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# Development, Diagnosis and Treatment of Post Traumatic Stress Disorder and the Vietnam Veteran Population

Bari S. Fisher  
*Portland State University*

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AN ABSTRACT OF THE THESIS OF Bari S. Fisher for the Master of Science in Education presented May 6, 1986.

TITLE: Development, Diagnosis and Treatment of Post Traumatic Stress Disorder and the Vietnam Veteran Population.

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

[REDACTED]

Carol Burden, Chairperson

[REDACTED]

Phyllis Lee

[REDACTED]

Hugo Maynard

Over the past 15 years, mental health professionals have seen an increasing number of Vietnam combat veterans suffering from stress disorders resulting from the trauma of combat and continued exposure to life threatening situations. Prior to 1980, professional repudiation of and

hostility toward Vietnam veterans and toward a clinical reality of Post Traumatic Stress Disorder was common while nondiagnosis and nontreatment was prevalent.

A number of studies point out that those veterans from the Vietnam War that were subjected to extensive combat showed more problematic symptoms during the period of readjustment (Figley, 1978; Kormos, 1978; Shatan, 1978; Wilson, 1978). Furthermore, literature on the Vietnam War has demonstrated that there are several dimensions of war stress which must be examined in analyzing the incidence and prevalence of readjustment problems found in Vietnam veterans. Exposure to and participation in atrocities (Foy, Sipprelle, Rueger et al, 1984; Haley, 1974), abusive violence (Laufer, Brett and Gallops, 1983; Laufer, Frey-Wounters, Donnellan and Yager, 1981), and exposure to the physical environment of Vietnam (Wilson and Kraus, 1982) played important roles in the veterans long-term response to trauma. Accumulating evidence indicates that there were a range of independent traumatic stressors implicated in the readjustment problems of Vietnam veterans (Figley, 1985).

When the American Psychiatric Association developed the category of Post Traumatic Stress Disorder in the DSM-III, the validity of stress related problems reported by Vietnam veterans became widely recognized. It may be viewed that the problems often reported by Vietnam veterans prior to the

DSM-III were perhaps instrumental in the establishment of the diagnostic category.

Since the institution of the PTSD diagnosis, our society has moved toward a more reflective position about the Vietnam War and a more accepting and understanding rapport with the approximately 2.8 million Americans who participated in it, of which almost one million saw active combat or were exposed to hostile, life threatening situations (President's Commission on Mental Health, 1978). Many citizens, including mental health professionals now have regrets, specifically about hostile attitudes and non therapeutic receptions which some returning veterans encountered.

As a result, one reaction now seen in diagnostic and treatment situations consists of expressions of support, respect, praise and reassurance from clinicians. In working with the veteran population, emphasis has been placed on a thorough assessment for appropriate diagnosis, an understanding of the therapeutic relationship, acknowledgement of stages of the recovery process and a variety of treatment approaches and modalities to ensure a provision of quality service.

Mental health professionals can make important ongoing contributions to the healing process for these veterans.

These professionals have much to offer in providing professional leadership that interprets and clarifies the nature of the Vietnam veteran's recovery process. Additionally, the mental health profession must play an active role if further knowledge is to develop and more effective methods of treatment are to emerge.

DEVELOPMENT, DIAGNOSIS AND TREATMENT OF POST TRAUMATIC  
STRESS DISORDER AND THE VIETNAM VETERAN POPULATION

by

BARI S. FISHER

A professional paper submitted in partial fulfillment of the  
requirements for the degree of

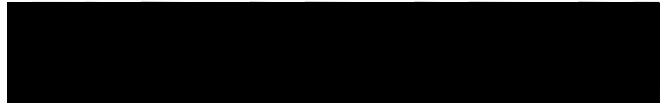
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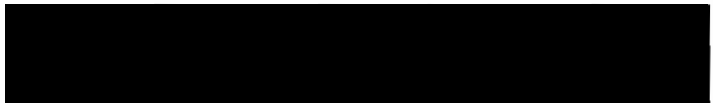
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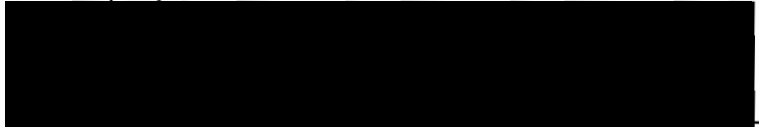
The members of the Committee approve the thesis of  
Bari S. Fisher presented May 6, 1986.



Carol Burden, Chairperson



Phyllis Lee



Hugo Maynard

APPROVED:



Richard Sojnen, Head, Special Studies, School of Education



Bernard Ross, Dean of Graduate Studies and Research

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## INTRODUCTION

War has always had a profound effect on those who engage in actual field combat. Recent literature on the Vietnam War has demonstrated that there are several dimensions which made it different from previous wars.

In addition, the nature of the Vietnam experience appears to have contributed to the development of Post Traumatic Stress Disorder (PTSD) as it appears in the 1980 edition of the American Psychiatric Association's Diagnostic and Statistical Manual. Greater understanding of PTSD on the part of mental health professionals will have a significant impact on the lives of those Vietnam veterans whose work, marital problems, substance abuse or anti-social behavior are often seen and responded to without awareness of the underlying presence of a combat-related disorder.

This thesis will present a review of the PTSD literature as it relates to Vietnam veterans in the following areas: 1) the history of stress disorders as they relate to combat exposure; 2) stressors of war and those unique to the Vietnam War experience; 3) diagnostic information; 4) PTSD symptomatology and diagnosis; 5) a review of the treatment literature, 1978 to the present; and, 6) summary implications and future research.

While the author notes that thousands of women served in the armed forces during the Vietnam era, August 1964 -

May 1975, their representation was in far fewer numbers than that of their fellow male veterans. For this reason, the term "veteran" used throughout this thesis is represented by the pronoun "he". However, the use of this term in no way lessens the acknowledgement nor the degree of readjustment problems suffered by women as a result of their military service during the Vietnam era.

## CHAPTER I

### HISTORY OF STRESS DISORDERS RELATING TO COMBAT EXPOSURE

It has been found that before World War I both military men and clinicians perceived combat as simply a question of courage versus cowardice (Smith, 1981), with no sense that there might be a lasting price to be paid for bravery. Awareness of acute, short-term reactions to combat was reflected in the homesickness described among French troops as early as the Napoleonic wars (DeFazio, 1978). Similarly, "irritable heart" was a manifestation of anxiety described in Civil War soldiers (Hendin and Hass, 1984). As a result, military reactions centered on weeding out those not fit for combat based upon the combatants' inability to perform and consequently the post traumatic stress in combat veterans remained unrecognized and unexplored.

The term "stress disorder" was first described among victims of civilian traumas which ranged from being struck by lightning to railway accidents (Trimble, 1981). The disorder was considered a consequence of physical injury to the nervous system carrying the names of various agents thought to have provoked it such as "lightning neurosis" or "railway spine" (Trimble, 1981). The common use of the term "shell shock" to describe combat reactions among soldiers in

In 1941, one of the first systematic studies of the war trauma condition, then called "chronic war neurosis", was conducted by Kardiner (1959). In future studies he identified five constant clinical features of the condition now known as Post Traumatic Stress Disorder (APA, 1980):

1. irritability;
  2. startle pattern;
  3. fixation of the trauma;
  4. atypical dream life; and
  5. proclivity to an explosive aggressive reaction
- (Kardiner, 1959).

Kardiner (1959) related irritability to exposure to auditory stimuli which induced a startle reflex, followed by fright and sometimes explosive violence. He also noted in the sufferers a sensitivity to other stimuli such as light or smell, associated specifically to the circumstances of the original trauma.

During World War II psychiatric efforts to understand traumatic stress were overshadowed by the immediate need to keep men functioning as combat soldiers. Psychiatrists were placed in combat areas, close ties between the soldier and his unit were emphasized and the soldiers' quick return to the combat unit after injury was considered essential (Glass, 1954; Kolb, 1977). In keeping with this goal, the symptoms of "traumatic neurosis" were further studied.

A commission of five civilian psychiatrists was appointed by Dr. William Menninger, Neuropsychiatric Consultant to the Surgeon General, to investigate in more detail the nature of symptoms caused by war. This commission reported a number of emotions and reactions of soldiers' stresses to battle which included fear, helplessness, distrust, loneliness, anger at feeling abandoned or betrayed, guilt over inadequate performance, horror and grief over loss of buddies and physical exhaustion from constant exposure to the stress of war. As a result, the term "combat exhaustion" was used to describe those symptoms that began with irritability, sleep disturbance and unusual sensitivity. In addition, associated symptoms of withdrawal, depression, and confusion resulted in eventual complete mental and emotional disorganization (Brende and Parson, 1985). The term "combat exhaustion" was broad enough to include virtually every psychiatric disturbance seen among combat soldiers.

Mott (1944) published several papers on the subject of war neurosis and classified it as hysteria which developed as a result of a combination of fear, fatigue and the personality of the soldier. In 1946 Dr. Menninger explained that the trauma of killing, the absence of morale building, the lack of military leadership and the death of comrades all worked together in psychologically "unraveling the

soldier" (Brende and Parson, 1984). Psychiatrists believed that contributing factors to the high rate of psychological casualties of World War II combatants were the combatants' personality make-up, the length of time soldiers had remained in a fighting zone, poor leadership which led to poor morale, defeat in battle, the lack of belief systems, and the lack of will power.

Following World War II, veterans' chronic symptoms such as guilt, agitation and hostile behavior were said to be manifestations of "personality disturbances" linked to pre-war and childhood problems (Greenson, 1945). However, the more specific symptoms related to war such as anxiety, depression and dreams were eventually referred to as "traumatic war neurosis" (Kardiner, 1959).

There have been a number of early studies on the immediate and long term psychosocial consequence of extraordinary stressful events (Futterman and Pumpian-Mindlin, 1951; Glass, 1954; Lifton, 1968). Clinical observations of concentration camp survivors, survivors of atomic explosions and natural disasters and work with combat veterans added new perspectives to the understanding of post traumatic stress (Futterman and Pumpian-Mindlin, 1951).

Lifton's work with Hiroshima survivors (1968) has paved the way for a broader and more descriptive terminology for post traumatic survivors. From his research, survivors of



overwhelming catastrophies were found to have changed psychologically. He found they experienced a bond to those who had died and a strong sense of guilt which in turn damaged their relationships with others. Lifton also noted that the survivors had a capacity to forget, deny or remain emotionally numb, resulting in a delayed response to their trauma.

During the Korean War approaches to combat related stress became more pragmatic. Due to the earlier work of Glass (1954), individual breakdowns in combat effectiveness were dealt with in a situational manner as compared to previous wars. Clinicians provided immediate on-site treatment to affected individuals, always with the expectation that the combatant would return to duty as soon as possible. Results from World War II showed that 23% evacuation rate from combat were for psychiatric reasons, but in Korea such evacuations were only 6% (Goodwin, 1980). It became clearer that the situational stress experienced by the combatant was the primary factor leading to a psychological casualty.

With American involvement in the Vietnam War, psychological battlefield casualties evolved in a new direction. Statistics showed that these casualties were at an all time low of 12 per 1,000 from 1966 to 1969 (Bourne,

1970). Clinicians decided that the preventative measures learned in Korea, that of on-site psychiatric treatment, had solved the psychological breakdown in combat. The media response supported the progress that had been made in military psychology and psychiatry.

As the Vietnam War continued additional trends were noted. The symptoms of some Vietnam combatants rarely resembled the anxiety related symptoms of the previous picture of combat fatigue. A professional step was then made to group all behaviors and syndromes that resulted in a combatant's refusal or inability to fight as "acute combat reaction". At this time a phenomenon of World War II re-emerged. After the end of World War II, some men suffering from "acute combat reaction" as well as some of their peers who had no symptoms at the war's end began to complain of common symptoms such as anxiety, aggression, dreams of the battlefield, depression and interpersonal problems. These were identified in a five year follow-up study by Futterman and Pumpian-Mindlin, (1951).

For World War II and Korean veterans, the incidence of psychiatric disorders increased as the intensity of war increased. There was a corresponding decrease in these disorders as the war drew to an end. The delayed symptoms noticed during post-war periods were noted to be few in

number and therefore no great significance was placed on them.

As the Vietnam War progressed in intensity, there was no increase in psychiatric casualties among combatants. It then became an unusual phenomenon that so many veterans were affected by war related symptoms after rather than during their Vietnam service. It was not until the early 1970's when the war was winding down that there appeared an increase in psychiatric disorders in Vietnam veterans.

During this same period many people were experiencing traumatic incidents in their lives, other than combat. There was a large number of airplane crashes, natural disasters, acts of terrorism on civilian populations and other catastrophic events. Mental health professionals working with victims of these events saw a picture similar to the troubled Vietnam veteran. Behavioral symptoms were almost identical.

Research conducted by Horowitz and his associates (1980) included a study of 66 persons with post-stress symptoms not related to combat. These people had experienced, within a given year, a variety of serious events in their lives such as body damage from an accident, assault, illness, or loss of a loved one. Most subjects exhibited clinical symptoms of depression, anxiety and over one-half reported "intrusion, avoidant symptoms", that of

repeated episodes of conscious and intense representation of the trauma. Findings showed that the reactions of those studied by Horowitz were in many ways identical to the reactions of those Vietnam veterans with stress related symptoms.

#### DEVELOPMENT OF A POST TRAUMATIC STRESS DISORDER

The subject of stress syndromes is not new with specific reference to the war combatant (Cavenar and Nash, 1976). Since the Vietnam War is this country's most recent war and also our most recent mass exposure of U.S. citizens to excessive stress, there became a growing need by the mental health community for specific diagnostic guidelines in assessment and treatment of a patient's stress disorder.

The American Psychiatric Association's Diagnostic and Statistical Manual first acknowledged the term Post Traumatic Stress Disorder in 1980. Prior to this revision, DSM I (APA, 1952) used the diagnostic category of "gross stress reactions" when referring to exposure of presumably healthy persons to extreme emotion and/or physical stress such as combat, rape, natural disaster or concentration camp confinement.

In the DSM II published in 1968, this diagnostic category was omitted and was mentioned only in the context of adult adjustment disorders as "transient situational

disturbances (APA, 1968). The basis for this disorder placed a major emphasis on pre-disposing personality factors such as demographic and family characteristics rather than on the traumatic event itself (Glass, 1969).

The DSM III (APA, 1980) renounced the assumption of pre-existent psychopathology and acknowledges that almost anyone may develop symptoms, either chronic (duration of symptoms at least six months or longer), or delayed (on-set of symptoms no sooner than six months) after experiencing a traumatic event. These symptoms may follow exposure to a "psychologically traumatic event that is generally outside the range of usual human experiences" (APA, 1980). Studies on psychiatric illness supported the contention that it is the severity of the stress itself rather than pre-existing personality characteristics that is the best predictor of psychiatric status after exposure to traumatic experiences, either individually or collectively (Bourne, 1972; DeFazio, 1975; Lifton, 1973).

According to the DSM III (APA, 1980) the central features of PTSD are:

1. exposure to a recognizable stressor;
2. the survivor re-experiences elements of the trauma in dreams, uncontrollable and emotionally distressing intrusive images and dissociative mental status; and,
3. the victim feels numb.

Also experienced is a loss of normal affect and emotional responsiveness where the survivor exhibits less interest and involvement in both work and interpersonal relationships.

Secondary symptoms may include startle response, hyperalertness, memory impairment, depression, survivor guilt, avoidance of stimuli which are associated with the trauma, explosiveness, a loss of capacity of intimacy and an addiction to alcohol or drugs.

This disorder reflects a natural process by which a survivor attempts to integrate a traumatic event into his or her present life. Defining the parameters of a clinical response to stress has provided new insight for theoreticians, clinicians and researchers in the understanding and treatment of persons who have survived traumatic experiences.

A growing number of reports on the long term chronic and delayed reactions of combat stress are being reported in literature. The larger percentage of PTSD cases now seen by the mental health community are veterans from the Vietnam era. Additionally, the larger proportion of these PTSD cases are of those veterans who served in Vietnam and southeast Asian combat zones.

Studies (Egendorf, Kadushin, Laufer, Rothbart and Sloan, 1981; Figley, 1978; Wilson, 1978) concerned with the psychological consequences of the Vietnam War have indicated

that as many as 800,000 combat veterans currently suffer from stress disorders. Such findings have indicated that combat stress disorders constitute a mental health problem which requires the attention and understanding of professionals in the field.

The following section will discuss the unique stressors that are characteristic of the Vietnam War and the effects on combatants.

## CHAPTER II

### STRESSORS OF WAR

While war itself is considered a source of stress, actual exposure to and participation in combat is a generally recognized cause of war stress (Lauffer, Brett and Gallops, 1983). In discussing the impact of war on both the combatant and his family, it is important to identify the elements of war which make it stressful.

Figley (1985) identified four major components which constitute a traumatic event and has applied them to war. They include:

1. War is perceived as being highly dangerous by the combatant. The soldier fears for his life and for the lives of his comrades. For those in the field, the fear of death is present 24 hours of every day;
2. The combatant experiences a sense of loss. Lives of both friends and enemy are lost. Youth and innocence are left behind while illusions of the "glory" of war quickly vanish and the soldier's perception of immortality is destroyed;
3. The war causes a sense of helplessness. A combatant is powerless to stop the fighting, killing and devastation. He has little control



over the situation or even his own fate; and,

4. The combatant is confronted with physical destruction and a personal disruption in his life.

For the family of the combatant, the horror of war is no less real or intense (Figley, 1983). While the combatant is struggling to survive, the family at home is confronted with a variety of adjustments as a result of the war-induced separation. Family members experience a wide range of emotions regarding the absent soldier. There is always the possibility that their loved one is dead, injured, missing in action, or even captured by the enemy. This uncertainty leads to a reluctant, but inevitable anticipation of loss (McCubbin, Dahl and Hunter, 1976).

The family's anxiety may be further increased by the fact that they may not be aware of the exact location or be familiar with the type of environment in which the combatant is stationed and fighting. Despite television and other media sources, it is still extremely difficult for the family to fully comprehend what combat is actually like and what their loved one is experiencing. As a result of these factors, the family's reactions to the separation may resemble a rollercoaster pattern, ranging from optimism to despair (McCubbin et al, 1976). To further compound the situation, the absence of the father/husband requires shifts

in roles within the family system to compensate for his absence. Wives, perhaps for the first time, must learn to make decisions on their own, take charge of the family and fulfill the responsibilities of both parents. Children may be burdened with additional tasks due to the father's absence while the family as a whole attempts to operate efficiently without the servicemember.

Finally, the family is concerned that if the soldier returns, what will he be like? Look like? Will he act the same? Additionally the family members will probably experience doubts about their actions during his absence. Will he be happy with the changes they have made? Will he be angry that changes were made in his absence?

#### UNIQUE STRESSORS OF THE VIETNAM WAR

While it can be stated that all wars are stressful, few have had the long term guerilla tactics or psychological elements of the Vietnam War. The typical combatant in Vietnam fought in a maximally stressful environment, one in which it was impossible to have some sense of control or predictability over the elements (Wilson, 1980). It was difficult to know or even recognize the enemy since they were rarely in uniform. American troops regularly had the experience of finding enemy troops in villages once believed

to be friendly. Because of the guerilla nature of the war, all people were involved. One could be mortared or fired upon anywhere. Grenades were thrown by children, women and the elderly. Live babies were booby-trapped. Blank (1981) states that as a result, a combatant's experiences in Vietnam was a source of on-going stress.

A feature of ordinary warfare is the chance for the combatant to "accomplish" something, especially the actual conquest of territory. In Vietnam, it was never quite clear what was to be accomplished. Ground was taken then given up, retaken only to be given up again. Since military officials needed some yardstick against which to measure battle progress, the "body count" was used as the sole criterion as movement toward victory; the report of enemy dead versus acquisition of territory (Blank, 1981).

The Vietnam War also became linked with the issues of American atrocities such as the killing of civilians and the torturing of prisoners. Violent acts of dismembering the enemy and fragging of officers created a dimension of terror for the combatant. Fraggings, the assault on a superior by using a fragmentation grenade, were often the work of enlisted men who believed their buddies had died due to some senseless military maneuver ordered by superiors.

Combatants learned to adjust to the dehumanization as a way of survival. DeFazio (1978) describes how euphemisms minimized the significance of people and events, blunted

affect and made everything sufficiently unreal. For example, the average combatant became a "grunt", a sort of sub-human no longer capable of thought or affect. People were "zapped", not killed.

In Vietnam there were also atrocities directed against the land which directly affected the people. Defoliation of forests and fields with herbicides, such as Agent Orange, plausible at the time for military reasons, turned out in retrospect to have produced lasting damage to the land in southeast Asia. Additionally, the effects of this defoliation process created medical and health problems for people who were exposed. Some difficulties included intestinal, skin and reproductive problems and birth defects.

At times the goal presented to the soldier by the military was that of winning the hearts and minds of the people of the country through health, sanitation or related work, combined with military operations. This proved increasingly stressful and often fruitless in the experience of many troops due to the environmental conditions such as:

1. enormous proportions of garbage generated by American military, often scavenged by Vietnamese for food;
2. exposure to sewage;
3. exposure to various deformities from disease and war wounds;

4. Intense heat, often above 100 degrees, followed by monsoon rains and accompanying floods, insects and mud;
5. physical dangers such as poisonous snakes, tiger attacks, rodents; and
6. malaria, heat stroke, dysentary and dengue fever.  
(Blank, 1981).

For those military persons committed to the war effort, the extraordinary limitations on offensive actions in Vietnam were a source of stress. This included on-again, off-again bombings throughout the duration of the war. According to Wilson (1978, p.13) "there was strong sentiment that the military leadership of American troops was, at times, not always adequate for the guerrilla nature of the war". On many occasions, poor decisions were made which either endangered or cost the lives of a squad or company. The seemingly meaningless death of friends often led soldiers to question their personal identity and purpose.

In contrast with previous wars, the average age of a Vietnam combatant was much younger, 19.2 years old as compared with 26 years of age of a World War II soldier. According to Erickson (1968), this age period for most adolescents involves a psychosocial moratorium during which the individual takes some time to establish a more stable

and enduring personality structure and sense of self. During this time, it is acceptable for young adults to experiment with education, jobs, travel, life-style and other activities related to identity integration and ideological commitment (Wilson, 1978). Erickson (1968) further identifies this stage, "Identity versus Role Confusion", as an important stage in one's psychosocial development. Unfortunately for the adolescents who fought the war, the role of combatant versus survivor, as well as the many ambiguous and conflicting values associated with these roles led to a clear disruption of this necessary plateau in one's development.

Racial tensions were often at a peak in Vietnam. As part of the Great Society's War on Poverty of the 1960's, Project 100,000 was conceived and implemented to give high school drop-outs, indigents, and unskilled American youths a chance to enter military service. Low-income recruits under the Project were primarily given combat-related military occupational specialities (MOS). Thus, over one-half of the servicemen who joined the Marine Corps and the Army under this program were sent to Vietnam (Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs, 1969). The Department of Defense revealed that Blacks were overrepresented in both combat duty and casualties, in

relation to their proportion among American personnel in Vietnam (Sloan and Phoenix, 1979). Black soldiers often viewed the Vietnamese and themselves as survivors, having survived years of beatings, lynchings, home and church bombings, discrimination and exclusion. According to Parson (1985) Blacks in Vietnam were aware of the irony that, although they fought alongside white soldiers against the enemy, they could not live in the same communities with whites in America. The psychological implications of this racial dynamic for both Blacks and whites were immense, and race relations in Vietnam deteriorated in 1968, especially after the murder of Dr. Martin Luther King and during the Tet Offensive.

#### CONTRIBUTING FACTORS TO POST-WAR STRESS

Many factors can be attributed to the post-war stress of Vietnam veterans. Bourne (1972) identifies the one year tour of duty as the single most important factor influencing psychiatric attrition in Vietnam. "A man knows that if he merely can survive for 12-13 months, he will be removed from the combat environment" (Bourne, 1972, p. 23).

Each soldier arriving in Vietnam in a small group of strangers had a different DEROS (date of expected return from overseas) by which to rotate back home. Often soldiers

who were strangers to a specific unit's speciality were transferred into units whenever individual rotations were completed. Combatants who had finally reached a level of proficiency and had also reached their DEROS were rotated. New troops with almost no skills were thrown into their places. These "new guys" were essentially avoided by the unit, at least until after a few months of experience; "short timers" did not want to risk getting themselves injured or killed by relying on inexperienced replacements. Seasoned troops would often stick together, forming very close small groups for short periods, which was a normal combat experience noted in previous wars (Grinker and Spiegel, 1945). However, as soon as a seasoned soldier got down to his last two months in Vietnam, he was struck by "a strange malady known as the "short-timer's syndrome" (T. Williams, 1980, p. 8-9). He would be withdrawn from the field and if logistically possible, be settled into a comparatively safe setting for the rest of his tour. His buddies would be left behind in the field without his skills and he would often be left with mixed feelings of joy and guilt.

Feelings of guilt about leaving one's buddies to whatever unknown fate in Vietnam often proved so strong that many veterans were too frightened to write once they



returned home, fearing what may have happened to those left behind. Parson (1984) writes that the soldier in Vietnam was not as concerned about winning the war in Vietnam as he was about himself and others surviving it.

A combatant often felt the presence of deception and miscalculation by U.S. leaders during his tour of duty in Vietnam (Sheehan, 1971). For example, there was the denial of American troop involvement in Cambodia while it was actually taking place. As a result, career military persons experienced an assault on their professional identity while confidence and trust in national leadership was also questioned. There were divisions amongst troops themselves in addition to intense national conflict about the Vietnam War. The mood of the U.S. was politically controversial and resulted in no full scale national commitment to the war effort.

The Vietnam War, the longest war in our history (1962-1975) was not a victory for the United States. This was the first instance in our national history of a defeat at war. Blank (1981) states that for some, the fact of defeat has contributed a major fault in the psychological defensive structure surrounding the war experience.

The administration of tranquilizing drugs first occurred in Vietnam (Jones and Johnson, 1975). This allowed

some men, whose condition in an earlier war would have warranted evaluation, to continue their duties until their normal rotation date. Often the widespread use of drugs and alcohol served its own medicinal purpose as a buffer against the stresses of the Vietnam experience while, as Horowitz and Solomon (1975) state, submerging and delaying stress related symptoms.

It was not recognized that many men who had either used substances to deal with the overwhelming stresses of combat or developed other behavioral symptoms of similar stress-related etiology were struggling with acute combat reaction or Post Traumatic Stress Disorder. Rather, their immediate behavior had proven to be problematic to the military and they were offered an immediate resolution in the form of administrative discharges with a character disorder diagnosis (Kormos, 1978). The administrative discharge proved to be another method to temporarily repress any further overt symptoms. It became another means of ending the stress without becoming an actual physical or psychological casualty. Early discharges served to lower the actual incidence of psychological breakdown as did the DEROS date (Goodwin, 1980). Eventually, this widely used practice came to be questioned and it was recognized that it had been used as a convenient way to eliminate many

individuals who had major psychological problems dating from their combat service (Kormos, 1978).

## REINTEGRATION

While the experiences for the combatant and his family during the war produced intense stress, dealing with the process of integration upon return was equally stressful.

The veteran's adjustment to civilian life was often further complicated by changes which occurred in society during his absence, such as changes in the government, changes in societal norms and values, and economic changes. During the veteran's absence, shifts often occurred in society's attitude toward the war, resulting in rejection of the very cause for which he risked his life. This was, perhaps, most evident for Vietnam veterans who returned home to find unprecedented opposition to the war and antagonism directed at them for fighting in it (Figley and Leventman, 1980).

Vietnam veterans commonly came home by airplane, arriving within 36-72 hours of being in a combat zone. Unlike World War II veterans who came home with their fellow soldiers on troop ships, Vietnam veterans were not able to spend days or weeks making a gradual transition from combat to peacetime. Powerful political and social antagonism

toward the war made Vietnam veterans question their participation in the war and denied them the social support necessary to integrate death, destruction and killing into a terrible but legitimate aspect of a soldier's life experience (Lipkin, Blank, Parson and Smith, 1982). Returning Vietnam veterans learned to be secretive about their experiences, reactions and activities in Vietnam. The public did not want to hear about Vietnam; they had been able to see and read about the horrors of war daily from their homes. While family and friends welcomed those returnees, at the same time they rejected the military experiences that had become a part of the individual's identity.

Some of the earliest opposition to the Vietnam War surfaced on American college campuses. While returning to college, young discharged veterans often found themselves rejected by their peers. During the homecoming period of the early 1970's, the media played roles in the negative labelling of Vietnam veterans. On television, these veterans were often portrayed as addicts, rapists, mass killers and morally offensive criminals (Goodwin, 1980).

During this same homecoming period, when the majority of veterans were discharged from the service, unemployment and economic cutbacks were prevalent. GI benefits were

significantly limited in contrast to World War II and Korean War eras. Many returnees experienced frustration in dealing with the Veterans Administration bureaucracy and came to feel alienated. Those veterans who were seen as having "discipline problems" in the military rather than suffering from stress disorders were given undesirable discharges and denied needed mental health services by the Veterans Administration due to ineligibility. Because of generational, political and life-style differences between Vietnam veterans and those of previous wars, the former have remained alienated from the large conventional veterans' organizations, such as the American Legion and Veterans of Foreign Wars.

Recent research indicates that as many as 800,000 Vietnam veterans, about 20% of those stationed in Vietnam, may have Post Traumatic Stress Disorder (Egendorf, 1981). The extent to which PTSD affects an individual varies. Many independent variables that account for the level of disruption of one's present life are at this point unknown. However, one proven indicator as to the intensity of the disruptive symptoms is the extent to which the veteran was exposed to actual combat (Goodwin, 1980). To some extent, all combat veterans have experienced some of the symptoms of PTSD.

The following chapter will introduce information regarding the diagnosis of Post Traumatic Stress Disorder as it appears in the DSM III (APA, 1980) and will apply this evaluation criteria to the Vietnam veteran regarding stress disorders.

CHAPTER III  
DIAGNOSTIC INFORMATION

HISTORY OF THE DIAGNOSIS

The diagnosis of "gross stress reaction" in the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (APA, 1952) referred to combat stress by way of example. "Although it had inaccurately specified that the condition could only be temporary, it conveyed at least a glimpse of stress disorder" (Blank, 1985, p. 73).

In 1968, the diagnosis was removed from the DSM II. In the late 1960's as the troops returning from Vietnam were reaching their peak, the psychiatric profession's official diagnostic guide backed away from stress disorders even further and the condition became part of the "adjustment reaction of adult life" category (APA, 1968).

For twelve years, 1968 through 1980, most American psychiatrists, psychologists and other mental health professionals based their encounters with Vietnam veteran patients on the official view that no Post Traumatic Stress Disorder existed. The non-availability of accurate guidance about diagnosis during this period "produced clinical

situations that were dysfunctional and bizarre" (Blank, 1985, p. 74).

Dr. Art Blank Jr., psychiatrist and Vietnam veteran, reported in a retrospective review that of all the Vietnam veteran cases he had seen in a Veterans Administration mental hygiene clinic between 1964-1972, eleven undiagnosed cases of traumatic war neurosis with unmistakable classical manifestation were found (1985). Additionally, at the same facility between 1972-1980, 64 previously undiagnosed cases emerged from the out-patient clinic and the general psychiatric wards (Blank, 1985). A similar survey conducted by Breen in 1982 produced similar results.

#### NON TREATMENT FOR PTSD

Prior to 1980 and the DSM III's inclusion of the PTSD category, it was generally impossible for Vietnam veterans with symptoms of the disorder to obtain specific treatment from mental health professionals. Non-diagnosis was one principal reason. Those few clinicians who did provide specific psychological treatment during this period reported skeptical and hostile reactions from colleagues concerning the existence of PTSD, the validity of Vietnam veterans' complaints and any key role for combat experiences in the production of the disorder. Additionally, treatment from the Veterans Administration was difficult to obtain since there was a one year time limitation for psychiatric



problems once a veteran was discharged. In most cases veterans were ineligible for treatment or their tendency was to avoid the V.A. entirely, seeing it as a representative of a government that many felt betrayed them in Vietnam. Due to the lack of legitimacy and the questionable character of the disorder, Blank (1985) and other clinicians who understood and treated Vietnam veterans with stress disorders since 1970 identified for some suicides and a number of seriously impaired lives because of non-diagnosis and non-treatment by their colleagues.

In late 1979 two events occurred simultaneously which addressed the needs of Vietnam veterans presenting combat related problems. First, the APA adopted the current diagnosis of PTSD for inclusion in the 1980 edition of their Diagnostic and Statistical Manual for Mental Disorders. Secondly, the Veterans Administration, upon the direction of Congress, established a nationwide system of specialized counseling centers (Vet Centers) for a wide range of readjustment problems of Vietnam veterans. Additionally, leadership in veteran organizations by Vietnam veterans, some out-spoken mental health professionals and the appointment of the first Vietnam veteran as head of the Veterans Administration also drew further attention to the plight of Vietnam veterans.

## LEGITIMACY OF PTSD DIAGNOSIS

Despite the evidence that establishes the relevance of the DSM III diagnosis for Vietnam veterans and the commitment of Congress to fund counseling program for them, many mental health professionals still question the existence of PTSD in this veteran population. Blank (1982) has succinctly summarized a number of these reasons for disagreeing with the disorder:

1. Although most Americans old enough to serve in the armed forces were concerned about the war, the degree of difficulty experienced after the war and those at the greatest risk for developing the disorder is greatest among the less than 10% (800,000) of veterans who were in combat;
2. Another reason these problems are not sufficiently recognized is a result of the veterans' military experience. Many participants in the war felt deceived or misused by the government, by society in general or the military in particular. As a result, many veterans became profoundly distrustful of all organizations, particularly the Department of Defense and the Veterans Administration. To a lesser degree, they came to distrust everyone who didn't share their experience;

3. The standard behavior of mental health professionals, their use of open-ended questions, refusal to disclose personal beliefs, and their unwillingness to share personal history, has made self-disclosure particularly difficult for Vietnam veterans;
4. Under-reporting of post traumatic problems is a result of failure on the part of the mental health professional to ask about military experiences. The lack of military history makes it difficult for therapists to recognize the process of recovery from war-time experience; and,
5. Veterans, themselves, resist being given a diagnosis. Their investment in returning to normality and maintaining that normality leads them to reject the identification of being troubled or having problems. There is fear of being labelled as mentally ill. Furthermore, the veteran often secretly suspects that he is really crazy and if pushed, will somehow behave as dramatically as the most sensational of disordered veterans. Consequently, the veteran often denies the problems, and together with the therapist, covertly colludes to avoid discussion of the war.

## EVALUATING FOR PTSD

The critical purpose of the diagnostic interview is to identify and establish the relationship between the content of the original traumatic experience and subsequent re-experiencing phenomena. These are prominent areas that must be discussed by the therapist and client in order to provide a comprehensive overview of the assessment and treatment of PTSD (Figley, 1985). Other information which is retrieved serves supplementary purposes, such as facilitating individualized treatment, establishing credibility and aiding differential and comprehensive diagnosis.

The specific information required to make the diagnosis of PTSD is clearly stated in the DSM III (APA, 1980). Three cardinal features which are essential in leading to a diagnosis are:

1. the existence of trauma;
2. the re-experiencing of the trauma; and,
3. clear indications of avoidance phenomena relating to the trauma.

## ROLE OF THE INTERVIEWER

While specific information regarding the trauma itself is required for the diagnosis, the process of obtaining this information can often be more difficult than knowing what information is required. The manner in which the diagnostic

interview is performed may facilitate or block the recognition of the diagnosis.

The clinician's willingness to make the PTSD diagnosis can be a major factor in overcoming these obstacles. An open and receptive, non-judgemental attitude by the interviewer is essential (Arnold, 1985). It is important not to project one's own feelings onto the veteran, viewing him as either a hero, victim of circumstances or a villain. Special attention must be placed on the impact of information given by the veteran, on the veteran himself. An interviewer's understanding of the feelings and behavior of the client must also be present to facilitate successful gathering of information. A key to understanding lies in discovering and acknowledging the underlying affective stress response of the veteran, which is often being grief, guilt or terror.

Arnold (1985) believes that pre-conceived ideas, negative opinions, a bored or mechanical attitude, or obvious skepticism by the interviewer can virtually ensure that critical information will not be given by the client. Conversely, a clinician's expression of shock can have the same effect, since veterans may react either by withdrawal or intimidation (Haley, 1974).

## GATHERING INFORMATION

The interviewer may want to begin the interview by addressing either current history or the veteran's military history. Alternating attention between "what happened then" and "how is it affecting you now" can readily identify the trauma and the veteran's response for the clinician. Whichever method is used, Arnold (1985) recognizes that in addition to the specific experiences of combat, it is essential to obtain a comprehensive history. This will include pre-military, military and post-military experiences. Blank (1985) states that perhaps the most remarkable and dramatic irrational professional reaction to Vietnam veterans is the failure to obtain this information.

## PRE-MILITARY HISTORY

The pre-military history should give the clinician insight into the early and continuing attitudes of the veteran, as well as those of significance to him. Arnold (1985) suggests that a review of the veteran's pre-military history can include:

1. patterns of living in childhood and adolescence;
2. the nature of relationships;
3. work history;

4. anti-social behavior, including fights and substance abuse;
5. personal identity;
6. values;
7. attitudes of family/peers toward the Vietnam War and the veteran's entry into service; and
8. the attitudes of family/peers toward the veteran's participation in the war.

#### MILITARY HISTORY

A major focus for the diagnosis is information regarding the veteran's military history. According to Lipkin, Scurfield and Blank (1983), this should include as a minimum:

1. family military traditions and attitudes;
2. motivations for, date and type of entrance into the service;
3. choice and significance of the branch of service;
4. training experiences;
5. military occupations specialty (MOS) acquired;
6. specialized training in guerilla or jungle war;
7. sequence of geographical assignments and how they were made;
8. manner of transportation to southeast Asia or Vietnam;

9. experiences on arrival and assignment to a unit;
10. reception by more experienced members of the unit;
11. developing relationships with buddies;
12. acquiring a nickname or reputation;
13. interactions with and attitudes toward non-commissioned and commissioned officers;
14. close association with villagers or southeast Asian troops;
15. sequence of geographical movements and combat engagements;
16. availability of sleep in the field;
17. numbers of casualties sustained by the unit and relationship of those wounded or killed;
18. killing of others (including proximity, methods, initial and later feelings, military necessity, degree of control);
19. witnessing of mutilation or torture of Americans;
20. witnessing or participation in mutilation or torture of Vietnamese;
21. being wounded;
22. providing or receiving rescues and medical evacuations;
23. experiences as combat tour was concluded;
24. whether more than one tour was served;
25. manner of transportation back to the U.S.;



26. reception by public, family and friends; and

27. date, manner and type of discharge.

#### POST-MILITARY

A sequential review of the veteran's post-Vietnam life will bring together many elements otherwise appearing to be isolated symptoms (Arnold 1985). This information should cover both immediate experiences upon return from Vietnam in confronting the public and family and his subsequent life course. Particular attention should be given to:

1. degree of success at establishing close relationships;
2. episodes of violence;
3. associated reexperiencing of combat events;
4. outbursts of rage; and,
5. unusual reactions to babies and children.

Success or lack of success in pursuing education or establishing a career may indicate how reexperiencing and avoidance have affected behavior. Religious practices and beliefs, especially when compared with those during pre-war years may give the clinician insight into the veteran's capacity for trust or sense of guilt.

History of previous psychiatric treatment should be reviewed by the clinician and, when possible, notes made available from the previous treatment facility. Narrative

statements, progress notes, reports of psychological testing, quotations of the patient's statements and social histories are often valuable aids in diagnosis.

#### OTHER DIAGNOSIS CONSIDERATIONS

Unfamiliarity by the clinician of the PTSD category and the specific relationship to Vietnam veterans can mean that the diagnosis may go unrecognized since primary indicators of the traumatic stress reactions may not be immediately apparent. Therefore, the issues of personality disorders should routinely be addressed (Sierles, Chen, and McFarland, 1983). To justify a diagnosis of PTSD, the examination should also justify or rule out the diagnosis of other mental disorders.

Current observations (Green, Grace, and Lindy, 1982) suggest that many veterans meet the diagnostic criteria for more than one mental disorder. They suffer from alcohol or drug abuse, depression, paranoia, anxiety disorders and character disorders. An initial objective is to stabilize the situation, distinguish and establish priorities for treatment of each of the separate problems.

Anti-social personality disorder is the principal diagnosis most often made for Vietnam veterans. The DSM III (APA, 1980) cites the inability to sustain consistent work

behavior, failure to accept social norms in respect to lawful behavior, the inability to maintain enduring attachment to a sexual partner and irritability and aggressiveness as central features of this diagnosis. A Vietnam veteran's history of employment problems, legal difficulties, substance abuse and unstable relationships often lead to this diagnostic conclusion by clinicians. Borderline personality disorder is more apt to be considered for veterans already diagnosed as having PTSD who have received treatment. Often such PTSD diagnosed clients demonstrate a persistence of suicide attempts, self injuring fights, substance abuse, manipulation and devaluation of professional staff, uncontrolled anger and rapid mood shifts which may be almost indistinguishable from that of a borderline personality disorder. The characteristics seen in Vietnam veterans are congruent with the characteristics of the borderline personality disorder diagnosis in the DSM III (APA, 1980). These symptoms include but are not limited to: impulsivity or unpredictability; patterns of unstable interpersonal relationships; inappropriate and intense anger; and, chronic feelings of boredom.

Personality disorders, by definition, begin in childhood or adolescence and are characteristic of most of one's adult life (APA, 1980). Accordingly, it is essential

to obtain a history of personal relationships, school and work, control of aggression and use of intoxicants in childhood, adolescence and during active military service before making a diagnosis of a personality disorder, whether in addition to or instead of PTSD.

A constricted affect in which both perception and expression of emotion are avoided may closely resemble the flattened affect found in schizophrenia. A number of Vietnam veterans were labelled schizophrenic, paranoid type, prior to the publication of the DSM III (APA, 1980). The DSM III (APA, 1980) describes schizophrenia, paranoid type, as "dominated by persecutory delusions; grandiose delusions; delusional jealousy; and hallucinations with persecutory or grandiose content". Strayer and Ellenhorn (1975) note that in one report, 77% of Vietnam veterans admitted to V.A. hospitals in 1975 received the wrong diagnosis of schizophrenia. Patients were typically drugged with anti-psychotic medications, and although these medications temporarily proved helpful in many cases, too often this was the only treatment provided. In fact, some psychiatrists supported the misdiagnosis by diagnosing veterans as having acute schizophrenia (Blank, 1985). Additionally, the flashbacks in which there is vivid visual and sometimes auditory re-experiences of prior traumatic events appeared, to the clinician, to be hallucinations. More often than not, misdiagnosis led to the wrong treatment or none at all.

A depressed mood is frequently seen by clinicians in their evaluation of Vietnam veterans. Naive assumptions about severity of stress can play a major role in the difficulties in recognizing PTSD in women and other non-combatants who served in Southeast Asia during the Vietnam War. Danger and anguish of nurses in field hospitals are clearly comparable to those of combat medics (VandeVanter, 1983). Similarly, prolonged duty assignments, such as bagging bodies and body fragments away from enemy fire, may result in unmistakable PTSD.

#### PSYCHOLOGICAL AND LABORATORY TESTS

Methods other than the clinical interview to validate a diagnosis of PTSD are in the developmental and pilot test stages and serve a useful ancillary role to the clinician derived diagnosis (Arnold, 1985). The Minnesota Multiphasic Personality Inventory (MMPI) scale; the MMPI sub-scale for the assessment of combat related PTSD developed by Keane, Malloy and Fairbank (1984); the Problem Checklist Items Reflective of Anxiety-Based Disorders developed by Foy, Sipprelle, Rueger and Carroll (1984); the Diagnostic Interview Schedule (DIS) by Robins and Helzer (1984); and the Structured Clinical Interview for the DSM III (SCID) by Spitzer and Williams (1983) are useful tools in assessing the formal diagnosis of PTSD.

The assessment of Post Traumatic Stress Disorder

involves a challenging set of factors including the need for special professional and personal qualities on the part of the clinician. This includes a willingness and sensitivity to probe directly into the various aspects of traumatic experiences and the ability to face one's own reactions to those of the veteran. Without adequate knowledge, interest and skills on the part of the mental health professional, appropriate diagnosis, interventions and treatment of Vietnam veterans cannot be made. The following chapter will discuss Post Traumatic Stress Disorder symptomatology and its diagnosis.

## CHAPTER IV

### PTSD SYMPTOMATOLOGY AND DIAGNOSIS

Literature on traumatic stress disorders (Foreman, 1980; Horowitz, Wilner, Kaltreider et al, 1980; Krystal, 1968; Lifton, 1968; Wolk, 1981) covers a broad range of events which are concerned with experiences outside the realm of everyday life. While PTSD is often associated with military combat and particularly the problems manifested by veterans of the Vietnam War (Figley, 1978), it also describes the reactions of individuals who have experienced other traumatic events such as serious crimes, accidents and natural disasters. Symptoms are indicative of the distress suffered by victims who are psychologically unprepared for such extreme and unusual occurrences.

#### DSM III CRITERIA

Research indicates that PTSD is a valid syndrome that is characterized by distinct patterning of symptoms resulting from traumatic stressors (APA, 1980; Figley, 1985; Foreman, 1980). Although the term "traumatic stressor" is not specifically defined, it generally involves an encounter with the possibility of sudden, violent death (Hendin and Haas, 1984).

Apart from the existence of a recognizable stressor,

the DSM III (APA, 1980) criteria for Post Traumatic Stress Disorder entails two primary symptoms:

1. numbing or reduced responsiveness to the outside world, commonly evidenced by diminished interest in previously enjoyed significant activities, a feeling of detachment from others or constricted affect; and,
2. re-experiencing the traumatic event, commonly through repetitive, intrusive recollections or recurrent dreams of the event.

In addition, at least two of the following symptoms are present for the diagnosis:

1. hyperalertness;
2. sleep disturbance;
3. survivor guilt;
4. impairment of memory or concentration;
5. avoidance of activities that arouse re-collection of the event; and,
6. intensification of symptoms by exposure to events resembling the traumatic incident (APA, 1980).

The DSM III represents an attempt to include, within one diagnostic framework, the consequences of very different traumatic experiences. These consequences have enough in common to make the criteria usable for diagnostic purposes.



## RECOGNITION OF SYMPTOMS

Vietnam veterans were largely asymptomatic at the point of their rotation back home. Often the joy of surviving continued to suppress any problematic symptoms. Additionally, the combatants' limited tours of duty, frequent "R and R"s and the practice of treating psychologically impaired combat veterans quickly and re-integrating them into their units, also gave reason for the delay of stress reactions.

It wasn't until a year or two after a Vietnam veteran's return that mental health professionals were beginning to see a pattern emerging among the veterans they treated. The pattern of symptoms, which seemed to occur independent of personality type, included intrusive recollections of traumatic events in the form of dreams, nightmares and flashbacks, and dissociative states during which the individual behaves as if re-experiencing the trauma. There were symptoms of arousal, hyperalertness, exaggerated startle response, difficulty in falling asleep and the feeling of being on the verge of losing control. Additional symptoms were related to depression, including a general diminished responsiveness to the world, described as "psychic numbing" (Lifton, 1973). Veterans felt detached from others, had difficulty maintaining close interpersonal relationships, lost interest in normal activities and felt

that life had lost its meaning.

The delayed manifestation of the symptoms with the usual on-set being six months after exposure to the trauma, and the failure of the American psychiatric profession to provide a suitable diagnostic framework in which symptoms could be understood created further problems for veterans and mental health professionals. Shatan (1973) concluded that the only way for affected veterans to find peace was to "carve out a dead peace in their souls where memories are re-lived forever but divorced from their emotional impact" (p. 643).

#### UNDERSTANDING THE CRITERIA

Symptoms and reactions to trauma can include one or more of a common set of symptoms. This configuration is partly a function of the nature of the trauma, psychosocial conditions before and after the trauma, and unique elements about the person experiencing the trauma.

In their research, Horowitz and his associates (1979) have concluded that denial/numbing and intrusive and repetitive thoughts or memories are universal responses to trauma. They also state that probably all survivors of trauma experience at least some unpleasant after-effects for a period of time. These affects include a full range of

accompanying symptoms such as loss of appetite, insomnia, interrupted sleep or the inability to stay asleep. Since the disorder can be psychologically painful, many individuals sedate themselves with alcohol or drugs, creating substance dependency.

Sonnenberg (1985) notes that the core of the disorder is a fear of loss of loved ones and friends, which result in the survivor keeping distant from those around him to avoid the inevitable pain of departure and loss. Thus, survivors are impaired in their functioning with family, friends and employers. Divorce and unemployment may result if the disorder goes unrecognized and untreated. It is important to note that although the above symptoms may be present for some veterans, they may remain fairly discrete experiences and do not have a negative impact on functioning. "Often the veteran was unaware of the syndrome to which he or she had fallen prey and unaware of its origin in the traumatic experience of combat" (Boulanger, Kadushin, Rindskopf, 1985, p. 20).

In 1978, Wilson noted that, for approximately 800,000 veterans of combat in southeast Asia, this problematic outlook became a chronic lifestyle. Additionally, it affected millions of persons who are in contact with these veterans; particularly their spouses, families and friends.

## STRESS RELATED SYMPTOMS OF VIETNAM VETERANS

### REEXPERIENCING THE TRAUMA

One of the most dramatic manifestations of PTSD in Vietnam War veterans is the reliving experience defined as the sudden acting or feeling as if traumatic combat events were reoccurring (Hendin, Haas, Singer, et al, 1985). This symptom was considered significant in that the DSM III listed it for diagnostic purposes along with recurrent dreams and recurrent intrusive recollections of the trauma.

Reexperiencing the trauma occurs in various states of consciousness. The phenomenon is usually repetitive, not voluntarily controllable, is emotionally painful and either exactly or closely reproduces the actual traumatic experience. The individual is awake but appears to be in a state of altered consciousness and often has subsequent amnesia for what takes place. This intrusion can last anywhere from a few seconds to hours.

"The most common form of reexperience is a sudden vivid memory which takes over full attention and is accompanied by the motions which occurred during the original experience" (Arnold, 1985, p. 103). When there are also visual re-perceptions of the trauma, veterans usually refer to them as "flashbacks". These intrusive images and thoughts often play a role in the daytime cognitive functioning of Vietnam

veterans. Episodes are triggered by common everyday experiences that evoke the memories of a battle or combat experience. Such stimuli as an automobile backfire, fireworks, helicopters flying overhead, the smell of diesel fuel or the presence of Asians can recreate the reoccurrence of trauma for the veteran.

#### SLEEP DISTURBANCE

DeFazio (1978) states that "perhaps the hallmark of reaction to a traumatic experience is the traumatic dream or nightmare" (p. 36). Regardless of how successful a veteran has been in escaping other symptoms, DeFazio believes the trauma will tend to be reflected in his dreams, which may last over the entire course of the veteran's life.

Studies of nightmares from earlier wars (Lidz, 1946) show remarkable similarities to sleep disturbance symptoms experienced by Vietnam veterans. A typical dream for the Vietnam veteran is of being helpless in the face of attack, or being shot at, being pursued and left with an empty weapon. Recurrent themes may also be the death of a friend or the death that was caused as a combatant. In the case of Vietnam veterans, these nightmares produce an anxiety reaction toward sleep. Experiencing the trauma in dreams is intense, therefore there may be an aversion to sleep, causing insomnia. Failure to achieve sleep, early morning

awakening and the inability to return to sleep once awakened are also reported by Vietnam veterans (Langley, 1982). Such sleep disturbance leads some veterans to find night time employment and others to consume alcohol or use drugs in order to induce sleep and suppress dreaming (Keane and Kaloupek, 1980; LaCounoiser, Godfrey and Ruby, 1980).

#### DEPRESSION

Depression has been recognized as a frequent emotional response among persons who have experienced traumatic events (Hendin and Haas, 1984). Many Vietnam veterans found it difficult to integrate the memory and associated fantasies of their combat experiences with their present life. This inability to assimilate a time of life into an on-going schemata led to the depressive symptoms of the veteran (Figley, 1978).

Shortly after their return from Vietnam, more than a third of a large sample of Vietnam veterans studied (Nace, Meyers, O'Brien, Ream and Mintz, 1977) were identified as clinically depressed. Nace and his colleagues (1977) described the consequences of depression as being manifest in high rates of unemployment, marital difficulties and drug and alcohol use. Additional studies (Helzer, Robins and Davis, 1976; Horowitz et al, 1975;) suggested that depression was particularly characteristic of veterans who

had been in combat and that the depression related to guilt feelings, either over survival or actions committed in Vietnam.

Due to the circumstances of war, extended grieving on the battlefield was a liability. Grief was therefore handled as quickly as possible. Men reported feeling numb and did not deal with the death of friends due to time and circumstances. This inability to mourn and work through losses of buddies often appeared as continuous sadness resulting in a depressed state. Additionally, Arnold (1985) suggests that the grief may have an existential quality, stemming from the loss of pre-combat innocence and trust.

#### GUILT

Guilt over killing and over enjoying life when death deprived one's friends of that possibility contribute to the depressive symptoms of the stress disorder. Rado (1956) states that in any traumatic situation in which people feel frightened or helpless, there is a deep rooted tendency to blame oneself, to treat one's fate as a punishment that in some sense must be deserved.

Guilt during combat can be viewed as a reaction to killing when killing is not necessary or committed with angry retaliation. Hendin, Haas and their colleagues (1983) believe that susceptibility to guilt is even greater for

those Vietnam veterans whose killings involved women, children and the elderly.

Guilt over combat experiences has played a significant role in the suicidal behavior or pre-occupation with suicide of a number of Vietnam veterans. The guilt of suicidal veterans has been described by Lifton (1973) as having a "self-lacerating" quality. Rather than simply fearing or expecting punishment for transgressions in combat, Lifton (1973) sees these veterans performing a "perpetual killing of the self", the individual's need for self punishment. Although suicide statistics of Vietnam veterans on a national level do not exist, those who work closely with men who saw heavy combat report the frequency of suicidal ideation as a manifestation of the stress disorder (Jury, 1979; Lipkin, Blank, Parson and Smith, 1982).

#### PARANOIA

A common adaptation seen in Vietnam combat veterans with symptoms of PTSD can be described as "paranoid". This response to combat trauma involves, according to Hendin and Haas (1984), eternal vigilance in dealing with others, an expectation that any argument is a prelude to a violent fight and a need to strike first in the face of potential aggression. Under emotional pressure, the veteran may perceive civilian life as an extension of the war and those



not within the veteran's immediate support system are seen as potential enemies.

Features of the paranoid reaction may be found among Vietnam veterans since, as Eisenhart (1975) has written, hypervigilance, aggressiveness and an accompanying denial of fear were so much a part of the veteran's combat experience. This may be seen in the weapons that some veterans carry. Their inclination to attack anyone coming from behind reflects a readiness for attack when danger is perceived although does not exist.

Paranoid adaptations are often characterized by a refusal to accept blame or responsibility. Therefore, a surprising number of Vietnam veterans deny feelings of guilt over their combat experiences. Although acts of violence for veterans with paranoid features may relieve their sense of frightened vulnerability, Hendin and Haas (1984) believe that the consequences of such behavior are most often shame, guilt, depression, fear of retaliation and more anxiety.

#### RAGE AND ANGER

Veterans and family members often report acts of rage and anger outbursts, at times for no apparent reason. While military training equated the rage with masculine identity in the performance of military duty (Eisenhart, 1975), upon return from Vietnam the rage in combat was displaced.

Consequently, the rage was frequently directed at those in authority, against those the veteran felt were responsible for getting him involved in the war and against those who did not support the war (Howard, 1976).

Krupnick and Horowitz (1981) report a theme of anger and frustration as a stress response symptom for Vietnam veterans. They state that a need arises for the veteran to find someone to blame for his misfortune. Veterans suffering from this symptom today feel a generalized mistrust of those in authority. As a result, many avoid taking advantage of opportunities, activities and have difficulty maintaining meaningful employment (Goodwin, 1980).

#### ISOLATION

Catastrophic events generate awe, curiosity, relief and discomfort among observers (Smith, 1985). When the event involves a socially controversial issue such as the Vietnam War, denial of the suffering of participants may be a part of the societal response. Because the public is troubled about its own ambivalence towards the situation, it is also unable to deal with the painful aspects of an individual survivor's experience. This pushes the veteran into an isolated or more isolated position because of public reaction. As a result, veterans are frequently

misunderstood and draw a line between themselves and those who did not share their experience.

Many Vietnam veterans found it difficult to forget the lack of positive support they received from the American public during the war. Upon their return from combat to the U.S., many were met by the crowds and media calling them "depraved fiends" and "psychopathic killers" (DeFazio, 1978). For some returning veterans, their subsequent nomadic, wandering lifestyle was a search for acceptance by others, or an attempt at creating a feeling that one could move away from the problems encountered as a Vietnam veteran. The fantasy of living the life of a hermit played a central role in many veterans' thoughts. Additional problems are created when the isolation is imposed on a marital situation.

Men, women, Blacks, Hispanics, green berets and medics, for example, frequently identify with others within their same group. Smith (1985) states that within such groups, the individuals emphasize special characteristics which separate them from others and consequently they cannot share their pain or diminish their grief around others. This focus on uniqueness also allows members of a group to band together and blame their problems on an external source. This, in turn, permits avoidance of the experience, personal

confusion, ambiguity and self blame. Smith (1985) states that "if one is a member of a group of isolated, unique and misunderstood survivors, then the individual cannot legitimately be blamed for what happened in Vietnam, to the individual and to others" (p. 143). For those veterans who have isolated themselves and avoided contact with a support system, Smith (1985) believes that they are most likely to have difficulty with ambiguity, personal integrity and especially control and personal accountability.

#### AVOIDANCE OF FEELINGS

Spouses and family members often describe their veterans as cold, uncaring individuals. Veterans, too, have described themselves as being "emotionally dead" (Shatan, 1973). While "psychic numbing" (Lifton, 1973) furthered the coping and survival abilities of combatants, it became non-productive when the period of trauma had passed and the individual was still numb to the effect around him.

Many veterans found it extremely uncomfortable to feel love and compassion for others. To do this, they would have to thaw their numb reactions to the death and horror that surrounded them in Vietnam. This numbing affect impedes the veteran's ability to grieve for actual losses and to experience joy.

Lack of trust and the inability to share social contacts often place the veteran outside the boundaries of society. This general alienation and detachment creates both inter- and intra-personal problems in all areas of the veteran's life. The effects of this withdrawal from significant others are feelings of hurt, rejection, and anger. Some feel the veteran is non-supportive, resulting in resentment for the veteran's inability to reciprocate for the care and support which others have provided (Harris and Fisher, 1985). Spouses, family and friends often felt pushed away due to the veterans strong negative self image; they cannot stand to be loved. Separation, divorce and unfulfilled relationship patterns occur.

#### CRIME

Since the late 1970's, law enforcement officials have been aware that a disproportionate number of Vietnam veterans have been involved in criminal activity (May, 1979). Brady and Rappoport (1974) reported that Vietnam veterans who had experienced heavy combat approved the use of violence to a significantly greater extent than did non veterans. Support for this research also comes from an examination of crime statistics. In 1978, a Presidential Review Memorandum estimated that 29,000 Vietnam era veterans were incarcerated in federal or state prisons and

approximately 37,500 were on parole, 250,000 were under probation supervision and 87,000 were awaiting trial.

A feature of veterans with PTSD symptomatology who have engaged in post-war crime is the large proportion who experienced excessively violent or criminal behavior while in Vietnam (Hendin and Haas, 1984). In their research, Hendin and Haas (1984) found that the crimes most often reported by Vietnam veterans since their return were assault and battery, assault with a deadly weapon, armed robbery, possession of a concealed weapon and homicide, both attempted and completed. Although further research is necessary, a relationship between combat and post-war crime is indicated.

#### SUBSTANCE ABUSE

The problem of drug abuse is regarded as an area in which the Vietnam veteran differs from those veterans of other eras (Siegel, 1973). Among some units in Vietnam, the use of drugs was almost universal (Bourne, 1972). Drugs were readily available for U.S. servicemen and at a fraction of their cost in the U.S. In addition to accessibility, the use of drugs in a combat zone had a particular appeal because of the psychological anesthesia it provided. It provided an opportunity to induce "psychic numbing" (Lifton, 1973) and a way to avoid intrusive thoughts, nightmares and

to achieve adequate sleep. The alienation and frustration experienced by the veteran upon his return from Vietnam increased the attractiveness of drugs as an escape.

In their research, Hendin and Haas (1984) found that most veterans who had used substances to deal with stress symptoms while in combat, continued their use even more as their symptoms worsened in the post-war period. Marijuana, tranquilizers and heroin tended to be used by veterans to reduce the rage associated with PTSD, to relieve the insomnia and to permit sleep without the interruption of combat-derived nightmares. Darvon and amphetamines enabled many veterans to function socially and at work despite their combat-induced stress disorders. Alcohol was used to achieve almost all of the above purposes (Hendin and Haas, 1984). Often the negative effects of substance abuse comes to light when family relationships and financial stability are in jeopardy.

A study mandated by Congress (Egendorf, 1981) which was based on an unbiased sample of almost 1,000 veterans and non veterans concluded that those who served in Vietnam had more problems than their peers. These problems were reflected in the areas of education, employment, a higher incidence of arrest, in drug use and in more medical and psychological complaints. Pre-traumatic strengths and weaknesses, the

trauma itself and subsequent events and experiences following the trauma must be addressed in the understanding and assessing the symptomatology of the PTSD of the Vietnam veteran. Without this familiarity, mental health professionals will not be in a position to provide the appropriate and needed treatment for this population.

Chapter V will examine a variety of modalities found useful in the treatment of Vietnam veterans and their families. Additional attention will be given the importance of the therapeutic relationship and the role of the therapist.



## CHAPTER V

### INTRODUCTION TO TREATMENT

The opportunity for treatment of PTSD for Vietnam veterans has been recognized formally by the Veterans Administration and by most mental health professionals. Though problems still exist regarding attitudes, diagnostic procedures and misdiagnosis, there is less controversy about the goals and approaches to treatment.

The ability to face pain and grief and to recognize the honor, joy and even excitement of the catastrophic situation indicates a healthy resolution to difficulties resulting from a traumatic incident (Smith, 1985). Trauma survivors who can hear and accept different perspectives of the traumatic event without undue turmoil demonstrate their strength, adaptability and resolution of the stress. If the survivor does not have these characteristics, then it is a good indication that the traumatic experience is not yet integrated. Whether or it needs to be integrated is a decision for the survivor and those close to the survivor. Whether it will be integrated is up to the survivor.

Most of the approaches to the psychosocial management of war related problems focus almost exclusively on the individual veteran. This is not surprising since the accepted form of treatment for most survivors of catastrophe centers around the individual, blatantly ignoring the family

connection (Figley and Salison, 1980). Individually-oriented therapy may be initially necessary as the veteran seeks to resolve specific war related issues. These issues may need to be dealt with prior to resolving interpersonal and family problems. The clinicians and veteran may choose either individual or group approaches in order to share and come to terms with the veteran's emotional reactions to the war. Eventually it is important to incorporate the veteran's network of social support which most often is his family. In order to facilitate the stress recovery process of Vietnam veterans, the therapeutic relationship role of the therapist, client and goals of treatment must first be addressed.

#### THERAPEUTIC RELATIONSHIP

Several authors have detailed the difficulty in treating Vietnam veteran clients (Egendorf, 1978; Haley, 1974; Howard, 1976; T. Williams, 1980). Frequently clients are distrustful, cynical and suspicious. Many veterans have such a poor self image that they do not feel deserving of help (Figley, 1978; Wilson, 1979). Considering the tendency for this population to have difficulty with authority figures it means that special care must be taken in developing the therapeutic relationship. When it comes to mental health delivery systems, these feelings of distrust

and suspiciousness take on a special focus. Veterans particularly distrust mental health professionals and large systems, specifically the Veterans Administration, which for them symbolizes the government that sent them to Vietnam.

In order to have a satisfactory therapeutic relationship, one must take into account the symptoms of PTSD that make such relationships difficult. Emotional numbing tends to give the impression that the veteran feels no guilt or remorse. Often traumatic events are related with little apparent affect. The anxiety the veteran feels over impulse control further helps to "seal off" affect. Many veterans have felt that their feelings of depression, anger and guilt as well as nightmares and flashbacks has meant that they are going crazy (T. Williams, 1980).

The difficulty in working with this population is further increased by the moral and political questions raised, making clinical detachment often an issue for the therapist. There are also times when the war stories shared by the client are gruesome, ugly and frightening. It becomes distracting for the therapist to listen to such stories without making judgement as to the "rightness or wrongness" of the Vietnam War.

Haley (1974) stated that the establishment of a therapeutic alliance for this group of clients is the treatment rather than the facilitator of treatment. She

sees that it is critical that in every sense, the therapist be "for real", a "real person", respectful of the veteran's strengths, concerned but not put off by the client's psychopathology. While Williams (1980) believes this may overstate both the importance of the counseling relationship and the adjustment problems of the veteran, it indicates differences from the traditional therapeutic relationship. Clinicians experienced in working with Vietnam veterans argue in favor of the therapist's willingness to share affectively. This allows the veteran to get in touch with his own destructiveness and to have some comfort in dealing with violent or aggressive behaviors (Blank, 1985; Figley, 1985; Smith, 1985; T. Williams, 1980).

#### ROLE OF THE THERAPIST

A crucial element of the therapy program is a trustful therapist-client relationship. Such an alliance enables the veteran to tolerate remembering, reexperiencing, understanding and working through stressful experiences.

The therapist is often a member of that society which did not support the returning Vietnam veteran. The therapist must accept that he or she may be mistrusted and tested by the client. Haley (1974) believes that a therapeutic alliance becomes possible when the therapist endures his/her own discomfort and permits anger and blame

by the veteran in the veteran's search for meaningful re-integration. Progress can be made when the therapist can be genuinely empathetic and tolerate the emotions aroused by the client.

Some clinicians like to prepare themselves for working with clients whose experiences are unfamiliar by reading the professional literature. There are a number of autobiographies, novels and poems written, edited and published by Vietnam veterans. Reading such literature as Fields of Fire (Webb, 1978), Rumor of War (Caputo, 1977), Dispatches (Herr, 1977), and Everything We Had: An Oral History of the Vietnam War by Thirty Three American Soldiers Who Fought It (Santoli, 1981) can better prepare the therapist in recognizing the history and experiences which this client population has experienced. Regardless of the amount or type of reading or what is personally known about Vietnam veterans, the best preparation for dealing with these clients, as suggested by Egendorf (1978), is for the therapist to dwell for a time on whatever they do know . . . then ask what, in their own experience, might need to be taken into account before you can respond as fully as one might like, or as a Vietnam veteran's therapist.

Though the answer(s) will be personalized, Egendorf (1978) says that two general categories will emerge:

1. The first having to do with what veterans are like  
Some have killed, raped, burned homes or witnessed these and other like events. A therapist's reaction that can hamper the capacity to listen includes horror, pain, hurt, guilt and fear; and,
2. The second source of difficulty for therapists may be their own image of themselves as members of a helping profession. Working with Vietnam veterans may cause feelings of hate, disgust, repugnance, and contempt to surface for the therapist. A professional needs to be prepared to see "negative" reactions in themselves and deal with them in such a way in order that therapeutic work can proceed.

It can be fatal to the relationship for the therapist not to recognize the intrinsic conflict of the war. A veteran often states that he is left feeling he had risked everything (his life) for nothing; friends were killed and maimed for nothing; he killed people for nothing; and was abused by society. To the veteran, the war is not an abstraction, but a highly significant event in his life. Veterans tend to have little patience with a therapist who skirts the issue of the Vietnam War; they often feel as though they have been discounted enough.

Confrontation with the therapist's own personal vulnerability to catastrophe, the challenge to one's moral

attitudes about aggression and killing, and the fear of transference and counter-transference issues are not uncommon occurrences for mental health professionals working with Vietnam veterans. It is important for therapists to recognize this within themselves, and to appropriately deal with their own issues in order to better help the veteran deal with his issues. For many veterans, their worst fear is that they will never be able to open up to anyone who was not in the war, without the other person being shocked or disgusted (Smith, 1985).

#### GENDER AND MILITARY SERVICE OF THE THERAPIST

A number of clinicians who have worked with the Vietnam veteran as a client have written that the therapist need not be a combat veteran himself or even an "era" veteran, one who was in the military during the Vietnam era but not stationed in Vietnam (Parson, 1984; Smith, 1985; T. Williams, 1980). Indeed, many therapists who are not combat veterans themselves have worked successfully with those having served in combat. It may take a special sort of courage and willingness on the part of the therapist, since there is a high possibility of distrust and suspiciousness on the part of the veteran client.

Many veterans however believe they cannot communicate what it was really like serving in Vietnam to anyone who was

not there. The reasons for this belief vary. According to Egendorf (1968), some veterans appear resentful and bitter. Some will express their despair over the impossibility of sharing the burden of the experience. Others will pride themselves on having known and seen what most people cannot fathom; and still others will say that the whole experience was "no big deal".

Many people who are not veterans have worked successfully with combat veterans. It may take a special sort of courage and willingness on the part of the therapist, since the possibility of distrust and suspiciousness is high on the part of the veteran.

T. Williams (1980) recommends however, that having a Vietnam veteran professional or para-professional available early in the referral and treatment process can benefit both the client and treating facility. He suggests it may take a combat experienced therapist to engage the client in treatment. Additionally, it may be helpful to have another veteran available to substantiate or rule out factious stories by veteran clients.

Being a Vietnam veteran and a therapist has not only advantages but disadvantages in dealing with clients. An obvious advantage is that the relationship and trust are quickly established. A common knowledge of terms, phrases and geographic locations are shared with major issues surfacing quickly. Vietnam veteran therapists often find



themselves more direct and confrontive because of having "been there" (T. Williams, 1980).

The major disadvantage of a Vietnam veteran therapist is that as therapy begins, the therapist can expect the occurrence or re-occurrence in himself of some PTSD symptoms. Intrusive daytime imagery, nightmares and anger have been reported by these therapists. Another difficulty that is reported is that the therapist finds that he or she is over extending oneself, both personally and professionally for their fellow veteran. This work can re-create long forgotten memories for the therapist and the development of a peer support system may become necessary for the veteran therapist (T. Williams, 1980).

Vietnam veterans tend to see women in sex role stereotypical ways. There may be a tendency to play the warrior role with an exaggerated masculine self image, one which the female therapist may view as seductive and/or intimidating. The veteran seems to fear intimacy and possible rejection. Haley (1978) reports that female therapists have been successful in working with combat veterans in that some have been able to deal with emotionality and intimacy issues more quickly than male therapists. Most difficulties in the therapeutic relationship between male client and female therapist can be resolved if recognized and addressed so that the issue of treatment can be dealt with.

What is needed is a therapist who is sensitive,

empathic, and knowledgeable, and who is able to use these qualities in a constructive manner with the client. Such a therapist must consistently be in touch with counter-transference feelings, and be ready and willing to utilize these feelings to enhance the therapeutic work. The therapist is to present and maintain him/herself as someone with whom it is possible to have a relationship, one that is sustaining, continuing and growth-enhancing. Moreover, the therapist must have the capacity to remain constant, to tolerate intense feelings, particularly aggression. Parson (1984) believes that each client needs to know that the therapist, whether veteran or non veteran, will be there for him when he feels most vulnerable.

#### EFFECTIVENESS OF TREATMENT MODALITY

Comparative outcome studies of psychotherapy have been designed to test the hypothesis that some forms of treatment are superior to others, at least for particular types of clients or particular disorders (Bergin and Lambert, 1978; Malan, 1973). However, empirical support for this position is limited.

According to Pilkonis, Imber, Lewis and Rubinsky (1984), individual psychotherapy remains the treatment of choice for most clinicians and patients. While much of the

comparative outcome literature consists of studies of different individual therapies, there are those studies who argue for the superiority of group therapy or marital/family therapy over individual approaches (Gurman and Kniskern, 1978; Parloff and Dies, 1977). Even if the global effectiveness of various modes of treatment proves to be roughly equivalent, Pilkonis et al, (1984) state that it seems likely that the major structural differences among them may lead to different outcomes. For example, group therapy may lead to certain interpersonal insights that are not characteristic of many individual psychotherapies. When variable outcomes did appear, they were more often attributable to difference among therapists than to differences across modes of therapy (Pilkonis et al, 1984).

Different modes of therapy can prove effective in alleviating symptoms and improving personal and social adjustment, though the processes through which this is accomplished vary from treatment to treatment. Parson (1984) states that the most useful arrangement in the treatment planning of the Vietnam veteran is to include him or her in some kind of group activity in a combined format, since the kinds of issues that arise early in treatment of this population revolves around distrust and isolation, the search for shared meaning and the need for sanctions from

others for the veteran's personal actions in Vietnam. Brende (1981) found the combined format, the "multiple modality" of individual and group treatment, to be effective in meeting a range of psychic and interpersonal problems of Vietnam veterans.

Seeing family members together in therapy can play a significant role during the readjustment period by creating a safe and non-judgemental environment in which the veteran and his family can work through the combat-related problems affecting the family. This treatment approach is supported by researchers and clinicians working with this population of survivors and viewed as helping the family system to make adjustments to the war- induced trauma of the veteran.

Although there is no single way to deal effectively with PTSD nor is there any quick cure to the problems associated with serving in war, there are some common and usual approaches in the treatment modalities which have been employed to promote the stress recovery process of Vietnam veterans and their families. The sections that follow will discuss the treatment of Vietnam veterans suffering from PTSD symptomatology in the individual, group, and conjoint settings.

#### EDUCATING THE CLIENT

Bard and Sangrey (1979) suggest that treatment

procedures focus on helping clients understand the etiology of their PTSD symptoms and teaching the client skills for coping with symptoms. Figley (1985) confirms that whatever treatment modality is employed, it is essential for the client to be clearly and quickly educated about different aspects of the stress recovery process and re-educated about these same aspects at later times during the clinical interventions. Figley (1985) identifies the following aspects he believes important for the clinician to address with the client:

1. Trauma is such a catastrophic experience that it can produce post-trauma symptomatology in almost anyone;
2. It is expected and normal to have intrusive imagery, numbing, rage, grief or other symptomatology following a trauma;
3. Many clinical experiences with trauma survivors indicate that some survivors continue to have significant post traumatic symptomatology years or decades following the trauma;
4. It is not unusual to fear that one will lose control of some emotions;
5. The symptomatology usually gets worse before it gets better. This seems to be a necessary step to

work through what you have to work through and it is only temporary;

6. PTSD is responsive to treatment;
7. Some symptomatology may not go away completely;
8. Symptomatology can at the very least be controlled and reduced in severity or frequency of occurrence; and,
9. Though initially it may be difficult for the client to believe, he may benefit from his traumatic experiences if he has a willingness to work through those experiences.

#### INDIVIDUAL TREATMENT

For some Vietnam veterans, the resolution of traumatic stress may take the form of individual psychotherapy. Psychotherapy for PTSD is a process in which the survivor integrates and masters the conscious and unconscious effects of the traumatic experience. According to Smith (1985), the goals go beyond relief of symptoms and include enhancing self esteem and self control, developing an appropriate sense of accountability and experiencing a re-newed sense of pride. Individual psychotherapy attempts to build on a survivor's independent work in these areas.

In his work as a mental health professional treating Vietnam veterans, Smith (1985) believes that there are nine

major themes which the veteran and therapist will encounter in the course of psychotherapy though not limited to the individual setting:

1. trust and rapport;
2. control;
3. anger, rage and blame;
4. uncovering;
5. transformation;
6. relationship to other life experiences;
7. repetition and falsification;
8. affective articulation; and,
9. animating action and the survivor mission.

#### TRUST AND RAPPORT

An intriguing part of the veteran's way of thinking is the lack of trust. Believing that no one can understand his pain, the veteran tests the therapist to confirm his preconception that "you, too, cannot understand". The therapist must address his or her investment and interest in the work, for the veteran will be questioning the therapist's motives, by engaging in threats or relating horror stories which will further test the therapist's perspective, commitment and tolerance.

Smith (1985) sees this testing process as a form of transference. The veteran is concerned with how the

therapist handles himself in the therapeutic relationship. Can the therapist stand being yelled at and being frightened; how will the therapist respond if the veteran acts out? Challenges to the therapist must be considered symbiotic action related to trauma unless proven otherwise (Smith 1981).

#### CONTROL

Control is described by many clinicians as the single most significant issue in treating Vietnam veterans, particularly at the onset of treatment (Figley, 1985; Hendin and Haas, 1984; Schwartz, 1984; Smith, 1985). Faced with anger, rage and acting out, clinicians respond to the combat veteran client in a number of ways. Limit setting and restraint of acting out frequently seems to provoke these responses by the veteran. Uncovering and catharsis of a traumatic episode are frequently followed by a flight from therapy. Relaxation techniques sometimes elicits a panic attack. Smith, (1981, 1985) believes that treatment of PTSD requires a delicately balanced approach involving the use of control and reformulation, the re-interpretation of the trauma. The appropriate attention to and re-enforcement of control must precede uncovering and reformulation (Horowitz, 1973). Inadequate attention to the control issue often results in the paradoxical results described above.



It can be assumed that when a veteran talks about or brings weapons to the session, he is expressing concern and the wish to discuss possible loss of control. Dealing with the issue of weapons in therapy minimizes the possibility that violence and tragedy will unexpectedly occur outside the session. The development of a therapeutic contract is then recommended. This includes safety valves such as locking up the weapon, giving it to another person or dismantling its parts. The veteran and the therapist together must identify the concern and take action.

A fundamental assumption of therapy is that the veteran has the power to solve his own problems. Should the therapist assert control and confiscate weapons, the personal responsibility which therapy intends to foster would not develop. When the client asserts control in a crisis, the actions are his while the therapist has been ally. This paradigm for therapeutic intervention permits action by the veteran, with their therapist-ally placed figuratively at the client's shoulder. It is a necessary approach to therapy with the veteran who suffers from PTSD (Smith, 1985).

Veterans frequently express concern over a repetitive experience, during which they feel they may lose control. Examples include an argument with a spouse or employer. The

first task is to establish control through a technique that involves discussion of the experience, identifying points at which conflict can escalate or be resolved and development of alternative actions. The therapist tries to structure "small" successes as the veteran assumes responsibility for and control over his actions. Deferring the uncovering of traumatic issues or providing additional sessions for the veteran during this time in therapy may also provide sufficient control and relief in reducing the veteran's concern.

#### ANGER, RAGE, BLAME

Some therapists view a veteran's anger, rage and blame against institutions, such as the Veterans Administration, as a hopeless cycle since it is directed at an external source. By attempting to correct this hopelessness, some therapists attempt to focus on the veteran's contribution. The veteran then hears that his rage is misunderstood and turns it on the therapist. Other therapists will show sensitivity to the anger by encouraging the veteran to ventilate, hoping that once expressed, this rage will diminish. T. Williams (1980) sees these approaches as traps since there are real and legitimate causes for rage in the veteran's experience of war, homecoming and public and governmental attitudes.

Smith's (1985) basic assumption is that profound guilt and self criticism are lying beneath the blame. Expressions of rage are a part of the stress recovery process which involves the understanding and direction of appropriate blame and responsibility to oneself and others. Veterans must understand the impact of their behavior and therapist must help them realize they are frightening to others. Non-judgementally, the therapist must acknowledge the veteran's anger without implying total approval or disagreement and assist the veteran in realizing does not have to escalate his angry behavior to gain therapeutic attention.

A valuable question to ask the client is "why the wrong doing of others is so important to the veteran today?" Many veterans have learned to use anger and rage as a defense against feelings of vulnerability. The client may feel threatened in successfully learning to handle his anger. As his anger becomes under control, the veteran must deal with the pain it has covered. At this point, the therapist must be alert to the feelings of despair and the possibility of self destructive thoughts or actions. Anticipation of these feelings and formulating a plan to cope can help prevent a crisis.

#### UNCOVERING

After addressing the presenting issues of loss of

control and anger, the therapist may then begin exploring the underlying traumatic event. Smith (1985) states that it is useful to wait for the veteran to allude to the importance of the trauma. This usually occurs when the client, in discussing current problems, talks of Vietnam. In the absence of the veteran bringing up the trauma, the therapist can begin inquiring by asking when the client first noticed his problem. Another approach is to ask if the veteran noticed a particular behavior or whether the behavior reminds him of anything. Once it has been established that something important happened in Vietnam, a detailed military history of events should be reviewed or obtained (See CHAPTER IV).

The therapist taking the history must listen for the specific meaning the trauma has for the veteran. Often the veteran is unable to remember specific events, however memory may improve in the course of discussion of peripheral events. Asking for geography, details of terrain or weather, or description of clothing or weapons may trigger retrieval of the critical traumatic event. The veteran, however, must determine the pace of the uncovering. A therapist's attention drawn to the client's agitation, anger, fear and crying can enable the veteran to stay alert to his own reactions, recognize the therapist's concern and control the speed of uncovering and depth of the probing.

## TRANSFORMATION

The key to resolution of stress reactions is reformulation of attitudes, expectations and cognitive set to allow integration of what really happened (Figley, 1985). As the client remembers the trauma, he relives it with the affective impact of the original experience (Egendorf, 1982). Gentle questioning by the therapist must then begin, with a willingness to reexamine, returning again and again to the same topic. While the first recounting of the trauma may result in an affective catharsis, dreams and other intrusive phenomena will continue.

Smith (1985) sees that the resolution of the traumatic experience is not simply the result of retrieval of a traumatic memory or abreaction of emotion. Only with exploration of the discrepancy between actions taken or omitted during the traumatic experience, and judgements and expectations subsequently made by the veteran regarding the previous behavior, will tension begin to dissipate. In individual therapy, therapists find that providing reassurance to the client will not be sufficient to change the client's self judgement. Shifts in therapy will take place by thoughtful acts of reparation, making amends for past actions (Egendorf, 1982).

## RELATIONSHIP TO OTHER LIFE EXPERIENCES

Current problems and traumatic events from Vietnam may be linked psychologically to other unresolved issues from the client's past. It is frequently the case that earlier life experiences find their parallel in the traumatic circumstances of war. In other cases, the veteran is more clearly impaired prior to their military service. It is still possible, however, for such individuals to also develop PTSD.

Treatment for stress disorders must take into account the entire clinical picture. Pre-military and post-military history of the client is therefore an important part of this process. The relationship of PTSD to other life experiences can be complex and much remains to be learned about this subject through future research (Hendin and Haas, 1984; Scurfield, 1985; Smith, 1985).

## REPETITION AND FALSIFICATION

In therapy, a traumatic episode will be repeated many times. Careful attention to each repetition will reveal important shifts, new details and new characters (Scurfield, 1985). Sometimes veterans appear to fabricate traumatic combat episodes. While frequently seen as attempts to claim compensation, it is also seen as a need by the veteran to elicit sympathetic understanding from both veterans and

civilians. Should this occur in therapy, an important task for the therapist is to let the veteran know that there is no hierarchy of suffering and the the pain and distress of nurses or those in "the rear" can be as devastating as that of combat survivors.

#### AFFECTIVE ARTICULATION

The range of emotion available to veterans is quite often limited (Hendin and Haas, 1984; Scurfield, 1985). In spite of pain and sensitivity to criticism, the only emotion often known to the veteran is anger. Rage becomes a mechanism to cover hurt, guilt, shame, doubt, vulnerability and intimacy. It serves to direct blame on someone else.

The task of articulating and learning to express a range of emotions is a crucial part of therapy. For many veterans, the first step is simply recognizing that they do feel. The next step involves learning to tolerate these emotions and eventually the exploration of feelings and behavior can lead to appreciate tenderness. As this occurs, the veteran must be alerted to expect emotions which have long been dormant, recognizing however that self control is still possible. A danger at this point is that the veteran, fearful of the intensity of these feelings, will drop out of therapy jeopardizing fulfilling relationships with others.

## ANIMATING ACTION AND THE SURVIVOR MISSION

The process of reparation and the survivor mission adopted by many Vietnam veterans represents an effort at reparation in the present for what was done in the past. Some veterans entering treatment are reluctant to wait for clarification as to what exactly they wish to "repair" and what form reparation might take. There is often the desire to help fellow veterans who suffer from stress related symptoms. Rather than discourage attempts at "action" and repair", the therapist should explore their impulses and eventually explore traumatic episodes which underlie the veteran's difficulties.

The survivor mission is not planned. Gentle questioning should continue throughout treatment as the veteran begins to identify unfinished business related to the trauma. Smith (1985) states the following:

beginning the task of exploring such current loose ends makes a powerful connection between the lost past and the present. Lacerating guilt over what can never be changed or undone can be transformed by present action, and the veteran realizes that there are things that can be done now and meaningful contributions that he or she can make. (p. 161).

This may take the form of a letter the veteran has wanted to write, or a visit to the family or grave of a buddy killed in Vietnam.

Interventions in the acute phase of post traumatic



reactions, generally follow a crisis intervention model such as that identified by Burgess and Holmstrom (1974). Figley (1985) states that the longer term effects of trauma, such as those suffered by Vietnam veterans, are more complex. Chronic and delayed PTSD may, in addition to PTSD symptomatology, also include associated symptoms and maladaptive coping patterns that have developed over time. In part, these symptoms may be a result of the survivor's struggle to cope with or attempt to avoid unresolved PTSD symptomatology.

It is a long road for some clients, from the first therapeutic visit to a resolution of his trauma of combat. A sign of successful resolution of the stress process is the ability to remember and face one's whole experience, the good and the bad, the sorrow and the joy (Smith, 1985). The time it may take an individual to achieve this resolution varies. For some, establishing a therapeutic relationship early in treatment can enable early uncovering and discussion of the trauma. For other clients, the denial of impact of the trauma on the veteran's life may impede or further delay resolution. At times, short-term psychotherapy is recommended to identify and clarify a veteran's individual issues regarding Vietnam before entering a rap group.

## RAP GROUP

The term "rap group" is applied loosely to several forms of treatment groups: leaderless groups, didactic groups, open and closed groups, topic-centered groups and client-centered groups (Yalom, 1975).

Like other survivor groups, rap groups encourage the bonding of survivors of similar traumatic events for therapeutic purpose. Survivors implicitly know that their reactions to the trauma are different than their reactions to previous "normal" events. The reactions and suggestions of others who have not experienced the traumatic event often confirm, in the survivor, "a covert feeling that they are abnormal" (Smith, 1985 page 168). Therefore, survivors often look to people who have experienced the same similar catastrophe for validation and normalization of their response (Coates and Winston, 1983). Through such interaction, survivors confirm that their response is, in fact, a normal response to an extraordinary event.

This treatment modality offers several advantages to the client:

1. reduction of isolation while providing a sense of community, comfort and support;
2. reduction of feelings of stigma and restoration of self pride;
3. confrontation by peers that seems more acceptable and reality-oriented because it comes from those

- with similar experiences;
4. the opportunity to process "unfinished business" from the trauma and post-trauma experiences in a supportive and understanding environment; and
  5. the opportunity to offer help in expressing emotions freely. (Smith, 1980, 1985; T. Williams, 1980; Wilson, 1980).

Like other treatment groups, rap groups operate on the premise that change must start with the individual even though others may have contributed to the individual's problem. For many Vietnam veterans, there is a need to find meaning for powerful, personal experiences and to acknowledge responsibility for their own acts (Smith, 1980). A special characteristic of the rap group for this population is that it provides a forum in which the veterans' value system and sense of meaning can be "re-fashioned" and a new sense of self can develop and symptoms wane, without societal sanction (Smith, 1980, 1985).

Rap group treatment is considered by a number of researchers and clinicians to be the treatment of choice for Vietnam veteran clients with PTSD symptomatology (Brende, 1981; Scurfield, 1985; Smith, 1980, 1985; T. Williams, 1980; Wilson, 1980). The possible link between a troubling episode and the veterans current distress can be explored within the rap group. By promoting discussion about the sometimes

ambiguous nature of combat, such as honor, pride, guilt and anger, the peer group frames the veteran's dilemma. Rather than repress the painful memory, the veteran learns to recognize the dilemma and live with it.

Historically, the rap group concept for treating Vietnam veterans evolved out of a need for this population to find meaning in their Vietnam and post-Vietnam experience and from a desire to deal with the psychological symptoms they suffered. Shapiro (1978) notes that the early rap groups were organized in 1971 by a small group of Vietnam veteran political dissidents belonging to the veterans' organization Vietnam Veterans Against the War (VVAW). Members of this organization contacted mental health professionals to assist them with a number of readjustment problems that they had been unable to deal with on their own.

Lifton (1973) Shatan (1973) and Shapiro (1978) have discussed their experiences as therapists-participants in these early self-help rap groups organized in New York City in the early 1970's and continuing until 1974. They found that for Vietnam veterans, these early group experiences were different, in significant ways, from traditional systems of group treatment. For example, the veterans suggested these groups be conducted on their own "turf", in their own familiar setting away from the formality of a

therapist's office or mental health facility. The veterans also wanted the group experience to remain in their control; the therapists were referred to as "the professionals" while the veterans were referred to as "the vets". Basically, "the group experience focused on the question of how to encourage psychological growth in a group of men who felt simultaneously alienated from society and committed to social change " (Shapiro, 1978 p. 157). From these therapists perspective, the groups were organized and conducted with significant modification of prevailing techniques in group work (Parson, 1984).

The VVAW veterans set many of the rules. They decided that any veteran who desired could attend the rap group and they preferred no rules on member attendance. Some veterans would therefore attend group once and then not appear again for weeks or months. Group hours would last up to four hours and by the end of the first year, two rap groups were operating on a once-a-week basis. In all, several hundred veterans and some 20 therapists participated in the New York City rap groups, individual therapy or the theme-centered workshops that grew out of the early model for rap group sessions.

The therapists in the early rap groups were, for the most part, psychoanalytically oriented psychotherapists or other psychodynamic professionals. The therapists' role as

an authority figure was minimized in this group structure and they became political allies which resulted in intimate contact with the veterans (Shapiro, 1978). Lifton (1973), Shatan (1973) and Shapiro (1978) note how remarkable it was for the professionals of these orientations to be able to put aside their ordinary mode of treatment functioning and intervening and make the necessary adaptation to the needs of the veterans. Parson (1984) notes, however, that the exploration of transference feelings which could conceivably have helped the men to better deal with their Vietnam and post-Vietnam experiences was only tangentially attended to by the therapists within this group format.

The "looseness" of the group structure, the general conduct and intervention procedures of the early group format was the very type of structure that has given this type of rap group experience its unique identity today. The different styles of Vietnam veteran rap groups utilized in today's treatment include:

1. open groups;
2. leaderless groups;
3. client-centered "hot seat" groups;
4. topic-centered groups; and,
5. initial working groups.

## OPEN GROUPS

Of primary importance within the rap group structure is building trust among members (Yalom, 1975) who then explore the relationship between traumatic experience and current problems. Exploration of the general Vietnam experience generally occurs in the first few meetings. As the group moves to deal with current problems, Smith (1980) states that Vietnam often emerges only in the context of specific painful memories triggered by discussion of current issues.

An open group creates several problems that Yalom (1975) sees as threatening the integrity, continuity and process of the group. In the open group format for Vietnam veterans, introduction of new members inhibits the evolution of group trust, camaraderie and intimacy and prevents deep exploration of traumatic experiences. The continuous addition of new members creates a need to repeatedly discuss Vietnam experiences in preliminary ways, waiting for each new member to "catch up" before the group can move on. Additionally, the open format relaxes the demands for attendance and participation by group members. The potential for commitment, for observations of each other and for "give and take", the basis of the rap group process, all diminish in the open group (Smith, 1980, 1985; Yalom, 1975). With constant changes in composition and no strong commitment, the group never gels, never grows and the

potential for the more destructive forces to emerge increases (Parson, 1984; Smith, 1985). Sometimes, however, the open group plays a useful role in providing information and as a setting for beginning exploration (Smith, 1985).

#### LEADERLESS GROUPS

Some veterans prefer to meet in a group setting without the benefit of a group leader or facilitator. However, Smith (1985) believes that leaderless groups have little usefulness for Vietnam veterans. He states that every rap group needs an experienced leader in group process and familiarity with the Vietnam veteran experience. Scurfield (1985) supports the importance of having a rap group with a leader or facilitator since it is their role to monitor powerful group forces and act to assist the group in controlling destructive or stagnating impulses. Without a leader, Scurfield (1985) says, the group can become destructive; everyone is free to play participant and never directly face issues. Appropriate attention to process or psychological damage may be required but not occur and the group may disintegrate without an identified leader.

#### CLIENT-CENTERED "HOT SEAT" GROUPS

In this type of rap group, each week one member is designated to occupy the "hot seat" and the group focuses on that veteran's problems. The advantage of this format is



that it solves potential non-participation problems. Silent or reluctant members eventually have their time and there is no question about whom to focus since this has been pre-determined. Another benefit of this client-centered group is that it can help restrict irrelevant discussions. Repetitive stories and skirting of issues within the group can be controlled.

A difference between this group and the other rap groups is that the focus is on pressing concerns that are brought out by current difficulties and memories. The individual member who is being focused on controls the timing of exploration and sharing. Smith (1985) sees this, however, as a disadvantage in that the format can produce too rigid a set of expectations. The climate of the group may pressure some to distort their experiences in order to gain acceptance. Additionally, if the leader is not skilled, the group climate can provide a cover for the group and its leaders, enabling them to avoid painful topics.

#### TOPIC-CENTERED GROUPS

As with "hot seat" groups, topic-centered groups attempt to structure the group's discussion. The leader or members select specific discussion topics that cover major issues that these members need to address. These groups can be useful as informational or initial exploratory groups (Parson, 1984; Smith, 1985; Yalom, 1975). Some experts

disagree with the effectiveness of this type of group and state that they are too limiting as a process group. The climate can suggest that only certain topics such as anger, emotional constriction or substance abuse or specific reactions and attitudes are legitimate subject subjects for discussion and the focus is too narrow (Brende, 1981; Scurfield, 1985; Walker, 1981). In a fully effective group, Scurfield (1985) believes that each member should feel that anything can be addressed and considered.

#### INITIAL WORKING GROUP

This group brings together eight to 15 veterans for a specific but specified period of time. Initial focus is upon the exploration of past war experiences in relation to current life. Hendin and Haas (1984), Scurfield (1985) and Smith (1985) view this type of group as the most common rap group treatment for Vietnam veterans.

The initial working rap group has closed membership and disclosure of personal war experiences and motivation for group membership is encouraged. Group members are also asked about current problems and to discuss aspects of their military experience that they still find unsettling today. During this group format, themes of guilt, grief, betrayal, pride, respect, anger, integrity, isolation, control, frustration and confusion emerge (Scurfield, 1985). Group

intervention focuses on encouraging members to understand not only content but group process.

Smith (1980) finds that this type of group is characterized, especially during the early weeks, by unevenness of process. Intense and deep disclosure will alternate with silence and reluctance. He further states that important material is often "dropped" during the closing minutes of a meeting. At this point, the role of the group leader becomes important for interpreting such behavior and labeling it for the group to discuss then or at a future meeting.

It is noted that in subsequent weeks for this type of group, members' resistance often will stiffen. Attempts will be made to limit the range of exploration and trauma. Avoidance techniques such as interrupting, changing focus, talking others out of their anger, splitting or challenging the therapist may also occur and will need to be monitored and addressed by the leader.

The initial rap group can last anywhere from 10-15 weeks, meeting for one and one half to three hours a week. The lingering difficulties from Vietnam often cannot be resolved in this period of time. Some veterans may chose to continue the process of resolution on their own or want further assistance within the group structure. For some, a con-current rap group may focus more dramatically on present

concerns.

Within the boundaries of the initial working rap group, the war and earlier experiences come into sharp focus in highly detailed and more defined episodes when bearing on present issues. Smith (1985) finds that this type of group is effective when the reported behavior of its members in the outside world changes. Furthermore, Smith (1985) notes that changes in the veteran's state of mind and accompanying behavior can be integrated into stable patterns after 12-18 months of group participation, depending on the client.

#### ROLE OF GROUP LEADER/FACILITATOR

Since the focus of Vietnam veteran rap groups is on the process of recovery shared with others, the role of the group leader or facilitator must be one of a "sympathetic facilitator of group process rather than as charismatic interpretor of individual behavior" (Smith, 1980 p. 31). Smith further states that whatever a leader's experience may be with other populations, the charismatic or authoritarian role is the most singularly significant inhibitor of the Vietnam veteran rap group process.

A crucial point observed about the early rap groups in New York City was that the group members valued the mental health professionals for their expertise, not for their role (Shapiro, 1978). The veterans challenged the professionals

and demanded to be treated as equals and yet respected the insight and experience of these same professionals (Parson, 1984).

Group leaders must be able to tolerate highly charged and volatile group sessions since these veterans are not likely to be polite, constrained therapy clients. Scurfield, (1985) recognizes that it is crucial for mental health professionals who are leading a Vietnam veteran rap group to be willing to "lay back" and facilitate a flow of "peer-initiated interactions". Initially, subtle rather than directive leadership will promote the group's development of trust toward the leader or leaders. Subsequently, group leaders can gradually introduce therapy techniques into the group process (Scurfield, Corker, Gongla and Hough, 1984).

It is not enough for a rap group leader to listen to veterans. He or she must challenge, if necessary, inappropriate group process. Additionally, an essential role of the leader is to help group members recognize the impact of their behavior on others; other group members, family and themselves. Self disclosure on the part of the group leader is essential and can provide an invaluable tool in establishing trust, continuity and illiciting positive change in the lives of group members.

As with individual treatment, when uncovering and re-experiencing of the trauma occurs within the group, it is often the most painful and difficult time for the veteran. They often become anxious, fearful and consider dropping out of the group. The resistance is strong and it becomes necessary for the group leader to become more active in directing the counseling process. Without such direction, Frye and Munger (1979) see the group process as becoming stagnate.

It is these demands and the personal vulnerability risked that causes some group leaders to decline rap group participation or to defeat the rap group process by "narrowly circumscribing its time, its topics, or its challenges to the leaders" (Smith, 1985, p. 174). Although all group leaders may fail at times, Smith (1985) sees that therapeutic courage lies in modeling the same vulnerability asked of the veteran. Group leaders who may have the most difficulty working with this population has been discussed earlier in this chapter.

#### ROLE OF THE RAP GROUP MEMBER

Participants in rap group need to know what to expect, what is required of them and what will be offered to them within this format. Veterans with thought disorders or those who otherwise lack the ability to listen adequately

are poor rap group candidates because they cannot share in a meaningful way with the other members. Such limitations must be addressed and dealt with by both the client and group leader.

Often rules are established by the group within the first or second meeting to ensure a non-violent atmosphere. Rules such as no member being under the influence of substances prior to group, no weapons and no physical violence toward another member or group leader allow for trust-building and enable a smoother flow for group process. A group member must also be aware and accountable for his own group attendance in order to maintain group continuity and consistency when dealing with issues. Nonattendance or inconsistent attendance by members can create problems discussed in the Open Group Format.

#### STRENGTHS AND WEAKNESSES OF THE RAP GROUP FORMAT

Many veterans are helped by the rap group process. However, these groups are controversial. In part, this controversy stems from the variety of group therapies mislabelled rap groups. Also, the group process can generate destructiveness as well as therapeutic results. Recognition of this potential leads some therapists to dismiss this treatment modality or to be overly restricting of the groups.

Fleming (1985) sees the rap group as process, rather than content oriented. By its very structure, the group thus lacks leadership and an agenda. Since Fleming (1985) sees the strong possibility that the group will only foster increased feelings of rage and helplessness in the veteran, he suggests emphasis be put on concrete rather than abstract thinking within a confrontive format. Traditional insight-oriented psychotherapy with an individual client is his recommendation for treatment of Vietnam veterans suffering from PTSD symptomatology.

Walker and Nash (1981), charging that no systematic approach to group treatment of Vietnam veterans has been proposed, outline a number of treatment issues they have found to be central in any therapeutic venture with those suffering from PTSD. They insist that their groups are not "rap groups" but therapy groups. They note that the rap groups useful in the early 1970's are no longer politically relevant and are not therapeutically applicable to a well defined PTSD of some years' duration (Walker and Nash, 1981). Their contention is, however, that group therapy, when properly administered, is the most effective method for treating the conflicts of Vietnam combat veterans.

Studies are in their infancy stage in documenting the advantages and liabilities of groups in the treatment of



PTSD among Vietnam veterans. It is not clear yet how, why and for whom the groups work. Some groups have been therapeutically successful, some ineffective and confused. This inconsistency, according to Walker and Nash (1981) and Walker (1981) has led to criticism of the rap group process.

Parson (1984), Scurfield (1985), and Smith (1980, 1985) among others however, see the rewards of watching and aiding the transformation from victim to survivor as being great. The demands in energy and vulnerability exceed those of many other groups, for clients and for the group leader. Despite criticism of the rap group process (Fleming, 1985; Walker, 1981; Walker and Nash, 1981), this form of therapy is both challenging and attractive to many therapists and clients (Smith, 1985).

#### TREATMENT APPROACHES

Cognitive, behavioral and social learning techniques have been reported as effective approaches in treating stress disorders (Scarturo, 1981). Hendin (1983) suggests that if treatment for stress disorders of Vietnam veterans ✓ is to be effective, the principles learned from therapy with post-stress victims must be integrated with principles more generally applicable to short-term psychotherapy. Multi-method, eclectic approaches to treatment are most widely practiced with this population (Scurfield, 1985; Smith,

1985; Ziarnowski, 1984). Approaches such as implosive therapy or flooding (Keane and Kaloupek, 1982); relaxation training, stress management and cognitive behavioral have been successfully utilized with this Vietnam veteran population.

#### IMPLOSIVE THERAPY (FLOODING)

The implosive therapy technique used in the treatment of Vietnam veterans is an adaptation of the technique developed by Stampfl and Levis (1967). Implosive therapy consists of the repeated imaginal presentation of the veteran's traumatic event until the scene no longer evokes high levels of anxiety. The therapist and the client "walk through" the traumatic experience together, with the client verbalizing and experiencing the emotions elicited by this approach. The goal is to eliminate avoidance of the memory and, through exposure, reduce anxiety to the traumatic combat events. If this approach is utilized in the rap group setting, other group members observe this interaction between the therapist and the group member.

The purpose of this treatment is not to change the nature of the trauma, but to decrease the individual's anxiety response to the memories of the trauma. Following successful treatment, events remain traumatic in nature, are likely to be recalled with sorrow, but avoidance of memories

and associated levels of anxiety are markedly reduced (Keane and Kaloupek, 1982).

Keane and his associates (1985) have made two basic assumptions in support of this approach. The first, that the Vietnam veteran's response to memories of specific traumatic events, intrusive thoughts, nightmares and avoidance is the primary factor in the manifestation of PTSD symptoms and the second, the traumatic memories may be motivating other maladaptive behaviors such as alcohol consumption and aggression. Thus, the memory of these traumatic events is the target of the implosive therapy technique. Use of this approach has been found therapeutic in the relief of PTSD symptomatology in Vietnam veterans.

#### RELAXATION TRAINING

Relaxation exercises are designed to reduce stress and tension while they provide additional means of controlling distress. Relaxation training is used for two purposes in the treatment of traumatized persons:

1. to facilitate the client's ability to imagine a scene; and,
2. to decrease residual anxiety following the presentation of traumatic scenes (Keane et al, 1985).

Progressive muscle relaxation techniques may involve up

to four group or individual sessions. An adaptation of Bernstein and Borkovec's (1973) progressive muscle relaxation may be used. Once learned, clients are encouraged to practice relaxation at home. Keane and his associates (1985) see the importance for relaxation techniques to be coupled with implosive therapy in order to facilitate and monitor events and reactions associated with the trauma.

#### STRESS MANAGEMENT

Unlike implosive therapy which focuses on the trauma, stress management techniques are applied to the current symptomatology. The client is taught specific skills that can help him more effectively cope with the social, behavioral and cognitive deficits typically found in PTSD.

Stress management techniques for PTSD may be applied in an educational format. Here the therapist informs the client as to how to better control his emotional reactions to stressors and how to choose more appropriate behavioral responses to stressful situations. These techniques may include adaptations of the following: progressive relaxation (Bernstein and Borkovec, 1973); cognitive restructuring (Ellis, 1962); problem solving (D'Zurilla and Goldfried, 1971); and anger control (Novaco, 1975).

## COGNITIVE-BEHAVIORAL

A cognitive-behavioral approach focuses on how information is being stored and utilized (Hartman and Burgess, 1985). Intervention efforts focus on re-shaping beliefs about the traumatic incident so that physiological states and their psychological responses are addressed in a useful cognitive framework. This theory (Festinger, 1957) points out the effort people make to maintain consistency between their attitudes and behaviors.

For many Vietnam veterans, there is an individual need to find meaning and purpose to past actions in the military. Moral dilemmas for the combatant posed by atrocities and fraggings, the senseless and unjustifiable death of buddies, and the controversy the Vietnam war produced create a significant amount of cognitive dissonance.

Janoff-Bulman (1985) supports re-defining the traumatic event in order for the individual to evaluate his participation in the trauma. This process maximizes the possibility of maintaining his theories of reality while basic assumptions about oneself and one's world become less seriously challenged.

Frankl (1963) also suggests that one way of making sense of a traumatic event is to find purpose in it. He states that if the victimization can be viewed as serving

a purpose, the survivor will be able to re-establish a belief in an orderly, comprehensible world.

Additional though less common treatment approaches have been found helpful in treating this population:

1. contingency contracting (Gelfand and Hartmann, 1975), a written or verbal procedure between two or more persons. It involves a consequences administered by one person to the other following the performance of specific behavior;
2. assertiveness training involves the honest and relatively straightforward expression of such negative feelings as anger and disappointment or such feelings as affection and praise (Rimm and Masters, 1977). Typically the client is given a homework assignment of attempting newly acquired response alternatives in their natural environment. Success can be measured by expressing oneself in an appropriate manner; and,
3. bibliotherapy, which is the assignment of reading materials outside of the therapy session (Glasgow and Rosen, 1978). Such reading is assigned as homework when it appears that the individual may benefit from materials related to behaviors targeted for change. A significant benefit to this technique is that it saves therapy time and can be

used as a strong stimuli for self-change for the client.

Therapists are cautioned against applying methods indiscriminately. Many methods of treatment require at least minimal training. Caution is suggested simply because a given procedure may not be advisable or even feasible with a specific problem, veteran, or within the confines of a specific treatment setting. The application of many approaches depends heavily upon the specific variables surrounding the target behavior for a specific individual. Therefore, a thorough behavioral assessment is recommended before selecting the appropriate intervention (Marafiote, 1980).

#### THE FAMILY SYSTEM

There have been several articles advocating family therapy as a recommended approach for treating Vietnam veterans (Brown, 1984; Figley, 1978; Scarano, 1980; C. Williams, 1980). However, there is little evidence analyzing the effects of the Vietnam War upon the veteran's family structure.

In the 1980's, extensive clinical attention and research focused on male Vietnam veterans, but little attention was given to their family members (C. Williams and T. Williams, 1985). Now the inclusion of families and women

partners is increasingly considered crucial to successful psychological treatment (Brown, 1984; Figley and Sprenkle, 1978; T. Williams, 1980). A major reason for this inclusion is based on research which states that while the veteran may be the "identified patient", the problems he experiences do not occur in isolation from other persons (Figley, 1985; C. Williams and T. Williams, 1985). The problems which occur are often perpetuated partly as a result of interactions with other people.

It is now generally recognized by clinicians experienced in working with trauma survivors that there usually is a substantial impact on the family (Figley, 1978; Figley, 1985; Stanton and Figley, 1978; Harrington and Jay, 1982; Hogancamp and Figley, 1983). Additionally, Brown (1984) has written how the emergence of a delayed stress response affects not only the Vietnam veteran but also family members. In spite of this dynamic within the veteran's family system, there are relatively few references in the literature on this topic. Reports regarding the impact on the families of concentration camp survivors (Barocas, 1971; Freybert, 1980) and on the families of rape victims (Notman and Nadelson, 1976) most closely resembles the impact of war trauma on the families of the Vietnam veteran. Few studies have focused on the impact on the relationship between PTSD and the family (Davis and



Friedman, 1985; Danieli, 1985). These studies confirm the descriptive accounts by others of the significant impact of PTSD symptomatology on the family system, both on the partner and to a lesser extent, on the child sub-system. A beginning step for helping families in treatment is to assist them in understanding the origins and dimensions of PTSD. Helping family members understand the elements of combat and providing knowledge of typical stress reactions can, according to Hogancamp and Figley (1985), go a long way in easing the readjustment period. If the veteran feels his experiences are at least minimally understood and that the family appreciates what he has been through, then it will relieve some of the tension. Moreover, Hogancamp and Figley (1985) believe that the family who is familiar with PTSD symptomatology will not be shocked or afraid if and when the veteran displays such behaviors. As a result, family members can be more effective and involved during the healing process.

Some researchers (Brown, 1984; C. Williams, 1980) who acknowledge the importance of opening the family system suggest that treatment begin by working with the family members separately. This approach can provide individual members the opportunity to identify their own needs, evaluate their concepts of self worth, and assess strengths

each brings into the relationship.

Brende and Parson (1985) note that "there are many clinicians who have made headway in helping families move toward family cohesion who once lived as if in a combat zone" (p. 123). In treatment, family members can grow to fulfill the vital functions of family life. Physical and emotional abuse towards spouses and children may cease, sexual and social relationships become more enriching and open communication for positive family interactions can occur.

#### CHARACTERISTICS OF IMPAIRED VETERAN FAMILIES

The impact upon the family is identified by the rigidity of family patterns. Figley (1978) and C. Williams (1980) attribute rigid family patterns to different aspects of the veteran's experiences since returning to family life. This rigidity from a systems perspective points out a distinction between traditional and non-traditional families which correspond to Minuchin's (1974) concepts of enmeshment and disengagement (C. Williams, 1980). Williams further surmises that family members perceive the veteran as ill, thus supporting the role of "identified patient". Figley (1978) however, suggests that family members develop and reinforce repetitive patterns to prevent the veteran from talking about Vietnam.

Most symptoms exhibited by Vietnam veterans suffering from PTSD are manifest interpersonally and have the potential to exacerbate other family problems (Figley, 1978, 1985). Substance abuse, most frequently alcohol, can have a negative effect on the financial stability as well as family relationships. Partners may actually share in the substance abuse or may be acting as "enablers". Enabling partners may cover for the veteran's abuses by making excuses for their behavior or by denying that a problem exists.

Cyclical outbursts of rage may reinforce a fear of going crazy and of losing control of behavior for the veteran. The rage may also induce fear and helplessness in family members who neither know when to expect it nor how to control it. Violence and battering may occur. C. Williams and T. Williams (1985) note that it is not surprising that violent reactions are often associated with use of alcohol.

A common feature of PTSD is that the veteran does not often sympathize with illness or pain of family members, but becomes hostile and distant. Such a reaction may occur even though the veteran has strong underlying loving and empathetic feelings and reactions. This unsympathetic reaction may be part of the "emotional numbing" which is common to PTSD and can impede the veteran's ability to grieve for actual losses. The effect of this withdrawal from significant others is that they may feel hurt,

rejected, unsupported, angry and resentful about their veteran's inability to reciprocate for the care and support they have provided.

Frequently there is an unspoken rule that veterans will not talk about their war experiences. They say that others, including wives and partners, could not understand. According to C. Williams and T. Williams (1985), part of the veteran's reluctance to talk about the war with their families is that the war happened a long time ago and therefore should not disturb the family now. Consequently, this unspoken rule encourages the veteran to repress the war memories and when ordinary life stresses occur, the memories return because the veteran has been unable to integrate his behavior during the war with his identify in peacetime. This "no talking " rule keeps veterans emotionally isolated from family and perpetuates a tendency to see themselves as special or different.

Isolation and alienation, a factor in the life of the Vietnam veteran may occur for the whole family unit. Harris and Fisher (1985) noted that female partners frequently complain that veterans are jealous and do not tolerate their partners having social activities external to the family unit. In deference to the veteran's request, some partners cut their own ties also. Frequent moves to find or maintain employment further keeps the family disrupted and maintains

isolation.

Clinicians are beginning to assess the effects of veterans with PTSD on their children (Haley, 1984; Scarano, 1982). Research finds that children may act out family pathology with depression or with behavioral or school problems. Veterans are often over-protective, place unrealistic demands on their children or complain about being unable to be emotionally close to their children. This ambivalence may be a result of the veteran having witnessed or participated in the killing of children in Vietnam. Whatever the etiology, there is frequently estrangement and emotional distance between veterans and their children.

#### TREATMENT FOR THE FAMILY

There is a small sampling of mostly theoretical and clinical descriptive literature on the impact and treatment of PTSD on the families of Vietnam veterans (Figley, 1978; Harrington and Jay, 1982; Hogancamp and Figley, 1983; Stanton and Figley, 1983; C. Williams, 1980) and on the specific impact of PTSD on female partners (Brown, 1984; Carroll, Rueger and Foy, 1983; Harris and Fisher, 1985; Palmer and Harris, 1983; Scarano, 1982).

Whether couple, family, significant other or children's group is the treatment of choice by the therapist and

clients, acknowledging the importance of the family system must first take place. Clearly, a routine part of the assessment and treatment planning process should give full consideration to the possible impact of PTSD on the veteran's family.

#### RISKS INVOLVED IN TREATMENT

Brende and Parson (1985) believe that even with the best help, whether individual, group or family treatment, Vietnam veterans with PTSD symptomatology seldom improve rapidly or easily and treatment can be lengthy, though rarely complete. Those who enter a specific treatment program face potential risks and knowing these risks may assist clients in becoming better prepared to begin and remain in treatment through difficult times.

The first risk is the possibility of only partial recovery. For many, this may make it seem not worth the effort to enter treatment, in particular for those looking for drugs or "magical" results.

There is also the risk of losing a job or a marriage. An unfortunate fact is that some Vietnam veterans have difficulties sustaining employment. This means that employers may not have patience with a veteran's unpredictable behavior problems until positive effects of treatment is acknowledged. At home, good intentions but

little patience may result in the partner not being able to wait for the veteran's recovery. As a result, the spouse may leave the veteran in the hands of the therapist and divorce him, free of the burden of responsibility for his welfare.

The veteran entering treatment may also feel the risk that if his personality changes, his family will lose respect for him. Others fear that the changes necessary for a break-through could be so dramatic that it may result in a psychotic breakdown.

Another risk that veterans face is experiencing more acute emotional pain after recalling disturbing memories and emotions that had previously been blocked. Many fear that reliving their experiences of war will unleash their "killer instinct". Most veterans are likely to do anything to avoid a situation in which they could lose control and hurt someone, including leaving treatment.

Giving up the desire for revenge is another barrier to a veteran entering and continuing treatment. Often if he learns to give up resentful and revengeful feelings, the veteran will no longer be the "walking time bomb" he describes himself to be. In developing trusting relationships with others, the veteran may grow to feel exceedingly vulnerable, depressed or suicidal.

Getting better means taking directions from authority figures among whom are the treating mental health professional. This can be a frightening experience for the veteran who evokes anger around issues of power, leadership and responsibility. Getting better also means self acceptance; acceptance of continuing to experience unpleasant dreams, anger and bad memories; acceptance of difficulties with ordinary relationships and with sexual relationships. Finally, getting better means to cease being a victim and to become committed to finding a purpose for living once again, while discovering meaningful and loving relationships with others.

While risks are present, a major role of the therapist is to help the veteran and the family become as much a part of the treatment as possible. This includes realizing a client's maximum potential for recovery at a given time while reengaging the client in treatment when additional assistance is required.

Currently, most of the approaches to the psychosocial management of war related problems focus on the individual veteran in either individual or group settings. These kinds of individually-oriented services are quite appropriate for most veterans who have received a thorough assessment regarding their PTSD symptomatology. Eventually, the family needs to be included in the overall treatment plan of the



veteran. The family can provide the therapist with an understanding of the veteran's military experiences and its impact of the family system. In addition, they can gain understanding of the veteran's war experience and insight about the impact on themselves.

The central purpose to be achieved in the treatment of the Vietnam veteran population is to facilitate the fullest possible reexperiencing and recollecting of the trauma in the "here and now" (Parson, 1984). Therefore, significant importance must be placed in creating a safe and non-judgemental environment in which the veteran and his family can work through the combat-related problems affecting them. In this environment, underlying feelings and conflicts that have been buried and were unavailable to the client will be uncovered. It is essential, whether in the individual, group or family setting, that everyone be guided through this awareness process in a way that minimizes the extremes of denial and intrusive repetition. The hope for the readjustment of Vietnam veterans exists in the continuation of the Veterans Administration's Vet Center program and the growing number of mental health professionals who are acknowledging and treating Vietnam combat veterans for their war-related trauma.

## SUMMARY AND RECOMMENDATIONS

This paper has examined a by-product of one of the most disastrous episodes in American history: the Vietnam War. This war was long and fought in a storm of political and moral controversy. Lessons that were learned from other wars were employed, often with counter-productive results. Since American society was never totally mobilized in support of the conflict in southeast Asia, the burden of the draft fell on the young, the poor and the non-white population. Sophisticated military weapons often were ineffective in the guerilla-type combat in Vietnam. The indistinguishable enemy, high civilian involvement, questionable leadership and the awareness of divided civilian support at home contributed to a sense of deep despair among Vietnam veterans. For them, their suffering seemed meaningless.

A high level of mental health expertise was utilized during the Vietnam War. This seemingly produced fewer psychiatric casualties in the combat setting than in previous wars, but it led to the denial of any existing stress disorder. Modes of intervention stressed rapid re-integration and return to combat duty for those combatants who showed signs of "battle fatigue". Once these combatants were returned to the civilian population, many veterans later presented with stress related symptoms not unlike those survivors from other traumatic, life-threatening

situations.

Since 1979 dramatic and precedent setting changes have de-politicized the debate over the mental health of Vietnam veterans. The American Psychiatric Association's recognition of a Post Traumatic Stress Disorder and the Veterans Administration's establishment of nationwide readjustment counseling centers have supported the plight of Vietnam veterans. In addition, Vietnam veterans are becoming more vocal themselves in writing about their combat experiences and playing active roles in the political system of this country.

While the tide is turning, there is a need to continue on this course. Out of the suffering of America's veterans, growth can occur and lessons can be learned. The American military system must examine the lasting effects of combat on it's veterans. Perhaps by instituting a readjustment debriefing for all military personnel returning from combat duty and their families, future combatants who are most susceptible to stress related disorders will be provided with the necessary treatment so that delayed rather than chronic problems can be managed. Political decisions to engage in war must examine the costs of fighting to soldiers involved in war without a national concensus.

The consequence of the Vietnam war has been severe for its veterans and their families. Vietnam veterans have been held accountable for the nation's rejection of the war

through inadequate benefits, unemployment, divorce, suicide and on going psychological problems. For those who now lead our nation by their political decision-making, the accountability for future wars must lay in their sense of actual distribution of public honor and blame. United States politicians and institutions must not withdraw, leaving those men and women who they send to war to make their own way home.

Mental health professionals can make important ongoing research contributions to the national healing and understanding process that must continue. Based upon the previous review of the literature, these areas needing further study and/or research include:

1. Research to date appears to inadequately incorporate the effect of PTSD on the family system. In the process of recovering from a traumatic event, the role of the family is critical. As noted earlier in this paper, there now exists only a small body of mostly theoretical and clinical descriptive literature on the general effects of PTSD on the families of Vietnam veterans. There are also few descriptions of the specific impact of PTSD on the spouse or partner dyad. Additionally, the literature fails to adequately address the needs and treatment of the children affected by the stress disorder. Further

research would need to address this area in much the same way current literature discusses the effect of alcohol on children of alcoholics and the intrusive problems it creates on the family system. The clinical assessor needs to pay closer attention to the role of the family structure in assessment and in treatment. When this system is not addressed and appropriate interventions made, the veteran may revert to old behaviors and show an increase in stress-related symptoms;

2. Statistics on incarcerated veterans and those in substance abuse treatment are incomplete and inconclusive. Often Vietnam veterans in such situations are pre-judged without the benefit of a thorough assessment for PTSD symptomatology. In particular, for the incarcerated veteran, there generally is no systematic attempt made to identify those who are suffering from PTSD. This results in a disproportionate number of Vietnam veterans who go unrecognized and untreated for their stress disorder. In some cases a carefully structured exploration and assessment of the full range of difficulties for this veteran population is recommended. Treatment must reflect cognizance that the roots of the problem are frequently in the stress disorder;

3. It has only recently been recognized that the term "Vietnam veteran" includes thousands of women. Although complete demographic information is not available from the U.S. government, it is known that thousands of women served in Vietnam mostly as nurses, while fewer worked in communications, intelligence, supply, security and in clerical positions. The problems that female Vietnam veterans have relating to their tours of duty have been ignored due to researchers and the female veterans themselves not identifying this population as being in combat situations. Limited research material has brought to light that many of these women were, in fact, exposed to the same or comparable stressors of war as their male counterparts. Female veterans have shared some of the same feelings of anger, guilt, and emotional constriction as others serving in combat areas. There is an urgent need for further research on the issues confronting female Vietnam veterans since more women are involving themselves in the military as a career. Areas to be addressed include how women experience, cope with and react to war that is different from men, and the effects on those who are confronted with unusual tragedy, suffering and death;

4. Helping professionals must play an active role in the development and reporting of effective methods of therapy for this population. For those already working with the Vietnam veteran population, continued documentation of research, theory and treatment must occur. For those working with the general population, it is important to be informed about war-related stress, PTSD symptomatology, the Vietnam conflict and the phenomena presented by the client. In particular, it is important for those professionals with limited experience in these areas to become educationally prepared, to be objective and to be a friend and advocate for the client while realizing one's own limitations. A mental health professional should also consider having their own support group with other like clinicians to provide for their own needs while working with this client population;
5. There presently is a range of creative therapies developed by mental health professionals to effectively work with Vietnam veterans and their families. Interventions by both veteran and non-veteran therapists have been inspired by their commitment and interest in those who survived the war. Social networks, peer support and help from

the Veterans Administration need to continue to aid veterans to integrate their war experiences. Reference to specific groups of Vietnam veterans, that of minorities and women in particular, must continue to develop in order for helping professionals to fully understand the implications and effects of their war-related stress; and,

6. Many Americans still find it difficult to talk openly with each other about the events of the Vietnam War years. While a new public attitude is emerging, the public should be encouraged to feel, reflect on and speak about unresolved experiences of the war and to be responsive to others' attempts to do the same.

As part of this new attitude, former combatants and the rest of the general population has to forgive itself for the Vietnam War, for the massive suffering and loss, for the wrongs to each other and for the blow to our national pride. Community healing can generate the possibilities for a more satisfactory way of living together. Only by beginning what appears to be an impossible task will we ever resolve the unfinished business of the Vietnam War.



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