Operation Iraqi freedom and mental health of Vietnam veterans

Janice Lynn Moody
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OPERATION IRAQI FREEDOM AND MENTAL HEALTH
OF VIETNAM VETERANS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Janice Lynn Moody
Ron Robinson
June 2005
EFFECTS OF THE IRAQ WAR ON THE MENTAL HEALTH OF VIETNAM VETERANS

A Project
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Janice Lynn Moody
Ron Robinson
June 2005

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ABSTRACT

The media portrayal of Operation Iraqi Freedom may increase negative symptoms of PTSD for Vietnam veterans. This study examined the unique manner in which previous war experience, Posttraumatic Stress Disorder (PTSD), and current media exposure to war violence impact individual responses regarding the mental health of Vietnam veterans. Quantitative along with qualitative data was collected, utilizing face-to-face verbal interviews to identify key variables and relationships, and offer measurability, duplication, and generalizability. Results indicate that exposure to subsequent war trauma has significant negative mental health effects on veterans. An increase in both symptom severity and frequency is found; along with support that media exposure reawakens and exacerbates PTSD symptoms. Basis for Erikson’s theory is determined, and limitations addressed. Implications for social work include that social workers be knowledgeable of presenting symptomology coinciding with reactivation of PTSD for implementation of proper assessment and intervention.
ACKNOWLEDGMENTS

It is with great respect that we sincerely thank Thomas M. Hawkins along with his staff at the Corona Vet Center for their invaluable time and support of this project. Additionally, it is with great admiration that we thank the Vietnam veterans who gave of their time for this project and the sacrifices each made in serving our country. It has been an honor and a privilege to interview them and learn more of their combat experience. They are all strong, courageous men and we truly appreciate their sacrifices.

Additionally, this project could not have gone forward without the expertise and guidance from Rosemary McCaslin, Ph.D., and April Taylor Ph.D. Their constructive contribution was invaluable to the completion of this project and the sanity of the researchers.
DEDICATION

This research project is dedicated to all military service members who have served before, who are serving now, and who will yet serve. We applaud you and thank-you.
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CHAPTER ONE

INTRODUCTION

Worldwide exposure to armed conflict has caused psychological distress in millions of people, oftentimes long after the events are over as the internalized traumatic events are relived in the form of Posttraumatic Stress Disorder (PTSD) as demonstrated in postwar Vietnam veterans. Operation Iraqi Freedom is currently portrayed by the media as synonymous with the Vietnam War. This exposure and comparison may reactivate unwanted memories and negatively impact the mental health of Vietnam veterans already diagnosed with PTSD.

Problem Statement

War is a complex political, economic, and social event that profoundly affects lives and institutions. The personal effects of war cannot easily be separated from the continuing and permanent change in society as a whole as the social effects are not immediately apparent. These social effects influence different disciplines at different moments, becoming apparent within their own timeframes (Modell & Haggerty, 1991). The Vietnam War has been acclaimed to have severe ramifications for veterans,
with the resulting effects unlike any other war in recent history. The experienced traumatic events, coupled with rejection upon returning home and lack of positive social support has resulted in a particularly devastating aftermath for those veterans (Lawson, 1995). More than 40 years after the Vietnam War, the after effects continue to haunt Vietnam veterans with devastating interpersonal and intrapersonal, severe, and often delayed reactions resulting from their experiences in battle.

Posttraumatic Stress Disorder (PTSD) has permeated the lives of men, women, and children for years, occurring in all classes, cultures, ages, and social groups. This includes associations between trauma exposure, current and later psychological and social problems, and short or long-term effects that devastate the lives and families of those involved. PTSD is a term commonly associated with military personnel plagued by horrific memories and after effects of combat, although it is not exclusive to war-related trauma. Other traumatic events such as rape, abuse, car accidents, or natural disasters can produce trauma symptoms and trigger the disorder. Anyone significantly impacted by the event
or who felt a serous threat to their own safety or to others' safety can be afflicted with PTSD.

The media currently portrays the conflict demonstrated in Operation Iraqi Freedom (OIF) as synonymous with the war in Vietnam. This comparison may prove problematic to those veterans who are currently affected by PTSD from the trauma they suffered while fighting in Vietnam. Research has demonstrated that those inflicted with PTSD may experience unwanted, reactivated memories when exposed to an event that simulates the original trauma (Christenson, Walker, Ross, & Maltbie, 1981; Fagan & Freme, 2004). As about 850,000 Vietnam veterans demonstrate varying symptoms of PTSD (Lawson, 1995; Pierson & Pierson, 1994), it is imperative to ameliorate the impact of destruction and disruption of their lives by providing detailed information on the connection between subsequent wars and increased PTSD symptoms.

Purpose of the Study

Vet Center programs are a prominent part of the U.S. Department of Veterans Affairs that facilitates the study of veterans with PTSD. These programs provide a broad
range of counseling, outreach, and referral services to eligible veterans, providing support and opportunity to resolve traumatic experiences and guilt (Hayman, Sommers-Flanagan, & Parsons, 1987). Recovery strategies utilized by the centers are research based and consist of cognitive behavioral therapy focusing on thoughts, feelings, and subsequent behavior along with support groups for sharing combat-related traumatic experiences (Lawson, 1995; U.S. Department of Veterans Affairs, 2003).

War in general has an emotional and psychological effect on those involved. The atrocities experienced by Vietnam soldiers during a war with extreme political upheaval, shifting strategic aims, lack of social support, the draft, and an unwelcome homecoming, created an especially adverse effect on the psychological well-being of those who survived. For veterans of the Vietnam War, subsequent wars serve as a reminder of their combat exposure, resulting in reactivated feelings of anger, frustration, depression, and intensified flashbacks (Kobrick, 1993).

When considering the possible risk factors of reactivation and intensification of PTSD symptoms faced
by Vietnam veterans on exposure to a current or recent war, it is beneficial to have a greater understanding of how a veteran's war experiences can be reawakened from this exposure along with treatment techniques useful in these circumstances.

This study proposed to provide a clear conceptualization of how Vietnam veterans who have previously been diagnosed with PTSD respond and cope with the additional stressors of the emotional and psychological effects presented by the present war in Iraq. It addressed specific symptoms as demonstrated through negative reactions to trauma including the emotional (e.g., anger and fear), mental (e.g., nightmares and flashbacks), and physical (e.g., headaches and sleep problems) reactions experienced.

A qualitative research approach was utilized for this study. Qualitative research is used where variables cannot be controlled or experimentally manipulated, and the questions are not always completely conceptualized and operationally defined. This approach used more natural and familiar processes than those in quantitative methods, such as face-to-face verbal interviews which are the basic and most common form of communication. This
natural type of data collection was crucial when soliciting information from participants which may be challenging for them to reveal, such as memories of war experiences.

The data collected in qualitative research identified key variables and how they relate to one another. Concerning PTSD, OIF, and the mental health of Vietnam veterans, qualitative research produced rich textual data collected from multiple data sources utilizing observations, conversations, and impressions to gain insight on how veterans perceived or experienced the current war.

To compliment the qualitative research, data was quantified to offer a more objective measurement of the frequency of themes along with intensity of particular statements. Utilization of a quantitative approach offered measurability, duplication, and generalizability and minimized the subjectivity of the personally constructed qualitative approach. The addition of quantitative data allowed research participants to remain separate and independent from the data analysis, eliminating bias.
Significance of the Project for Social Work

War is not something to be viewed as in the past and influencing present behavior, but is instead a present concern that can influence present and future behavior, is highly personal, and very public. With political upheaval and world events affecting the lives of Americans today, future wars and threats of wars are inevitable. Many Vietnam Veterans lead profoundly disrupted lives, with impaired occupational, social and interpersonal functioning due to PTSD. As demonstrated in research, this is not exclusive to those veterans of the Vietnam era, but affects all soldiers who have been involved in combat-related atrocities (Christenson, Walker, Ross, & Maltbie, 1981).

As current treatment strategies are showing limited success in systematic effectiveness for treating combat-related PTSD (Wang & Wilson, 1996), it is imperative to examine all perspectives of PTSD and reactivation of symptoms for specific, helpful treatment approaches. The results of this study will contribute to social work practice, policy, and research through a conceptualization of combat-related PTSD in Vietnam veterans and subsequent reactivation and intensification
of symptoms that will stimulate innovative perspectives regarding assessment, clinical treatment, social education, treatment evaluation and research methodology.

Assessment of the situational context of circumstances and specific behavior before, during, and after troubling events is crucial to understand the forces that shape and maintain problematic behavior. At this time the process of combat-related PTSD and subsequent reawakening of symptoms can be studied as it is happening, therefore offering a conceptualization that may inspire ground-breaking perspectives concerning the assessment phase of the generalist intervention process. Proper assessment is vital when looking at overall effectiveness of treatment strategies, justifying the resolve to focus on this phase.

The occurrence of combat-related PTSD has been well established in Vietnam veterans. Far less attention has been focused on the potential effects of wartime trauma following subsequent wars. The purpose of this study was to empirically investigate the question: Is the current war in Iraq adversely affecting the mental health of Vietnam veterans currently diagnosed with PTSD?
CHAPTER TWO
LITERATURE REVIEW

Introduction

The social problem of Operation Iraqi Freedom (OIF) has spawned a renewed interest in war trauma, with previous victims of war seeking assistance in relation to the aftereffects of their own experience. This study relates to the unique manner in which life developmental stages, previous war experience, subsequent diagnosis of Posttraumatic Stress Disorder (PTSD), and current media exposure to war violence may impact individual responses regarding mental health.

Theories Guiding Conceptualizations

Past theoretical perspectives guiding research concerning trauma-related responses include those of Freud, Piaget, Beck, and Erikson. Freud described the intrapsychic process as overexcitation of the stimulus barrier (Wang, 1996) and negative identity (Erikson, 1968). Beck’s cognitive model uncovers underlying schemas that form cognitive distortions about self, others, and the world. Piaget offers a similar cognitive development position with assimilation and accommodation, whereby
life experience shape schemas and schemas shape perceptions of life experiences (Lawson, 1995).

In studying Vietnam veterans in a human developmental context, consideration of Erikson’s developmental stages and the concept of life stage crisis in relation to internal and external factors was imperative. Vietnam was described as America’s first “teenage” war (Lawson, 1995) with soldiers in combat younger than those in previous wars (Murray, 1992). This younger age created the propensity for increased vulnerability to PTSD (Modell & Haggerty, 1991). Research suggests that developmentally, the young soldiers serving in Vietnam were struggling with Erikson’s stage of Identity versus Role Confusion and were not safe to explore and forge a distinct sense of self. Subsequently, role confusion caused them to view the world as untrustworthy and dangerous, superimposing negative expectations on new relationships (Lawson, 1995), and prohibiting achievement of Erikson’s next stage of Intimacy versus Isolation (Erikson, 1980).

The stage of Identity versus Role Confusion for adolescents and young adults is a major conflict; it raises the need to establish a consistent personal

According to Erikson (1968, 1980), identity confusion usually manifests itself at a time when commitment to physical intimacy, occupational choice, and psychosocial self-definition are required. Upon returning home, many veterans suffered rejection and criticism (Hayman, Sommers-Flanagan, & Parsons, 1987; Murray, 1992) raising questions of positive self-definition. Furthermore, they oftentimes suppressed emotion and were unable to express feelings resulting in marital difficulty (Lawson, 1995; Murray, 1992; Shehan, 1987). As Vietnam veterans with PTSD experience the stressors of returning home to a family and a new job, profound interpersonal difficulties involving intimacy, trust, and isolation become apparent (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Lawson, 1995; Shehan, 1987).

Vietnam War

Beginning in February of 1961 and ending in May of 1975, the Vietnam War was a brutal, atrocity-producing engagement. Attacks were often sudden, unexpected, and
devastating, creating a stronger fear of death than in previous wars (Shehan, 1987). Vietnam was considered one of the most dangerous wars, with the risk of being killed seven times greater and the risk of being paralyzed eight times greater than in World War II (Hayman, Sommers-Flanagan, & Parsons, 1987). Such trauma has been shown to result in a variety of abnormal psychological states for the Vietnam veteran (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Hayman, Sommers-Flanagan, & Parsons, 1987; Kobrick, 1993; Lawson, 1995; Murray, 1992; Shehan, 2001), demonstrating that in contrast to other wars, the life experiences of Vietnam veterans were unique.

A thorough analysis of the Vietnam War is beyond the scope of this study, although some of its factors deserve mention. First, tour of duty was solitary and discontinuous, lasting approximately 12 months with the main goal of staying alive. Secondly, transition time from battlefield to home was usually within 36 hours, too brief to process the trauma experienced. Additional factors include guilt, sense of defeat, lack of positive support, criticism, and rejection from friends and family upon return (Hayman, Sommers-Flanagan, & Parsons, 1987;
Lawson, 1995). Last, there was a one-year time limit in obtaining treatment for neuropsychiatric problems obtained during combat, restricting service for those with delayed reactions (Lawson, 1995). It was not until veterans began returning home, and oftentimes years later, that professionals became aware of the strength, severity, and often delayed reactions of posttraumatic symptoms (Murray, 1992).

Vietnam veterans with PTSD pose a micro view of the problem as subjective only to the veteran. The reality is seen at the macro level however, as the Vietnam veterans existence in society is disordered: manifesting greater hostility, experiencing dysfunctional relationships, the majority unemployed (Mazzeo, Beckham, Witvlier, Feldman, & Shivy, 2002), displaying heavy substance abuse (Rosenheck & Fontana, 1998), showing divorce rates as high as 70% (Wang, 1996), and having frequent hospitalizations for psychological problems (Shehan, 1987).

Further research shows that PTSD is associated with high health-care, economic, and personal costs resulting in medical-care costs for Vietnam veterans with PTSD 60% higher than average. The social obligation to implement
effective prevention and treatment for this population is vital (Marshall, Jorm, Grayson, & O’Toole, 2000).

War is a repeated, complex social occurrence that plays itself out in the lives of those who experience it. As the soldier’s problems turn into society’s problems, there is an increased need to incorporate micro and macro level interventions to decrease the impact of war on society (Modell & Haggerty, 1991).

Posttraumatic Stress Disorder

A growing awareness of the frequency and significance of PTSD in the American population is creating an increasing concern. With at least 3.6% of Americans diagnosed with PTSD (Fagan & Freme, 2004), 850,000 are directly related to combat exposure in Vietnam (Hayman, Sommers-Flanagan, & Parsons, 1987; Lawson, 1995).

Diagnostic criteria for PTSD were introduced into the nomenclature of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) by the American Psychiatric Association in 1980 as a consequence of post-war stress symptoms resulting from the Vietnam War (Kobrick, 1993; Lawson, 1995; Orr et al., 1990). Although Vietnam is
responsible for the standards of diagnosis, PTSD is far from being Vietnam specific. Previous studies provide information on symptoms of traumatic stress in World War II veterans (Christenson, Walker, Ross, & Maltbie, 1981; Murray, 1992), with further research suggesting severe psychological stress reactions occurring from battle can be observed throughout recorded history (Hayman, Sommers-Flanagan, & Parsons, 1987).

From "shell shock" to "war neurosis" after World War I, "traumatic war neurosis" to "combat exhaustion," to "operational fatigue" after World War II, "gross stress syndrome" after the Korean War, to PTSD after Vietnam (Kobrick, 1993), stress disorders are a common factor underlying postwar behavior with long-term psychological impact on veterans (Hendin, 1983).

Knowledge of PTSD in general includes typical and predictable negative reactions to trauma including emotional, mental, and physical reactions. Emotional reactions include helplessness, fear, anger, hopelessness, detachment, feeling hollow, and being easily agitated. Mental reactions include recurring dreams or memories of the event, experiencing flashbacks as if the event were re-occurring, avoiding anything
associated with the trauma, forgetting important aspects of the trauma, feelings that surroundings are unreal, and problems with concentration. Physical reactions include pounding heart, rapid pulse and breathing, headaches, trouble sleeping, inattention, hypervigilance, and being easily startled (American Psychiatric Association, 2000). Other problems associated with PTSD include substance abuse, interpersonal violence, aggression, anger and hostility (Beckham, Feldman, Kirby, Hertzberg & Moore, 1997), with the severity positively associated with combat exposure (Mazzeo, Beckham, Witvliet, Feldman, & Shivy, 2002).

Operation Iraqi Freedom

There is a new groundswell of interest in the problem of PTSD produced from the long-term residual effects of combat and the vulnerability of veterans to future stressors that may reactivate the symptoms.

In the current fight against terrorism, OIF (from April 3, 2003 to the present), American soldiers fight to gain control of Iraqi cities. In President Bush’s press conference (April 13, 2004), the serious violence encountered by our military troops in Iraq was discussed.
The first question asked of the President compared Iraq to Vietnam. Bush denied the analogy (The Associated Press, 2004), yet the rapid spread of the news media brought the topic of another Vietnam War directly into the homes of Americans (Newsweek, April 19, 2004; The Associated Press, April 13, 2004; The Financial Times Limited, April 15, 2004; The News on CNBC, April 14, 2004; USA Today, April 14, 2004). With up to 700 embedded journalists covering the complexity of the war in Iraq (Ritea, 2003) viewers are subjected around the clock to journalists under fire, along-side soldiers in combat (Ricchiardi, 2003). Although this may offer a comprehensive first-hand view, research shows that credibility and journalistic objectivity may be lacking (Lawler, 2003; Samara, 2003). With the additional factor of continuous news coverage, and embedded journalists offering conflicting and oftentimes confusing reports one statement rings clear, the comparison between Iraq and Vietnam.

Although the differences are clear between Vietnam and Iraq, jungle versus desert, fourteen years versus two years, and up to 500 soldiers a week killed versus 1587 (as of 5-3-05) for two years (respectively), the media
are noting similarities: open ended wars of choice, shifting strategic aims (Thomas, 2004), and public demonstrations against war. Other similarities involve the questioning of the involvement of American troops in both wars and the short adjustment period from battlefield to home (Hayman, Sommers-Flanagan, & Parsons, 1987; Lawson, 1995). Furthermore, both Iraq and Vietnam share the difficulty of distinguishing enemy from ally (Hayman, Sommers-Flanagan, & Parsons, 1987; Shehan, 1987).

The message of the Iraq/Vietnam comparison as viewed by Vietnam veterans can be particularly devastating to those with PTSD. Research from the Gulf War era suggests that for Vietnam veterans, the stressful nature of the media coverage could reactivate stress symptoms from their combat experience (Kobrick, 1993; Long, Chamberlain, & Vincent, 1994). For Vietnam veterans, subsequent wars (e.g., OIF) are not only a reminder of their own war experience with reawakening of intense psychological reactions (Christenson, Walker, Ross, & Malthie, 1981; Fagan & Freme, 2004; Kobrick, 1993; Long, Chamberlain, & Vincent, 1994), but also reactivation of physiological reactions (Hobfoll et al., 1991).
Furthermore, research not only demonstrates greater physiological reactivity when exposed to trauma cues (Orr et al., 1990; Wolfe et al., 2000), but also elevated physiological reactions in response to stimuli that is nonspecific to combat, such as a visit to the hospital (Savarese, Suvak, King, & King, 2001).

This research provides support for further study of Vietnam veterans, PTSD, and correlations with the current war on Iraq. It is imperative that social workers be knowledgeable of presenting symptomology that coincides with reactivation of PTSD (Barsalou, 2001). Moreover it is paramount that proper assessment and intervention programs are implemented within the social work system as current therapy techniques have not proven consistently effective (Bisson, 2003; Humphreys, Westerink, Giarratano, & Brooks, 1999; Forbes et al., 2003; Rothbaum et al., 1999).

Current Therapeutic Techniques

The professional literature offers a narrow spectrum of innovative treatment techniques concerning Vietnam veterans with PTSD. Lawson (1995) presented a model to identify schemas (an organized and particular way of
perceiving and responding to situations) by incorporating cognitive, behavioral, and interactional components of treatment in relation to psychological and interpersonal functioning. As Vietnam veterans may experience negative themes in all of the schema areas (safety, trust, power, esteem, and intimacy), specific techniques for implementing cognitive and behavioral change include cognitive restructuring and demonstrating how the schema, situational triggers, emotions, and experience are connected.

Other treatment approaches include a combination of cognitive behavior therapy and pharmacotherapy with antidepressants (along with mood stabilizers) utilized as the most common medication regime. This combination treatment approach has resulted in significantly better outcomes than provided by most other treatment studies concerning depression, anxiety, and PTSD symptoms according to Humphreys, Westerink, Giarratano, and Brooks (1999), and Schnurr, Friedman, and Foy (2003). Although in contrast, Forbes et al. (2003), state that pharmacotherapeutic studies have offered a poor response to treatment.
Additional treatment modalities include the use of specialized inpatient units (established in the U.S. in 1978) that usually require long lengths of stay. These have been utilized for treatment of PTSD, but have not produced significant sustained symptom reduction (Humphreys, Westerink, Giarratano, & Brooks, 1999). Virtual reality imaging has also been included and has proven to have significant (yet small) effects in reducing PTSD and related pathology in veterans (Rothbaum et al., 1999).

Current trends in treatment for PTSD for post-war veterans include Imagery Rehearsal Therapy (IRT) which has demonstrated some improvements in overall PTSD, mood, and broader based general symptomatology. IRT focuses on a specific traumatic event and, using mental imagery, re-plays and reorganizes the experience in the veteran’s cognitive schema (Forbes et al., 2003).

In regards to the entire spectrum of micro treatment practices concerning PTSD, research demonstrates that Vietnam veterans with PTSD require long term counseling due to the far-reaching impact of their conceptualization of experience (Lawson, 1995).
Current gaps in the literature include the impact of personality pathology on the broader psychopathology of PTSD (Forbes, McHugh, Debenham, & Hopwood, 2002). Limitations of the research disclosed self-report measures which may affect the results through response bias (Mazzeo, Beckham, Witvliet, Feldman, & Shivy, 2002; Orr et al., 1990). Other problems include small sample, the use of varied measures, lack of control subjects (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Forbes, McHugh, Debenham, & Hopwood, 2002; Savarese, Suvak, King, & King, 2001; Wolf, 2000), and failure to measure the severity of the traumatic experience (Bolton, Litz, Britt, Adler, & Roemer, 2001).

Summary

As millions of Americans watch the continuous news coverage concerning OIF, their attention is riveted to the technological and military aspects of warfare and the service personnel who are engaged. Included in those viewing are American Vietnam veterans who currently exhibit posttraumatic stress disorders as a common factor underlying their postwar behavior. Reacting to the plight of the armed forces after the Vietnam War and in response
to the concern for limiting the negative psychological and psychosocial ramifications concerning these veterans, the complex and intricate interplay between the past and present events were examined.
CHAPTER THREE

METHODS

Introduction

In consideration of the possible risk factors of reactivation and intensification of symptoms of Posttraumatic Stress Disorder (PTSD) faced by Vietnam veterans on exposure to a current or recent war, it is imperative to address the subject and find understanding. Chapter Three documents the steps used in developing the project. In exploring this problem, specific procedures were addressed including sampling, data collection, utilization of specialized instruments, and data analysis to identify key variables for corroboration and elucidation of severity of the problem.

Study Design

The intent of this study was to explore and provide a clear concept of Vietnam veterans with posttraumatic stress disorder (PTSD) and the likelihood of increased negative impact on their mental health from further exposure to war. This thesis takes the form of a two-phase study. The first phase used quantitative analyses designed to contrast PTSD symptoms before
Operation Iraqi Freedom (OIF) with veterans’ current level of symptoms. In the second half, a qualitative research methodology consisting of a one-group posttest design was employed to provide further information on the mental state of Vietnam veterans when vicariously subjected to current war trauma as experienced through normal television viewing. Additionally, a quasi-experiential approach was utilized and supplemented a recorded time-line of world events for exploration of possible confounds from before the September 11, 2001 attacks to current.

Sampling

Study participants included 31 male Vietnam veterans with a previous diagnosis of PTSD. Veterans were recruited from the Corona Vet Center located in Riverside County, California which services clients from both rural and urban areas. Non-probability, purposive sampling was utilized. Purposive sampling, also referred to as theoretical sampling, can yield considerable data concerning information rich cases required for an exploratory study. Purposive sampling allowed selection
of diverse participants thereby increasing
generealizability to other veteran populations.

Selection criteria included veterans who,
1) experienced combat in the Vietnam theatre, 2) had
previously been diagnosed with PTSD, and 3) were
currently experiencing PTSD symptoms. Ethnicity, age, and
branch of service were a consideration in offering
diversity to the sample. Therapists employed by the
vetern’s center helped to identify potential
participants based on the candidate’s high stability,
williness, availability, and low risk for elevated
anxiety from study participation. Participation in the
study was non-compensatory.

Data Collection and Instruments

Participants completed a demographic questionnaire
(Appendix A). Measures for the quantitative and
qualitative portions of the study are displayed in
Appendices B and C respectively.

Tables 1a and 1b (Appendix F) respectively show the
interval and nominal/ordinal demographic information
collected including current age, age at enlistment, age
at beginning of combat exposure, age at end of combat
exposure, total years of service, level of education, marital status, whether or not they were drafted, branch of service, and discharge status.

**Quantitative Measures**

In order to measure symptoms concerning adjustment problems of PTSD before and during OIF, each participant completed a self-rated, 18-item PTSD symptoms scale designed specifically for this research. This scale was adapted from the Transcend Workbook designed by the Veterans Affairs Medical Center for veterans with PTSD. Items covered a wide range of symptoms including sleep abnormalities, flashbacks (and other maladaptive thought processes), violence, anxiety, and intimacy problems, all of which are indicative of PTSD. Participants were asked to indicate the degree to which they experienced each symptom both before OIF as well as the degree to which they currently experience each symptom. Items were rated on a 4-point Likert scale (0 = not a problem at all, 3 = extreme problem) with higher numbers indicating greater severity of symptoms. Inter-item reliability for the symptoms scale was strong (α = .777 and .766 before and during OIF respectively).
A factor analysis of participants' responses to the symptoms scale was conducted. The purpose of the analysis was to identify different symptom categories that may vary uniquely with dependent variables.

Principal components extraction with varimax rotation was performed on the 18 before OIF symptom items. Four factors, accounting for 59.34% of the variance in symptom ratings were extracted (factor loadings, communalities, and percents of variance and covariance are shown in Table 2, Appendix F). The first factor accounted for 16.43% of the variance (eigenvalue = 4.71) and included agreement with 6 symptoms: difficulty remembering, memories of bad things, lack of interest, hostility/violence, difficulty feeling close to others, and feeling emotionally numb. This factor was labeled emotional ($\alpha = .77$) and scores ranged from .33 to 2.67. The second factor accounted for 16.33% of the variance (eigenvalue = 2.60) and included agreement with 5 symptoms: difficulty falling asleep, flashbacks, difficulty concentrating, tension, anxiety, and panic attacks. This factor was labeled anxiety ($\alpha = .77$) with scores ranging from .60 to 2.80. The third factor accounted for 14.67% of the variance.
(eigenvalue = 1.99) and included agreement with 3 symptoms: thoughts of hurting self, suicidal thoughts, and feeling worthless. This factor was labeled worthlessness (α = .83) and scores ranged from .00 to 3.00. The fourth factor accounted for 11.90% of the variance (eigenvalue = 1.38) and included agreement with 4 symptoms: difficulty staying asleep, difficulty trusting, jumping at noises, and nightmares. This factor was labeled non-trust (α = .57) with scores ranging from 1.00 to 2.75.

Subsequent analyses of symptoms utilize the full scale as well as the four subscales described here, i.e., emotional, anxiety, worthlessness, and non-trust, both before and during OIF (Table 3, Appendix F).

In order to analyze veterans’ level of intimacy, a subscale was created using three items: Inability to feel close to family, difficulty trusting, and feeling emotionally numb (α = .68). These variables were specifically chosen because of their relevance to achieving quality relationships according to Erikson’s theory of psychosocial development (Lawson, 1995; Murray, 1992; Shehan, 1987).
Qualitative Measures

Face-to-face, semi-structured interviews were conducted. Strengths of this type of data collection method include flexibility, and an increased likelihood of participant response to sensitive or personal questions. The interview schedule was adapted from the Transcend Workbook (Veterans Affairs Medical Center) and included main questions as well as prompts to be used to elicit further detailed descriptions. The interview schedule asked specific questions regarding beliefs and attitudes (e.g., Did you agree with the way other Americans treated the Vietnamese?), reactions to OIF (e.g., Do you agree with the way American soldiers are treating the Iraqi prisoners?), media exposure (e.g., Do you follow the news on OIF?), symptoms (e.g., Do you think the frequency of your symptoms have been affected by OIF?), reactions to September 11th, 2001 (e.g., What was your first reaction to the news of the terrorist attacks?), and treatment intervention (e.g., Is current treatment helpful?).

In the course of the interview, feelings, insights, and perceptions were included as data sources and were recognized, clarified, monitored, and manually recorded.
along with other observations, impressions, and verbalizations in order to uncover veterans' personal realities and perspectives. In addition, each interview was audio taped to ensure the integrity of analyses conducted after the completion of the interview.

All measures were pre-tested with three Vietnam veterans to measure for time allowance, subject comprehensiveness, and participant sensitivity to the subject matter.

Procedures

Data were collected between December 2004 and January 2005 utilizing a research team consisting of a White female and an African American male. To minimize distractions, veterans were individually invited to a private room at the Veteran's Center. After being advised that the interview process could be stopped at any time without consequences, veterans were requested to read the letter of consent (Appendix D) and place an "X" in the appropriate space to indicate their willingness to participate (100% agreed to participate).

In fulfillment of the quantitative portion of the study, participants were asked to verbally account for
the information on the demographic questionnaire, along with rating their symptom severity along a continuum, contrasting severity from before OIF to current, while a researcher recorded the responses utilizing the symptoms scale. This procedure was utilized to assure complete understanding with a thorough investigation of participants’ reactions concerning their PTSD symptom severity.

The instrument that was used for the qualitative portion of data collection was an interview schedule. Participants were presented verbally with questions from the interview schedule while their responses and reactions were recorded both in written and audio tape format. The schedule included questions as well as prompts to elicit further detailed responses. In both the quantitative and qualitative portions, one researcher asked questions while the other took detailed notes.

During the interview process, non-verbal adverse reactions (e.g., sweating, excessive fidgeting, hand-wringer, breathing difficulty, twitching) were closely monitored to know if and when termination of the interview was necessary. Additionally, the interview process began with instructions for participants to stop
the interview if at anytime they felt uncomfortable. All of the interviews were completed fully without any problems.

After the interview was completed a debriefing statement containing information concerning follow up of the project was read to the participant (Appendix E) and they were invited to ask questions regarding the project. The entire procedure lasted approximately 60 minutes.

Protection of Human Subjects

Prior to participation, an informed consent statement advised all participants of confidentiality, and the option to terminate participation at any time during the interview process without penalty. It included identification of the researchers and an explanation of the purpose and the voluntary nature of the study. Demonstration of the protection of confidentiality was the omission of any physical traits, family history, name, address, or any other identifying personal information. A written debriefing statement was included to explain the goals of the study and to respond to any issues arising from participation. An oral explanation of the debriefing statement informed the participants that
if they experienced any undesirable effects from the study or unwanted behavioral responses, they should contact the Vet Center for a follow up intervention session as deemed necessary by the participant.

Data Analysis

In order to report valid and reliable descriptions of the phenomenon of recurring PTSD from each veteran’s perspective, this study attempted to go beyond simple explanations and examine the content of the interview more intensively, exploring in-depth meanings and interpretations.

With the permission of the participant, each interview was audio taped to ensure the accurate reporting of empirical observations. The qualitative procedures that were utilized included the categorization and coding of participants’ responses. To accomplish this, units of analysis (total response to any one interview question) were coded, categorized, and operationally defined. Units of analysis were quantified by recording the frequency with which certain themes appeared. Furthermore, attempts were made to examine not
just the frequency of the variables but also their intensity.

Coding was grounded in content analysis of both the manifest content (the obvious) and the latent content (the subtle) in terms of meaning, depth, and intensity of responses. Ordinal categories (3 = strong conviction concerning statement, 2 = average feelings, and 1 = ambivalent feelings) were developed to indicate the intensity of particular statements. Construction of an absolute frequency distribution to count the number of times each intensity value occurred was created and comparative analysis was conducted utilizing cross-tabulation to analyze the nominal-level variables. Specifically, the chi-square test of association was used to find patterns and relationships between the intensity value categories. Where appropriate, variables/categories identified in the interview were related to the symptoms scale.

Analysis of the symptom scale overall included bivariate correlation analysis. T-tests were used to examine severity of symptoms before and during OIF, symptom subscales, frequency and severity of symptoms, and symptom severity and media exposure.
Additionally, to test Erikson's theory, participant's ages were divided into younger and older groups for developmental analysis. An independent t-test was used to examine the relationship between veterans' mean age during the beginning of combat exposure and relevant items on the symptoms scale.

Summary

This chapter included exploration of the problem of reactivation of PTSD symptoms as addressed through the procedures of choosing a sample, collecting data, preparing specialized instruments, and analyzing data for identification of key variables in search for patterns of relationships. The types of scales and interview schedule that was utilized for this study were illustrated along with measurement procedures to be employed. Participant protection was addressed and measures to test Erikson's theory were presented.
CHAPTER FOUR

RESULTS

Introduction

Included in Chapter Four is a presentation of the results. Data were examined concerning the veterans’ PTSD symptoms (severity and frequency), their feelings concerning the current war in Iraq, media exposure, comparisons of Iraq War to Vietnam War, treatment of Vietnamese and Iraqi prisoners, Erikson’s developmental theory, and effectiveness of current psychological treatment.

Presentation of the Findings

Preliminary data analyses revealed no significant effects of interviewer and this variable was excluded from all subsequent analyses.

Quantitative Analysis

Participants in this study included 31 male Vietnam veterans with a previous diagnosis of PTSD. In order to examine PTSD symptoms before and during Operation Iraqi Freedom (OIF), mean ratings on the total symptoms scale as well as each subscale were analyzed using two-tailed, paired t-tests. The results showed a significant increase
in severity of overall symptoms from before OIF 
\( M = 27.45, \text{ mode } 29, SD = 7.11 \) compared to during the war \( M = 34.81, \text{ mode } 30, SD = 7.99 \), \( t(30) = -5.22, \ p < .000 \).

Consistent with the overall symptoms scale, comparisons of the subscales using two-tailed, paired t-tests revealed significant increases in symptoms during OIF compared to before, on three out of the four subscales. On the emotional subscale, respondents' mean intensity of symptoms showed an increase during OIF 
\( M = 1.95 \) compared to before \( M = 1.48 \), \( t(30) = -5.54, \ p < .001 \). Additionally, the anxiety subscale demonstrated an increase in mean symptoms during OIF \( M = 2.10 \) compared to before \( M = 1.57 \), \( t(30) = -5.09, \ p < .001 \). Issues of mistrust increased significantly during OIF 
\( M = 2.48 \) compared to before \( M = 1.94 \), \( t(30) = -6.04, \ p < .000 \) as well. However, there were no significant differences in feelings of worthlessness from before OIF 
\( M = .97 \) compared to during \( M = .91 \), \( t(30) < 1, \text{ n.s.} \).

Furthermore concerning symptoms, a bivariate correlation analysis showed a significant negative correlation between current symptoms and education level 
\( r = -.47, \ p < .01 \) demonstrating that the lower the
veterans' educational level, the higher their reported symptoms.

Concerning frequency of symptoms, veterans were asked if their symptoms occurred more often, the same, or less since the war in Iraq. The majority of participants (77.4%, n = 24) reported that the frequency of their PTSD symptoms increased since OIF rather than decreased (0%) or stayed the same (22.6%, n = 7), $\chi^2(2, N = 31) = 29.48$, $p < .001$.

Concerning frequency of symptoms as well as the severity of symptoms during OIF, an independent samples t-test revealed that veterans who reported an increase in frequency of symptoms reported greater severity of symptoms ($M = 2.06$) than those whose frequency of symptoms remained the same ($M = 1.49$) $t(29) = 3.51$, $p < .001$.

Analysis of Qualitative Responses

Media Exposure and its Effects. Concerning media exposure to OIF, 87.1% (n = 27) of participants claimed that they followed the war via the media, $\chi^2(1, N = 31) = 17.07$, $p < .001$. In order to examine the severity of the symptoms during OIF in conjunction with
those following the news on the war, an independent samples t-test showed that the severity of symptoms reported during the current war in Iraq are greater in those veterans who follow the news ($M = 1.99$) than those who do not ($M = 1.50$) $t(29) = 2.06, p < .05$.

In order to examine the relationship between the reported media exposure and the frequency of PTSD symptoms, a 2-tailed Pearson Correlation was utilized and revealed a significant positive correlation between the amount of news viewed and frequency of symptoms, showing the more news the veterans viewed, the more frequently they experienced symptoms, $r = .44, p < .02$.

Consistent with this finding, chi-square analyses revealed a significant relationship between following the news on OIF and frequency of PTSD symptoms. A greater proportion of veterans that followed the news on Iraq reported increases in symptoms (85% symptoms increased, 15% stayed the same) compared to those who did not follow the news on Iraq (25% increased, 75% stayed the same), $\chi^2(1, N = 31) = 7.22, p < .01$ (Table 4, Appendix F). These data represent a strong trend but should be interpreted
with caution as an overwhelming proportion of veterans followed the news on Iraq (87%).

Operation Iraqi Freedom. Among demographic variables, only ethnicity differentiated responses. A chi-square analysis showed a significant relationship between ethnic status and agreement with American troops fighting in Iraq. Specifically, non-minority veterans were more likely to agree with the war (65% agree, 35% disagree) than were minority veterans (27% agree, 73% disagree), \( \chi^2(1, N = 31) = 4.05, p < .05 \) (Table 5, Appendix F).

In addition, veterans were questioned about the comparison of the Iraq War to the Vietnam War. Regarding these comparisons by the media that OIF is becoming another Vietnam War, significantly more veterans considered the two wars to be comparable (74.2%, \( n = 23 \)) than not (25.8%, \( n = 8 \)), \( \chi^2(1, N = 31) = 7.26, p < .01 \). Furthermore, veterans who saw similarities between the two wars disagreed with the American troops being in Iraq (39% agree, 61% disagree) more so than did those who did not see similarities between the two wars (87.5% agree,
12.5% disagree) $\chi^2(1, N = 31) = 5.56, p < .02$ (Table 6, Appendix F).

**Terrorist Attacks.** Veterans were asked if their feelings about September 11th were separate from their feelings about the War in Iraq. The data showed a significant difference in that 71% (n = 22) of participants claimed that they were separate events, and 29% (n = 9) stated that the two events were connected, $\chi^2(1, N = 31) = 5.46, p < .05$. In addition, significantly more veterans felt anger at the time of the attacks (61.3%, n = 19) than frustration (16.1%, n = 5), or other emotions (22.6%, n = 7), $\chi^2(2, N = 31) = 11.10, p < .01$.

**Treatment of Prisoners of War.** A Chi-Square Test was conducted concerning the treatment of the Vietnamese by the American soldiers during the war in Vietnam. Data revealed a significant difference between the number of veterans in agreement with the treatment (90.3%, n = 28) compared to not (9.7%, n = 3), $\chi^2(1, N = 31) = 20.16, p < .001$. Similarly, when asked about the treatment of the Iraq prisoners, a significantly greater number of veterans agreed with the way American soldiers treated
Iraqi prisoners (67.7%, n = 21), \( \chi^2(1, N = 31) = 3.90, p < .05 \).

In regards to publicity concerning mistreatment of the Iraq prisoners, overwhelmingly the veterans thought that the War was too publicized (90.3%, n = 28), \( \chi^2(1, N = 31) = 20.16, p < .001 \). Regarding the intensity of the veterans’ answers concerning the publicity, 64.5% had strong convictions regarding their opinion, whereas 35.5% demonstrated moderate expression.

**Theoretical Perspective.** In order to look at the theoretical perspective of Erikson’s theory in relation to the young age of veterans at the time of combat exposure, an independent t-test was utilized and showed that veterans who began combat at younger ages, between the ages of 18 and 19, showed greater severity of symptoms (\( M = 2.25 \)) than did those who started combat between the ages of 20 and 26 (\( M = 1.69 \)), demonstrating a decreased capacity of relational intimacy \( t(29) = 1.84, p < .05 \).

**Treatment.** In regards to treatment, 25.8% (n = 8) of veterans reported seeking treatment more often since the war in Iraq, whereas 74.2% (n = 23) sought the same
CHAPTER FIVE

DISCUSSION

Introduction

Included in Chapter Five is a presentation of the conclusions gleaned as a result of completing the project. This research study was designed to empirically investigate the relationship between media exposure to Operation Iraqi Freedom (OIF) and the mental health of Vietnam veterans previously diagnosed with Posttraumatic Stress disorder (PTSD). Results showed that according to participants, media exposure to OIF resulted in a significant overall increase of severity and frequency of PTSD symptoms, along with a significant positive correlation between the amount of news viewed and frequency of symptoms. Accordingly, the recommendations extracted from the project are presented.

Discussion

Given the risk of reactivation and intensification of PTSD symptoms among Vietnam veterans exposed to current or recent wars, and in light of recent war related events, it is imperative that the relationship between OIF and PTSD symptoms be explored. Several
interesting outcomes emerged from the findings of this study concerning PTSD symptoms and the effects of media coverage of Operation Iraqi Freedom (OIF).

Severity and Frequency of Symptoms

One of the most significant findings of this study was the overall increase in both symptom severity and frequency upon exposure to OIF. This is consistent with prior research that indicates reactivation of underlying PTSD symptoms may be precipitated by an event that simulates the original trauma (Christenson, Walker, Ross, & Maltbie, 1981; Kobrick, 1993; Long, Chamberlain, & Vincent, 1994). Specifically, the literature reflects that symptomatic response to trauma (that occurred after the onset of PTSD) is positively correlated with PTSD symptoms from previously experienced trauma (Qin, et al., 2003). Furthermore, those who experienced prior war trauma and are once again subjected vicariously to subsequent war, are more likely to have more severe symptoms (Hobfoll et al., 1991).

Additional research shows that Vietnam veterans who exhibit high levels of PTSD symptoms before exposure to subsequent war trauma, tend to report more revived memories (accompanied by heightened physiological
reactivity) of their Vietnam experience, not only during the subsequent war, but after as well (Quin et al., 2003).

Comparisons of the subscales also showed a significant increase in symptoms during OIF compared to before, on three out of four subscales (emotional, anxiety, and mistrust). The fourth subscale (worthlessness) did not show any difference from before OIF to during (Table 3, Appendix F). The lack of variation on the worthlessness subscale may be partly due to aggressive treatment techniques, along with medication therapy.

Continuing this line of analysis, the factor analysis of these subscales showed that problems associated with emotionality, anxiety, mistrust, and worthlessness account for over half (59.34%) of the variance in the instrument. Additional explanations for the remainder of the variance are still unaccounted for, and could be related to many other factors not covered in this study (nature and severity of the veteran's experienced traumatic events, length of time before treatment, length of time in treatment, support systems, personality, etc.). Further research in these areas would
benefit veterans with PTSD to note other areas in their lives that are detrimental to their symptoms. Increase in symptomology can be devastating for the veteran who has worked for years to achieve some form of readjustment. Moreover, this study found that those veterans whose frequency of PTSD symptoms increased in frequency also reported greater severity of symptoms. It is imperative that the problem of increased severity and frequency of PTSD symptoms due to exposure of subsequent war trauma be acknowledged and addressed.

Meanwhile, this study found that the lower the veteran’s educational level, the higher their reported symptoms. Others agree that the risk of PTSD is increased with less premilitary education (Friedman, Schnurr, & McDonagh-Coyle, 1994). It stands to reason that education will not only reduce anxiety associated with the unknown and unexplained, but assist the veteran in coping mechanisms to alleviate and reduce overall symptomology of PTSD.

**Media Exposure and Posttraumatic Stress Disorder Symptoms**

The media coverage of OIF has been immediate, pervasive, and graphic. Concerning this media exposure,
the current study revealed that the severity of symptoms reported during OIF is greater in those veterans who follow the news. Additionally, the more news they viewed, the more frequently they experienced symptoms. These findings are in accordance with prior research that suggests that Vietnam veterans may be susceptible to increased PTSD symptom levels due to media coverage of war trauma (Chiaramonte, 1992; Long, Chamberlain, & Vincent, 1987; Pantin, Schwartz, Prado, Feaster, & Szapocznik, 2003). Other research reports that media exposure of war situations creates marked distress in veterans, triggering PTSD symptoms up to 50 years after the end of the war in which they served (Hilton, 1997).

Additional research demonstrates that direct exposure to graphic television images concerning trauma has an interactive effect with media viewing, resulting in more PTSD symptoms, while exacerbating current exhibited symptoms (Schuster et al., 2001). Furthermore, the intensive exposure of news coverage concerning disaster is associated with psychopathology (Ahern et al., 2002).

Accordingly, other research supports a need to develop guidelines that limit the potential negative
effects of graphic media exposure with interventions including informed viewer discretion, direct warnings, and providing background information on upcoming news stories. However, the research states that the viewers themselves must take responsibility for following the recommendations set forth by the media and limit their exposure to prevent further psychological harm (Putnam, 2002).

As the news media draws similarities between OIF and the Vietnam War, this study found that significantly more veterans considered the two wars to be comparable than not, while those who saw similarities between the two wars disagreed with OIF. As the Vietnam War is one of the main factors related to PTSD symptoms for Vietnam veterans (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Hayman, Sommers-Flanagan, & Parsons, 1987; Kobrick, 1993; Lawson, 1995; Murray, 1992; Shehan, 2001), the similarity of the traumatic experience of Vietnam and subsequent wars may result in feelings of opposition to any traumatic event that resembles the original experience.

In discussion of publicity of OIF, the veterans in this study thought the war was too publicized with the
majority holding strong convictions regarding their opinions. A reasonable evaluation of the evidence suggests that as the media exposure leads to detrimental mental health consequences, this finding is consistent that veterans would find excessive publicity a negative factor.

Media coverage of the national tragedy of the 9-11 terrorist attacks was a profoundly shocking event to all who were exposed. Consequently, it was imperative to explore the degree to which participants in this study were able to distinguish their emotions from the tragedy of 9-11 and OIF. The overwhelmingly majority of veterans claimed that the two events were separate.

**Ethnic Differences**

Considering ethnicity, this study’s results show that non-minorities were more likely to agree with OIF than were minorities. This finding is supported through the literature concerning PTSD and ethnicity (Penk et al., 1989), which states that minorities are more conflicted about war participation than non-minorities.

There are a number of factors that might contribute to this ethnic discrepancy, including experienced racism in the military and/or at home (be it environmental,
economic, or institutional racism), overidentification with the non-white enemy, a bicultural identity, and nonmembership in the majority culture (Friedman, Schnurr, & McDonagh-Coyle, 1994; Penk et al., 1989). It should be noted that these factors along with others may explain the phenomenon of increased PTSD prevalence rates among minorities, relative to whites (Friedman, Schnurr, & McDonagh-Coyle, 1994). Other research offers support for identification of ethnocultural factors association with poor post-war adjustment and higher rates of PTSD (Figley, 1985; Penk et al., 1989).

A review of related ethnic evidence from this study shows a significant difference between the number of veterans who agreed with the appropriateness of treatment of the Vietnamese by American soldiers during the Vietnam War compared to those who did not agree. Likewise, when the veterans were asked about the appropriateness of treatment of the Iraqi prisoners by American soldiers, a significantly greater number also agreed with the treatment. This comparison demonstrates conformity in that if veterans agree with the treatment of the opponent in one war, they will also agree with the treatment of the opponent in subsequent wars.
The findings of this research demonstrate the importance for clinicians who work with ethnic minority veterans to understand the additional complications these veterans may have experienced, and to take responsibility for assessing and treating the full range of problems that they face.

**Erikson’s Developmental Theory**

In accordance with Erikson’s developmental theory of the stage of Identity versus Role Confusion, this study found that the younger veterans who began combat between the ages of 18 and 19 showed greater severity of symptoms concerning the inability to feel close to their family, difficulty trusting others, and feeling emotionally numb, than veterans who started combat between the ages of 20 and 26.

This research utilized emotional problems as variables to examine Erikson’s theory. According to research, emotional numbing, which is adaptive for the purpose of psychological survival during combat, proves to be maladaptive concerning relational intimacy, as the veteran withdraws, isolates, and experiences interpersonal relationships that are devoid of intimacy (Silverstein, 1994).
The decreased capacity of relational intimacy among younger veterans demonstrated by this study is consistent with other research examining personality using Erikson’s theory of psychosocial development. During the time an adolescent would typically be establishing a stable, enduring personality structure, veterans were instead placed in the conflicting roles of combatant versus survivor, triggering the younger veterans to view the world as untrustworthy and dangerous, superimposing negative expectations on new relationships (Lawson, 1995). The aforementioned role confusion results in identity crises and is explained by Erikson as resulting in impairment (due to the pressure of war) in central control over themselves, known as a loss of ego identity (1968). This role confusion prohibits achievement of Erikson’s next stage of Intimacy versus Isolation (Erikson, 1980) which is evident by the decrease of relational intimacy found in this study. Additional research suggests that induction into the military during this developmental stage of life frequently leads to devastating results for the veteran (Silverstein, 1994). In conjunction with Erikson’s theory, research supports that the younger the veteran, the greater the propensity
for vulnerability to PTSD (Friedman, Schnurr, & McDonagh-Coyle, 1994; Modell & Haggerty, 1991; Murray, 1992), which in turn is related to marital problems and divorce (Friedman, Schnurr, & McDonagh-Coyle, 1994).

Treatment

This study looked at treatment concerning the veteran's PTSD symptoms. Although participants overall symptoms increased in severity and frequency during OIF, their subjective opinion included that the psychotherapeutic and psychopharmacological approaches utilized by the Vet Center have resulted in positive treatment outcomes. In accordance with past research, the Vet Center utilizes common essential treatment principles, including establishing a therapeutic partnership through assessment and trust building, providing PTSD education, stabilizing, offering anxiety and anger management, processing the trauma through facilitating the re-experience of the veteran's war exposure in a safe environment, and reintegration into society (Friedman, Schnurr, & McDonagh-Coyle, 1994; Hayman, Sommers-Flanagan, & Parsons, 1987).
Limitations

Interpretations of the finding of this study are limited by a number of factors. As an exploratory study, it is limited in its external validity due to the lack of a random sample, and the veterans subjection to other war related events. Although a quasi-experiential approach was taken, variables revealed on the historical time-line could not be prevented. The historical context during the time period the interviews were conducted included sensationalized news media coverage of the Iraq prison abuse (Abu Ghraib) scandal, beheadings by the terrorists in Iraq, a major U.S. led offensive strike against insurgents in Falluja, car and suicide bombings, and the absence of weapons of mass destruction in Iraq.

It is common for historical factors to pose uncontrollable confounds on research. The relationship between these historical factors and the topic of the research however, warrants particular note.

Consistent with this concern was the possible confound of the terrorist attacks on September 11, 2002. Questions regarding those attacks were examined to attempt to distinguish private meaning and
interpretations of that traumatic event apart from the current war in Iraq.

Although a strength of this study was its mixed methods design and specialized population, the time and labor intensive methodologies required for such research yielded a relatively small sample. As a result, some of the findings must be interpreted with caution and must be replicated.

Related to the mixed methodology, qualitative responses were quantified for comparison with scaled variables. This decision, though enriching the quantitative findings, necessarily resulted in some loss of richness in the qualitative data itself.

As with all self-reported data, there is the possibility of response bias. Other potentially important confounds, which may compromise this study, include the veterans' self report of the use of anti-depressants (58.1%), anti-anxiety medication (58.1%), sleep aids (45.2%), alcohol (58.1%), and illegal substance use (6.5%) that could have been more extensively and validly measured. Particularly given that they were asked about difficult traumatic experiences, some may have had difficulty accurately assessing and reporting the impact
on their psychological health due to the medication (whether prescribed or self-administered). This may have made it particularly difficult for participants to provide retrospective data.

The exploratory posttest only group design that was utilized for this study may demonstrate an inability to control for extraneous variables (e.g., amount and type of media exposure), and threats to internal validity (e.g., history, and psychological/physical maturation), limiting generalizability.

Despite the methodological limitations, this research initiated the process of analysis and aided in discovery of relationships concerning reactivation of PTSD symptoms and the social phenomenon of OIF.

Recommendations for Social Work Practice, Policy and Research

The reawakening of veterans' war experiences on exposure to subsequent wars has not received the attention that it deserves. For veterans with PTSD (and some without), a current war can significantly produce negative affects (Kobrick, 1993). Currently, American troops are serving for prolonged periods in Iraq and Afghanistan in a hazardous combat environment. It is
expected that the mental health care needs of these veterans will be consistent with past war trauma victims and possibly result in PTSD as well. The intent of this study was to explore and provide a clear concept of Vietnam veterans with PTSD and the likelihood of increased negative impact on their mental health from further exposure to war. This study can be expanded to include current military service members and address their future mental health needs as well.

As the findings of this study suggest that media exposure to subsequent war trauma can reawaken past war experiences and increase PTSD symptoms, it is imperative that mental health workers explore both the traumatic event and its personal meaning and effect on the veteran. If not understood, the previously experienced trauma can intensify their PTSD symptoms with no possibility of understanding the relived trauma or how to diffuse it.

It is also important for social workers to obtain a deep understanding of the complex political, historical, and social forces that contributed to the context of the war, which may subsequently affect the veteran’s behavior. Research demonstrates that combat veterans, when re-exposed to trauma require more intensive
treatment than those who were not exposed to prior trauma. Furthermore, when the symptoms are persistent, as in the chronic PTSD experienced by many Vietnam veterans, the problem becomes critical (Hobfoll, 1991).

Specifically, social workers can help veterans with PTSD to explore their situation, gain insight into the political, historical, social, and cultural context of the war, examine their increased symptomology, and make peace with their past traumatic experiences.

Further research in the area of reactivation of PTSD symptoms following subsequent war trauma would raise awareness of the significance of this issue, and aid in the refinement of treatment procedures for veterans. Further research would be beneficial in determining susceptibility to reactivation of PTSD symptoms caused by other forms of violence such as rape, assault, accidents, or natural disasters as well.

Conclusions

The results of this investigation have important implications concerning veterans with PTSD and reactivations of symptoms due to further war exposure. Variables such as increased PTSD symptomology, media
exposure to war, ethnicity, Erikson’s developmental theory, study limitations, future directions for research, and implications for social work were addressed. Overall, the results of the analyses provided support that a significant relationship exists between PTSD, additional variables of interest in this study, and exposure to Operation Iraqi Freedom.
APPENDIX A

DEMOGRAPHICS
DEMOGRAPHICS

Please respond as accurately as possible and answer all questions on the following 2 pages. Thank you for your cooperation.

1. Age: ______

2. Ethnic Background (check which one best describes you):
   _____ Asian       _____ African American       _____ American Indian
   _____ Caucasian   _____ Hispanic/Latino
   _____ Other (Please Specify) _______________________

3. Check the HIGHEST level of education completed:
   _____ Some Junior High       _____ A.A. Degree
   _____ Some High School       _____ B.A./B.S. Degree
   _____ High School Diploma    _____ Masters Degree
   _____ Some College           _____ Doctorate Degree

4. Age of enlistment ______

5. Age at combat experience ______ to ______

6. Were you drafted? _____ Yes     _____ No

7. Status: _____ Active      _____ Discharged

8. Marital Status:
   _____ Single     _____ Married        _____ Never Married
   _____ Divorced   _____ Widowed

9. What branch of the armed forces did you serve in?
   _____ Army       _____ Air Force      _____ Marines
   _____ Navy       _____ National Guard _____ Reserves

10. How many years were you in the service? ______

APPENDIX B

SYMPTOMS SCALE
## Symptoms of Post-Traumatic Stress

Rate each item on a scale of 0-4 according to how intensely you have felt this to be a problem for you.  
0 = not at all  1 = minor impact  2 = serious problem  3 = extreme problem  
Column 1 is **before** the Iraq War, Column 2 is **currently**

<table>
<thead>
<tr>
<th>Item</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty falling asleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flashbacks about war events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of hurting self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty remembering some things</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vivid memories of unpleasant events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of interest in “fun” activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility/Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant tension or anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty staying asleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot feel close to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty trusting others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling worthless</td>
<td></td>
<td></td>
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<tr>
<td>Feeling emotionally numb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic attacks</td>
<td></td>
<td></td>
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<tr>
<td>Jumping at slight noises</td>
<td></td>
<td></td>
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<tr>
<td>Nightmares</td>
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</tbody>
</table>
APPENDIX C

QUESTIONNAIRE
<table>
<thead>
<tr>
<th>Questions:</th>
<th>Prompts:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Military Service:</strong></td>
<td>What branch? What was your major job or specialty? What were your expectations or fears about being a soldier?</td>
</tr>
<tr>
<td>What were your reasons for entering the Service?</td>
<td>How much time spent in combat? What was your first experience like? What are your most vivid memories of that event? What was the most stressful thing about combat?</td>
</tr>
<tr>
<td><strong>Combat Experiences:</strong></td>
<td>OR</td>
</tr>
<tr>
<td>Were you involved in war zone duty?</td>
<td>Do you feel that your job was easier or harder than those in combat? What exposure to combat did you have?</td>
</tr>
<tr>
<td><strong>Non-Combat Experiences:</strong></td>
<td></td>
</tr>
<tr>
<td>Did you avoid combat?</td>
<td>What were your feelings toward military authorities? What were your relations like with the Vietnamese?</td>
</tr>
<tr>
<td><strong>Attitudes:</strong></td>
<td></td>
</tr>
<tr>
<td>Did you agree with the way other Americans treated the Vietnamese?</td>
<td></td>
</tr>
</tbody>
</table>

67
<table>
<thead>
<tr>
<th>Questions:</th>
<th>Prompts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree with the way American soldiers are treating the Iraqi prisoners?</td>
<td>What are your feelings concerning their treatment? How would you handle it differently? Do you think it's too publicized?</td>
</tr>
<tr>
<td>September 11th, 2001:</td>
<td>What was your first reaction to the news? What were your first thoughts?</td>
</tr>
<tr>
<td>How did you hear about the terrorist attacks?</td>
<td></td>
</tr>
<tr>
<td>Operation Iraqi Freedom:</td>
<td>First reaction to the news? First thoughts? How has it affected your life? Is it separate for you from the war in Vietnam? Does it bring back any memories?</td>
</tr>
<tr>
<td>What do you think/feel about the war in Iraq?</td>
<td></td>
</tr>
<tr>
<td>Media:</td>
<td>More/less than before Iraq? How often? How long? Do you avoid the news about Iraq?</td>
</tr>
<tr>
<td>Do you follow the news on the war in Iraq?</td>
<td></td>
</tr>
</tbody>
</table>
### Questions:

#### Media Continued:
- What do you think/feel about the media
- Comparison to Vietnam?

#### PTSD:
- Do you think that your symptoms of PTSD have been affected by Operation Iraqi Freedom?

#### Treatment:
- Have you come in for treatment more/less since the war began?

### Prompts:

- First reaction to the news?
- First thoughts? Are your feelings about 9-11 separate from the war in Iraq? How has it affected you physically? Mentally?

- Could you give me some examples? Of your symptoms; what bothers you the most? What have you done about it? What more could you do?

- Is current treatment helpful? What other treatments would you recommend? Do you know of someone who would benefit from treatment for PTSD? How could you help them?

What is the most important thing that you have learned about yourself since Vietnam?
APPENDIX D

INFORMED CONSENT
INFORMED CONSENT

This research project is being conducted by Janice Lynn Moody and Ron Robinson, both MSW student researchers at California State University San Bernardino (CSUSB). The purpose of this study is to gain understanding of the unique ways in which previous war experiences, Post-traumatic Stress Disorder, and current media exposure to war violence may impact individual responses among Vietnam veterans.

You will be asked to participate in a semi-structured interview that will take approximately 45 minutes to complete that will include questions about your experiences regarding military service, along with your personal responses to the war in Iraq. You will also be asked to fill out a survey regarding PTSD symptoms from before the war and currently. In regards to this project, your identity and responses will remain confidential, as your name and other identifying information will not be recorded. Please keep in mind that your participation in this study is completely voluntary and that you may choose to withdraw at any time without penalty. Whether or not you choose to participate, will in no way affect the services you receive from this center.

This interview process may bring up painful memories for participants, but the benefit of the shared experience may prove to be therapeutic. You may stop the interview at anytime if it makes you uncomfortable. If you feel you need further assistance, please contact the Corona Vet Center (909) 734-0525.

This research has been approved by the Institutional Review Board at CSUSB. If you have any questions concerning this project please contact our faculty supervisor, Rosemary McCaslin, Ph.D., A.C.S.W. (909) 880-5507.

Please Check: _____ I have read the above description, understand the study’s nature and purpose, and agree to participate.

Please Check: _____ I agree to the use of audiotape during the process of this interview, with the understanding that after the necessary information for this study is extracted, the tape will be destroyed.
APPENDIX E

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

The purpose of this study is to provide a clear concept of how Vietnam veterans who have previously been diagnosed with Post-traumatic Stress Disorder respond to and cope with the present war in Iraq.

The results of this research project will be available in the John M. Pfau Library on the California State University San Bernardino campus in September, 2005. Copies will also be available at the Corona Vet Center where we will offer a presentation of the findings.

If you have any questions or concerns regarding the nature of this study, please contact our faculty supervisor Rosemary McCaslin, Ph.D., A.C.S.W. (909) 880-5507. If the content of this study has made you feel uncomfortable in any way and you wish to discuss these feelings with a professional, please contact the Corona Vet Center (951) 734-0525. Thank-you for your invaluable participation in this research project.

Sincerely,

Janice Lynn Moody and Ron Robinson,

MSW student researchers, CSUSB
APPENDIX F

TABLES
Table 1a. Demographic Description of Participants on Interval Variables as a function of Ethnicity

<table>
<thead>
<tr>
<th>Interval Variables</th>
<th>White n = 20</th>
<th>African American n = 6</th>
<th>Latino n = 4</th>
<th>Asian n = 1</th>
<th>Total Sample n = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Current Age at Enlistment</td>
<td>58.65</td>
<td>3.4</td>
<td>60.33</td>
<td>6.7</td>
<td>57.5</td>
</tr>
<tr>
<td>at Beginning of Combat</td>
<td>18.7</td>
<td>2.0</td>
<td>19.0</td>
<td>1.3</td>
<td>19.0</td>
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<tr>
<td>at End of Combat</td>
<td>20.25</td>
<td>2.3</td>
<td>20.17</td>
<td>2.0</td>
<td>19.75</td>
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<td>4.8</td>
<td>8.0</td>
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<td>3.0</td>
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Table 1b. Demographic Description of Participants on Ordinal and Nominal Variables as a function of Ethnicity

<table>
<thead>
<tr>
<th>Ordinal and Nominal Variables (%)</th>
<th>White n = 20</th>
<th>African American n = 6</th>
<th>Latino n = 4</th>
<th>Asian n = 1</th>
<th>Total Sample n = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>some High School</td>
<td>5</td>
<td>16.7</td>
<td></td>
<td></td>
<td>6.5</td>
</tr>
<tr>
<td>High School Diploma</td>
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<td>33.3</td>
<td>50</td>
<td>100</td>
<td>25.8</td>
</tr>
<tr>
<td>some College</td>
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<td>33.3</td>
<td>50</td>
<td></td>
<td>51.6</td>
</tr>
<tr>
<td>AA</td>
<td>10</td>
<td>16.7</td>
<td></td>
<td></td>
<td>9.7</td>
</tr>
<tr>
<td>BA/BS</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>3.2</td>
</tr>
<tr>
<td>MA</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>3.2</td>
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<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Married</td>
<td>60</td>
<td>66.7</td>
<td>100</td>
<td>100</td>
<td>67.7</td>
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<tr>
<td>Divorced</td>
<td>40</td>
<td>33.3</td>
<td></td>
<td></td>
<td>32.3</td>
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<tr>
<td>Drafted (yes)</td>
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<td>16.7</td>
<td></td>
<td></td>
<td>9.7</td>
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<tr>
<td>Branch of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td>30</td>
<td>16.7</td>
<td>25</td>
<td></td>
<td>25.8</td>
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<tr>
<td>Navy</td>
<td>20</td>
<td>16.7</td>
<td>25</td>
<td></td>
<td>19.4</td>
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<td>Air Force</td>
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<td>16.7</td>
<td></td>
<td></td>
<td>9.7</td>
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<tr>
<td>Marines</td>
<td>40</td>
<td>50</td>
<td>50</td>
<td>100</td>
<td>45.2</td>
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<tr>
<td>Discharged</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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Table 2. Component Loadings, Communalities, and Percents of Variance for Principal Components Extraction and Varimax Rotation on Symptom Scale Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Emotional</th>
<th>Anxiety</th>
<th>Worthlessness</th>
<th>Non-trust</th>
<th>Communalities</th>
</tr>
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<tbody>
<tr>
<td>Difficulty remembering</td>
<td>.74</td>
<td>.34</td>
<td>-.13</td>
<td>-.01</td>
<td>.67</td>
</tr>
<tr>
<td>Memories of bad things</td>
<td>.57</td>
<td>.41</td>
<td>.18</td>
<td>-.03</td>
<td>.53</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>.67</td>
<td>.21</td>
<td>-.06</td>
<td>-.09</td>
<td>.51</td>
</tr>
<tr>
<td>Hostility/violence</td>
<td>.64</td>
<td>.11</td>
<td>.14</td>
<td>.21</td>
<td>.49</td>
</tr>
<tr>
<td>Difficulty feeling close</td>
<td>.60</td>
<td>.19</td>
<td>.38</td>
<td>.28</td>
<td>.62</td>
</tr>
<tr>
<td>Feeling numb</td>
<td>.62</td>
<td>-.13</td>
<td>.13</td>
<td>.33</td>
<td>.64</td>
</tr>
<tr>
<td>Difficulty falling asleep</td>
<td>.07</td>
<td>.73</td>
<td>.22</td>
<td>.37</td>
<td>.73</td>
</tr>
<tr>
<td>Flashbacks before war</td>
<td>.33</td>
<td>.71</td>
<td>-.09</td>
<td>.22</td>
<td>.67</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>-.04</td>
<td>.76</td>
<td>.12</td>
<td>.00</td>
<td>.59</td>
</tr>
<tr>
<td>Tension or anxiety</td>
<td>.27</td>
<td>.63</td>
<td>-.13</td>
<td>-.10</td>
<td>.50</td>
</tr>
<tr>
<td>Panic attacks</td>
<td>.27</td>
<td>.65</td>
<td>.10</td>
<td>-.13</td>
<td>.53</td>
</tr>
<tr>
<td>Thoughts of hurting self</td>
<td>.05</td>
<td>.07</td>
<td>.90</td>
<td>-.02</td>
<td>.82</td>
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<tr>
<td>Suicidal thoughts</td>
<td>.10</td>
<td>-.09</td>
<td>.89</td>
<td>.12</td>
<td>.82</td>
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<tr>
<td>Feeling worthless</td>
<td>.037</td>
<td>.17</td>
<td>.74</td>
<td>-.26</td>
<td>.53</td>
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<tr>
<td>Difficulty staying asleep</td>
<td>.06</td>
<td>.06</td>
<td>-.08</td>
<td>.78</td>
<td>.63</td>
</tr>
<tr>
<td>Difficulty trusting</td>
<td>.31</td>
<td>.04</td>
<td>-.12</td>
<td>.67</td>
<td>.56</td>
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<tr>
<td>Jumping at noises</td>
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<td>-.23</td>
<td>-.37</td>
<td>.59</td>
<td>.65</td>
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<tr>
<td>Nightmares</td>
<td>.07</td>
<td>.07</td>
<td>.11</td>
<td>.45</td>
<td>.22</td>
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<tr>
<td>Percent of variance</td>
<td>.16</td>
<td>.16</td>
<td>.15</td>
<td>.12</td>
<td></td>
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</table>
Table 3. Mean Ratings of Subscales for Before and During Iraq War

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Before Iraq War</th>
<th>During Iraq War</th>
<th>$t$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>1.48</td>
<td>1.95</td>
<td>-5.54***</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.57</td>
<td>2.10</td>
<td>-5.09***</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>.97</td>
<td>.91</td>
<td>.349</td>
</tr>
<tr>
<td>Trust</td>
<td>1.94</td>
<td>2.48</td>
<td>-6.4***</td>
</tr>
</tbody>
</table>

***$p < .001$
Table 4. Crosstabulation of PTSD Symptom Frequency by Whether or Not Participants Followed the News on Operation Iraqi Freedom

<table>
<thead>
<tr>
<th>follow the news on Iraq</th>
<th>PTSD symptoms frequency</th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>frequency</td>
<td>frequency</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>increased</td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>Count</td>
<td>23</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>% within follow the news on Iraq</td>
<td>85.2%</td>
<td>14.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Std. Residual</td>
<td>.5</td>
<td>-.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>no</td>
<td>% within follow the news on Iraq</td>
<td>25.0%</td>
<td>75.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Std. Residual</td>
<td>-1.2</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>24</td>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>% within follow the news on Iraq</td>
<td>77.4%</td>
<td>22.6%</td>
<td>100.0%</td>
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</table>
Table 5. Crosstabulation of Agreement or Disagreement of Operation Iraqi Freedom by Ethnicity

<table>
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<tr>
<th></th>
<th>feelings about Iraq war</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>agree</td>
<td>disagree</td>
<td>Total</td>
</tr>
<tr>
<td>Minority</td>
<td></td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>% within</td>
<td></td>
<td>27.3%</td>
<td>72.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Std. Residual</td>
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<td>-1.1</td>
<td>1.2</td>
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</tr>
<tr>
<td>Count</td>
<td></td>
<td>13</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>Non-Minority</td>
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<td>65.0%</td>
<td>35.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within</td>
<td></td>
<td>.8</td>
<td>-.9</td>
<td></td>
</tr>
<tr>
<td>Std. Residual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td>16</td>
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<tr>
<td>% within</td>
<td></td>
<td>51.6%</td>
<td>48.4%</td>
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</tbody>
</table>
Table 6. Perception of Comparison of How Operation Iraqi Freedom Compares With Vietnam War by Agreement or Disagreement of Operation Iraqi Freedom

<table>
<thead>
<tr>
<th>feelings about Iraq war</th>
<th>comparison of Iraq to Vietnam</th>
<th>Total</th>
</tr>
</thead>
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<tr>
<td></td>
<td>similar</td>
<td>dissimilar</td>
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<td>agree</td>
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<td>7</td>
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<tr>
<td></td>
<td>39.1%</td>
<td>87.5%</td>
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<td>1.4</td>
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<td></td>
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<td>1</td>
</tr>
<tr>
<td>disagree</td>
<td>14</td>
<td>1</td>
</tr>
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<td></td>
<td>60.9%</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>.9</td>
<td>-1.5</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
REFERENCES


ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Team Effort: Janice Moody & Ron Robinson

2. Data Entry and Analysis:
   Team Effort: Janice Moody & Ron Robinson

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Team Effort: Janice Moody & Ron Robinson
   b. Methods
      Team Effort: Janice Moody & Ron Robinson
   c. Results
      Team Effort: Janice Moody & Ron Robinson
   d. Discussion
      Team Effort: Janice Moody & Ron Robinson

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