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A STUDY OF VIETNAM COMBAT VETERANS' PERCEPTION TOWARD DEPRESSION: TEN YEARS AFTER THE WAR

A Project
Presented to the Faculty of
The School of Education
California State University
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Education: Counseling Option

by
Dorothy Ryan
1985
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Approved by:

Advisor

Committee Member
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td></td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>8</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>9</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>10</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>11</td>
</tr>
<tr>
<td>II. REVIEW OF THE LITERATURE</td>
<td>14</td>
</tr>
<tr>
<td>Current Depression among Vietnam Combat Veterans</td>
<td>14</td>
</tr>
<tr>
<td>The Homecoming Experience</td>
<td>21</td>
</tr>
<tr>
<td>Date of Expected Return from Overseas</td>
<td>22</td>
</tr>
<tr>
<td>Current Suicidal Tendencies of Vietnam Combat Veterans</td>
<td>24</td>
</tr>
<tr>
<td>Summary</td>
<td>27</td>
</tr>
<tr>
<td>III. METHODOLOGY</td>
<td>29</td>
</tr>
<tr>
<td>Subjects</td>
<td>29</td>
</tr>
<tr>
<td>Instruments</td>
<td>29</td>
</tr>
<tr>
<td>Procedures</td>
<td>31</td>
</tr>
<tr>
<td>Limitations</td>
<td>32</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>34</td>
</tr>
<tr>
<td>Vietnam Combat Veterans' CES-D Scores</td>
<td>34</td>
</tr>
<tr>
<td>Non Veterans' CES-D Scores</td>
<td>36</td>
</tr>
<tr>
<td>Comparison of Vietnam Combat and Non Veteran CES-D Scores</td>
<td>36</td>
</tr>
<tr>
<td>Vietnam Combat Veterans' VCVQ Scores</td>
<td>39</td>
</tr>
<tr>
<td>Summary</td>
<td>41</td>
</tr>
<tr>
<td>V. DISCUSSION</td>
<td>43</td>
</tr>
<tr>
<td>Discussion of the Findings</td>
<td>43</td>
</tr>
<tr>
<td>Implications for Future Research</td>
<td>47</td>
</tr>
<tr>
<td>Concluding Remarks</td>
<td>48</td>
</tr>
</tbody>
</table>
## APPENDIX

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>VETERANS' PERMISSION FORM</td>
<td>50</td>
</tr>
<tr>
<td>B</td>
<td>CES-D SELF-REPORT QUESTIONNAIRE</td>
<td>51</td>
</tr>
<tr>
<td>C</td>
<td>VIETNAM COMBAT VETERANS' QUESTIONNAIRE</td>
<td>52</td>
</tr>
<tr>
<td>D</td>
<td>ATTEMPTED AND ACCOMPLISHED SUICIDES REPORTED TO: VA CENTRAL OFFICE DURING THE YEARS OF 1981 - 1982</td>
<td>53</td>
</tr>
<tr>
<td>E</td>
<td>RATES OF SUICIDE IN PERIODS OF WAR SERVICE BETWEEN THE YEARS OF 1970 - 1980</td>
<td>54</td>
</tr>
<tr>
<td>REFERENCES</td>
<td></td>
<td>56</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Means &amp; Standard Deviations of CES-D Scale Scores for 30 Vietnam Combat Veterans.</td>
<td>35</td>
</tr>
<tr>
<td>2. Means &amp; Standard Deviations of CES-D Scale Scores for 210 Male Non Veterans</td>
<td>37</td>
</tr>
<tr>
<td>3. Analysis of Variance of CES-D Scale Scores Between Vietnam Combat and Non Veterans.</td>
<td>38</td>
</tr>
</tbody>
</table>
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I also want to extend my appreciation along with special thanks to Dr. Cooney for the many hours she contributed towards this effort, and to Dr. Pendleton for his support and assistance.

I would like to extend my deepest gratitude for the understanding and loyal support of my husband, Scott.
CHAPTER I
INTRODUCTION

Bitterness, anger and anxiety ... depression, loneliness and alienation ... sleeplessness and inability to get close to others ... flashbacks to combat and suicidal feelings ... drug and alcohol dependence ... and so much more. Problems like these plague the lives of far too many of the men and women in our society sent thanklessly to fight the war in Vietnam. For at least half a million Vietnam veterans, these problems are so severe that their lives and families are seriously disrupted.


The survivors of traumatic events have long been known to suffer many psychological consequences. Of all the possible stressors known to man, combat is one of the most devastating. War situations expose its victim to an infinite amount of pernicious stimuli which is far beyond that of normal peace time living. This impact is encapsulated in each individual and can affect generations to come.

Prior to World War I, psychological sequelae resulting from exposure to combat were perceived in terms of the man being weak, lacking military discipline or both (Figley, 1978; Goodwin, 1980). After World War I, specific clinical syndromes came to be associated with combat duty. One of the earliest psychopathologies related to combat was the diagnosis of "shell shock". Shell shock was defined as the
result of high air pressure of exploding shells with the following symptoms: anxiety, irritability, overwhelming depression, restlessness, insomnia, nightmares, and startle reaction to noises (Abse, 1984; Figley, 1978; Glass, 1969; Goodwin, 1980; Nefzger, 1970).

In the years following World War I, large numbers of men were treated for combat related stress disorders which resulted in more sophisticated theoretical approaches to this phenomena. Several events, which had an impact on the etiology of the shell shock syndrome, helped to further evolve the phenomena into the term 'war neurosis'. In 1940, Hurst published much information describing an etiology of traumatic neurosis resulting from shell shock that appeared to result in the molecular disturbances due to electrical changes in the central nervous system. However, this concept was quickly abandoned when individuals experiencing psychological breakdowns appeared, who had little or no direct exposure to combat (DeFazio, 1984; Figley, 1978; Goodwin, 1980; Grinker & Spiegel, 1945).

Concurrently, the psychoanalytic school of thought, which was a major influence at that time, was emphasizing in the etiology of predisposing personality factors of combat soldier rather than the actual traumatic events (Figley,
1978; Glass, 1969; Goodwin, 1980). This concept was revised by Simmel, one of Freud's students, who demonstrated the use of hypnosis with German soldiers to relieve or reduce stress symptoms. This led to the assumption that the etiologic factor of war neurosis resided in the repression portion of predisposing personality factors.

The Veterans Administration (VA) was also studying chronic and delayed forms of stress that were combat related. In 1941, Kardiner published a series of studies on chronic cases that were seen at the Bronx VA Hospital. Through his observations, he identified several common symptoms that were similar to the symptoms identified as shell shock. Kardiner in identifying delayed reactions felt that many of the symptoms he observed were due to conditioning because the individual's continued and persistent over-reaction to sound would understandably lead to irritability and explosiveness. He concluded that the conflicts in one's perceptions of the social world led to maladaptive behaviors and for the combat neurotic, the issue was the incapacity to adapt to the unstable somatic conditions of war. The last two concepts toward the etiology of war neurosis persisted throughout World War II.

Approaches to combat stress became even more pragmatic during the Korean War, with the inception of clinicians
providing immediate onsite treatment to those individuals showing stress symptoms (Glass, 1954). By 1958, Glass gathered a substantial amount of data relating to combat neuroses. He argued that this information has indicated a high correlation between the total number of days of combat exposure and the psychiatric breakdown of the individual. He concluded that after 80 to 100 days of combat exposure, the soldier has an increased vulnerability to psychological breakdown along with a decline in his performance. Thus, one of the concepts that emerged from the Korean war was the distinction of combat exhaustion as being separate from the physical fatigue form of exhaustion. This study originated the new term 'combat fatigue' that designates essentially the same category of symptoms described by 'shell shock' and 'war neuroses'. This new term, 'combat fatigue' became a focal point of interest for researchers, which resulted in many new studies on the casual relationship between combat experience, post stress reactions and individual differences.

Dodds and Wilson (1960) conducted several studies using groups of World War II veterans with chronic post-combat stress. They concluded that there existed a remarkable similarity between the behavioral and physiological responses of individuals experiencing combat fatigue and labora-
tory animals that had been purposely conditioned to elicit such responses. Dobbs and Wilson's theoretical adaptation was that combat fatigue could be a conditioned response.

Over a duration period of eight years, Archibald and Tuddenheim (1963) conducted several follow up studies on World War II and Korean combat fatigue cases. They found that combat veterans with stress syndromes indicated significantly higher rates of experiencing depression, severe headaches, combat dreams, irritability, excessive jum-
piness, sweaty hands or feet, diarrhea, and heart pounding both during and after their war experiences. Furthermore, combat veterans reported that these symptoms had increased in severity over time. Archibald and Tuddenheim concluded, similar to Freud, that the question of predisposing per-
sonality factors may be as significant as the actual life-
threatening experience.

These new approaches to the phenomenon of combat fati-
gue led the way to the indoctrination of new war strate-
gies. These new strategies seemed to be very gratifying because the percentage of Vietnam combat veterans who suf-
fered severely crippling wounds was 300 percent higher than World War II and 70 percent higher than the Korean War while the evacuations for psychiatric reasons dropped from 23 percent in World War II, to 6 percent in the Korean War, to 1.2 percent in the Vietnam War (Bourne, 1970; DeFazio,
1984). The major problem with this concept was that stress response syndromes were only seen as being experienced right after the termination of specific environmental stress events.

The Vietnam War presented a new type of catastrophic problem because battlefield psychological breakdowns did not materialize during the combat experience or even for a length of time after that experience. These delayed stress reaction effects now labeled as 'post-traumatic stress disorders' (PTSD) have proven to be particularly pernicious in nature as the symptoms do not emerge until a substantial length of time has occurred between the stressful event and the onset of the symptoms. Thus, symptoms were often not connected as a retroactive by-product resulting from the Vietnam war even though statistics indicated that during the next decade, after America terminated its involvement in Vietnam, the number of reported neuropsychiatric disorders significantly increased (Bourne, 1970; Goodwin, 1980). The individuals who were suffering from PTSD, along with the mental health professionals, did not understand why they were experiencing these feelings at this time. The Vietnam veteran was also faced with another dilemma. Because his stress reactions did not emerge until long after he was discharged from the military, the American government often denied him the use of the Veterans Admin-
istration medical assistance systems. These men were unable to receive either physical, psychological or financial help from the government.

In 1973, Van Putten and Emory gathered case history data in order to focus attention on the veteran's psychological problems resulting from the Vietnam war because it had been previously ignored by the American government. They noted that many patients waited years after their discharge to seek help because they rejected authority and did not trust institutions. The only reason these veterans sought help was because they were in desperation. Van Putten and Emory also discussed the problem of the veterans' explosive aggressiveness, flashbacks of combat scenes and extreme paranoia which had often led to erroneous diagnosis by clinicians.) PTSD was not a bona fide diagnosis at that time, so many of these veterans were diagnosed as having schizophrenic disorders, psychomotor epilepsy or acute substance abuse.

In 1980, the American Psychiatric Association published a third edition of the Diagnostic and Statistical Manual of Mental Disorders now referred to as the DSM III which contains a new category: Post-Traumatic Stress Disorder, Acute, Chronic and/or Delayed. This new category was developed as a result of the work of many professionals (researchers and clinicians) in a variety of disciplines.
Post-traumatic stress disorders are defined by the DSM III as the maladaptive emotional response that an individual may experience following any traumatic event. A traumatic event is characterized by feelings of a great loss and include combat, auto accidents, natural disasters, and rape. This disorder is often characterized by persistent high levels of the following symptoms: depression, anxiety, isolation, rage, avoidance of feelings, alienation, survival guilt, anxiety reactions, severe sleep disturbances, nightmares, intrusive thoughts, impairment of memory and concentration.

This new category in the DSM III, along with the voices and literature from so many individuals, brought into focus the problems that plague the lives of many men and women in our society today which stemmed from past experiences during the Vietnam War. By clarifying some of the psychological issues underlying PTSD, this study hopes to contribute to a better understanding of the people who suffer from this disorders.

Statement of the Problem

The amount of PTSD symptoms that has been experienced by individual Vietnam combat veteran varies; however, there is a clear indication that the number of individuals experiencing PTSD is on the increase. In 1980, Goodwin
indicated that between 1964 and 1973, 2.8 million men and women served in Vietnam. Of that, 56,000 were killed, 300,000 were wounded, and 500,000 had been experiencing PTSD. In 1981, Walker indicated that of the 2,769,000 who served in Vietnam; 57,000 were killed, 303,701 were wounded, and between 500,000 and 700,000 had been experiencing PTSD. In 1982, Langley indicated that of the 2.8 million who served in Vietnam; 56,000 were killed, 300,000 were wounded and between 750,000 and 800,000 had been experiencing PTSD.

It would appear that there is a relationship between the experiences that veterans had resulting from the Vietnam war and the emergence of depression following the war. The problem is to investigate the perceptions of Vietnam war veterans relative to their viewpoint on depression and how the Vietnam war might have influenced current depression among these war veterans.

**Purpose of this Study**

This study was designed to explore and gather information from selected Vietnam veterans relative to:

1. Their perceptions of current depression.
2. Any relationship that the Vietnam war may have had relative to present feelings of depression.
Need for this Study

Statistics and literature both indicate that for many individuals in our culture, the Vietnam conflict is not over.

In 1981, Walker stated that the Vietnam veteran has a 23 percent higher suicide rate than other people in the same age group. Along with this, he also stated that there are approximately 29,000 Vietnam veterans in prison, 37,000 on parole, 250,000 on probation, 87,000 awaiting trial and that 55 percent of all out-patients being treated for substance abuse through the VA hospital are Vietnam veterans. In 1981, Freidman indicated that the Vietnam veterans have a higher rate of divorce, unemployment and legal problems than their non veteran peers. The aforementioned figures suggest that both the individual veteran as well as our society are presently paying a very high price for this war. The war in Vietnam has been over for ten years, but for many, the conflicts and depression that evolved out of Vietnam still to this day remain unresolved.

Research directed toward male experiences of depression is quite limited. The few studies that focused on depression in the Vietnam combat veteran support the concept that many Vietnam combat veterans are currently
experiencing a full-fledged depressive syndrome in addition to the other symptoms of PTSD. The scores of the Vietnam veterans on the Minnesota Multiphasic Personality Inventory (MMPI), the Beck Depression Inventory (BDI), and the Zung Depression Scale are consistently within the pathological range for depression. This was best evidenced by Fairbank, Keane & Malloy (1983) study. Their results which were obtained from the MMPI, BDI, and Zung showed clear evidence that Vietnam veterans experiencing PTSD consistently scored in the pathological range on the dimension of depression.

The information obtained in this study may provide for a clearer understanding of these individual's feelings and perceptions. This greater understanding of these individuals may lend itself to revising and adding on to present day strategy treatment programs; thus, resulting in more effective treatment in reducing the anguish and pain being felt by so many of these veterans.

Definition of Terms

1. **Post Traumatic Stress Disorder (PTSD)**. This term derives its psychiatric nomenclature from the DSM III under anxiety disorders. The operational criteria for diagnosis encompasses four major areas. They are:
   a. the exposure to a recognizable stressor such as combat, catastrophic natural disasters, auto acci-
dents, concentration camp confinement, and kid
napping.

b. Reexperiencing the trauma through recurrent
dreams, flashbacks or intrusive thoughts.

c. Numbing of responsiveness as indicated by reduced
interest in external activities, feelings of
detachment or estrangement from others, and con-
striction of affective responses.

d. Two or more of the following symptoms that were
not present prior the trauma: hyperalertness,
sleep disturbance, survivor guilt, memory impair-
ment, difficulty in concentrating, avoidance of
activities which bring about the recollection of
the traumatic event and exaggerated startle
responses.

2. Diagnostic and Statistical Manual of Mental Disorders

It is the most widely used categorization of disorders
manual which provides unity and organization to the
diagnostic portion of the profession.

3. Depression. The DSM III defines depression as: an
affective disorder residing from an emotional state
that interferes with the organism's normal social and
bodily functions. These depressions are clinical sta-
tes in which persistent abnormal emotional symptoms are
associated with: appetite disturbance, sleep distur-
bance, change in body weight, psychomotor agitation or retardation, difficulty in concentrating, decreased energy; feelings of worthlessness, guilt, helplessness, and hopelessness; anxiety, suicidal tendencies, crying spells, loss of interest in work and other activities, and an impaired capacity to perform minimal everyday social functions.

4. **Vietnam combat veteran.** Is defined in this study as those individuals who served in the Armed Forces between 1960 and 1975, who were also stationed in Vietnam and had experienced at least one of the following:
   a. actual combat or crossfire.
   b. actual death of comrades other than by natural causes.
   c. continually working with mutilated bodies.
   d. being bombed.
   e. being seriously hurt other than by chance or accident.

5. **Vietnam era veteran.** Is defined as those individuals who were a member of the armed forces between 1960 and 1975 but did not serve in Vietnam. They received no war exposure. This definition differs from the one stated by the Veterans Administration as they also include the Vietnam combat veteran as part of the Vietnam era veteran, and this study chose not to.
CHAPTER II
REVIEW OF THE LITERATURE

The review of the literature covers four major areas. The first section reviews current depression among Vietnam combat veterans. The second section reviews the home coming experience of the Vietnam combat veteran. The third section reviews the date of expected return from overseas (DEROS), and the last section reviews literature concerned with current suicidal tendencies of Vietnam combat veterans.

Current Depression among Vietnam Combat Veterans

The problems with depression in the Vietnam combat veterans have received considerable attention from mental health researchers and service providers. Depression will be defined in this study as the presence of symptoms on four dimensions (Radloff, 1980): (1) The cognitive dimension refers to the depressed persons' hopeless and helpless beliefs about themselves and that nothing they do matters or that nothing will ever get better for them. (2) The motivational/behavioral dimension refers to feelings of apathy and lack of energy. (3) The affective dimension includes feelings of sadness and depression; however, the feelings of irritability, anxiety, anger, and hostility can also be prevalent. (4) The vegetative dimension refers to
disturbances of appetite and sleep. The intensity of these symptoms can vary depending on the severity of the individual's depression.

Recent studies indicated that depression was often the most frequently experienced symptomatic reaction element of PTSD. They also indicated that depression was experienced significantly more often and at a higher severity by these Vietnam combat veterans than by the majority of the civilian population (Atkinson, Sparr, Sheff, White & Fitzsimmons, 1984; Helzer, Robins, Wish, & Hasselbrock, 1979).

In 1983, Faribank, Keane and Malloy conducted a very thorough study on PTSD symptoms in which the subjects were presented with five major psychological inventories. They were: The MMPI, the BDI, the STAI, the FSS, and the Zung. All five tests concluded that those Vietnam combat veterans who were diagnosed with PTSD also were experiencing depression significantly more than the 'norm' set up for that particular test. The depression experienced by these individuals was so severe that the results obtained from their scores on the MMPI stayed consistently within the pathological range on the depression profile.

In 1984, Foy, Rueger, Sipprelle and Carroll studied the effects of PTSD by using the MMPI. Their results of the depression profile on the MMPI indicated that these Vietnam
combat veterans were scoring significantly higher than the norm of the population. Thus, this study could help to confirm and bring more validity to the aforementioned studies.

Recently, the clinical etiology of depression has been viewed as a two-fold phenomenon. First, there is a reaction to a precipitating event such as combat. Second, there are different levels of susceptibilities within each individual (Beck, 1967; Radloff & Rae, 1979; Radloff, 1980; Klerman & Weissman, 1980; Warren & McEachren, 1983). The question is which is the prevalent etiological factor for current depression -- the precipitating event or susceptibility of the personality.

One position towards current depression in the Vietnam combat veterans was that high levels of susceptibility within an individual could have been derived from long-standing personality disorders; thus, causing presenting problems in living (Fisher, 1972). Strange (1969) indicated that service in Vietnam was the secondary etiological factor to current psychological problems such as depression. His claim was that most individuals who are presently experiencing problems in living had a history of personality disorders. Support for the position that precipitating events, such as combat exposure, are not a major contributing factor in current problematic symptoms evolved
around the comparison of the MMPI profiles. When compared, the profiles of the Vietnam combat veterans were similar to the in-patient Vietnam era veterans who did not serve in Vietnam, and dissimilar to the profiles of psychiatric in-patient war veterans of preceding wars (Braatz & Lumry, 1969). Strange (1974) also indicated that the emotional problems between the Vietnam combat veterans and their non-military peer group were similar. Therefore, current problematic symptoms could not be a retroactive by-product of combat exposure.

Other mental health professionals disagreed with the position of Vietnam combat veterans with psychiatric problems also had long-standing personality disorders. Their claim was service in Vietnam (exposure to combat) was the primary etiological agent in current depression. Helzer, Robins and Davis (1976) gathered information from 470 Army enlisted men who served in Vietnam in 1971. This study was looking at the relationship between men who actually experienced combat and their later depression. Their results confirmed their hypothesis and gave a clear indication that post Vietnam depressive syndromes were significantly more frequent in men who experienced combat.

The relationship between life stress and psychiatric disorder has been found in a number of populations. In
1971, Berkman replicated Langner and Michael's previous study and found that the greater the psychiatric risk, the greater the stress induced psychological disorders. Dohrenwend (1967) found that test scores taken from Langner's psychological symptom inventory increased or decreased over two years according to negative or positive life experiences. In 1971, Myers, Lindenthal and Pepper studied the correlation between life stress events and the presence of psychiatric symptomatology in a normal population. Their high correlational findings also confirmed the position that precipitating events are the major factor in psychological sequelae.

The Vietnam combat experience was quite unique in that it could not have been seen as just one or two precipitating events. (Counter-guerrilla combat experience was a cumulative, chronic, recurring pattern of traumatic exposure to possible personal death, death of comrades, and surrounding destruction.) The primary factors in the psychological casualties of combat veterans were due to the ambiguous and paradoxical conditions in which the Vietnam war was fought, its situational stress of recurring traumatic experiences, and the sense of being alien and profoundly lost, yet imprisoned in a situation as absurd and unreal as it was deadly (Bourne, 1970; Eisenhart, 1977; Figley, 1978; Goodwin, 1980; Lifton, 1972; Marin, 1981; Shatan, 1973).
The veteran who was experiencing PTSD, especially depression, would often cry when recalling various combat events as he has usually experienced at least one event in which he has witnessed the violent death of a close friend (Bourne, 1970; Figley & Leventman, 1980; Goodwin, 1980; Howard, 1975). Unable to avenge his comrade's death as the enemy was usually nebulous, these individuals often developed a sense of helplessness about their condition. Many men felt that regardless of how they acted, the situation was still the same, an endless, chronic pattern of casualties and deaths with no ground gained or perceivable goals attained (Bourne, 1970; Figley & Leventman, 1980; Goodwin, 1980; Howard, 1975; Langley, 1982). "Regardless of how well one worked, sweated; bled and even died, the outcome was the same" (Goodwin, 1980, p. 11). This feeling of helplessness resulting by one or a series of traumatic events becomes internalized. The individual then comes to feel helpless not only in controlling his external environment, but also in his own state of mind. A high incidence of depression is seen as resulting from the internalized lack of control (Seligman, 1967).

Along with the death and the feeling of helplessness were the compromises made by each soldier in order to survive. The thought, feelings, and fears were based on the harshest of realities and remained omnipresent in the minds
of these men until they learned to emotionally detach themselves from the situation. Psychic numbing was a good battlefield strategy, as grieving and depression were not only unproductive but also dangerous. This same strategy was then carried back to civilian life where it often rigidified over time and thus became maladaptive and counter productive. As a result, many Vietnam combat veterans are now experiencing a continued, chronic sense of free floating, unidentified depression (Eisenhart, 1977; Lifton, 1975; Marin, 1981; Shatan, 1973).

On the average, soldiers in Vietnam were younger than their counterparts from former wars. The average age for the Vietnam soldier was 19 while in World War II, the average age was 26. Many investigators claim that well-adjusted late adolescents were emotionally brutalized by their experiences in Vietnam (DeFazio, 1975; Goodwin, 1980; Shatan, 1973). The younger the person is at the time of induction, the less likely that a coherent identity had been formed. (Many investigators felt that the younger Vietnam veteran had an unclear identity and; therefore, had less resources to cope with the stresses of combat and stateside re-orientation.) This could be a major contributing factor towards the extreme depression often experienced by the Vietnam combat veteran.

Life now is barely tolerable for many Vietnam veterans
and they have often resorted to isolation and/or self-medication (Brende, 1984; Boscarino, 1981; Helzer, 1984; Lacoursiere, Godfrey & Ruby, 1980). The Vietnam war was not any worse than any other war; however, certain facts and events that were unique only to this war may have been contributing factors to the onset of delayed stress phenomenon.

The Homecoming Experience

Another circumstantial event which was unique only to the Vietnam war and which contributed significantly to those veterans now experiencing a heightened sense of depression was the homecoming experience (Bourne, 1970; Bours, 1973; Egendorf, 1975; Eisenhart, 1977; Figley, 1978; Figley & Leventman, 1980; Goodwin, 1980; Horowitz & Solomon, 1975; Howard, 1975; Langley, 1982; Moskos, 1975; Pilisuk, 1975; Renner, 1973). Due to the ambiguity of the Vietnam war, many Americans did not support its cause. Thus, an angry, hurt, guilty, depressed, and alienated man came home to an unresponsive and often hostile society. He desperately tried to put together some positive resolution to this profound event but no one at home seemed to care. Instead, he was greeted with anti-war protestors and was given no opportunity to share his feelings and experiences or even have them validated. Many of these men returned home feeling used, deceived and betrayed by their family,
friends, authority figures, and the government (Bourne, 1970; Bours, 1973; Figley, 1978; Marin, 1980; Shatan, 1973; Walker, 1981; Walker & Nash, 1980; Williams, 1980). Many experienced the impossibility of explaining to others what drove them. All of these factors helped to increase their guilt and sense of alienation. Home was no longer home for many of them. When their response to the world around them could not have been spoken or acted upon, they suffered inside causing them to plunge deeper into distress and depression (DeFazio, 1975; Howard, 1975). For them, the suffering of others was real. The dead remained dead, and the maimed were forever maimed. This type of knowledge, the staggering burden or anguish, horror, guilt and moral pain stemming from the realization of one's past acts, was especially difficult for many Vietnam veterans to bear as it isolated them and often set them irrevocably apart, thus locking them simultaneously into a silence and a solemnness that was as much a cause of their depression as their past experiences and memories. Many often felt, why even bother any more (Bourne, 1970; Figley & Leventman, 1980; Langley, 1982; Lifton, 1975).

**Date of Expected Return from Over Seas (DEROS)**

The date of expected return from over seas was also unique to the Vietnam war and subsequently a probable
factor in the delayed stress issue of current depression. The psychiatric casualty rate in previous wars had been extremely high, and since increased risk of psychiatric sequelae had been found to be associated with longer exposure to the stress of combat (Glass, 1954), the rotation system in Vietnam was limited to 12 months. The new battlefield strategy gave promise to the men that they could be evacuated and sent back home without being either physically or psychologically injured. The goal was to reduce the frequency of psychiatric breakdown associated with war stresses. However, recently it has been found that the 12-month rotation system has also hindered and undermined the development of group cohesion and identification, thus resulting in a highly individualized and encapsulated event for each individual. The war began the day the soldier landed in Vietnam and ended when he returned to the United States (Bourne, 1970; Figley, 1978; Goodwin, 1980; Langley, 1982; Moskos, 1975; Renner, 1973). This meant that tours in Vietnam were isolated, individual events with the DEROS date as their fantasy that all problems and pain will cease on a specific day.

The individualized rotation system was considered to be detrimental as survival whether physical or emotional depends on strong group cohesion and identification (Grinker & Spiegel, 1945; Renner, 1973). For this reason,
soldiers would often single out one other individual (a buddy) in which he could depend on and receive companionship from. The need for mutual dependency and companionship among the soldiers encountering guerrilla warfare was so great that intense emotional outbursts often resulted when a buddy was killed (Langley, 1982; Renner, 1973). When the individual's tour was completed, he returned to the United States alone, unaccompanied and was usually processed back to civilian life within 36 hours (Goodwin, 1980). Such procedures prohibited the men from collectively working though and integrating their war experiences with one another, and providing the possibility of resolving or coming to terms with their emotional injuries (Bourne, 1970; Figley & Leventman, 1980; Goodwin, 1980). The Vietnam veterans were left to cope alone with the personal aftermath of the war. Never before had American soldiers returned home alone, so quickly and so unwelcomed.

Current Suicidal Tendencies of Vietnam Combat Veterans

Research directed towards actual suicides and suicidal tendencies in the Vietnam combat veteran is quite limited. Most of what is known about suicides comes from studies like Atkinson, Sparr, Sheff, White, and Fitzsimmons (1974) which focused on the full range of PTSD. The results of the study have indicated that 45 percent of the veterans
experiencing PTSD acknowledged their proneness to suicidal behavior while only 15 percent of the veterans without PTSD acknowledged their tendency towards suicidal behavior.

Probably the most detailed and current literature on the topic of suicide was in 1984, when the Veterans Administration in Washington DC published a pamphlet entitled *Suicides: Vietnam Era Veterans within VA Health Care System*. Under the sub-heading of: Suicides between October 1, 1978 and September 30, 1980, this pamphlet states the following:

During this period of time, Vietnam Era Veterans constituted 14% of patients in VA medical centers. However this group represented 29% of the suicide population. The Vietnam Era veterans, therefore, overcontributed by 15% of the total number of suicides ... It is the Vietnam Era veterans who still make up roughly one-third of all suicides. They deservedly require the most focused attention for suicidal prevention, because they have consistently overcontributed a higher percentage among all suicides in VA medical centers.

In the same pamphlet, attempted and accomplished suicides in the year 1981 and 1982 were broken down by age groups which also indicated that the Vietnam era veterans are contributing disproportionately to the overall suicide rates (see appendix D).
In a preliminary study made by the Veterans Administration on the mortality pattern of the Vietnam era veteran between 1965 - 1982, of the 17,372 deaths, 1,610 (9.27%) were deaths by suicides. These were actual documented suicidal deaths with death certificates. Attention has been directed toward gathering more conclusive evidence on suicidal rates among the Vietnam combat veterans. The Veterans Administration is currently running a nationwide study on approximately 60,000 deaths to assess their pattern of mortality (Veterans Administration, Washington DC, 1984).

In 1982, the Veterans Administration Wadsworth Medical Center in Los Angeles, California printed a pamphlet entitled: Status of Suicides in Veterans Administration Hospitals (Report VI), which showed the suicide rate in the years 1970 - 1980 among the Vietnam era veterans to be between 325 and 450 (See Appendix E). The authors of this pamphlet, Farberow and Williams also stated:

The comparison over the years by rates presents a much different picture. These show that the Vietnam, veteran has consistently obtained the highest rate of suicide of any of the groups, an average of 383 .... In general, it is still the Vietnam veteran who requires the most focused attention for suicide prevention, with a consistent overcontribution and the consistently
highest rate among all of the hospital suicides (see appendix F).

Even though the statistics from these pamphlets are frightening, it still does not account for 100 percent of the suicidal deaths among the Vietnam era veterans as there are a number of ways a veteran can kill himself and not have it appear to be suicidal. The Veterans Administration also relies solely on reported information in which not 100 percent of the deaths are reported. Therefore, only a portion of the actual suicides are being reported to the Veterans Administration.

Summary

The studies and literature discussed in Chapter II have indicated that current depression in the Vietnam combat veteran is acute. They are currently experiencing an extreme amount of depression, and they are consistently scoring significantly higher on depression than the normal population.

Studies and literature indicate that the homecoming experience often helped to exaggerate their feelings of guilt, depression and alienation. The veterans were given little or no opportunity to share their feelings or have them even validated; thus, they suffered inside causing them to sink deeper into depression.
Literature has revealed that the 12-month rotation system (DEROS) created considerable damage to the need of group identity; thus, making this an individual war for each veteran. The veterans from the Vietnam war missed the 'long boat ride home' where they could make some resolution toward their war experiences. The Vietnam combat veteran was left to cope alone with his personal aftermath of the war.

Finally, the literature review on the suicidal tendencies of the Vietnam veteran is of grave concern. The extreme high rates of suicides alone should be evidence that these people are hurting and are in need of help.

When all the aforementioned literature review and studies are taken into consideration, the evidence is overwhelmingly clear, the war in Vietnam did have a profound negative effect on those individuals who fought there.
Subjects

A total of thirty male Vietnam combat veterans, living in the southern California area, participated in this study. Nineteen of these participants were participating in group activities in connection with the Riverside Vets Center. Eleven of these subjects were participating in group activities in Barstow. All served in the armed forces between 1965 and 1974, and had undergone actual combat in Vietnam. They had been diagnosed as experiencing some level of PTSD. As many of these participants preferred total anonymity, no demographic data was obtained.

Instruments

All participants completed two sections of self-report questionnaires that were used for the collection of data in this study.

Section I consisted of the first questionnaire called The Center for Epidemiological Studies--Depression Scale (CES-D). The CES-D (Radloff, 1977) is a 20-item scale which were selected from an item pool derived from existing depression scales including the Beck Depression Inventory and the Minnesota Multiphasic Personality Inventory. These measures have proven to be highly valid and reliable tests
of depressive symptoms. The CES-D is designed to sample the major components of depressive symptomatology: the affective, the cognitive, and the somatic. Scale items consist of first person statements in which examinees indicate how often during the past week they have felt or behaved in the manner described. Respondents rate each of the 20 items on a 4-point scale ranging from 0 to 3 and are identified as follows: 0—rarely or none of the time (less than 1 day); 1—some or little of the time (1-2 days); 2—occasionally or moderate amount of time (3-4 days); 3—most or all of the time (5-7 days). The scale attempts to access the following aspects of depression: loss of appetite, feelings of guilt and worthlessness, depressed mood, feelings of helplessness and hopelessness, sleep disturbance, and psychomotor retardation (Radloff, 1977).

Even though the CES-D was developed for use within the general population, it has also proven to be valid in differentiating between clinical and non-clinical samples (Radloff, 1977). All the variables in the 20-item content was sometimes positively and sometimes negatively stated with scoring adjusted appropriately. The higher the score, the greater the amount of the variable being measured i.e. the higher the depression score, the more the participant was rating himself as being depressed (see appendix B).

Section II consisted of the second questionnaire which
was called The Vietnam Combat Veterans' Questionnaire (VCVQ). This was a 10-item questionnaire developed by the author for this study. Participants rated each of the 10 items on a 4-point scale ranging from 0 to 3 and are identified as follows: 0—never, 1—sometimes, 2—often, and 3—very often. The items used to define each variable are indicated below in abbreviated form (see appendix C for items as they appeared in the questionnaire).

1. Amount of perceived combat (#1).
3. Current depression was retroactive to the Vietnam war (#5, #9).

Procedure

The participating Vietnam veterans were contacted at the end of a group session and were told that participation in the study was on a voluntary basis and that they were free to withdraw from the study at any time by contacting the researcher. After giving their signed informed consent (see appendix A), the instructions to both questionnaires were read and questions pertaining to these instructions were answered. After both questionnaires were completed and handed back to the researcher, a debriefing session took place in which the purpose of the study was discussed. At the end of the debriefing session, each participant was
asked if they felt alright and any feelings they wanted to talk about was discussed.

The participants received a seven-day follow-up in person by the researcher to double check for any problems that might have arisen as a result of their participation in this study.

**Limitations of the Study**

There were several limitations to this study. First and foremost was the difficulty in obtaining the study sample. The refusal to participate maintained at a constant 30%. A major symptom of this target population is isolation and distrust toward any representative of authority or institution. It may be that refusal to participate indicated very high levels of PTSD which would include high levels of depression; therefore, this study did not include those Vietnam combat veterans who were most depressed, making this an important factor in the selection of subjects.

Outreach and Satellite treatment programs were utilized in acquiring access to the sample population. Individuals who were seen by these programs were self-identified and the actual progress made between the time of admittance and the time this survey was conducted was unknown. It may be that these individuals were more depressed prior to self-
identification in the program. This is also an important factor in the process of subject selection.

The design utilized was retrospective i.e. subjects responded to self-report questions pertaining to present feelings of depression based on past precipitating events. Finally, this sample was relatively small (n 30); thus, there may be a greater degree of error associated with generalizations from this sample.
CHAPTER IV
RESULTS

The purpose of this study, as stated in Chapter I, has been to investigate the Vietnam combat veterans' current depression and see if they view their depression as a result of the Vietnam war. All of the participants used in this study have been diagnosed as experiencing some level of PTSD.

The data in this study was subject to several types of statistical analysis; therefore, this chapter will present the results of the study in the following order: (1) Vietnam combat veterans' mean and standard deviation scores on the CES-D, (2) matched, non veteran populations' mean and standard deviation scores on the CES-D, (3) comparison on the Vietnam combat veteran and the non veteran population on CES-D scores, (4) Vietnam combat veterans' mean, and standard deviation on the VCVQ.

Vietnam Combat Veterans' CES-D Scores

Table 1 presents the means and standard deviations of the Vietnam combat veterans for each of the 20 items listed in the CES-D questionnaire. In discussing their four highest scores out of a possible 3.0, the veterans consistently scored higher on the affective dimension with feeling sad at the top ($M = 2.16$). The second highest
<table>
<thead>
<tr>
<th>Item Name</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bothered</td>
<td>1.10</td>
<td>.99</td>
</tr>
<tr>
<td>Appetite loss</td>
<td>.77</td>
<td>.81</td>
</tr>
<tr>
<td>Blues</td>
<td>1.80</td>
<td>1.06</td>
</tr>
<tr>
<td>As good as others</td>
<td>1.86</td>
<td>1.19</td>
</tr>
<tr>
<td>Concentration</td>
<td>1.20</td>
<td>1.05</td>
</tr>
<tr>
<td>Depressed</td>
<td>1.87</td>
<td>1.00</td>
</tr>
<tr>
<td>Effort to do things</td>
<td>1.53</td>
<td>1.07</td>
</tr>
<tr>
<td>Hopeful</td>
<td>1.13</td>
<td>1.10</td>
</tr>
<tr>
<td>Failure</td>
<td>1.17</td>
<td>1.08</td>
</tr>
<tr>
<td>Fearful</td>
<td>1.47</td>
<td>1.04</td>
</tr>
<tr>
<td>Restless sleep</td>
<td>1.83</td>
<td>1.11</td>
</tr>
<tr>
<td>Happy</td>
<td>1.00</td>
<td>.98</td>
</tr>
<tr>
<td>Less talkative</td>
<td>1.23</td>
<td>.97</td>
</tr>
<tr>
<td>Lonely</td>
<td>1.90</td>
<td>1.06</td>
</tr>
<tr>
<td>Others unfriendly</td>
<td>.50</td>
<td>.73</td>
</tr>
<tr>
<td>Enjoyed life</td>
<td>1.13</td>
<td>.87</td>
</tr>
<tr>
<td>Crying spells</td>
<td>.53</td>
<td>.86</td>
</tr>
<tr>
<td>Sad</td>
<td>2.16</td>
<td>.91</td>
</tr>
<tr>
<td>Disliked by others</td>
<td>.60</td>
<td>.81</td>
</tr>
<tr>
<td>No motivation</td>
<td>1.30</td>
<td>.87</td>
</tr>
</tbody>
</table>
score was on feeling lonely ($M = 1.90$), the third highest score was on feeling depressed ($M = 1.87$), and the forth highest score was on the cognitive dimension in which they had a mean score of $1.86$ for feeling they are as good as others (self worth).

**Non Veterans' CES-D Scores**

Table 2 presents the means and standard deviations of the matched, non veteran population for each item listed on the CES-D questionnaire. This particular data was matched for gender, age group, and race by Lenore S. Radloff from the Center for Epidemiologic Studies in Maryland who graciously submitted the information for this study. The data serves as a baseline to compare how depression occurs in the non veteran population to the depression experienced in the Vietnam combat veterans. The non veteran population consistently scored highest on the cognitive and behavioral dimensions with feeling hopeful toward the future at the top ($M = .82$). The second highest score was on motivation to do things ($M = .81$), the third highest score was on having difficulty sleeping ($M = .74$), and the forth highest score was on concentration ($M = .59$).

**Comparison of Vietnam Combat and Non Veteran CES-D Scores**

Table 3 presents the scores derived from a $F$ test when comparing the Vietnam combat veterans' CES-D scores to the
TABLE 2

Means and Standard Deviations of CES-D Scale Scores for 210 Male Non Veterans

<table>
<thead>
<tr>
<th>Item Name</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bothered</td>
<td>.57</td>
<td>.85</td>
</tr>
<tr>
<td>Appetite loss</td>
<td>.47</td>
<td>.85</td>
</tr>
<tr>
<td>Blues</td>
<td>.22</td>
<td>.58</td>
</tr>
<tr>
<td>As good as others</td>
<td>.46</td>
<td>.97</td>
</tr>
<tr>
<td>Concentration</td>
<td>.59</td>
<td>.86</td>
</tr>
<tr>
<td>Depressed</td>
<td>.45</td>
<td>.75</td>
</tr>
<tr>
<td>Effort to do things</td>
<td>.81</td>
<td>1.10</td>
</tr>
<tr>
<td>Hopeful</td>
<td>.82</td>
<td>1.11</td>
</tr>
<tr>
<td>Failure</td>
<td>.10</td>
<td>.39</td>
</tr>
<tr>
<td>Fearful</td>
<td>.18</td>
<td>.54</td>
</tr>
<tr>
<td>Restless sleep</td>
<td>.74</td>
<td>.99</td>
</tr>
<tr>
<td>Happy</td>
<td>.46</td>
<td>.81</td>
</tr>
<tr>
<td>Less talkative</td>
<td>.43</td>
<td>.79</td>
</tr>
<tr>
<td>Lonely</td>
<td>.18</td>
<td>.56</td>
</tr>
<tr>
<td>Others unfriendly</td>
<td>.13</td>
<td>.43</td>
</tr>
<tr>
<td>Enjoyed life</td>
<td>.39</td>
<td>.86</td>
</tr>
<tr>
<td>Crying spells</td>
<td>.28</td>
<td>.21</td>
</tr>
<tr>
<td>Sad</td>
<td>.23</td>
<td>.56</td>
</tr>
<tr>
<td>Disliked by others</td>
<td>.08</td>
<td>.29</td>
</tr>
<tr>
<td>No motivation</td>
<td>.50</td>
<td>.79</td>
</tr>
</tbody>
</table>
### TABLE 3

Analysis of Variance of CES-D Scale Scores Between Vietnam Combat and Non Veterans

<table>
<thead>
<tr>
<th>Item Name</th>
<th>F [1,239]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bothered</td>
<td>9.68</td>
</tr>
<tr>
<td>Appetite loss</td>
<td>3.21</td>
</tr>
<tr>
<td>Blues</td>
<td>149.09</td>
</tr>
<tr>
<td>As good as others</td>
<td>51.00</td>
</tr>
<tr>
<td>Concentration</td>
<td>16.69</td>
</tr>
<tr>
<td>Depressed</td>
<td>84.41</td>
</tr>
<tr>
<td>Effort to do things</td>
<td>11.31</td>
</tr>
<tr>
<td>Hopeful</td>
<td>23.47</td>
</tr>
<tr>
<td>Failure</td>
<td>105.75</td>
</tr>
<tr>
<td>Fearful</td>
<td>110.31</td>
</tr>
<tr>
<td>Restless sleep</td>
<td>30.68</td>
</tr>
<tr>
<td>Happy</td>
<td>10.93</td>
</tr>
<tr>
<td>Less talkative</td>
<td>25.28</td>
</tr>
<tr>
<td>Lonely</td>
<td>185.40</td>
</tr>
<tr>
<td>Others unfriendly</td>
<td>15.59</td>
</tr>
<tr>
<td>Enjoyed life</td>
<td>19.21</td>
</tr>
<tr>
<td>Crying spells</td>
<td>12.72</td>
</tr>
<tr>
<td>Sad</td>
<td>257.98</td>
</tr>
<tr>
<td>Disliked by others</td>
<td>45.00</td>
</tr>
<tr>
<td>No motivation</td>
<td>25.94</td>
</tr>
</tbody>
</table>
non veteran's CES-D scores. These comparisons used a one-way analysis of variance (ANOVA) utilizing the differences in the means and standard deviations from each of the two groups. This was done by providing the computer with the means, standard deviations, and number of subjects for each group. With this information, the computer could retrace and calculate previous steps, thus, arriving at a $F$ test. Before discussing the four major differences between the two groups, it should be noted that the majority of the items were at the $p < .01$ level. The highest scoring difference between the two groups was the feelings of sadness $F (1,239) = 257.98, p < .001$. The second highest score was feeling lonely $F (1,239) = 185.40, p < .001$. The third highest score was feeling blue $F (1,239) = 149.09, p < .001$, and the forth highest differentiating score was on feeling fearful $F (1,239) = 110.31, p < .001$.

**Vietnam Combat Veterans' VCVQ Scores**

Table 4 presents the means and standard deviations for the Vietnam combat veterans on all 10 items listed in the VCVQ. Item 1 and 2 depict the amount of actual experienced combat. On an average, this group of Vietnam combat veterans perceived they encountered combat approximately 67 percent of the time and their level of danger (on a scale from 1 to 100) was at the 71 percent level. In discussing
<table>
<thead>
<tr>
<th>Item Name</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combat duration</td>
<td>2.03</td>
<td>.89</td>
</tr>
<tr>
<td>Amount of danger</td>
<td>2.13</td>
<td>.86</td>
</tr>
<tr>
<td>Depressed</td>
<td>2.17</td>
<td>.79</td>
</tr>
<tr>
<td>Restless sleep</td>
<td>1.87</td>
<td>.94</td>
</tr>
<tr>
<td>Retroactive moods</td>
<td>1.77</td>
<td>.68</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>.83</td>
<td>.75</td>
</tr>
<tr>
<td>Life is meaningless</td>
<td>1.17</td>
<td>.75</td>
</tr>
<tr>
<td>Crying spells</td>
<td>1.03</td>
<td>.90</td>
</tr>
<tr>
<td>Retroactive depression</td>
<td>1.87</td>
<td>.78</td>
</tr>
<tr>
<td>Self medicate</td>
<td>.70</td>
<td>.88</td>
</tr>
</tbody>
</table>
their four highest scores out of a possible 3.0 score, the veterans consistently scored the highest on feeling depressed \((M = 2.17)\). The second highest score was equally on two different items: (1) restless sleep and (2) feeling their depression retroactively involved the Vietnam war \((M = 1.87)\), and the forth highest score was on their current moods as a by-product of their experience in Vietnam \((M = 1.77)\).

**Summary**

The aforementioned results described by both the CES-D and the VCVQ indicate that the Vietnam combat veteran is experiencing disproportionate levels of depression when compared to the 'normal' population. The CES-D scores portray the non veterans as experiencing some depression from time to time but never lasting for any real length of time. However, the CES-D scores depict the Vietnam combat veteran as being continually, chronically depressed with no hope for the future. This individual fights the feelings of depression at least once a day for the rest of his life. This type of depression could be classified by the DSM III as a major depressive disorder.

The profile of the Vietnam combat veteran as shown by the VCVQ indicate that they are currently experiencing an extreme amount of depression. The finding concurs with the
CES-D questionnaire -- depression is at problematic levels. The VCVQ also brings out the fact that the majority of these individuals feel combat in Vietnam has had a negative profound effect on them causing feelings of sadness, loneliness, fearfulness and depression to be present within them. The results obtained from this study also correlate with the results from previous studies using the BDI and the MMPI -- that high levels of depression is a symptom for those Vietnam combat veterans who are experiencing PTSD.
CHAPTER V
DISCUSSION

This chapter will present the information in the following order: (1) the discussion of the findings, (2) implications for future research, and (3) concluding remarks.

Discussion of the Findings

To help focus the discussion towards relevant aspects, the major purpose and findings of the study will be reiterated. The purpose of this study was to evaluate the hypothesized current levels of depression in the Vietnam combat veteran who is experiencing PTSD. Two questionnaires, the CES-D and the VCVQ, were utilized to access the severity of their current depression, the relationship between current depression and Vietnam combat experience, and the perceived life-threatening danger they experienced. The sample of Vietnam combat veterans was compared to a sample of non veterans who were matched on: (1) gender (male), (2) age range (between 30 and 40 years old), and (3) race (caucasian). The expectation was that the sample of Vietnam combat veterans would score significantly higher than the control group on the depression scale. The results confirmed the expectation.

The findings also indicated the prevalence of
depression among this sample of Vietnam combat veterans, as 83 percent of them fell into the clinically depressed range of the CES-D. The usual prevalence rate of depression established by the CES-D for non-psychiatric samples is between 15 and 19 percent (Radloff, 1977). When comparing the scores of the Vietnam combat veteran sample to the sample of 70 Washington County psychiatric in-patients, the mean score among the Vietnam combat veterans was 27.89, and the mean score for the psychiatric in-patients shown in Radloff’s 1977 study was 24.42. The implication is the 60 percent of the sample Vietnam combat veterans scored higher on the CES-D questionnaire than the 70 psychiatric in-patients in Washington County.

The findings in this investigation supports previous studies — that depression is a major symptom of PTSD (Atkinson, Sparr, Sheff, White, & Fitzsimmons, 1984; Fairbank, Keane & Malloy, 1983; Helzer, Robins, Wish & Hesselbrock, 1979; Helzer, Robins & Davis, 1976; Nace, Meyers, O'Brien, Ream & Mintz, 1977; Silver, 1984). The results from the study agrees with Fairbank, Keane & Malloy (1983) and Nace, Meyers, O'Brien, Ream & Mintz (1977) studies in which the level of depression measured often remained in the clinically depressed range regardless of which test was used.

Many problems can occur concerning the disporportionate
levels of depression experienced by the Vietnam combat veteran. Experiencing this amount of depression, the individual is presumably functioning at a very low level as employment would be hard to maintain and decisions would be hard to make. Problems of misdiagnosing the symptom as a major depressive disorder could be easily made. The CES-D results from the study do indicate there is some differences between depression experienced by the Vietnam combat veteran and those who are severely depressed. Even though the Vietnam combat veterans' scores were higher on the depressive dimension, their scores also reflected a reasonable sense of self worth. In contrast, the severely depressed individual also suffers from extreme low self-esteem as indicated by Prosen, Clark, Harrow and Fawcett's 1983 study.

Finally, the results from the study also supports Foy, Rueger, Sipprelle & Carroll (1984) study, that the extent of combat exposure is often a precursor to present day depression. The Helzer, Robins, & Davis (1976) study was validated by this study in which they observed levels of depressive symptoms substantially higher in combat veterans than in non veterans. They also indicated a strong correlation between combat experience and depression. However, in 1979, Helzer, Robins, Wish, & Hesselbrock's study concluded that preservice personality variables seemed to
be better predictors of clinical outcome than combat experience. A possible reason for this discrepancy is that the sampled subjects for the 1979 study consisted of veterans who used illicit drugs in Vietnam. The results from two studies conducted by Figley (1978) and Horowitz & Solomon (1975) suggested that veterans experiencing PTSD reported significantly higher levels of combat in Vietnam than did veterans not experiencing this disorder.

In conclusion, the information derived from the present study is consistent with findings from the aforementioned studies. More important, the data presented here suggest the depression currently experienced by Vietnam combat veterans has reached clinical levels. The major findings of this study would seem most easily conceptualized and interpreted by viewing Vietnam combat veteran's depression within the context of the affective dimension—feeling blue, sad, and lonely. Related studies investigating male depression have found that males associate depression with guilt, weakness, and failure resulting in low self-esteem (Goldman & Ravid, 1980; Posen, Clark, Harrow & Fawcett, 1983). Unlike male depression characterized by previous studies, the findings from this study indicate that Vietnam combat veterans' self-esteem and sense of self worth remains in the 'normal' range while they are in this severe state of depression. In light of
the findings from the study, treatment strategies concerning depression among the Vietnam combat veteran may need to be focused a little differently than when treating severely depressed individuals.

**Implications for Future Research**

In this section, directions towards future research are discussed. The main findings of this study was that high levels of depression was a major symptom of PTSD which had been most often found in men who experienced prolonged combat. Whether this depression was experienced by Vietnam veterans who are not experiencing PTSD is unknown. Future research comparing larger samples of Vietnam veterans, whose diagnosed as experiencing PTSD with those not experiencing PTSD utilizing more variables such as locus of control and demographic data could help to determine the actual nature of the post Vietnam syndrome.

As stated in Chapter 2, the review of literature indicates several major differences between the Vietnam war and previous wars: (1) the average age of the soldier, (2) the 12 month rotation system, and (3) the lack of civilian population support. Future inquiry into isolating each of the variables and then comparing their relationship to PTSD may also help in determining the nature of the Vietnam veteran's psychological sequelae. Research in this area
could help bring about more effective treatment programs focusing on specific issues and techniques which could help in relieving some of the hurt, pain, and anguish felt by so many of these men.

**Concluding Remarks**

Post-traumatic stress disorders are estimated to affect over two thirds of the veterans who experienced heavy combat in Vietnam. The symptoms include: (1) major depression often accompanied by a sense of helplessness, (2) social isolation or withdrawing from family and friends, (3) alienation or a sense of emotional numbing, (4) sleep disturbances, (5) intrusive thoughts, (6) feelings of rage, (7) feelings of guilt for surviving when others did not, and (8) anxiety reactions. Diagnosing the individuals correctly can also be a presenting problem when considering the multitude of symptoms PTSD encompasses along with high test scores on the depressive and schizophrenic dimensions.

In all wars people are traumatized, maimed, and killed. All wars bring about deep social and psychological ruptures that intrude on individual lives in ways that cannot be ignored by those affected or by others who care and want to understand them. For this reason, military war strategies need to include the establishment of preventive treatment
programs. The focus of these programs would be to treat and desensitize any military member returning from high stress areas. The goal of the program would be to help the individual bring some resolution to that segment of his or her life before processing him back into the main stream of life. Hopefully, this could resolve future post-war syndromes; thus, ending the severity of hurt, pain, and anguish to be felt by individuals of future wars.
APPENDIX A

VETERANS' PERMISSION FORM
'Veteran Permission Form

Dear Veteran:

This questionnaire will be kept confidential. The purpose of this survey is to gather information on: [1] Your perceptions and feelings toward your present depression, if any, and [2] if you feel that the Vietnam war is responsible for you presently experiencing depression. I am interested in your feelings. There are no right or wrong answers. If you have any questions regarding this survey, please feel free to contact me. I will be working at the Riverside Vets center every Monday evening.

You may drop out of this survey at any time by contacting me. I will respect and understand your feelings.

I would appreciate you participating in this survey. I feel, the more information that can be obtained and written on, the more this can help to bring about a better understanding of your feelings. Thus, help the American public to better understand your situation, how you feel, and give you the respect that is so long overdue. Hopefully, such surveys like this one will also help us not to make the same mistake again.

If you are interested in the results of this survey, please let me know. If you are willing to take part in this survey, please sign your name. Remember that your name will not appear on the questionnaire or anywhere else in this survey.

Sincerely,

Dodie Ryan

I will give my permission for any answers and information to be used in this study. I understand I may freely drop out of the survey at any time. I realize that I can contact Dodie Ryan if I have any questions.

_________________________  __________________________
Signature                                      Date

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CALIFORNIA 92407-2397
APPENDIX B

THE CENTER FOR EPIDEMIOLOGICAL STUDIES

DEPRESSION SCALE QUESTIONNAIRE
THE CENTER FOR EPIDEMIOLOGICAL STUDIES
DEPRESSION SCALE QUESTIONNAIRE

INSTRUCTIONS: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. Please place an "X" in the most appropriate box corresponding to the question you are answering.

<table>
<thead>
<tr>
<th>Code #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Rarely or none of the Time</th>
<th>Less than 1 day</th>
<th>Some or Little of the Time</th>
<th>Occasionally or Moderate amount of Time</th>
<th>Most or all of the Time</th>
<th>5-7 days</th>
</tr>
</thead>
</table>

**During the past week:**

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people disliked me.
20. I could not get going.

THANK YOU
APPENDIX C

VIETNAM COMBAT VETERANS' QUESTIONNAIRE
VIETNAM COMBAT VETERANS' QUESTIONNAIRE

INSTRUCTIONS: Please place an "X" in the most appropriate box corresponding to the question that you are answering.

<table>
<thead>
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<th>Code #</th>
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1. My actual combat time experiences while in Vietnam was. ................................
2. How often were you in danger of being killed or wounded in Vietnam. ..............

"Since I got out of the service following Vietnam...."

3. I get depressed easily.................................................................
4. I have trouble sleeping...............................................................
5. I feel that Vietnam is affecting my present day depressed moods...
6. I have suicidal feelings and thoughts..........................................
7. I feel like life is not meaningful; nothing matters anymore...............
8. I experience crying spells when I think of events which took place in Vietnam.................................................................
9. I feel that my present depression results from my past experience in Vietnam.................................................................
10. I drink to reduce those unwanted feelings which I am now experiencing.................................................................
APPENDIX D

ATTEMPTED AND ACCOMPLISHED SUICIDES
REPORTED TO: VA CENTRAL OFFICE
Attempted and Accomplished Suicides
Reported to: VA Central Office
During the Years of 1981 - 1982

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<td>06</td>
<td>05.2</td>
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* Age range for the Vietnam War veteran
APPENDIX E

RATES OF SUICIDE IN PERIODS OF WAR SERVICE
Rates of Suicide in Periods of War Service

Between the Years of: 1970 - 1980

YEAR
1980
1979
1978
1977
1976
1975
1974
1973
1972
1971
1970

RATE 0 50 100 150 200 250 300 350 400 450

All Others
Vietnam
Korea

World War II
World War I
APPENDIX F

PERCENT AND RATE OF SUICIDES IN PERIODS OF WAR SERVICE
**PERCENT AND RATE OF SUICIDES IN PERIODS OF WAR SERVICE**


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<thead>
<tr>
<th>YEARS</th>
<th>WWI</th>
<th>WWII</th>
<th>KOREA</th>
<th>VIETNAM</th>
<th>ALL OTHERS</th>
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<tbody>
<tr>
<td></td>
<td>%</td>
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<td>%</td>
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REFERENCES


