lated by complex social processes associated with the therapeutic setting. Staff expectations and behaviors can play a role in influencing patients prone to episodic psychosis with assaultiveness and lead to self-fulfilling prophecies.

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Brief Report

Posttraumatic Stress Disorder in Medical Personnel in Vietnam

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The literature on Vietnam veterans and posttraumatic stress disorder (PTSD) has increased significantly in recent years (1–3). PTSD secondary to war experience is becoming well known to mental health professionals. However, little has been written about the incidence of PTSD among physicians, medics, corpsmen, nurses, and others who served in the medical professions in Vietnam. This report explores the unique characteristics of PTSD in this population. It is based on ten years' clinical experience working with Vietnam veterans, with a special emphasis on those who served in the medical professions.

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Military medical occupations carry with them an inherent contradiction: war connotes death, medicine implies life. Those who provided direct medical care in Vietnam had a twofold task: to ensure the survival of others while guarding their own. Medics, corpsmen, and nurses became agents in the struggle of life against death.

It would be difficult to deny that constant immersion in death constitutes a severe stress that is generally outside the range of normal human experience (4). And yet implicit in medical training is the philosophy that one is to be a selfless caretaker, somehow immune to the emotional impact of the job.

Although certain symptom patterns are common among all Vietnam veterans, symptomatology suggestive of PTSD takes on unique characteristics among combat and noncombat medical personnel, combining the caretaker, combatant, and survivor aspects of their experience. The following case example illustrates.

A Vietnam veteran with no known premorbid illness presents with symptoms suggestive of posttraumatic stress disorder. He served as a Navy combat corpsman in 1967 and received serious multiple combat injuries that resulted in sterility. He suffers from a pervasive sadness that persists during months of counseling. He has a recurring nightmare that he is accompanying his squad during a sweep of a village and discovers a woman in the late stages of labor. He goes to help her. His Marine buddies try to stop him. He delivers a baby girl at Marine gunpoint. Another squad member beheads the child and gives the lifeless form to the mother before killing her.

After months of individual and marital counseling, the veteran and his wife adopt a baby girl. She is Oriental. The nightmare ceases.

Signs and symptoms of PTSD

Major signs and symptoms of PTSD in Vietnam veterans include helplessness, survivor guilt, anger, isolation and estrangement, and low tolerance of frustration. The unique aspects of these symptoms in medicial personnel are described below.

Helplessness. Many medical personnel still experience a feeling of pervasive helplessness because of the futility of their efforts to deal with an overwhelming wave of human casualties. Often coupled with this feeling of helplessness is a lingering preoccupation with

death, which is sometimes manifested in somatic symptoms.

Survivor guilt. Interviews with several medics, corpsmen, and nurses indicate that the guilt common to many of the combat soldiers who served in Vietnam takes a special form with health personnel. Despite the incredible and heroic life-saving acts they performed almost daily, many are plagued by the feeling that what they did was not enough. This sense of inadequacy is often seen in those who performed triage duty, which carried with it the probable consequence that someone would die so that others might live (5). To react emotionally to that responsibility could render one dysfunctional and incapable of performing essential life-saving duties. Becoming close to people could mean inevitable pain, since the probability of losing them would be high. The implications for subsequent psychic numbing and emotional distancing are evident.

Anger. Anger resulting from the Vietnam experience is probably the most common denominator among Vietnam veterans (6). The degree of anger varied among members of the medical profession whom we studied. Some felt ill prepared for the experience and continue to blame the military for inadequate training. Others felt the frustration of not being able to retaliate or vent frustration as some "grunts" (combat soldiers) were able to do. Some were not authorized to carry weapons, despite the fact that a red cross was often a prime target.

Anger also resulted from the fact that during their Vietnam experience nurses, corpsmen, and medics performed life-saving techniques, including surgical procedures, that they were not permitted to perform when they returned to the States. After their return nurses often abandoned their profession in disillusionment because they were not able to use the valuable experience gained from trauma medicine in Vietnam. Medics discovered that they would have to undergo additional training to receive certification as emergency medical technicians.

It is interesting to note that medical personnel seemed to feel less anger and resentment toward the Vietnamese people than did some Vietnam veterans. That may be due to the fact that they had more interaction with the Vietnamese culture on a personal basis through such activities as medical civilian action patrols.

Despite the incredible and heroic life-saving acts they performed almost daily, many medical personnel are plagued by the feeling that what they did was not enough.

Isolation and estrangement. Feelings of isolation and estrangement are especially prevalent among medical personnel. Not only did they feel alienated from their society, like many other returning veterans, but also from their peers. A combat medic or corpsman solely responsible for between 12 and 20 men often felt uniquely alone, with no other medical personnel to share his experience. Medics in combat vet rap groups describe feeling on the periphery of the group, since they were not considered combat personnel. "But I wasn't really in combat" or "I didn't see that much action" are not uncommon responses of medics, despite the revered role they held and the trauma they endured. Their isolation may have been increased by such situations as being asked for drugs by peers or to care for one soldier before another.

Medical personnel rarely saw the result of their efforts. Field medics often never knew if those they helped were alive, since they were quickly evacuated to other facilities. Hospital personnel routinely performed patchwork surgery on soldiers, and the fruits of their labors often remained unknown to them.

The physicians who served in Vietnam are a generally silent population. It is probably safe to assume that they felt as isolated as or even more isolated than other health personnel. Perhaps the omnipotence attributed to physicians makes it even more difficult for them to show human emotion.

Low frustration tolerance. Frequently a medic or corpsman who made split-second life-saving decisions in Vietnam finds it difficult to make simple decisions ten years later. The same people who performed admirably during round-the-clock medical emergencies may have a low tolerance for frustration. These problems may derive from a fear of failure or of taking risks, since making a mistake in Vietnam could literally mean the difference between life and death.

Discussion

Although treatment techniques for PTSD do not differ for medical personnel and other veterans, any successful intervention with medical personnel requires a sensitivity to their unique experiences.

It is possible that the premorbid personality of many members of the medical corps included a high sensitivity to human suffering. This predisposition may increase the likelihood and severity of posttraumatic stress disorder. In addition, the initial idealism of some helping professionals could compound the disillusionment they felt when they were confronted with the futility of their position.

Therapists should be keenly sensitive to the sense of loss that these particular veterans feel. For them the sense of loss is often compounded by the fact that they saw it as their duty to prevent loss and yet most likely experienced it the most (7). As would be expected, grief work has proven effective with this population, as it has with other veterans. Individual intervention can also be geared toward tapping and reframing (cognitive

restructuring) the unique strengths they needed to perform their responsibility in Vietnam.

Involving medical personnel in a group with other Vietnam veterans can provide an opportunity for them to receive absolution from peers and can help reduce the isolation some have felt from their fellow veterans. However, a homogeneous group, consisting solely of those who served in caretaker roles, can be extremely effective and may be the ideal approach to take before involving medical personnel in a heterogeneous group with other combat vets.

Above all, this group of veterans should be treated as survivors, as has been suggested in working with all veterans (8). However, they should be viewed not only as survivors of a disaster, but also as the rescue workers who tried to help others survive. Recent research has shown that rescue workers suffer much the same reaction as victims of a catastrophe because of the responsibility they bear for undoing the effects of the tragedy (9). In civilian life, rescue workers are on the scene after the event. However, in Vietnam some medical personnel were present during and after the catastrophe and had to maintain a high level of intensity throughout. This intensity and duration combined to cause protracted stress.

It is generally accepted that the severity of posttraumatic stress disorder is proportionate to the level of exposure and intensity of stress. It would seem that the exposure to trauma and the intensity of stress endured by medical personnel in Vietnam was extraordinary. PTSD among these veterans takes special forms, combining the caretaker, combatant, and survivor aspects of their experiences.

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Open Forum

In Defense of State Hospitals

George S. Sigel, M.D.

Each year the public hospital system fulfills the needs of approximately 155,000 chronic patients (1). Estimates vary about the number of long-term patients who need or will need hospital care. Many patients are barely surviving in the community. Others regress and need to be quickly rehospitalized; recidivism can approach 50 percent annually. Still other patients are discharged before an appropriate community placement can be arranged.

It is unlikely that state hospitals will soon be replaced by a "dynamic system of resources" as some have hoped (1); community programs have not yet supplanted the state hospital system. As Kolb observed, "The delusion must be dispelled that modern biopsychosocial therapies have done away with chronicity or socially impairing behavior in many who have and will suffer psychoses" (2).

Community-based services, while ideal for many, cannot always meet the needs of the more regressed or potentially violent chronic patients, who often require longer-term or intermittent hospitalization. Bachrach suggests that state hospitals may continue to be needed until their essential functions can be performed as well or better by community-based programs (3).

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This article focuses on four state hospital functions that deserve special attention: accessibility, responsibility, comprehensiveness, and shelter.

Accessibility. Longer-term patients living within the community can regress quickly and occasionally fail to respond to community-based intervention. Immediate hospitalization may be indicated. General hospital psychiatric units often have waiting lists that preclude an admission on the same day as referral; a two- to three-week delay is often the rule. Many of these units have been unwilling to accept involuntary and court-ordered referrals. They prefer instead to carefully select their patients to ensure successful treatment (4). State hospitals are usually the facilities of last resort and will admit patients rejected or discarded by other hospital systems. Patients can be admitted quickly, insurance is not a prerequisite, and involuntary status can be arranged. The state facilities are accessible.

Responsibility. "Dumping" is a