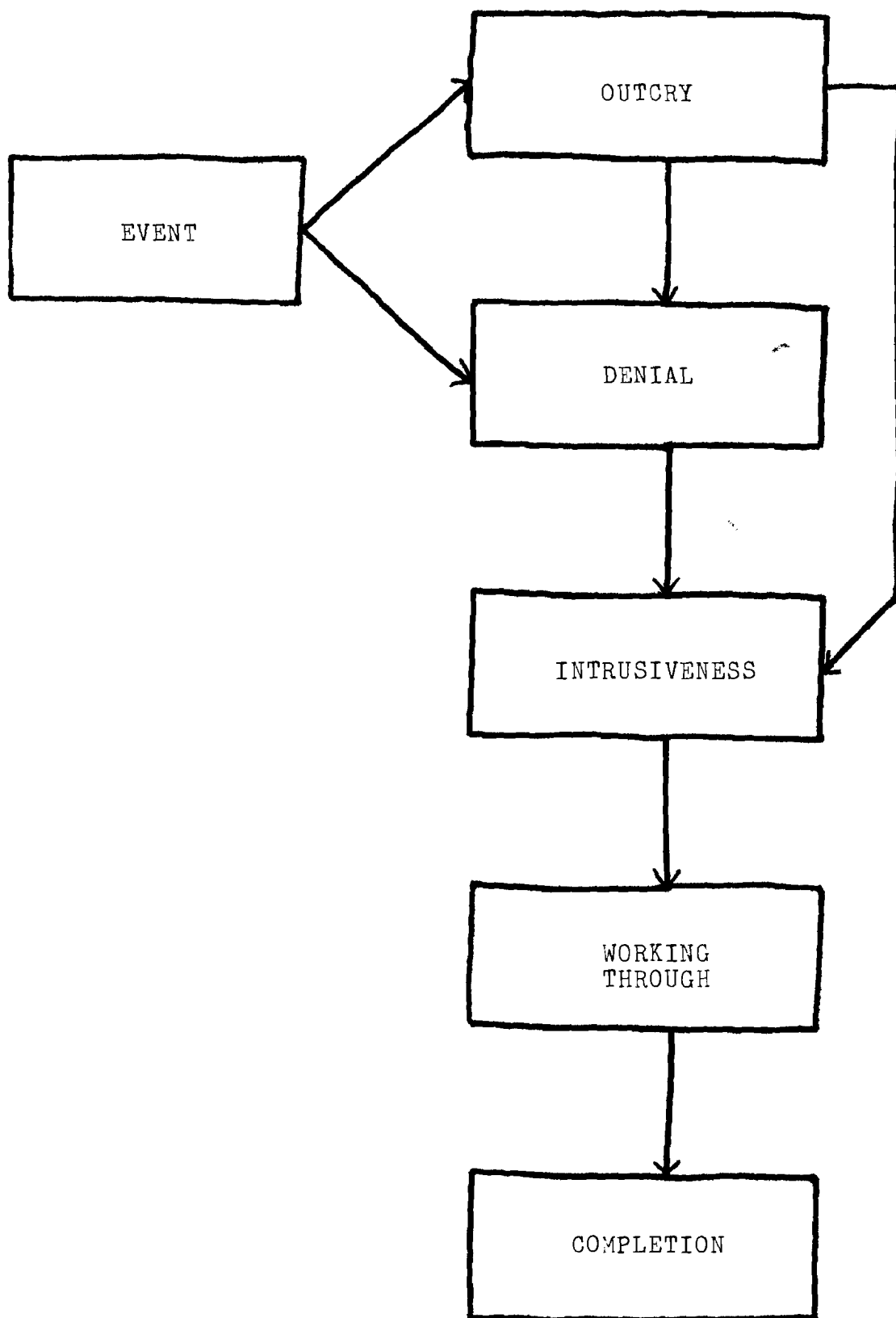


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(Figure 3)

Phases of Response After a Stressful Event



Proposed Levels and Subtypes
of Post-Traumatic Stress Disorder

1. Passive Subtype--Observation of Trauma.
2. Passive Victim--Events occur to innocent person.
3. Victim--Life threat without action to others by self.
4. Victim--Rape Trauma Syndrome.
5. Victim-Agressor--Combat Trauma Syndrome.

Levels of Anger

1. MAD
2. ANGRY
3. RAGE
4. FURY

APPENDIX

What is Grief Work?

Grief work is just what it says: the task of mourning. And it is work--hard, long, painful, slow, repetitive, a suffering through the same effort, over and over.

Grief is an important, normal response to the loss of any significant object or person. It is an experience of deprivation and anxiety which can show itself physically, emotionally, cognitively, socially, and spiritually. Any loss can bring about grief: divorce, retirement from one's job, amputations, death of a pet or plant, departure of a child to college or of a pastor to some other church, moving from a friendly neighborhood, selling one's car, losing a home or valued object, loss of a contest or athletic event, health failures, and even the loss of confidence or enthusiasm. Doubts, the loss of one's faith or the inability to find meaning in life can all produce a sadness and emptiness which indicate grief. Indeed, whenever a part of life is removed, there is grief.

Most grieving begins with a period of shock, numbness, denial, intense crying, and sometimes collapse. Grief moves into a prolonged period of sorrow, restlessness, apathy, memories, loneliness and sleep disturbances. Pathological grief reactions occur when this normal grief process is denied, delayed or distorted. This most often can be expected when

the death has been sudden or unexpected, or when the cause of death was violent. Pathological grief is grief that is intensified, delayed, prolonged, or otherwise deviating from normal grief, resulting in a bondage to the deceased that prevents one from coping adequately with life.

GRIEF GROUP

Grief Group is designed as an introduction to loss and the grieving process. Phases of grief are specified and awareness of the grief pattern and history are emphasized. It serves as an in-depth look at sudden death and pathological grief.

Importance is placed on self disclosure of grief and for the veteran to take his grief needs, once identified, to his individual and group psychotherapy sessions.

Grief group is, by design, intended to reduce symptomatology of PTSD in: Reexperiencing Traumatic Event, Impaired Memory/Concentration, Fear, Anxiety, Disinterest/Apathy, Depression, Anger/Rage, Guilt, Avoidance of Feelings, and Isolation from others.

Job 30: 16-23

And now the life in me trickles away,
days of grief have gripped me.

At nighttime, sickness saps my bones,

I am gnawed by wounds that never sleep.

With immense power it has caught me by the clothes,
clutching at the collar of my coat.

It has thrown me into the mud

where I am no better than dust and ashes.

I cry to you, and you give me no answer;

I stand before you, but you take no notice.

You have grown cruel in your dealing with me,
your hand lies on me, heavy and hostile.

You carry me up to ride the wind,

tossing me about in a tempest.

I know it is to death you are taking me,

the common meeting ground of all that lives.

INDICATORS OF PATHOLOGICAL GRIEF

- Increasing conviction I am no longer valuable as a person.
- Subtle or open threats of self destruction.
- Antisocial behavior.
- Excessive hostility, moodiness, or guilt.
- Excessive drinking or drug abuse.
- Compulsive withdrawal and refusal to interact with others.
- Impulsivity.
- Persisting psychosomatic illnesses.
- Preoccupation with the dead person.
- Extreme emotional expression.
- A resistance to any assistance or help.
- Stoic refusal to show emotion or to be affected by the loss (this indicates denial and avoidance of grief).
- Intense business and unusual hyperactivity.
- Refusal to change the deceased's room, or to dispose of his or her clothing and other possessions, or admit that my friend is really dead.

PHASES OF GRIEF

The literature on grief indicates that there are certain identifiable and predictable stages in the grief process. The phases generally include:

- (a) shock, numbness, denial, and disbelief
- (b) anger, guilt
- (c) bargaining
- (d) pining, yearning, depression
- (e) resolution

These stages can be obvious to you or you may not be aware they are taking place. It depends on the individual person and on the nature of the loss. Sleeplessness, irritability, anxiety, or apathy may be the main evidence of an individual's grief. Still, other individuals may act as if nothing at all has changed and refuse to recognize or deal with the grief he is repressing.

Remember, the intensity of grief varies with the significance of that which you lost. Generally, grief is felt intensely when a loss is fresh or new. The intensity gradually decreases in strength as time passes. The length of time we feel the pain of grief depends upon how much the person or object we lost meant to us. Important to remember is that the more the object or person means to us, the more time we need to deal with the loss.

If our sense of identity was derived from the object or person we lost, we may feel that our purpose in life is gone and that we no longer control our own destiny.

Losses that occurred in Vietnam were especially difficult to deal with. Often there was little or no time to stop and deal with or process the deal which was the loss of our own self and identity in the confusion of war. Unfortunately, we were not aware of the loss of our own identity or perhaps simply did not want to deal with it. We'll cover this topic next session.

IDENTITY LOSS

(Pre-Military)

For most veterans, identity loss began to occur almost immediately after entering the military. The message given you was that regardless of who you were, or what you were in civilian life, you were expected to conform and be assimilated into the mass as soon as possible.

This loss of the pre-military identity is felt to be very significant, especially in respect to what was to follow for those who went on to Vietnam. Although many were not aware of the loss of pre-military identity, the loss went untended and other, much more impacting and severe losses would confront you.

Before going further then, we need to identify who we were prior to the military. What were our beliefs, values and morals? Many of us did not finish high school prior to the military. The loss of youth and "good times" went largely to the wayside. It may be rather difficult, but spend a few moments thinking of who you were before the military. Did you have a steady relationship with a girl? Did you get along with your parents and family? Did you believe in God and attend church? Were you popular in school? Did you have many friends? How heavy were you into alcohol or drugs, if you were? Had you been sexually active? Did you respect yourself for who you believed yourself to be?

All of these questions speak to losses which most likely needed dealing with. The task then is to identify the losses and to apply the grief process to them.

IDENTITY LOSS

(Vietnam Issues)

In our last three sessions we attempted to become aware of the phases of grief and finally, to look at pre-military identity loss.

Today we're going to focus on identity loss issues from Vietnam, which range from dealing with death, in many capacities, to perhaps the most overlooked loss, the loss of self. Even though it may not have been very apparent, most of us had some idea of what we thought we were when we arrived in Vietnam. However, for the most part, it didn't take long for the identity of the trained soldier to become complete and wash away (so it was felt) the identity of the kid who was there not so long ago.

Many Vietnam veterans speak of a point they recall in which everything changed. The war became very personal, very real. They no longer sought only to survive but to make the enemy pay for specific deaths close to the veteran. Once again, the loss of a previous identity, that of a soldier only doing his job, was not mourned or dealt with. The identity of the "death dealer" was taken on. With this more powerful identity came the "non-good" identity. Bit by bit, the veteran was gaining a new, more personally terrifying identity.

The "youth" was no longer. He had changed his identity and throughout his time in country he had probably not given much conscious thought to this identity change and loss. Perhaps drugs and/or alcohol were turned to in order to compensate, or get by.

Grief was expressed by not getting close to others, by self-medication with drugs and/or alcohol. Loss became a fearful thing and numbing was a technique many used to anticipate loss. Death was noted, but not dealt with.

SUDDEN DEATH

Vietnam was the "Land of Sudden Death." Death struck from any and every angle and was often silent in its approach and termination. Sudden death in combat was different in many ways from the deaths known while still a youth at home. The sudden, explosive death of combat was far removed from the deaths of grandparents or other family members who died of medical reasons. Car accidents, too, were traumatic, but not of the caliber of an enemy who is earnestly stalking you to kill you. To observe peers--friends--your own age dying around you in horrible and sometimes hideous ways served only to drive home the message that your own death was but imminent. Sudden death left one with an overpowering sense of helplessness.

This type of death serves to overwhelm our sense of power and ability to have control. As you may recall from experience, the rage and fury is a direct product of sudden death. This rage and fury was generally taken out on captured enemy or, more often, innocent villages and their inhabitants. This expression of rage helps to counter the feelings of helplessness.

Guilt feelings are common in the survivors of sudden death. You may recall wondering later, "Why is he dead and I'm not?" You may also recall the "if only's"; the bargaining

with whomever to get another chance to make the death not happen, to prevent the one you cared about from dying. Such statements as, "If only it were me instead" or "If only I'd done this different" tend to illustrate the guilt one is willing to own as the response to sudden death.

The occurrence of sudden death also brings with it a strong need to comprehend what happened; to make sense of the death and the events surrounding it. This need to understand helps the mind numb the pain and avoid the totality of the death experience. Blame is afixed; if not to the enemy, then to God for allowing it to happen. You may specifically recall saying, upon seeing the deaths of friends, babies, or young children, "There can't be a God if He'd let this happen." This statement speaks not only to the need to understand, but to blame as well. This is also seen as the root cause for the "Death of God" which you may or may not have personally dealt with.

In summary, sudden death must be addressed as an extremely important part of why you are in this treatment program.

GRIEF ISSUES

(Post-Vietnam)

Upon return to the States from Vietnam, you may have encountered a less than favorable welcoming committee, if any at all. Probably not what you were used to expecting from Uncle Pete or perhaps another World War II veteran. "What happened? How did they know what I did?" Or perhaps, "How can I tell them about it even if they would ask me?"

For the most part, then, Vietnam was something that you did not openly admit to knowing anything about, let alone telling people you had been there. It was stuffed down. Much like stuffing a green pepper and then cooking it. But only when it's been cooked can you see the juices leaking out of it. Vietnam was very similar in many respects. You could hide it and push it down, but it always had a way of leaking out. For example, the broken marriages; countless jobs; drug or alcohol usages, more than likely to excess.

Other issues of loss leaked out; the loss of trust, the constant fear of betrayal, the ever present isolation, be it physical or mental. Another big issue is sexual dysfunction. Relationships with families are notoriously poor for many Vietnam veterans. It is felt that many, if not all of these factors, stem from incomplete and insufficient loss and grief work.

For many Vietnam veterans, deaths of family and friends brings but muted and numbed response, clearly similar to the responses learned in Vietnam. Funerals are, for the most part, openly avoided. Many blocks to successful grieving exist for the returned veterans. Let us now turn to several factors that tend to delay or suppress grief and therefore, its resolution:

1. You may not recognize the change that has taken place as a loss to be grieved. (Loss of youth, for example.)
2. You may not accept that a loss has occurred.
3. You may not expect to mourn losses that do not deal with death.
4. Feelings such as anger, rejection, or guilt may complicate and hide the underlying grief.
5. People important to you may give you the impression they are uncomfortable or disapprove of your expression of pain.
6. You may have difficulty with previous losses that aren't resolved yet, that may leave you fearful to deal with new losses.
7. You may not want to upset or add to the grief of others, and this might cause you to stuff your feelings back down.
8. Your overdependence on the lost person or object which gave you some self-fulfillment or self-identity can make it difficult to let go.
9. Your wish that the loss had not occurred, can keep you from the resolution or acceptance of the loss.
10. Sex role (Big boys don't cry) or culture conditioning (Macho image in the Spanish-American Culture) can block the expression of grief feelings.

Grief Awareness Inventory

1. I am grieving for. . .

Why am I grieving for this person or object?

What is the importance of this loss?

Why have I not yet grieved this loss?

2. I felt anger when. . .

What was going on at the time?

Who was involved?

Why was the incident so important that you remembered it to write it down?

3. I express my grief by. . .

Upon what do I express this grief, people or objects?

Is this method of grief expression acceptable to me or would I like to change it?

4. My greatest sense of loss is. . .

How do I recognize this as my greatest sense of loss?

What does this loss mean to me?

5. The loss I fear most is. . .

Why is this loss so fearful to me?

What is my investment in what I fear I'll lose?

6. The pain I tend to hide most is. . .
 Why do I try so hard to hide this pain?
 What do I fear would happen if someone knew?

7. The death I felt most was. . .
 Why did I feel this death so heavily?
 What did this person/object mean to me?

8. Specifically, I need to deal with the death of. . .
 Why have I not yet dealt with this death?
 What do I gain from not allowing this person
 to die?

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