GROUP THERAPY WITH VIETNAM VETERANS: A BRIEF REVIEW

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This paper reviews the benefits and general considerations regarding group therapy with Vietnam veterans. A review of veteran rap groups and traditional therapy groups highlights the similarities and differences between types of groups used to treat this population. The importance of countertransference reactions and the need to consider a variety of treatment approaches is emphasized.

The inclusion of post-traumatic stress disorder (PTSD) as a psychiatric disorder in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (1980) and the recent increase in the number of publications on this subject highlights the renewed interest with which mental health professionals are rediscovering "the psychology of life threatening events beyond the range of ordinary human experience" (Penk & Robinowitz, 1987, p. 3). Although the Vietnam war has been over for more than 14 years, many veterans continue to experience symptoms of psychological distress as a result of the trauma associated with combat. Some professionals have estimated that of the approximately 3.4 million men and women who served in Southeast Asia during the Vietnam war, as many as 850,000 may be currently experiencing some degree of combat-related stress symptoms and may need some form of counseling or therapy (Hayman et al., 1987; Langeley, 1982; Lipkin et al., 1982).

The symptoms of post-traumatic stress disorder are multifaceted. The cognitive, behavioral, affective and social functioning of the individual is usually affected. However, these symptom clusters may vary among individuals and over time. The definition of PTSD, first included in the DSM-III and continued in the DSM-III-R (APA, 1980, 1987), shifts the emphasis from predisposing
personality factors to the actual experience of traumatic events as the most significant etiological factor. For a brief review of the history of post-traumatic stress disorder see Goodwin (1987) and Parson (1984).

Recent studies emphasize the important role of exposure to combat-related trauma in the subsequent development of PTSD (Card, 1987; Foy & Card, 1987). After reviewing the existing empirical studies investigating the etiological factors associated with the development of PTSD in Vietnam veterans, Foy et al. (1987, p. 26) concluded that there was significant data to support a residual stress model "which emphasizes the nature and extent of trauma exposure as critical factors" associated with the development of PTSD. Current research also supports the diagnostic validity of PTSD as a "relatively homogeneous syndrome of psychological symptoms that seems to follow traumatic events" (Boulanger et al., 1986; Keane et al., 1987, p. 42; Silver & Iacono, 1984).

Post-traumatic stress disorder falls under the general diagnostic category of Anxiety Disorders. There are four criteria needed for a diagnosis of PTSD (APA, 1987):

1) The historical antecedent of a traumatic event that would cause significant symptoms of distress in most people. Post-traumatic stress disorder may develop after exposure to a variety of traumatic stressors besides combat such as assault, rape and natural disasters (Modlin, 1986).
2) A reexperiencing of the event(s) through intrusive memories, dreams, associations and dissociative states.
3) A persistent avoidance of stimuli associated with the trauma or numbing of responsiveness as indicated by avoidance of thoughts, feelings or activities associated with the trauma; psychogenic amnesia for particular aspects of the trauma; diminished interest in activities; emotional distancing from others; restricted range of affect and a sense of foreshortened future.
4) The presence of two other symptoms that were not present prior to the traumatic event, such as hypervigilance, sleep disturbance, irritability or outbursts of anger, difficulty concentrating, and an intensification of symptom severity when exposed to events that symbolize or resemble the traumatic event.

The current diagnostic criteria for PTSD no longer distinguish between acute and chronic subtypes of stress reactions. Delayed onset is specified if the onset of symptoms is at least 6 months after exposure to the trauma. Although it is currently recognized that some symptoms of PTSD usually begin shortly after the trauma, reexperiencing symptoms may develop after a latency period of months or years. It may be difficult to diagnose stress reactions immediately following a traumatic event because the initial symptoms may be confused with other disorders (e.g., other anxiety or affective disorders) and the prominent symptom clusters of PTSD (i.e., intrusive imagery) emerge only over the course of time (Boulanger et al., 1986).

There is considerable evidence suggesting that service in Vietnam is a significant factor associated with the development of psychological and social readjustment difficulties among veterans (Shatan, 1978). Many studies have described the adjustment problems facing Vietnam veterans (Egendorf, 1982; Figley, 1978, 1984; Streimer et al., 1983; Walker & Cavenar, 1982). For example, 2 years after the end of the war a sample of Vietnam veterans who had recently been discharged from active duty (N = 40) reported significant adjustment problems involving depression, hostility and guilt (Strayer & Ellen-