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GRIEF AND THE TREATMENT OF
POST-TRAUMATIC STRESS DISORDER

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ABSTRACT

The effects of grief and grief-repression are described as being critical aspects of Post-Traumatic Stress Disorder. Qualitative interview and extant program material are utilized to assess the role of grief in the PTSD syndrome, and a program that incorporates grief-related therapy is described. Implications of grief-related therapy for the treatment of PTSD are also discussed.

INTRODUCTION

"Jeff"

Jeff, my friend, My closest
Friend I knew.
You're no longer here to
pal around
We went to school together,
You and me.
When we went to war together,
You and me.
We fought by each other's side
We talked about the girls
We left behind,
Shared the same food and
foxhole together--
You and me.
But on my orders one night
You took my place and died

For me.
I found your body and cradled
It in my arms.
And slowly let the tears run down.
I looked at your torn and mangled
Body. And all I could say was, "I am
sorry."
But Jeff, you may be the lucky one.
Because I am still dying out here.

(A Vietnam veteran)

Vietnam veterans constitute a significant American minority group. At a relatively young age (the average Vietnam soldier was nineteen) they were sent to fight a war the controversial nature of which caused them to receive substantial blame for carrying out the directives of what now is viewed as misguided leadership.

Vietnam left emotional scars not only on the nation's soul, but on the over three million youths who served there. But the manner by which to deal with these scars also represents a problem. A number of studies in which the emotional effects of the war on the participants were examined (e.g., Starr, 1973; Lifton, 1975; Mantell, 1975; Wilson, 1979; Figley and Levantman, 1980; Moskos, 1980; Wikler, 1980; and Goodwin, 1981) specify how particular aspects of the war may contribute to emotional problems in veterans after their return to the United States. These include the age of Vietnam soldiers, the moral ambiguity of the war, the lack of positive feedback, and hostility from the public, the system of individual terms of service which undermined group solidarity, and the lack of a clear-cut enemy (Goodwin, 1981). In sociological terms, these factors combine to render the Vietnam experience anomic, in that normative guidelines were absent. The experience was also alienating, both in terms of the veteran's relation to fellow soldiers and, upon returning home, a sense of betrayal perceived of a society that failed to appreciate the sacrifices made.

Although it initially appeared that psychiatric casualties were much lower for Vietnam soldiers than the number of psychiatric breakdowns recorded during World War II and Korea, this was in fact an illusion. For many Vietnam veterans psychiatric problems began to emerge after they returned to "the world" (Figley and Levantman, 1980:xxiv). Gradually, a general pattern of symptoms became evident, and by the late seventies this phenomenon began to be referred to as Post-Traumatic Stress Disorder (PTSD). The syndrome is characterized by a number of interrelated symptoms the elements of which include depression, isolation from others, rage, avoidance of expression of feelings for others, survivor guilt, anxiety reactions, sleep disturbances and nightmares, and intrusive thoughts of combat-related experiences (Goodwin, 1981:13-19).

Perhaps the most extensive effort to study PTSD to date is Wilson's The Forgotten Warrior (1979). In addition to interviewing over 400 Vietnam veterans, Wilson subjected them to a battery of social-psychological tests from which a number of patterns associated with the syndrome were uncovered. Among the most significant of these was that the youthful average age of Vietnam G.I.s meant that they had been denied a period of late adolescence for development; an opportunity for a "moratorium" or a time to develop a consistent set of values and a sense of self-identity. Instead, they were forced to cope with experiences and pressures that would strain the resources of much older men.

Grief Repression

Though scholars such as Lifton (1975) discuss the role of survivor guilt in the development of PTSD, few focus on the fact that suppression of the normal grief response is a ubiquitous combat phenomenon. The mass media creates images of war which give the impression that expressions of grief and bereavement are either infrequent or are not central to the combat experience. In the film "Patton," for example, General Patton is portrayed as telling his soldiers that they need not worry about being motivated to fight, since they will "know what to do when they see their friends

faces turned to goo." The implication, of course, is that the only legitimate response is to seek revenge against the enemy. More realistically, there exists a number of reasons to hypothesize that the kinds of horror experienced by Vietnam combat soldiers would have more traumatic effects than would those experienced in other facets of life. Relatively few people witness violent death, and in a peacetime environment the image of death is usually relegated to morgues or to the funeral industry.

The literature on the psychological effects and reactions to protracted grief indicate that depression, rage, and other reactions are common response patterns in peacetime situations. These problems tend to increase when grief is found to emerge from the disaster-related deaths of loved ones. The difference between grief experienced in peacetime and in war is that in war a soldier would mourn a dead or dying buddy at the risk of his own life. The exigencies of survival and maintaining group functions mandate that grief reactions be repressed. As one veteran quoted by Robert Lifton (1975: 189) in Home from the War stated, "Every time you'd start to feel human, you'd get screwed."

PTSD also has secondary side effects as well, such as geographic, employment, and marital instability. Occasional PTSD-related criminal acts, and the retreatist behavior expressed through alcoholism and drug abuse have also been documented. The effects on spouses, children, family and friends require more effective means for dealing with PTSD (Marafiote, 1980). Marafiote contends that once the relationship between unresolved grief and PTSD is acknowledged, greater treatment success will follow.

Grief-Related Treatment Modalities

Stories told by veterans about their experiences in Vietnam point to the need to develop a treatment modality for dealing specifically with PTSD--one which is able not only to address the overt symptoms of PTSD, but to ferret out the deep, grief-related etiology of the syndrome.

In the past the failure of many Vietnam veterans to cope with the pressures related to jobs, family life, and other aspects of "normal" existence led to mental breakdown, violence, and other pathologies that have been treated on the basis of generally accepted psychiatric diagnoses (Gusman, 1983). Following an incident sufficiently disruptive to render suffering to friends, family, or employers, a veteran or a member of his family will typically approach a social worker, who, in turn, will arrange either for individual out-patient counseling or admission to a Veteran's Administration hospital. These efforts may temporarily alleviate the symptoms, but do little to deal with underlying causes of the problem. After making this overture, veterans attempt to resume a "normal" life and may even appear to succeed temporarily. Almost inevitably, however, the veteran is again unable to function, and the revolving-door process begins leading to serious strain within marriages and to negative effects for children and friends (Williams, 1980).

Although efforts to deal with PTSD are moderately successful, only a few veterans have been adequately treated to alleviate the syndrome. Kuramoto (1980), for example, points out that over one-half of the Veterans Administration medical facilities are devoted to psychologically related problems and that there has been a substantial shift towards out-patient treatment. Passed in July, 1979, Public Law 96-22 created the Veterans' Outreach Counseling Program, which led to the establishment of Veteran Centers in most large cities. A place where Vietnam veterans can receive "help without hassles," outreach centers are staffed primarily by counselors who are also Vietnam veterans. Offering individual counseling, family counseling, rap groups, employment and veterans' benefits counseling, discharge upgrading, and educational, medical, and vocational assistance, these centers fill an important void in meeting the needs of veterans. Because of a Griefwork program conceived and implemented by one of the co-authors in 1981, counselors are exposed to therapeutic techniques similar to those developed by Kubler-Ross (1982). Since many of the Outreach staff are themselves former Vietnam veterans, they, too,

take part in workshops designed to provide them with the knowledge to deal with their own unresolved grief.

The Gusman Program

The need for a program to effectively deal with PTSD has long been recognized. In 1978, Fred Gusman, a Vietnam-era veteran and a trained social worker and psychologist, responded to that need by establishing a residential treatment program at the Veterans Administration Mental Rehabilitation Center located in Menlo Park, California. The program is designed to care for a maximum of 90 patients and a long waiting list for admission exists.

Most patients display serious symptoms ostensibly related to their Vietnam experience, and manifest a variety of psychopathological behavior including life-threatening behavior. The Gusman program is specifically designed to help these veterans experience the identity-forming "moratorium" previously denied them. Much of the program involves assisting veterans to sort out their feelings about themselves and to evaluate the meaning of life within a therapeutic environment free from worry of such things as employment and family life. Development of interpersonal ties and a strong sense of community are stressed; sociological characteristics not previously experienced during the time in Vietnam. A personal orientation dominated the Vietnam experience which, in turn, caused each to think primarily in terms of individual rather than group survival. Gusman assists veterans to relate to one another within formal therapy groups, one-to-one encounters and informal group "rap" sessions. Development of close personal ties substitutes for the fact that, unlike veterans of the World Wars and the Korean War, Vietnam veterans returned home individually after their tour of duty and often found themselves in "the world" without having an opportunity to adjust to normal life. The Gusman program retroactively provides a kind of "deprogramming."

Finally, one of the most striking aspects of the program involves the various ways in which the

patients are not only encouraged, but actively "pushed" to uncover deeply-buried and previously unexpressed thoughts and feelings related to their grief. The most moving and dramatic role-playing sessions we witnessed were those in which patients spoke to dead "buddies." Externalizing their deep-rooted grief and guilt, patients were able to resolve some of these feelings.

In the discussion to follow, the authors will focus on one particular aspect of PTSD which has not been given full attention in the literature; specifically, the role of grief and bereavement and the repression of grief which we believe represent significant elements of PTSD.

METHOD AND DISCUSSION

During 1983 the authors conducted a series of interviews with staff counselors and Vietnam veterans (N = 48) who participated in a unique program at California Mental Rehabilitation Center of the Veterans' Administration located in Menlo Park, California. We tape recorded and then transcribed the unstructured interview data, but the wishes of respondents who did not wish to be taped were respected. Whereas the use of questionnaires would yield quantitative data, the distrust Vietnam veterans express toward non-veterans led the authors to adopt an unstructured format. Poems and other statements in which grief-related feelings were expressed by these veterans also comprise part of the data.

The authors also took part in staff and therapy group meetings as participant observers. Because of the sensitive nature of the subject matter, and a general distrustful reaction among Vietnam veterans toward non-veterans, the authors spent considerable time developing trust and rapport with the subjects. The questions posed attempted to elicit the feelings veterans had about war-related experiences especially as they pertain to the deaths of "buddies," and retrospectively, how they felt when the deaths occurred. Various techniques also were utilized as part of our

own effort to deal with the feelings and perceptions of the interviewees without causing them undue stress or depression.

The Gusman program represents one special effort to deal with the many facets of PTSD and requires that the staff be trained in a wide variety of counseling and treatment approaches. The program emphasizes the common bond existing between patients because of shared Vietnam experiences, and employs a wide range of individual and group therapeutic approaches in a communal context. These approaches include encounter groups, psychodrama, Gestalt and behavioral techniques, physical conditioning, remedial and supplementary education, vocational counseling, and participation in a variety of recreational activities. Psychological testing, administered before veterans enter the program, assists in identifying the most effective approach.

Treatment involves three phases. First, acute psychological problems are dealt with by developing a sense of trust and rapport between staff members and veteran patients. During this stage, veterans are encouraged to review painful combat experiences that cause them to experience nightmares, flash-backs, and intrusive, compulsive thoughts. Clients take part in intensive group therapy sessions known as "Nam I" in which they are encouraged to verbally recall and to act out through role-playing the events that led to the deaths of buddies. The following example highlights the method used: One veteran, a former sergeant, was blindfolded and asked to mentally place himself back into a situation in which a young lieutenant died--a death he felt responsible for. Then the veteran was requested to describe in detail how he felt toward the lieutenant. During this process, the patient related that the lieutenant had asked for assistance at a time when he (the sergeant) had just completed several weeks in the field and was looking forward to a much needed period of rest and relaxation. Reluctantly the sergeant went out in the field with the lieutenant and in a perfunctory manner "showed (him) the ropes." On his very first mission the lieutenant was killed. Believing that he was

responsible, the sergeant carried feelings of guilt for fifteen years. This guilt was dealt with through a dramatic process of role-playing in which the sergeant asked the lieutenant's forgiveness. Such emotionally charged scenes represent a common, moving, and impressive aspect of the program.

In the second phase, assisted by "Nam II" groups, such as relaxation therapy, values clarification, anger group, conflicts and resolution, minority group rap sessions, and art therapy, patients review their pre- and post-Vietnam experiences and then attempt to integrate memories of Vietnam with other experiences. The emphasis placed in this phase is on assisting patients to recognize that their war-related experiences constitute a small, albeit important aspect of their lives. Assisted by staff members, the patients also begin to plan reentry into their community.

In the third and final phase veterans begin to actualize their plans to return to jobs, family, and community. "Nam III" groups are formed to discuss ways in which war experiences can be dealt with on a long-term basis. Patients become involved in attempting to re-establish contacts relating to employment, education, and family ties. Phase three of the program also entails a "testing-out" period in which patients leave the program for short periods and then return to discuss their experiences in group settings and with the staff, and to receive social and psychological support. Patients are also encouraged to serve as volunteers in community-based projects through assisting the elderly, the handicapped, and juvenile delinquents.

Another aspect of the overall thrust of the program is worthy of comment. After discharge, patients are encouraged to retain their ties with the program through various types of individual and family counseling activities. They participate in these activities aimed at consolidating and reinforcing the gains obtained, from the program while on in-patient status. Eventually veterans are able to establish their own support network and then withdraw completely from the Gusman program.

The extent to which unresolved grief is a central tenet of PTSD is evidenced in the continued anguish that veterans felt over the loss of buddies. Things that happen to combat soldiers are difficult to imagine for those unfamiliar with war, and for this reason each interviewee emphasized that it is simply impossible for anyone to fully relate to the meaning of the environment. As one veteran put it: "I could tell you the sights and the sounds and how we felt but it doesn't convey half of what it was like."

Another veteran stated that when a buddy went on patrol one afternoon:

I stayed behind. Before he went, he said 'Well, I'll see you on the other side.' I said, 'What do you mean?' He was gone outside of the perimeter about five minutes and one round was fired at him. They brought him back and his head was blown to bits. I was down there for about an hour scraping my buddy's brains off the sandbags, trying to put him back together.

The emotional reaction to the horror of war has to be repressed if one's own survival is to be ensured. This is particularly true of medics who assist the wounded and try to comfort the dying. One former medic told us of three different situations experienced during his first month in Vietnam. The first event involved a dying soldier who had both arms and legs blown off when a land mine was detonated. The soldier, a Catholic, begged to be given the last rites, but the medic, a Protestant, was only able to recite the Lord's Prayer.

Soon thereafter, the second event occurred. The medic's helicopter was shot down and the entire group was overrun during an enemy attack. Having run out of ammunition, the medic started swinging blindly in the dark with an entrenching tool and, despite sustaining several wounds, survived. When he awoke the next morning, he discovered that along with several enemy

he had also killed two of his wounded comrades with the tool.

The third traumatic event took place when a gravely wounded soldier begged the medic to "put him out of his misery." The medic, believing that it is wrong to take the life of another, finally yielded to the dying man's wish and shot him in the head. At the time, the medic was eighteen years old. Although managing to function well enough to hold a responsible middle-level management job, the former medic was admitted to the Menlo Park program because of fits of uncontrolled rage, one of which nearly resulted in the death of his girlfriend.

Temporary repression, required by the exigencies of psychological and physical survival, is not appropriate for dealing with the horror and grief experienced. As another interviewee put it: "It never leaves. I keep seeing my buddy's blood all over my jacket." The medic described above felt guilty about not being able to offer the last rites to his dying comrade. This sense of guilt was exacerbated by the event in which he accidentally killed his own comrades.

In relating similar events, another veteran described why it was necessary to repress grief:

You couldn't be effective and not squelch it. You had to learn to shut down all your emotions. You just shut down. You become numb. And the situation either resolves itself or it doesn't. But either way you can't be hurt. That's what you tell yourself anyway. You know instinctively that you'll flip if you don't do something like that.

CONCLUSION AND IMPLICATIONS

It seems axiomatic that war, in the final analysis, is "about" death. Yet until recently few analysts have accepted the possibility that unresolved

psychological grief may be responsible for the PTSD symptoms manifested by many Vietnam veterans. It seems imperative that these insights as well as information pertaining to the techniques used in the Gusman Program be shared with members of the helping and mental health professions who deal with individual and family crises related to the effects of PTSD.

Provided that members of the helping professions recognize the potential effect of the relationship between grief and the PTSD syndrome, some assistance should be forthcoming. At the very least, veterans and their family members could be encouraged to recognize that a normal human response to death and tragedy did not occur at the appropriate time and that this can still be properly dealt with. In addition to disseminating this information to professionals, such as social workers, clergy, psychiatrists, and law enforcement officials, training should include a basic understanding of the dynamic effects of PTSD enabling them to respond to its victims more effectively.

Although the data required to scientifically confirm the success of the Gusman Program are not yet available, a preliminary in-house evaluation by Berman et al. (1982:922) stated:

In a recent outcome study of a random sample of 40 graduates of the program, the staff were asked to rate whether the program was successful in helping the patients reach three objectives considered the most essential goals of the program: achieving relief from acute psychological distress, resolving a crisis with a spouse or significant other, and securing employment or beginning or continuing school. Based on patient interviews at the time, discharge staff judged that 24 of the graduates, or 60 percent, reached the goals.

The lack of information to fully assess the efficacy of this program stems in part from the overwhelming amount of work for the staff involved at the

nine centers operated by Gusman. Realistically, a thorough program impact assessment would require the assistance of outside evaluators. The subjective information provided by Berman et al. (1982), however, offer some support for the authors' contention that the role of grief in the etiology of PTSD is real, it is substantial, and it requires programs and therapeutic techniques to resolve the problem.

Although the program's effectiveness has not been thoroughly evaluated, Gusman's approach does demonstrate that efforts to treat veterans with PTSD require that staff members either be veterans themselves or have specialized training. It is also noteworthy that victims of PTSD are not merely being treated as being mentally ill or "character-disordered", but receive specialized assistance available from persons able to empathize with these experiences.

Finally, it should not be forgotten that soldiers are, above all, human beings. This humanity should not be denied regardless of how much it has been repressed in the past. Policy-makers who favor military solutions to political problems should recognize that the human consequences of their decisions are inevitably deep-seated and long-lasting, influencing the lives of all participants whose "war within" continues to affect them, their families, and their communities.

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