

1994

## Post-traumatic stress disorder and the Vietnam veteran: Indentification of symptomatology for the mental health professional

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### Recommended Citation

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## Post-traumatic stress disorder and the Vietnam veteran: Identification of symptomatology for the mental health professional

### Abstract

The war in Vietnam has left enormous emotional scars on America (Goderez, 1987). One facet of this tragedy is the fact that there are more than 500,000 Vietnam Veterans who are suffering delayed war stress (Goodwin, 1980). These veterans experience bad dreams, insomnia, uncontrollable anxiety, and depression. Often they are tormented with flashbacks. Many are afflicted by drug and/or alcohol addictions. Collectively, these stresses contribute to the fact that the Vietnam veteran's risk of suicide is 23% greater than is true for the general American population (Blair & Hildreth, 1991; Goodwin, 1980; Shore, 1986).

Post-traumatic Stress Disorder and the Vietnam Veteran:  
Identification of Symptomatology for the Mental Health  
Professional

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A Research Paper  
Presented to  
The Department of Educational Administration  
and Counseling  
University of Northern Iowa

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Arts

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by  
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December 1994

Entitled: Post-traumatic Stress Disorder and the Vietnam  
Veteran: Identification of Symptomology for the Mental Health  
Professional

Audrey L. Smith

October 26, 1994  
Date Approved

Adviser/Director of Research Paper

10/26/94  
Date Approved

Second Reader of Research Paper

10/26/94  
Date Received

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The war in Vietnam has left enormous emotional scars on America (Goderez, 1987). One facet of this tragedy is the fact that there are more than 500,000 Vietnam Veterans who are suffering delayed war stress (Goodwin, 1980). These veterans experience bad dreams, insomnia, uncontrollable anxiety, and depression. Often they are tormented with flashbacks. Many are afflicted by drug and/or alcohol addictions. Collectively, these stresses contribute to the fact that the Vietnam veteran's risk of suicide is 23% greater than is true for the general American population (Blair & Hildreth, 1991; Goodwin, 1980; Shore, 1986).

The following scenario, adapted from two sources, is typical for a veteran suffering from trauma brought about by the Vietnam War. Blair and Hildreth (1991), Huppenbauer (1982), and Norman (1982) all recognize that the symptoms exhibited here are indicative for a diagnosis of Post-traumatic Stress Disorder (PTSD) as established by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), third edition (American Psychiatric Association, 1980).

*Thomas is a 45 year old male with complaints of sleeplessness, depression, flashbacks, and uncontrollable anxiety. Recently, Thomas consumed a large amount of alcohol and found himself committed to a mental health unit due to anger outbursts*

and loss of control. He denies any alcohol or drug abuse prior to entry in the Army in 1966. History of mental health disability is also absent prior to his enlistment into the army.

Thomas is a veteran of the Vietnam war. He reports hitchhiking around the country for ten years after returning from Vietnam. He discloses that he had difficulty relating to others and that he found himself isolating from the public. He could not hold a job and he thought of himself as "crazy" due to being plagued with terrifying nightmares, flashbacks, and hypervigilant behavior. He possessed a fear of sleeping. He reports that in 1982, after several admissions to psychiatric units and attempts at taking his life, that he was diagnosed as having Post-traumatic Stress Disorder. "I know now that I am not crazy, I just have symptoms related to the stress of war," Thomas reports with relief in his voice. (Goodwin, 1980; Howard, 1976).

The purpose of this paper is to study, through the review of literature, the predominate symptomatology exhibited by Vietnam veterans experiencing Post-traumatic Stress Disorder (PTSD). A second purpose is to present mental health professionals with the findings so that they may more effectively treat the Vietnam veteran.

Blair and Hildreth (1991), Brown (1984), Goderez (1987), Goodwin (1980), Huppenbauer (1982), as well as Norman (1982) all

identified Vietnam veterans as unique in their issues and at great emotional risk due to circumstances surrounding the Vietnam war. For example, Brown (1984) wrote that the war in Southeast Asia was atypical for the American soldier in that the nature of combat was guerrilla tactics. It was a primitively fought war, suggested by the fact that booby traps accounted for a large portion of the American casualties. In fact, the enemy was rarely in a uniform and American troops were forced to conduct search and destroy missions on an enemy who was often likely to be a civilian. The Vietnam war had no lines of demarcation. Blair and Hildreth (1991) noted that there were no secure areas in Vietnam and death or injury to the American soldier could occur anywhere. Further, Brown (1984) indicated that the American soldier in Vietnam was under constant stress to simply survive. Therefore it is the Vietnam veterans--particularly combat veterans who underwent extreme stress during the war in Southeast Asia--who are the focus in this paper.

As a result of the Vietnam war, many Vietnam veterans have found it necessary to seek the assistance of mental health professionals for alleviating PTSD symptoms as well as for enabling them to function within the range of socially accepted behavior. Often the veteran has reached the point of losing family, friends, and/or a job before he or she recognizes the need

for and presents to the mental health professional for assistance (Norman, 1982). Whatever the circumstances, it is important for the mental health professional to identify the symptoms and to appreciate the unique needs of this particular group.

Blair and Hildreth (1991) noted that mental health professionals often exhibit resistance and anger toward PTSD clients. In fact, many professionals doubt the legitimacy and realities of this diagnosis even though the diagnosis has been recognized by the American Psychiatric Association (DSM III-R, 1987). Consequently, it remains difficult for most Vietnam veterans suffering from PTSD to receive quality mental health care within their home communities. Further, Blair and Hildreth emphasized that programs and plans of care for PTSD clients frequently are laden with personal control issues, biases, and issues of pathological staff group dynamics. These concerns make it crucial for the clinician to recognize PTSD for what it is and to overcome preconceived beliefs about those who suffer from PTSD symptoms.

Blair and Hildreth (1991) noted that knowledge of PTSD symptoms enables the clinician to treat Vietnam veterans more appropriately and with compassion. They emphasized that misunderstandings of, and resistance to, PTSD is a result of

ignorance rather than indifference. They also supported the idea that a knowledge of the extenuating circumstances, the predisposing factors, and the etiology of PTSD enables clinicians to more effectively treat veterans. Peebles (1989) believed that "PTSD" has attracted the attention of the public and that it has "legitimized the relentless suffering of Vietnam veterans and lifted it out of the realm of psychopathology into the realm of fundable war casualty" (p. 274).

#### Definition and Description of Post-traumatic Stress Disorder

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) Third Edition, Revised (American Psychiatric Association, 1987), symptoms associated with Post-traumatic Stress Disorder occur after a psychologically traumatic event generally outside the range of usual human experience. The traumatic event is so stressful that it causes significant symptoms of distress in most individuals. Examples may include natural disasters such as floods or earthquakes, accidental human-made disasters such as car accidents and airplane crashes, and deliberate man-made disasters such as bombings and death camps. The DSM-III-R indicates that PTSD appears to be more severe and longer lasting when the traumatic event is a deliberate man-made disaster such as a war. Goodwin (1980) emphasized that Post-traumatic Stress Disorder is

not a psychiatric illness, but rather, it is a delayed reaction to stress that the individuals have experienced.

Diagnosis of PTSD requires the presence of four criteria:

(1) the historical antecedent of a traumatic event; (2) a re-experiencing of the event through intrusive memories, dreams, or association; (3) a decline in involvement with the environment by loss of interest in significant activities, distancing from others, or reduced affect; and (4) from the following list, two other symptoms that were not present prior to the traumatic event: hyperalertness, sleep disturbances, survivor guilt, difficulty with memory or concentration, an increase in severity of symptoms when exposed to activities or events that are symbolic or representative of the trauma, and an avoidance of trauma-related activities and symbols (American Psychiatric Association, 1987). In addition, there must be a duration of symptoms for at least one month.

#### History of the Term Post-traumatic Stress Disorder

Post-traumatic Stress is a concept that has been around for at least 100 years. Josef Breuer and Sigmund Freud (1893) formulated the first formal theory about psychological reaction to trauma. Ferenczi, Abraham, Simmel, and Jones (1919) reported their study of World War I combat stress reactions and applied Freud's then-current theories about unconscious conflict rather

than his original ideas about trauma. As a result of their work, stress reactions became connotatively associated with psychopathology; and combat stress reactions became known as "war neuroses" (Peebles, 1989). Later, in World War II the term *combat exhaustion* replaced *war neuroses*. In 1952 the first edition of the Diagnostic and Statistical Manual (DSM-I) the American Psychiatric Association changed the name *combat exhaustion* to *gross stress reaction*. The evolution continued, and in 1968 this term was again replaced in the DSM-II (American Psychiatric Association, 1968) by *transient situational disturbances*. It was in the wake of the Vietnam War that the DSM-III (1980) introduced the current term: *post-traumatic stress disorder*.

Goderez (1987) and Goodwin (1980) agreed that the inclusion of the diagnosis of "post-traumatic stress disorder" in the DSM-III marked the official acceptance by the psychiatric community that severe stress can compromise subsequent psychological functioning in previously normal adults. Prior to APA's recognition of PTSD, veterans were diagnosed as suffering from anxiety, personality disorder, or psychotic disorders depending upon their most serious presenting symptomatology.

#### The War in Vietnam

In order to better understand the symptoms of PTSD exhibited by the Vietnam veteran it is crucial to have some knowledge of the

circumstances affecting the Vietnam soldier. For instance, the median age of the American soldier in Vietnam was 19.2 years (Mullis, 1984); this was much younger than the median age of soldiers in previous modern wars. Huppenbauer (1982), along with Blair and Hildreth (1991), stated that due to the psychosocial developmental level, the younger adolescent American soldiers were more susceptible to the stress of the war than were soldiers in World War II and in the Korean conflict.

Shaw (1990) explained that in Vietnam, the soldier was subjected to chronic fatigue, sleep deprivation, constant battle tension, and marginal sustenance with food and water. This environment took a toll on the physical and mental health of the American soldier resulting in the gradual loss of biological resilience. Emotionally, the Vietnam soldier experienced a sudden awareness of the basic fragility and contingency of human life; the tension was so overwhelming that consequently, many soldiers turned to a wide utilization of mind-altering drugs and alcohol in an effort to deal with the overwhelming war stress.

As an attempt to reduce emotional strain on the American soldiers, the American government purposefully designed shorter tours of duty in Vietnam than had been the case in previous wars (Goodwin, 1980). The tour of duty in Vietnam was to be only 12 or 13 months, and referred to as "DEROS" or "date of expected return

from over seas". The advantage of this concept was clear: the soldier merely needed to emotionally and physically hold together for a designated period of time; and then at the conclusion of DEROS, the Vietnam soldier would return home where the memories of the brutal war could be left far behind. Unforeseenly, the "DEROS" idea was not effective. Due to the soldiers entering and exiting Vietnam singularly, "DEROS" acted to work against group cohesiveness with the deterioration of unit morale, unit cohesiveness, and unit identification. Unfortunately, DEROS also fostered a feeling of isolation due to the fact that the time spent in Vietnam was a solitary, individual episode (Goodwin, 1980; Mullis, 1984).

Emotionally for the Vietnam soldier, the DEROS date became a fantasy: it was one specific day when all problems would vanish and the soldier would heroically fly home to the United States where he or she would return to typical life tasks (Goodwin, 1980). Profoundly, the Vietnam soldier's return to the states was less than this fantasy. Huppenbauer (1982) explained that it took the World War II soldier from weeks to months to return to the United States; in contrast, the Vietnam soldier was evacuated by air, sometimes in midbattle, often times alone, and was home less than thirty-six hours later. This resulted in the grueling reality that the Vietnam soldier still frequently occupied a

uniform encrusted with blood and mud from the last fire fight. Sequentially, the DEROS fantasy abated when the soldiers' homecomings were dissented with name calling and accusations of the soldier being a "baby killer". Consequently, many Vietnam veterans concealed the fact that they had been associated with the war in Vietnam (Goodwin, 1980).

The Vietnam War soldiers received no debriefing upon return to the United States. Initially they were asymptomatic: the joy of having survived suppressed any problematic symptoms (Mullis, 1984). Mullis referred to this period of time as a "Recoil Phase:" a latency period in which the veteran experienced a feeling of well-being and relatively good functioning in the community. Then after a year or more passed, the veteran began to note significant emotional changes: symptoms of PTSD surfaced.

#### Symptoms

This section will detail the seven most prevalent symptoms of Post-traumatic Stress Disorder in the Vietnam veteran. They include depression and survival guilt, isolation, rage, avoidance of feelings/alienation, sleep disturbances/nightmares, anxiety reactions and intrusive thoughts.

The literature reviewed clearly demonstrates that a variety of PTSD symptoms are displayed by the Vietnam veteran (Brown, 1984; Gerlock, 1991; Goderez, 1987; Goodwin, 1980; Huppenbauer,

1982; Mullis, 1984; Norman, 1982). Most of the literature indicated that many of these symptoms are interrelated and do not exist singularly. However, Blum (1984) believed differently and indicated that symptoms may present individually or in combination. It is important to note that, according to the DSM-III, the manifestation of several symptoms are required for PTSD diagnosis. Goderez (1987) indicated that belligerence, violence, suspiciousness, poor work history, severely disrupted interpersonal relationships, and drug and/or alcohol abuse are common indicators of a Vietnam veteran suffering from PTSD. Goodwin (1980) supported this idea and noted that veterans also often display risk-taking behaviors, psychophysiological disorders, and a generally self-destructive and marginal personality. Huppenbauer (1982) agreed with the high incidence of emotional problems evident in Vietnam veterans; she maintained that veterans experience an increased rate of divorce, unemployment, and crime and possess greater suicide statistics.

Symptoms of Post-traumatic Stress Disorder in the Vietnam Veteran began to occur when the elation of having survived the war had begun to wear off (Goodwin, 1980). Most often symptoms surfaced from nine to thirty months after discharge when the Vietnam veteran failed to adapt to the typical civilian environment. The traumatic war experience had elicited feelings

of helplessness and a sense of danger, psychological dysfunctioning, emotional lability, impairment in judgement, perception, and cognition, as well as somatic disturbances (Huppenbauer, 1982; Shaw, 1987).

### Depression

More than any other symptom of PTSD, most Vietnam veterans experience the symptom of depression (Ashley, 1992; Goodwin, 1980). In fact, Blair and Hildreth (1991) indicated that depression is the most serious symptom of PTSD in the Vietnam veteran. The degree of depression varies and can include disturbance of sleep, psychomotor retardation, feelings of worthlessness, and difficulty in concentration.

Goodwin (1980) explained that depression is closely associated with the lack of time allowed to grieve over the multitude of losses experienced during the war. Goodwin (1980) and Howard (1975) both noted that during the Vietnam war it was perilous to extend the grief process. On the battle field, allowing the soldier time to grieve would have been unproductive and potentially a liability for the individual as well as the entire troop. Gerlock (1991) added that feeling guilt from the loss of friends, witnessing damage to people and to their homes, and even just surviving the war impacted the Vietnam veteran. Consequently, many veterans still report feeling numb from the war

experiences, and they feel depressed because they believe that no one can understand what they have gone through (Brown, 1984).

Clewell (1987) and Goderez (1987) agreed that depression is a symptom of PTSD and that guilt over past actions results in self-destructive and suicidal behaviors among the Vietnam veterans. It appears that the civilian part of the veteran may set out to punish or even kill the combat part of the individual.

Clewell (1987) labeled this feeling "survivor guilt" and believed that it is an element of depression. This phenomenon is the reaction of awareness of self-centered destructiveness and the response of the conscience to one's actions. Many veterans ask the question of "why me and not them" regarding their survival over their comrades' demise. Similarly, Goodwin (1980) believed the guilt to be based on the actual death of comrades and the continual struggle for the survivor to live. Lifton (1973) further explained the reaction as the Vietnam veteran's sense of having betrayed his buddies by letting them die while he stayed alive. This conflicts with the veteran's feelings of relief and even joy for having survived; in fact the pleasure of having survived becomes a further source of guilt. Failures in all aspects of life may result from this inner conflict and affected Vietnam veterans become increasingly depressed and hopeless about life. Peterson (1990) reported that almost 17% of Vietnam

veterans suicided between the date of their return from the war and the date of his collection of data.

### Isolation

Many Vietnam veterans exhibiting symptoms of PTSD have few friends. Ashley (1992) and Goodwin (1980) agreed that Vietnam veterans often avoid others and tend to mistrust authority. Blair and Hildreth (1991) labeled this symptom of isolation as "emotional distancing." They believed that this symptom is directly related to the veteran's inability to trust others.

Vietnam veterans suffering from PTSD frequently isolate and distance themselves from their peers. Goodwin (1980) reported that veterans feel rejected when their peers do not want to hear about their Vietnam experiences. In fact, many have spent time drifting and hiding in the mountains to just get away from the stresses associated with being a Vietnam veteran. It is not uncommon for the veteran to isolate in the home and for the wife to be the source of financial income (Brown, 1984).

The symptom of isolation appears to have initiated from the soldier's learning to avoid emotional attachments and to hold back feelings of caring and trust (Goodwin, 1980). Brown (1984) concurred and related that veterans presenting with PTSD have difficulty maintaining close personal relationships because their

emotional response is numbed--a process that was essential for survival in combat. Now that the war is over, Huppenbauer (1982) emphasized that the veterans persist with emotional distancing which results in marital, family, peer, and employment problems.

### Rage, Anger, and Belligerence

Antisocial behavior, including violence, is another common symptom of PTSD (Collins, 1990; Egendorf, 1981). Goodwin (1980) noted that Veterans diagnosed with PTSD often experience a rage that is very frightening to those around them as well as to themselves. Ashley (1992) added that rage is the primary PTSD symptom which brings a Vietnam veteran into therapy. Goodwin (1980) found that rage is frequently associated with flashbacks: the veteran believes that he or she is back in Vietnam fighting the "gooks;" and when the veteran is forcibly confronted by others a struggle for life occurs. Enacting the "flashback," frequently the veteran "physically strikes out" for survival, leading to a crisis situation (Coughlan & Parkin, 1987).

Another theory to explain the exacerbation of rage, anger and belligerence symptom was presented by Goderez (1987). He believed that this behavior of an ostentatiously belligerent stance has been adopted by the need to frighten others away to ensure his or her own safety. The anger and rage affect the PTSD Vietnam veterans' employment stability. In fact, it is not unusual

to interview a veteran who has held 30-40 jobs during the past 10 years (Bailey, 1990).

Huppenbauer (1982) considered the symptom of anger to be normal and expected in a combat situation, but she pointed out that in situations in which the anger persists for years after the danger and the conscious sense of helplessness have passed, the anger may be emitting from feelings that have been repressed or intentionally suppressed through treatment. The behaviors which emit are detrimental to the working of the family system. Coughlan and Parkin (1978), along with Rabin and Nardi (1982) concur with Huppenbauer, and they have identified that the families of Vietnam veterans are frequently tainted with wife and child abuse.

#### Avoidance of Feelings and Alienation

Many Vietnam veterans experience avoidance of feelings. This is consistent throughout the literature (Brown, 1984; Goodwin, 1980; Huppenbauer, 1982; Nelson, 1989; Norman, 1982). For example, the Vietnam veterans suffering from PTSD recount incidents in which they do not feel emotion over the death of a relative (Ashley, 1992) and, many wives of PTSD veterans complain that their spouses are cold and uncaring individuals (Brown, 1984; Goodwin, 1980; Huppenbauer, 1982). Coughlan and Parklin (1987) indicated that veterans suffering from PTSD often distance

themselves from family and friends and display stereotypical masculine roles. Blair and Hildreth (1991) labeled this behavior as "emotional distancing."

Goodwin noted that what becomes especially problematic for Vietnam veteran with PTSD is an inability to experience the joys of life. Brown (1984) concurred with Goodwin and added that often veterans describe themselves as being emotionally dead; they find it uncomfortable to feel love and compassion for others. Brown supported Goodwin further by his statement that Vietnam veterans go through life with an impaired capacity to love and care for others: without feeling of direction or purpose in life. Many veterans wonder why they even exist. Huppenbauer (1980) termed this behavior as "psychic numbing."

### Anxiety

Anxiety is very evident in the PTSD veteran (Brown, 1984; Gerlock, 1991; Goodwin, 1980; Huppenbauer, 1982; Nelson, 1989; Norman, 1982). Ashley (1992) explained anxiety to express itself as a restlessness in the Vietnam veteran which is evidenced by uncontrollable cold sweats and a bounding pulse. He found that it is rare to encounter Vietnam veterans who do not possess a heightened sense of hearing and smell that can be traced to the war. These heightened senses potentiate the veteran's

uncomfortable feeling around crowds and in unfamiliar surroundings.

Goodwin (1980) agreed with Ashley about the definition of anxiety and indicated that many Vietnam veterans experiencing PTSD symptoms describe themselves as very vigilant human beings. He explained that many veterans talk about being uncomfortable standing out in the open. They continue to protect themselves as if they were in Vietnam. For example, often they will seek cover or seclusion in a wooded area or in their home. They tend to sit in a corner of a room in order to have a clear view for safety. Goodwin believed that these are all learned survival techniques. Consequently, the veteran is highly anxious much of the time--a coping mechanism that probably saved his or her life in the war, but which now as a civilian, unnecessarily utilizes much of the veteran's energy. Norman (1982) concluded that anxiety may be provoked in the PTSD veteran by simple triggers such as helicopters, prolonged rainy days, and the sight of Vietnamese refugees.

### Intrusive Thoughts

Brown (1984), Gerlock (1991), Goodwin (1980), Huppenbauer (1982), Nelson (1989), and Norman (1982) all agreed that this symptom, intrusive thoughts, is intertwined with the symptom of anxiety. Veterans affected by PTSD report that very common

sensory stimuli will elicit intrusive thoughts. Goodwin (1980) described these triggers to range from loud sirens, to helicopters flying overhead, to the smell of diesel fuel (the commodes and latrines contained diesel fuel and were burned when filled with human excrement), to green tree lines, to the sound of popcorn popping (the sound is close to that of small gun fire in the distance), and to rain (it rains for days in the jungle in Vietnam). Brown (1984) agreed with Goodwin, adding that Vietnam veterans will go into a dissociative-like state in which they actually reexperience events of the war. This state of consciousness referred to as "flashbacks" may last for a few seconds or up to several days (Goodwin, 1980).

Bremner, Southwick, Brett, Rosenheck, and Charney (1992) agreed with Goodwin's (1980) belief that "anxiety triggers" described a connection between dissociation at the time of combat trauma and the development of PTSD. These episodes of dissociation are especially troublesome for veterans who are still "numb" and attempting to avoid the feelings associated with the war. For others, flashbacks are constant reminders of their time spent in Vietnam. Through a study of veterans with the diagnosis of panic disorders, Green, Grace, Lindy, Gleaser, and Leonard (1990) identified that panic disorder is associated to war experiences. In fact, their study further supported the idea that

the war in Vietnam did affect the anxiety level and post-war functioning of the Vietnam veteran.

### Sleep Disturbances and Nightmares

According to Ashley (1992), Blair and Hildreth (1991), Goodwin (1980), and Norman (1982) sleep is an enemy to many Vietnam veterans because it is frequently associated with traumatic nightmares. Often, the Vietnam veteran will try to avoid sleep by watching television late into the night. Many veterans find that they spend much time drinking alcohol or smoking cannabis in order to relax themselves to a dull cognition prior to sleep. Still, the nightmares persist and many veterans awake feeling tense and exhausted (Goodwin, 1980).

### Conclusion

On the basis of this study the following conclusions are suggested. First, there is consistency in the literature reviewed regarding the symptomatology present in Vietnam veterans experiencing unusually high levels of stress during their tour in the Vietnam War (Blair & Hildreth, 1991; Brown, 1984; Gerlock, 1991; Goderez, 1987; Goodwin, 1980; Huppenbauer, 1982; Mullis, 1984; Norman, 1982) Second, the delineated symptoms of depression and survival guilt, isolation, rage, avoidance of feelings/alienation, anxiety reaction, sleep disturbances/nightmares, and intrusive thoughts, consistently

found among Vietnam veterans who experience PTSD do support the necessary criteria for PTSD as defined by the APA. Third, there is agreement in the literature (Ashley, 1992; Brown, 1984; Gerlock, 1991; Goodwin, 1980; Huppenbauer, 1982; Norman, 1982) that knowledge of the issues surrounding the Vietnam war is pivotal in alleviating misconceptions about the Vietnam veteran.

Fourth, the literature (Ashley, 1992; Blair & Hildreth, 1991; Brown, 1984; Gerlock, 1991; Goodwin, 1980; Huppenbauer, 1982; Mullis, 1984; Norman, 1982; Peebles, 1989) does indicate that together the identification of the PTSD symptomatology and the increased knowledge base of the war in Southeast Asia, can assist the mental health professional in providing the veteran client with a better understanding of his/her individual issues. Further, once a basic understanding of an individual's concern have been ascertained, the mental health professional can then concentrate on formulating and providing appropriate treatment (Blair & Hildreth, 1991; Peebles, 1989). Finally, the historical information presented in this paper concerning the Vietnam veteran and the war can assist the mental health professional in identifying and understanding the unique needs of the veteran presenting symptoms of Post-traumatic Stress Disorder.

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