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Combined Individual and Group Therapy for Vietnam Veterans

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Rap groups, ever since they began to be used during the early 1970s, have been found helpful for Vietnam veterans to share their painful experiences about the war (Lifton, 1973). Lifton (1978) described how the veterans themselves originated those groups, which came to be know as rap groups, rather than psychotherapy groups, partly as a way of avoiding the implication that veterans with psychological pain had to become patients in order to experience healing. Lifton sensitively described how the leaders of therapy groups tended to withdraw into a traditional analytic mode if the emphasis of the group was on treatment. Such a withdrawal by group therapists only augmented the already existing anger toward persons in authority. Shatan (1973) described the self-help nature of Vietnam rap groups, apparently as one way of avoiding another betrayal, which they had come to expect from anyone in a leadership role.

Do rap-group leaders need to be a special breed? Veterans or nonveterans? Trained or untrained? Those questions have been discussed within training sessions for Vietnam veteran outreach work-

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ers. In our experience with Vietnam veterans, listening to the horrors of war experiences and being confronted with the rage of group members has been a significantly difficult and challenging task. Not every trained group therapist can meet the challenge effectively, particularly if he is not a Vietnam veteran. But who qualifies as a group leader with Vietnam veterans? Blank (1979) stressed the fact that rap groups are most helpful for the participants when they are led by uniquely qualified group leaders, leaders who won't retreat into traditional psychoanalytic techniques, leaders who are empathic human beings, leaders who can sensitively listen to the horror stories about killing and dying and committing atrocities in Vietnam, and leaders who can respond effectively to the angry feelings expressed by the group members. Those qualities have been thought to be present in Vietnam veterans who have received training in rap-group leadership. But since we have not found such persons, we have had to use nonveterans as group leaders. They have been selected persons with both the skill and the knowledge necessary to make them good group therapists, as well as the openness to learn about the uniqueness of the post-Vietnam combat symptoms. Since we have combined traditional knowledge about group therapy with the knowledge we have been learning about Vietnam veterans and rap groups, we have decided to use the phrase "rap-group therapy" to refer to the therapeutic process.

The goal of rap-group therapy, by our definition, is the resolution of postcombat symptoms. Even though the symptoms have physical, emotional, and behavioral aspects, they appear to be the various manifestations of repressed or split-off experiences of fear, rage, grief, guilt, and shame, as was described by Shatan (1978). At the core of each man's experience has been found to be the fear of death, which Lifton (1978) described as "the indelible death image and death anxiety." Every veteran harbors an unrelenting fear that at any moment he may be the victim of a surprise attack, a booby trap, or an assassin's knife. Second, every Vietnam veteran has eventually revealed a profound sense of abandonment or betrayal, feelings that may erupt early in therapy or may be split off to the point that they do not emerge until later. Third, each veteran has harbored guilt and grief about dehumanization, even though it was a defense against the pain of the loss of buddies who were killed or severely injured.

His subsequent feelings of grief and despair and his guilt about surviving were frequently displaced into an escalation of killing or even "a pyramiding of atrocity upon atrocity" (Hersh, 1970). The guilt and grief related to the losses, to the dehumanization that took place, and to the act of killing and torturing that occurred in Vietnam can eventually be expected to emerge during therapy.

Even though every combat soldier has been traumatized (Kardiner, 1959) and harbors the residual effects of that trauma within him, he is unable to disclose his pain until the right circumstances allow it—and then only gradually. Not even the trauma victim may be aware of what will unfold during the therapy process. His experiences have been too painful to keep within his awareness. Consequently, the experiences are split off but pop out repetitively and intermittently (Horowitz and Solomon, 1975). Yet those experiences come to have a major controlling effect on the veteran's life, because of the symptoms that repetitively emerge in the form of flashbacks, nightmares, headaches, blackouts, rage attacks, paranoid feelings, antisocial behavior, and dissociative symptoms (DeFazio, 1978).

An effective therapeutic modality should provide a means of integrating split-off traumatic experiences, so that flashbacks, nightmares, and rage attacks can become here-and-now behavior that can be worked with during therapy. When past traumatic experiences are relived in the form of here-and-now behavior, they become a necessary part of the therapy, which has been called "healing recapitulation" (Figley, 1979). When such experiences are relived during therapy, they are thought to be reenactments of the original trauma. When they are handled therapeutically, it may lead to the healing of split-off traumatic experiences. Forthwith, I will refer to the reliving of past experiences within the context of therapy as "therapeutic revivifications." They have been defined as spontaneous regressions into the past, and they occur with war veterans during hypnotherapy (Grinker and Spiegel, 1945; Conn, 1949; Brende and Benedict, 1981).

A group member's revivification can be an emotionally painful experience but also an emotionally integrating one. A therapeutic intervention can be the first step toward integration of that previously split-off experience. Within a group setting, such an intervention may include group support in the form of empathy, mutual sharing,

and even physical holding. However, there must be a considerable amount of group trust that evolves before such a therapeutic revivification can take place.

THERAPEUTIC PLAN

As we began rap-group therapy with several Vietnam veterans, we were quite aware of our lack of experience. We hoped to maximize our effectiveness by using individual psychotherapy with selected veterans who came to be members of the group. We based our therapeutic approach—combining group and individual therapy—on a number of assumptions:

First, we assumed that the development of a trusting therapeutic relationship would be impossible to achieve in group therapy alone. Yet trust was a prerequisite for those patients with feelings related to abandonment and betrayal. We felt that the addition of an individual therapist was particularly necessary to help patients with feelings of helplessness and rage related to abandonment and rejection, as Masterson (1976) described in his work with borderline patients.

Second, we assumed that combination individual and group therapy might provide the best opportunity for therapeutic revivifications, which usually don't occur within the setting of traditional individual therapy. Although we expected that such experiences were likely to occur, we were careful to respect each veteran's wish not to remember painful experiences, knowing that one first needs considerable time, therapeutic rapport, and group trust.

Third, we assumed that, by adding an individual therapist, he or she could provide the additional support necessary for the veteran who develops overwhelming anxiety and needs frequent therapeutic sessions. We did not think that the individual therapist would necessarily have to be one of the group therapists.

Fourth, we assumed that individual and group therapists needed to remain in constant communication with each other to minimize distortion about one process in relationship to the other and to impart important information that the veteran might withhold in one of the processes.

Fifth, we assumed that a group process proceeds through a series of stages to accomplish its purpose and that a number of factors are

considered essential if the group is to become an effective healing agent. Yalom (1975) included many of the following factors in his book on group therapy:

1. Stability of the group membership and the group leaders
2. Therapists with qualities of empathy and genuineness
3. Self-disclosure and eventual sharing of experiences by group members
4. Acceptance of those shared experiences and feelings by the other group members
5. Development of group cohesiveness, which usually takes at least 12 sessions
6. Capacity of the group leader and the group members to tolerate the direct expression of hostility (Blank, 1979)
7. Willingness by each of the group members to allow himself to be helped by the therapists and the members of the group
8. Therapeutic revivifications of significant painful experiences
9. Insight, hope, and purpose

CRITERIA FOR COMBINATION THERAPY

Two of my colleagues began rap-group therapy with six Vietnam veterans in October 1979. I worked with two of the veterans in individual therapy before their entrance into the group—one for a year and the other for four months. A third veteran was referred to me for individual therapy shortly after the group began. Thus, three of the six group members were in combination therapy.

The first Vietnam veteran, M., had made significant improvement in his symptoms after being in individual therapy for a year. However, he had not talked about his Vietnam experiences, and it was hoped that the group would help him to do that. After beginning the group, he met with me monthly for individual therapy, about as often as I had met with him before the group started.

The second Vietnam veteran, J. S., was angry and resistant to joining the group. During the three months before his entrance into the group, I prepared him by confronting his predominant characterological symptoms: anger and distrust. Since those feelings primarily dated back to significant problems in his childhood but were escalated by his Vietnam experiences, I expected the group to help him

with his war experiences and his problems that dated back to his family. He continued to meet with me twice a week after the group began.

The third Vietnam veteran, L. C., spent five years in combat or near combat situations. He was referred to me for individual therapy after he started with the group. He immediately found the group to be extremely important for him, a place where he could talk about the part of his life that was the most meaningful for him. Since he was completely subsumed by his Vietnam experiences and his persistent memories, recurrent flashbacks, and dreams about the war, he was admitted to the hospital. The nearly psychotic nature of his symptoms included two suicidal gestures and semidissociative rage attacks. Although he could talk extensively about his combat experiences within the group, he so overidentified with them that we hoped his relationship with me as an individual therapist would help him more easily give up his identification as a combat soldier.

DEVELOPMENT OF TRUST

It often takes up to 12 sessions for group cohesiveness and trust to develop (Yalom, 1975). Without the establishment of that cohesiveness, group members do not feel free to share feelings of helplessness and shameful memories. During the twelfth group session, members of our group revealed themes that could have occurred only after the development of adequate trust:

1. Fear of being vulnerable
2. "Confession" that they had used alcohol to numb their feelings of fear, hopelessness, and guilt
3. Anger about the lack of group stability
4. Revelation of "bad" parts: helplessness and rage
5. Fear of losing control over rage
6. Grief about the loss of significant persons (therapeutic revivification)

THE MOST VULNERABLE GROUP MEMBER

During the twelfth group-therapy session, one of the members of the group, L. C., shared his feelings of vulnerability. That sharing

was a significant new phase for him, since he had narcissistically dominated the group with his accounts of heroic war efforts that he had been involved in. He expressed how frightening it was to feel helpless and to be overwhelmed with memories of having killed.

> I started drinking in 'Nam after about the sixth month I was there ...trying to forget the killing part.... I started seeing faces in the dark, and I started having the .45 by my bedside...or a knife under my pillow.... It was easy to start a fight after getting drunk. I really started drinking hard after losing some of my friends. I started drinking two or three bottles a day, and then I got to five bottles.

He revealed that it was his enormous fear while in Vietnam that had caused him to drink. It was a significant step for him to share that fact within the group, since he had previously taken pride in his toughness and ability to kill and how the booze had only temporarily deadened his fear. Then he described his attempt to get off the booze.

> I met this girl that eventually became my wife. When I first met her, I don't remember seeing her...or her name...I was so drunk. I was up to five quarts a day, and I mean constant. When I went out on a mission, I carried two bottles of Jack Daniels in my backpack. Not only for the jitters and nerves but for the wounded, too. It was hard to stop. Very hard.... I had to go out to her grandfather's house, and it took me two weeks to dry out, and I mean I went through hell! I mean to go cold turkey. It was the worst thing you can go through. Jesus! Gosh! I sweat myself out going through those hallucinations. I was having battle scenes all over again. They took all my guns and knives away from me, so I didn't have them to hurt anybody with. It took me two weeks ...and I never touched it for a long, long time. Booze is like a crutch...to help you get it out of your brain. But now, even with the medication I am receiving, I wish I could get 'Nam out of my brain for good. I'd give anything in the world to get 'Nam out of my brain. I can lay in bed at night and close my eyes, and I'll still see faces from back there.

Flashbacks

His description of the constant pain and flashbacks that were vividly in his mind had been recurrent since the beginning of the group.

He had tried alcohol, but it helped only temporarily. Although he wanted to be free from them, he seemed aware for the first time now that the flashbacks were important reminders of the war that he didn't want to give up completely. He wanted to find a way of easing up the recurrent pain he had been experiencing.

> Maybe the solution isn't to get it out of your mind completely but to get it to where the emotions aren't bothering you so much or where you can remember it, and you'll feel some guilt and pain but not so much...so that you don't have so many headaches or so many nightmares or don't have to sleep with a knife.

Group Stability

As the group theme came to be the feeling of helplessness and vulnerability and other members of the group talked about fear and vivid memories of helplessness, they became angry because many of the group members were absent. As L. C. said:

> It seems like we can't get everyone here at one time. J. A. doesn't care. He doesn't give a damn one way or another. But the group who is here now...the three of us can discuss the nitty-gritty of what's inside of us.

The Bad Part Inside

L. C.'s nitty-gritty inside of him was experienced as a bad part of him. He described it: "I've got so much inside me, it's like a ball, if it ever falls out." However, he was reluctant to reveal the bad part, which appeared to include his fear and helplessness. "To release emotion, even a little emotion...would make me feel belittled," he said. However, in spite of his attempt to control the bad part inside of him, it was continually reactivated by triggering events.

> Don't ask me why I want to see one of them Vietnam pictures. I said I'd never go to another Vietnam movie, but I just couldn't help myself. There's a compulsion inside of me saying that I've got to see this or to find out if it's real or fake. It's like I ain't got no control. I sat there, and it was about the advisor teams that went over first that really happened. I cried about that last night, and I had a nightmare. It scared the hell out of my wife because of the knife [I keep under the bed]. So she crawls out of bed

and goes upstairs. It's just the compulsion inside me. I can't control it.

The Other Bad Part: The Killer

When the group therapists pointed out the fear that the group members had of revealing themselves, *M* spoke for the group: "I've got a feeling like we're scared to let loose. We just haven't got to the point where we can turn that inner self loose and see what the other person sees as our problem." Then L. C. talked about that inner self: "I found out recently that I didn't think it [the killer] was still inside of me. That I could kill anybody easily under the right circumstances for the right reason with no hesitation. I found that out over the holidays." He went on to say that he had been provoked into threatening to kill his neighbor with a gun after he found out that the neighbor had threatened his child with a gun. His own behavior scared him and activated feelings of guilt that he could suddenly lose control and kill someone. However, that revelation was a breakthrough for him. "The main thing I learned was that it was wrong. It was the wrong thing to do. He had no right at pointing a pistol at my children, but I had no right to threaten to blow his goddamned head off. I had the fear of losing my self-control."

Giving Up the "Killer" Within

The accepting nature of the group members and the therapists helped L. C. defuse the fear of his own aggression. Then L. C. shared his newfound awareness that he was beginning to give up his anger: "I'm slowly pulling away from the anger now. I don't just sit down and get mad because of what I went through and how I was victimized. And I don't want to anymore." However, as he gave up that part of himself, he became more aware of his fear and helplessness. That awareness was frightening, and he needed the support of a cohesive group.

THE IMPORTANT GROUP WORK

The other members also shared their fear about the hidden angry feelings that could come out, and the group members became involved in supporting one another. One group member described his

difficulties yet his success at sharing his feelings:

> I'm not telling everybody, and it's painful, but I tell the people it affects every day. They have to know. You just have to finally spill your guts out. I was thinking about suicide. I came here and I was forced into telling.... I finally told my mom that I was wild because of Vietnam...somewhere you just got to break down and tell them.

The therapist replied: "That's one of the purposes of this group. To share experiences and for all of us to help with the pain that you feel."

At that point, one of the group members began to focus empathically on L. C., who was sitting with his head down. "I know that some of the things are still bothering you...like when those two people died," referring to the fact that two of L. C.'s best friends were killed in Vietnam, and he had held them both in his arms during the final moments that they were alive. L. C. began to cry slightly, and the group members began to assure him that he could share his feelings and talk about what had happened. That triggered a revivification of the times that he had been with his dying buddies. He began to sob. The therapist made a significant intervention, suggesting that it was not a mark of weakness to cry. Then he asked two members of the group to sit on either side of L. C. while he began to sob louder and to relive what had happened. "I tried my best to save him..." he cried out in despair. As his grief emerged, the group was able to support him.

During a subsequent session, L. C. revealed how important it had been for the two members to have sat by him as he cried. "If those two guys hadn't have been there, I might have jumped out a window."

DISCUSSION

There is little available literature on the effective combination of individual and group psychotherapy and none as it applies to the treatment of Vietnam war veterans. However, the lack of formality involved in the treatment of Vietnam veterans lends itself to a combination of various therapeutic and counseling techniques that can sometimes be used simultaneously.

This paper has attempted to give preliminary information about therapy for Vietnam veterans, using both individual and group techniques, all focusing on the same task, that of therapeutic revivification as a part of the integration process involved in the recovery of posttraumatic symptoms.

The example that was used in this paper pointed out that the development of cohesiveness in the group was a prerequisite for a therapeutic revivification of the loss of buddies during combat. However, the individual therapeutic process also seemed to enhance the development of trust, partly because the individual therapist was perceived as an important consultant to the group and, hence, an indirect group leader. Thus, the patient was aware of the fact that the individual therapy and the group therapy were parts of the same process—that of helping him to give up control over his feelings of fear and grief through the development of trust.

Since Vietnam veterans have a difficult time developing trust as a group, either group therapy or individual therapy alone may be inadequate for that purpose. Thus, combining individual therapy and rap-group therapy can often be most effective.

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