

To the Graduate Council:

I am submitting herewith a dissertation written by Craig Wilburn Burnette entitled "The Relationship of Rap Group Participation, Self-Management Effectiveness, and Support Unit Help to Aggressiveness in Vietnam In-Country Veterans." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Educational Psychology and Guidance.

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THE RELATIONSHIP OF RAP GROUP PARTICIPATION, SELF-MANAGEMENT
EFFECTIVENESS, AND SUPPORT UNIT HELP TO AGGRESSIVENESS
IN VIETNAM IN-COUNTRY VETERANS

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All statements, comments, and opinions stated herein are the total responsibility of the author and should not be construed or interpreted in any way to represent the policies or regulations of the Veterans Administration or any of its programs.

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ABSTRACT

Sixty-six Vietnam in-country veterans from the Knoxville, Tennessee and Birmingham, Alabama areas were surveyed to determine the relationship of rap group participation, self-management effectiveness, and support unit help to aggressiveness. The subjects were divided into three groups: veterans who were currently attending rap groups at the local Vietnam Era Veterans Outreach Center; veterans who had attended rap groups during the past year; and veterans who had never attended rap groups were in the third test group. Pre rap group and post rap group levels of aggressiveness and self-management were assessed. Instruments included the Interpersonal Behavior Survey, the Tennessee Self-Description Form, and two surveys developed by the researcher to assess level of combat and support unit help upon return from Vietnam. Also sociodemographic data were collected.

Statistical analyses were done through the SPSS computer package. Analyses of covariance, Pearson product-moment correlations, and an Eta correlation were performed. Of the seven types of aggressiveness as measured by the Interpersonal Behavior Survey, Expression of Anger was the only one found to decrease significantly as a result of rap group participation. Also correlational results suggested that as aggressiveness decreased, self-management effectiveness increased. Significant negative correlations were found between aggressiveness and social self-management. Further correlational results suggested that as the level of support for the returning Vietnam in-country veterans decreased, aggressiveness slightly increased. Results also indicated a strong correlation between level of combat and aggressiveness.

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CHAPTER I

INTRODUCTION

The Vietnam War officially began August 4, 1964 and ended May 7, 1975. During this time approximately 8.3 million American men and women served in the military service. Of these, 3.2 million served in Southeast Asia, i.e., Vietnam, Cambodia, Thailand, Laos, and surrounding seas. More than 59,000 servicemen and women were killed in Vietnam and more than 300,000 were wounded (Phillips, 1980). While this casualty figure exceeded the Korean War figure, it was exceeded by a much larger figure in both World War I and World War II.

The Vietnam War though has distinguished itself from these other wars along several lines other than casualty rates. Several researchers and clinicians (Blank, 1982; DeFazio, 1978; Figley, 1978; Shaton, 1973) have described in detail the uniqueness of the Vietnam War and its subsequent impact on the American soldiers. First, it was the longest war ever fought by U.S. forces. While the official dates are August 4, 1964 to May 7, 1975, U.S. military advisors were sent to Vietnam in the late fifties. The first official American casualty in Vietnam was recorded in 1959 (Karnow, 1984). During subsequent years troop levels in Vietnam fluctuated in considerable amounts with peak troop strength being approximately 600,000 during 1968 and 1969. Wilson (1980) has pointed out that the length of the war helped to politicize it and in turn caused confusion within the public and military domains concerning our occupancy goals and objectives. This confusion had a direct impact

on the morale, esprit de corp, and confidence of the service men and women serving there.

Another uniqueness was the age of the U.S. combatant serving in Vietnam. The average age of the Vietnam combat veteran was 19.6 years, while in World War II the average age was 26 years and in the Korean War it was 25 years. Wilson (1980), using Erickson's theory of psychosocial development, points out that a person in the 17 to 25 age bracket is beginning to integrate his/her ego-identity with societal expectations. Most cultures allow the youth in this age bracket to explore activities without necessarily making commitments or prematurely defining an adult set of roles and responsibilities. To be thrust into a situation where daily stresses and decisions are based on life and death issues, while this integration is occurring, could have devastating effects on a person's subsequent life.

Blank (1982) points out that the Vietnam War was unique in the type of warfare that was used there. The predominant feature was the guerilla tactics used by the enemy. In guerilla warfare there are no frontlines. Ambushes, booby traps, hit and run attacks were the military tactics most used. American troops were in a constant state of alert, as they could be engaged in combat at any time and at any place by enemy forces. Booby traps added to this alertness as one had to monitor continually his/her every move so as not to trigger one of these devices. These booby traps also added to the frustrations of the American soldier as many times there would be no enemy personnel to engage when one of these devices was triggered, thus there would be no release of the emotions created by being in such a stressful

situation. Also in guerilla warfare the enemy is not always identifiable. Farmers, villagers, children, and Vietnamese people working on American bases were potential enemies. They might be gathering information useful to attacking enemy forces or they might be implanting booby traps resulting in the wounding and killing of U.S. personnel. Not being able to identify exactly who the enemy was resulted in many instances of "innocent" civilians dying.

Another uniqueness of the Vietnam War was the tour of duty required. In World War II the tour of duty was for the duration of the war or until seriously wounded. In Korea there was a point system. Points were earned for wounds and/or months in combat. Upon gaining thirty points personnel were allowed to return to the U.S. In Vietnam a tour of duty was twelve months for Army and Air Force personnel, while thirteen months of in-country time was required of Marine and Navy personnel. As a result of this standard, there was a continual turn over of troops, resulting in difficulties in maintaining unit integrity, morale, and esprit de corp. It also established a "survivor's complex" in which an individual was constantly aware of how long he/she had to go in-country. As a persons time became "short," i.e., only a few weeks or days left in Vietnam, units attempted to provide extra protection for him/her so he/she would survive. This served to focus attention away from the military mission and toward simple, human survival (Blank, 1982).

This limited tour of duty further isolated the soldier as it insured he/she would go over alone and return alone. This was in contrast to the unit integrity of World War II where troops shipped

over together, fought together, and returned together, thus having the opportunity to talk about their experiences. During the Vietnam War a soldier could be in combat on Tuesday and home to dinner on Thursday. This quick transition from combat to a normal life was a shock for many (Figley, 1978).

Finally, as Smith (1980) has reported there was no homecoming, welcome, or sanction for the returning soldier. This was the first time in recorded history where the persons a society had required to serve in its militia had not been held in a positive regard whether they had won, lost, or drawn. As a result, many veterans became angry and bitter towards government institutions and society in general.

All of these factors have been recognized as contributing to a present day situation in which Vietnam-era veterans find themselves suffering from what is generally called readjustment problems (Williams, 1980). Some of these problems are so intense and multi-faceted that they have been classified as a psychological disorder within the diagnostic and Statistical Manual of Mental Disorders III (DSM-III). Post Traumatic Stress Disorder (PTSD) is being used more frequently by mental health professionals to identify the specific problems Vietnam-era veterans experience as a result of their participation in the war. Mental health practitioners have long recognized and tried to explain the various significant and persistent psychiatric symptoms that occur in veterans who are exposed to combat. Shell shock, war neurosis, combat fatigue, traumatic neurosis, and gross stress reaction have been used (at various times) to try to explain

the problems seen among combat veterans. All of these various diagnoses were rooted in the belief that persons who suffered from them were somehow flawed in their personality development; thus, any problem triggered by military service was a result of a personality defect that had occurred before their entry into the military. With the diagnostic classification of PTSD, mental health professionals are able, for the first time, to recognize that the traumatic event itself, and not just pre-morbid factors, could be the source of the psychological reactions seen in the veterans (Scurfield, 1985).

While having the inclusion of PTSD in the DSM III was seen by many as a major breakthrough in the diagnosis and treatment of war-related problems, it was not accepted by all mental health professionals (Scurfield, 1985). Research on PTSD and the readjustment problems of Vietnam-era veterans has focused on refining and describing the symptomology associated with PTSD, clarifying the problems suffered by these veterans, and exploring effective treatment modalities for these problems.

Statement of Problem

The purpose of this study was to examine selected variables and their impact on aggressiveness in Vietnam-era veterans. Variables such as level of combat, support unit upon return from Vietnam, self-management effectiveness, and rap group participation will be examined to understand their influence and interaction with aggressiveness.

Nominal Definitions

1. Level of combat. The amount of combat, i.e., low, medium, high, in which a person reported to have participated in during the Vietnam War.
2. Rap group. A group designed to encourage an individual to talk freely about life experiences with other group members who have had similar experiences.
3. Self-management effectiveness. The extent to which an individual has effective habits in four broad areas of life: work, social, health, and leisure.
4. Support unit. Any person(s) or thing(s) identified by an individual that gives that individual emotional, physical, psychological, moral, or economic support.
5. Vietnam-era veterans. Anyone who served in the U.S. military service during the period August 4, 1964 to May 7, 1985.

Assumptions

1. The instruments used in the study are valid and reliable measures of the constructs.
2. Responses of the subjects were honest and accurate within the limits of their perceptions.

Limitations

1. Ethnic minorities and women were underrepresented. Consequently, generalizability is largely limited to male caucasians.

2. All subjects came from the Knoxville, Tennessee or Birmingham, Alabama areas; thus, generalizability is limited to those geographical areas.

3. Caution is needed in interpretation of these data, because all subjects were volunteers and all data were collected through the self-report method.

CHAPTER II

REVIEW OF LITERATURE

This chapter contains a comprehensive review of the literature on post-traumatic stress reactions with particular emphasis on these reactions in Vietnam era veterans. There is also a review of the theoretical and empirical literature on several variables that affect post-traumatic stress reactions in these veterans. These variables are self-management effectiveness, level of combat, support unit, and treatment modalities. While research on Vietnam-era veterans has begun to increase over the past five years, only the most pertinent studies will be cited. Whenever possible, reviews of the literature are cited rather than individual studies.

Post-traumatic Stress Reactions

Victor Frankel (1959), a Nazi concentration camp survivor, stated that an abnormal reaction to an abnormal situation is normal behavior. Post-traumatic stress reactions though, particularly those that persist over time, have been seen as resulting from deficits in a person's personality that predispose him/her to having psychological or somatic symptoms following the trauma. Kalinowski (1950) hypothesized that these reactions were prolonged so that veterans could qualify for disability compensation and other sources of secondary gain. These ideas of predisposed reactions and/or secondary gains imply that those who are "healthy" must somehow have unlimited abilities to handle stressful events no matter how intense or enduring (Scurfield, 1985).

With the end of the Vietnam War, attention began to be given to the psychological treatment of its combatants. It was quickly noted that many Vietnam veterans refused to be treated in conventional treatment facilities, i.e., VA hospitals, outpatient clinics, and local mental health centers. Likewise, they refused or terminated treatment by "conventional" mental health professionals no matter what the setting (Blank, 1985; Shatan, 1973). Given this posture, researchers and clinicians began to examine the etiology of the symptoms these veterans presented as well as the treatment modalities that seemed to be effective. Consequently, many contemporary therapists and/or researchers began presenting alternative diagnoses and methods of treatment when faced with post-traumatic stress reactions (Williams, 1980).

Etiology of Post-traumatic Stress Disorder

Scurfield (1985) has written extensively on the issues and etiology of post-trauma stress. He notes that clinicians have, over the years, attempted to explain, in various ways, significant and persistent psychiatric symptoms occurring in military veterans who have been exposed to varying amounts of combat. During World War I "shell shock" or "war neurosis" were the terms used. In World War II came the terms "combat fatigue" or "traumatic neurosis." In 1952 the Diagnostic and Statistical Manual of Mental Disorder I (DSM-I) contained an official diagnostic classification entitled "gross stress reaction." This diagnostic label was used to classify acute post-trauma stress reactions, but there was no consensus on how to

classify trauma reactions that persisted over time. This classification was dropped entirely from the DSM-II in 1968, and acute PTSD had to be classified as either adult adjustment reaction or transient situational disturbance. Diagnostic categories that indicated a pre-morbid personality, such as neurosis or personality disorder, were used to explain chronic long-lasting symptoms.

With the publication of the DSM-III in 1980 came the diagnostic classification of PTSD. The inclusion of such a classification was significant in that it was official recognition that almost anyone could develop psychiatric symptoms following exposure to trauma and that the nature and severity of the stressor itself is a, if not the, most important factor associated with the symptoms that emerge post-trauma. Along with the general classification of PTSD came two sub-types: (1) "chronic" in which the symptoms endure for six months or longer, and (2) "delayed" in which the symptoms appear no sooner than six months after the trauma. The criteria for PTSD include: a) a recognizable stressor that would cause almost anyone to have significant symptoms of distress, (b) a reexperiencing of the trauma through recurrent and intrusive thoughts about the event, (c) recurrent dreams of the event, (d) flashbacks due to an association with an environmental or ideation stimulus, (e) numbing or reduced involvement with the external world, (f) hyperalertness, (g) sleep disturbance, (h) survivor guilt, (i) memory impairment, (j) avoidance of activities that could cause recollection of the trauma, and (k) symptom intensification as a result of exposure to events that symbolize or resemble the traumatic event.

Despite this official recognition of PTSD, much controversy remains about the validity of this disorder. Some believe PTSD was included to satisfy advocacy efforts by groups of Vietnam veterans and professionals supporting them. Some believe that criteria are too narrow and should also include symptoms such as rage, impulse-control problems, stress-related somatic symptoms, and paranoid-like ideation. Also, the argument has developed that DSM-III does not discriminate enough between trauma survivors whose symptoms are a part of a "normal" stress recovery process as opposed to ones who are experiencing a "disordered" recovery process. Perhaps the most controversial argument, though, is whether exposure to the trauma itself or pre-morbid personality factors result in PTSD. The notion of pre-morbid personality factors means that a person has factors or deficits that are present prior to the trauma and these deficits cause the person to display psychological or somatic symptoms after the trauma (Scurfield, 1985).

Research has been conducted that examines the relationship between pre-morbid personality factors and post-trauma disorders. Ader (1945), Leopold and Dillon (1963), Ranson (1974), and Ursano (1981) all found no significant correlation between pre-trauma factors and the presence or severity of post-trauma difficulties. The populations in these studies included head injury victims, concentration camp survivors, Vietnam veterans, Air Force POWs, and survivors of an off-shore oil explosion.

Archibald and Tuddenham (1965) in a follow-up study of 157 World War II and Korean veterans found that 19 of 22 stress symptoms measured just after their exposure to combat stress were significantly

greater in frequency at the time of the follow-up study, conducted 10 to 20 years later. This outcome corresponds with the findings of Chodoff (1970), Leopold and Dillon (1963), and Ursano (1981) and suggests that stress symptoms persist over time and may in fact increase in severity.

Hocking (1970) reported in his research on 303 World War II concentration camp survivors that pre-morbid personality is an important factor only in disorders that occur during everyday stress and strains to which most people adapt. On the other hand, being subjected to severe, prolonged stress results in the development of post-trauma difficulties among virtually all people exposed to it.

Penk et al. (1981) directly tested Figley's (1978) hypothesis that combat veterans would demonstrate more behaviors associated with PTSD than noncombat veterans. Eighty-seven combat and 120 noncombat veterans seeking help for substance abuse were compared on demographic, family, military, and postmilitary variables. Also, comparisons were made on MMPI scores and on childhood and present Family Environment Scales. Support for Figley's hypothesis was found to include a significant difference between heavy and light combat veterans. This study is limited by the fact that the data are self-reports and obtained only from substance abusers and only in one treatment setting.

Worthington (1976) surveyed 147 male veterans living in Salt Lake County, Utah. They were seen within 12 months of their release from Army active duty. His results found a relationship between high adjustment scores on the Tennessee Self-Concept Scale, the

Socialization Scale of the California Psychological Inventory, the general anomie factor of meaninglessness from the Elmore Scale of Anomie and post service marriage and professional occupation status. Low adjustment scores were related to having marital problems, having no religious affiliation, being a high school dropout, and being unemployed. He also concluded that veterans with post service readjustment problems had adjustment problems during Army service, and that veterans with no readjustment problems were older, had been in school, had no problems with authorities before service, and had served a church mission (Church of Jesus Christ of Latter-Day Saints) prior to service. He concluded that pre-existing factors, not effects of the military service, accounted for post war problems. This study is limited by its failure to distinguish between combat and noncombat veterans. Also, all data were derived from self-reports, veterans just released from military duty, and primarily from Mormons.

Foy, Sipprelle, Rueger, and Carroll (1984) examined 43 Vietnam veterans seeking psychological services at a VA Medical Center. These vets were divided into two groups classified as PTSD positive and PTSD negative. The groups did not differ in age, race, education, or other demographic variables. All subjects were given a series of interviews and tests that examined pre-military, military, and post-military adjustment, combat exposure, and current psychological symptoms.

Results demonstrated that the extent of combat exposure is more strongly associated with PTSD symptomatology than is pre-military adjustment. To a lesser degree, military adjustment was also found

to be related to PTSD symptoms and not to pre-military adjustment. The limitations of this study are that the data were collected through self-report and given by individuals whose current status (PTSD) may have influenced their recollections.

Egendorf, Kadushin, Laufer, Rothbart, and Sloan (1981) published a four volume study in which a national sample of non-help-seeking Vietnam veterans were interviewed extensively on their present social, economic, and psychological adjustment. The results indicated that post-military readjustment problems were directly related to Vietnam combat service and not to pre-military variables.

Card (1983) in her book Lives After Vietnam was the first researcher to have hard data (as opposed to recollections) on Vietnam era veterans before they entered the service. Her study focused on three groups of men. One group of approximately 500 served in the Vietnam war zone during the 1960s. Another group of approximately 500 served in the military during the same time but were never sent to Vietnam. The last group of approximately 500 never served in the military. Extensive sampling and weighting were done to insure the groups were well matched on early, pre-service characteristics.

All these men had been studied as 9th graders in 1960 and again in 1974 as part of a study known as Project TALENT. This study was to examine the career potential and achievements of Americans in high school in 1960. The 1960 survey gathered data on academic abilities, vocational and avocational interests, personalities, home life, and plans for further schooling, work, and military service. The 1974 TALENT follow-up gathered data on educational experiences and

plans, career experiences and plans, military experience, if any, marriage and family life, and health and community activities.

Card then followed up in 1981 with a survey that examined their schooling patterns, work and achievements, physical, social, and psychological health, and family and personal life. In the psychological realm, Vietnam veterans reported more incidence and severity of psychological problems than did the non-Vietnam veterans and non-veterans. Problems included insomnia, loss of behavior control, inability to get close to another person, withdrawal from the external environment, anxiety, depression, and hyperalertness. The data showed that non-Vietnam veterans were much more similar to non-veterans than to the Vietnam veterans. The author concluded that the "specialized Vietnam experience," not the general military service experience, caused the differences. Also, the author concluded that "the incidence and severity of PTSD at midlife were not related to either the soldier's pre-service characteristics or to his general adjustment to military life while in the service but were strongly related to the intensity of combat experienced as a young soldier in Vietnam" (p. 149).

Anger and/or Aggressiveness as a Stress Reaction in Vietnam Veterans

Having counseled Vietnam veterans for a number of years, this researcher has observed a wide range of problems and issues presented by them in their search for help. Many of these presenting problems have coincided directly with those outlined previously under the classification of PTSD. However, another problem repeatedly observed

was anger or rage. These feelings seemed to generalize in such a way that there was a constant anger within many of the veterans. This perpetual anger usually led to problems with impulse control and with the occurrence of sudden, angry feelings and behavior that may be triggered by an event seemingly unrelated to the actual feelings.

This observation of the high incidences of anger and rage among Vietnam veterans is similar to what was found in the survivors of other catastrophic traumas (Horowitz, Wilner, Kaltreider, & Alvarez, 1980). Krupnick and Horowitz (1981) reported that a major theme in stress response syndromes common to both survivors of bereavement (loss of others) and to survivors of personal injury trauma is "rage at the source of the trauma." This anger may be directed at any person or figure even remotely felt to be responsible for the trauma, or the anger may be directed toward person(s) who died and thus abandoned the survivor. Finally, the anger could be focused toward the unfairness of "fate." Examples of targets of anger for Vietnam veterans are the government, the Veterans Administration, Vietnamese, buddies who died, authority figures, "draft dodgers," and "Jane Fonda types."

Scurfield, Corker, Gongla, and Hough (in press) have conducted the only study this researcher could locate that identified specific treatment issues discussed in rap groups composed of Vietnam combat veterans. Using three "rap/therapy" groups of Vietnam combat veterans that were independently established at a Veterans Administration Medical Center, the researchers collected data over a nine month period on, among other things, the symptoms or treatment issues most

discussed. Out of the 24 symptoms/issues identified, anger was overwhelmingly the most dominant issue in the rap group, while the second most frequent issue was impulse control. The researchers pointed out that the anger typically focused on the government, the Veterans Administration, Vietnamese, significant others whom the veterans felt did not understand or want to understand their experiences, and society as a whole for failure to recognize the Vietnam veteran and his/her problems since the war.

The impulse control issues were identified as having started either while in combat in Vietnam or sometime after coming home. The veterans dealt with the issues of fear of and/or actual loss of control of violent and angry feelings. The researchers noted that most of the veterans appeared to over-control their emotions, fearing that if they ever allowed themselves to feel any emotion, they would lose control of themselves. A significant number of the veterans were leading life styles that centered around physical outbursts against other persons and feeling as though they could not control their actions and/or were justified in doing them.

Other issues identified in this study were (1) guilt, either survivor guilt, or guilt at having participated in or witnessed civilian deaths; (2) primary relationships, which centered on the apparent lack of understanding and/or interest in their Vietnam experience by significant others, and the problems with establishing and maintaining good relationships with friends and family; and (3) depression, which came about a year or two after returning from Vietnam but was not consciously identified by the veteran as being

related to their Vietnam experience. This depression many times seemed to be covering immense anger, and vice versa. For most of the veterans these feelings had never been acknowledged nor processed in relationship to the Vietnam experience until they became involved in these rap groups.

Given that not all Vietnam veterans are having readjustment problems and specifically are not having problems related to their anger, the question emerges as to why not. One factor that has been discussed in the literature is the helpfulness of a support unit upon the veteran's returning home. Frye and Stockton (1982) identified independent variables that statistically discriminated between Vietnam veterans who were experiencing PTSD and those who were not. Of the five variables found to distinguish between these groups, a negative perception of their family's helpfulness upon their return home accounted for 44% of the discriminate function, which was the highest percentage of any of the variables. Other variables and their percentages were as follows: (a) higher level of combat in Vietnam (22%); (b) an external locus of control (12%); (c) a more immediate discharge after the war (13%); and (d) a more positive attitude toward the Vietnam War before entering service (9%). This study supports the clinical observations of Shatan (1974), Blank (1982), and Smith (1982), all of whom have noted that veterans in treatment continue to seek "sanctions" for their actions. These "sanctions" and permission to talk about their experiences were seemingly withheld from these veterans upon their return. An interview in the Knoxville Journal, March 8, 1984, with a Vietnam veteran being seen at the local Vet

Center points out this issue very clearly as the veteran stated:

"I was criticized by my own people, by my parents, by my brothers. They said they didn't believe in the war. We came back...We weren't accepted in society...You can't keep things bottled up inside you. I've seen a lot of this come out in these meetings. It's a shame that after so many years have lapsed...this should have happened 10-12 years ago. This should have happened right after everybody came back" (p. 43).

Treatment Sources and Methods

Introduction

Bitzer (1980) found that as late as 1977 Vietnam-era veterans had not received VA disability compensation at a rate comparable to World War II veterans. He noted several possible reasons and specifically related that in California, for example, Vietnam-era veterans needing mental health treatment were avoiding VA psychiatric hospitals due to their reputation for extensively using medications as primary treatment.

Shatan (1973) pointed out that new approaches to treating the problems of Vietnam-era veterans needed to occur. Blank (1982) has discussed the distrust many Vietnam-era veterans have displayed towards both government-run mental health institutions and the traditional psychotherapeutic methods used. He also noted the lack of trust veterans have with many therapists who are older and unable to relate to their experiences. Further, Blank (1985) has outlined 16 attitudinal or behavioral reactions to Vietnam veterans and to PTSD that either he or other mental health professionals have recognized in clinicians and clinical researchers. He notes that

these "irrational" reactions have hindered severely the psychological treatment of Vietnam-era veterans. Some of these reactions are as follows: (1) denial of the validity of the PTSD construct; (2) irrational insistence on the primacy of predisposition; (3) generalized hostility and contempt toward Vietnam veterans; (4) hostility toward professionals who treat Vietnam veterans; and (5) intrusion of the mental health professional's unresolved Vietnam War experiences.

Thus, out of the frustration of "not being understood" many Vietnam era veterans combined to start their own self-help groups to deal with their readjustment problems. Some of these organizations, Swords into Plowshares, Twice Born Men, Flower of the Dragon, and Vietnam Veterans Against the War, began to offer "rap groups." These rap groups were run by volunteer mental health professionals, as well as sometimes being leaderless. They were composed almost entirely of Vietnam combat veterans who could identify with one another's issues and problems. They were seen as peer support groups where veterans could relate with someone who understood (Smith, 1980).

Williams (1980) discussed the nationwide efforts of the Disabled American Veterans (DAV) to start up store front centers in large cities. These centers dealt with the identification and treatment of post-traumatic stress disorders in Vietnam-era veterans and served as a model for the VA's attempt at reaching out to this veteran population.

Vietnam Era Veterans Outreach Centers

In June, 1979 the Congress of the United States through Public Law 96-22 directed the VA to set up what is now called Operation

Outreach or the Readjustment Counseling Services Program. The program consists of a nationwide network of Vietnam Era Outreach Centers, i.e., Vet Centers. The centers are located away from existing VA medical facilities. They are informal places, with music playing, coffee available and casually dressed staff. The staff is specifically selected for their clinical knowledge and their sensitivity and empathy for Vietnam era veterans. Also many of them are Vietnam era veterans themselves.

The Vet Centers provide a broad range of services including individual and group counseling (rap groups), assistance in employment problems, educational concerns, VA benefits, discharge upgrading, Agent Orange information, and referrals to other community agencies. The centers are open to all Vietnam era veterans and their significant others. The veterans are eligible for help from the centers even though their problem may not be recognized at first as being service connected. The first centers opened in late 1979, and there are now 180 located across the United States, Puerto Rico, and the Virgin Islands. Thus far, more than 350,000 Vietnam era veterans and their significant others have sought help at these centers. In doing so they have presented a myriad of psychological, social, and economic problems. The severity of these problems has been wide ranging and the treatment and solutions have been varied (Blank, 1985).

Building on the work of Shatan (1973), Lifton (1975), and Williams (1980), Vet Centers have, on the whole, served as a place where Vietnam era veterans could come and either individually or in a group relate their military experiences and the feelings they had about

them in an atmosphere of trust, respect, dignity, and empathy. Rap groups, in particular, have served as both a safe arena and a catalyst for veterans to bring out the actual experiences and concomitant feelings that they have held within themselves over many years.

Scurfield (1985) notes that group treatment with other survivors has been advocated by many clinicians to be the treatment of choice for post-trauma reactions. The advantages of this type of treatment are noted as follows: (1) a reduction of the feeling of aloneness with an increase in a feeling of support and comfort; (2) a reduction of stigmatization and a restoration of self-pride; (3) a peer confrontation system where confrontation seems more valid and acceptable when it comes from those with similar experiences; (4) a chance to process "unfinished business" resulting from the trauma as well as post-trauma experiences in an atmosphere of support and understanding; and (5) assistance in expressing current and "buried" emotions freely. Brende (1981), Lifton (1978), Walker and Nash (1981), Williams (1980), and Wilson (1980) have discussed the value of Vietnam veterans rap groups. They point out that these groups provide a forum for clarifying the veterans' values and ideologies. They also provide an opportunity to place the war and their role in it in some historical/political context. Furthermore, the rap groups give them the opportunity to focus their energy towards constructive behaviors such as community work and social action. Scurfield (1985) also notes that research to date on group treatment of post-trauma reactions is almost entirely of clinical narratives.

Self-management Effectiveness

Regarding the issue of effective self-management habits, Williams, Jozwiak, and Hector (1984) contend "that the behavioral habits which characterize a person's life provide the most direct and definitive measurement of the quality of life" (p. 5). They believe persons who develop effective self-management habits in the work, social, leisure, and health activities are less likely to experience stress and better able to deal with external stressors. Williams et al. (1984) found that effective self-managers reported excellent balance in the areas of social, leisure, work, and health activities, while ineffective self-managers demonstrated substantial deficiencies in their work and health activities. The relationship between self-management effectiveness and stress reactions in Vietnam era veterans has not been explored.

Hypotheses of the Study

A review of present research on the readjustment problems of Vietnam era veterans demonstrates that in areas such as therapy modality and effectiveness and specific variable interactions, there are many questions to be researched. Thus, the present study will examine the following hypotheses:

1. Self-reported aggressiveness will diminish more for Vietnam in-country veterans who currently participate in rap group sessions than for Vietnam in-country veterans who have never participated in rap group sessions.
2. Self-reported aggressiveness will be less for Vietnam in-country veterans who have previously participated in rap group

sessions than for Vietnam in-country veterans who have never participated in rap group sessions.

3. Self-reported aggressiveness and self-management effectiveness will be negatively related.

4. Subjects with a helpful support unit upon return from Vietnam will report lower aggressiveness than subjects who had no helpful support unit.

CHAPTER III

METHOD

Subjects

Participants in this study were 66 Vietnam in-country veterans from a fifty-mile radius around Knoxville, Tennessee and Birmingham, Alabama. All subjects had served in Vietnam sometime between 1960 and 1975. All subjects were seeking or had sought help from the local Vietnam Era Veterans Outreach Center. Data collection on the subjects began during the summer of 1984 by obtaining permission from the Office of the Southeast Regional Manager of the Readjustment Counseling Services, Veterans Administration to survey Vietnam in-country veterans who were and/or had participated in rap groups at two Vietnam Era Veterans Outreach Centers. Further permission was obtained from the staff persons of these centers located in Knoxville, Tennessee and Birmingham, Alabama.

Initially, 100 Vietnam in-country veterans were contacted to ascertain if they wanted to participate. Of the initial subjects contacted, 21 chose not to participate. During the time of treatment and data collection another 13 dropped out of the study for a variety of reasons, e.g., hospitalization, relocation, or decided not to participate further.

Sociodemographic Characteristics of the Subjects

Percentage distributions of sociodemographic variables for all subjects appear in Table 1, Appendix A¹. The majority (72.7%) of the subjects fell into the age range, 35-40, which is the range into which

¹All tables appear in Appendix A.

the majority of present Vietnam era veterans fall according to military personnel levels and draft quotas during the Vietnam War era.

Current marital status data showed a much higher rate of divorce in the present sample than in Card's (1983) research (21.2% vs. 8%). One possibility could be because the majority of the subjects in this study were persons who were dealing with psychological problems, thus putting added strain on interpersonal relationships. It is very common for Vet Centers to have a great demand for family/marital counseling. Also, Card's research was a general survey with no focus on specific populations other than Vietnam veterans vs. nonveterans.

High school degrees/GEDs had been obtained by 98.5% of the veterans as compared to 94.9% of the Vietnam veterans surveyed by Card. The BS/BA, Masters, and Ph.D. percentages in this study vs. Card's survey were 24.2 vs. 26.2, 6.1 vs. 8.7, and 1.5 vs. 1.8.

Employment data showed a 21.2% rate of current unemployment among the present subjects. This figure is almost four times the unemployment rate (6.0%) for Vietnam era veterans reported by the Department of Labor's Bureau of Labor Statistics (BLS) for the month of February, 1985. Such a large discrepancy can be partially accounted for by the fact that many veterans report giving up looking for jobs after a period of time and do not report to employment offices where such figures are kept. The BLS reported in February, 1985 that 169,000 Vietnam era veterans in the 35-39 age group were looking for work (Atallah, 1985).

In occupational categories, 12.1% of the current subjects considered themselves unskilled, while the largest percentages were in the skilled labor/trade or professional categories, 31.8% and 24.2% respectively.

These percentages are similar to the ones found by Card.

Income levels among the present subjects ranged from 10.6% reporting less than \$5,000 per year to 28.8% reporting \$15,000 to \$24,999 per year and the same percentage reporting \$25,000 + per year. In 1981 the Vietnam in-country veterans surveyed by Card reported an average annual pay of \$12,423. At that time non-veterans in the same study averaged \$13,625 per year.

In the present study no subject reported coming from an upper class background as a child. Lower-middle, middle, and upper-middle accounted for 91.1% of the subjects' socioeconomic class backgrounds, while 9.1% came from a lower class. These statistics support Kadushin, Boulanger, and Martin (1981) who found significantly lower service rates among the upper class.

In health status area, while most subjects (97%) reported fair to excellent health, 43.9% reported a significant physical/psychological handicap. These results may be due to the veterans' perception of their physical/psychological problems as related to Vietnam. Card reported 26.5% of the Vietnam veterans in her study listed negative physical/psychological effects as a result of their Vietnam experience. She noted that the percentage might have been higher if the open-ended question that addressed that issue had not been asked at the end of a lengthy questionnaire. Also, in the present study, 53% of the subjects reported no hospitalizations in the last 5 years, while 39.4% reported hospitalizations in the 1-4 range during the same time period. Prescribed medications were used by 39.9% regularly, while 62.1% did not.

Instruments

The Interpersonal Behavior Survey (IBS)

This instrument was developed to differentiate aggressive behaviors from assertive and non-assertive ones and to sample sub-classes of these behaviors (Mauger et al., 1979). There are four sections of the IBS, which can be used singularly or, for the most reliable results, as a whole. When used as a whole, the IBS consists of 314 items written in the present tense at a sixth grade reading level. It is answered in a true-false manner.

The individual scores on the IBS are plotted under four scales on the profile. Only two scales will be used in this study. These are as follows:

Validity Scales. This group indicates test-taking attitudes and whether or not a profile is interpretable. The scales are Denial, Infrequency, and Impression Management.

Aggressiveness Scales. These scales measure the general response classes of aggressiveness including behaviors, feelings, and attitudes. These scales are: (1) General Aggressiveness, Rational, (2) Hostile Stance, (3) Expression of Anger, (4) Disregard for Rights, (5) Verbal Aggressiveness, (6) Physical Aggressiveness, and (7) Passive Aggressiveness.

Reliability of the IBS was established by using a test-retest format over both a 2-day and a 10-week period. Coefficients for the 2-day interval ranged from a low of .84 on the Physical Aggressiveness Scale to a high of .93 on the General Aggressiveness, Rational Scale. In the 10-week interval, coefficients ranged from a low of .81 on the Disregard for

Rights Scale to .93 on the Physical Aggressiveness Scale.

Convergent and discriminant validities have been evaluated for the IBS and a number of well-known personality inventories. The General Aggressiveness, Rational Scale (GGR) correlated .57 with the Aggressive Scale of the Edwards Personal Preference Scale. Also, the GGR correlated at the .65 level with the total Hostility Scale on the Buss-Durkee Hostility Inventory.

The Tennessee Self-Description Form (TSDF)

This instrument was developed to measure self-management effectiveness in four areas of life (Williams et al. 1984). The four areas are work, health, social, and leisure. Behavioral habits in these areas are measured to give an overall score of self-management. Forty-seven behaviors are listed and respondents are asked to indicate how often they engage in these behaviors.

Reliability was determined by using a test-retest format over a two-three week period. The coefficients reported were .67 = Work, .50 = Social, .79 = Health, .72 = Leisure, and .64 = Total.

Items on the TSDF were determined by having a group of mental health professionals review a pool of 163 items and categorize them into one of the four areas plus a miscellaneous category. A majority had to agree about the placement of an item; the average agreement was .89. The average agreement on the valence of the items i.e., whether the item reflected effective or ineffective living was .88. A copy of this instrument appears in Appendix B.

The Support Unit Survey (SUS)

This instrument was developed by the researcher to survey Vietnam in-country veterans as to the helpfulness of a support unit upon return from Vietnam. Veterans were asked if they had a support unit or not. If they did they were then asked to rate its helpfulness. A copy of the survey appears in Appendix C.

The Combat Exposure Scale (CES)

This instrument was developed to measure levels of combat among Vietnam theatre veterans (Card, 1983). Respondents are asked to rate such items as "How often did you fire your weapon at the enemy?" and "How often did you see someone killed?" Ratings range from "never" (1) to "very often" (5). A copy of this instrument may be found in Appendix D.

Demographic Survey

A 16-item demographic survey was developed by the researcher to obtain standard demographic information such as age, marital status, income, occupation, educational level, etc. A copy of the survey appears in Appendix E.

Operational Definitions

1. Aggressiveness was operationalized as the subject's score on the General Aggressiveness, Rational scale of the Interpersonal Behavior Survey developed by Mauger and Adkinson in 1980.
2. Level of combat was operationalized as the subject's total score on the Combat Exposure Scale.
3. Self-management effectiveness was operationalized as the subject's total score and his/her scores on the four subscales of the Tennessee

Self-Description Form developed by Williams, Jozwiak, and Hector in 1984.

4. Support unit helpfulness was operationalized as the subject's score on the Support Unit Survey (i.e., the yes/no response and the degree of helpfulness).

Procedures

This study began with the selection of two Vietnam Era Veteran Outreach Centers that offered time-structured, i.e., ten to twelve weeks, rap groups for Vietnam in-country veterans. They also oriented these rap groups towards processing the "Vietnam experience." This processing consisted of leader, as well as client, directed exploration of "issues" surrounding the Vietnam War and the personal experiences of the people who participated in the war. Some of these issues were as follows: survivor guilt, drug and alcohol abuse, racial conflicts, political conduct of the war, military tactics, and homecoming. All rap groups used audio visual techniques to some extent. These consisted primarily of films of the Vietnam War and its impact on veterans' lives.

As each rap group began, the staff member(s) responsible for leading the group distributed a package of materials developed by the researcher. Each package contained a letter explaining the study as well as a consent form and the various surveys to be used. The General Information Letter and Consent Form used by the researcher can be found in Appendices F and G. Persons who agreed to participate then completed the surveys. The researcher did not lead or co-lead any of the rap groups surveyed.

Simultaneously, two other groups of Vietnam in-country veterans were contacted through the mail by the researcher. These veterans had

been identified by each Vet Center staff as persons either who had completed a rap group in the last three months to one year or who had never participated in a rap group or individual counseling. Those veterans who chose to participate were sent identical packages of materials. They were asked to complete the surveys and return them to the researcher in an enclosed stamped envelope.

Upon completion of the rap groups all participating veterans in all research groups were again contacted and asked to complete the follow-up surveys. A copy of the second General Information Letter can be found in Appendix H. The groups and their testing and treatment conditions are shown in Table 2.

CHAPTER IV

RESULTS AND DISCUSSION

Analysis

This study used the pretest-posttest control group design. Statistical analysis of the data was accomplished by using programs in the Statistical Package for the Social Sciences (SPSS). Since the groups being compared were of unequal size, a Bartlett-Box F was computed to assure homogeneity of variance. Analysis of covariance was used to test the first and second hypotheses, thus controlling statistically for any initial differences in the groups. The covariate was the pretest scores of General Aggressiveness on the IBS. When a significant F was obtained, a Newman-Kuels multiple comparisons test was used to locate significant differences (Huck, Cormier, & Bounds, 1974). For the third hypothesis, Pearson product-moment correlations were used to determine the relationship between aggressiveness and self-management. The fourth hypothesis was analyzed by using the asymmetric statistic, Eta. Eta is a measure of association used when the independent variable is nominal level and the dependent variable is interval or ratio (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975).

Means and Standard Deviations for the IBS and TSDF

Table 3 contains the means ($\bar{X}$) and standard deviations (SD) for all subjects (N=66) on the IBS and TSDF. The table shows both pre and post results. In general, the subjects in this study scored high on General Aggressiveness and the aggressiveness subscales. Their pretest mean score was 54.40 on the General Aggressiveness, Rational (GGR) scale. In comparison

Mauger et al. (1980), in discussing the IBS, reported that the groups scoring the highest on the GGR scale were teenage sons of Air Force personnel ($N=24$, $\bar{X}=58$), lacrosse players ($N = 108$, $\bar{X}=56$), U.S. high school students ($N=108$, $\bar{X}=56$), and assaultive prisoners ($N=32$, $\bar{X}=54$). Low scores were recorded by college students instructed to fake good scores ($N=26$, $\bar{X}=41$) and Florida psychiatric in-patients (acute care) ($N=74$, $\bar{X}=43$).

On the Expression of Anger (EA) scale and the Hostile Stance (HS) scale the pretest mean scores of the subjects were 54.80 and 53.30 respectively. Mauger reports high EA scores with lacrosse players ($\bar{X}=57$), assaultive prisoners ($\bar{X}=56$), and Veterans Administration drug treatment in-patients ($\bar{X}=55$). Further, high HS scores are reported with teen-age sons of Air Force personnel ($\bar{X}=58$) and U.S. high school students ($T=56$). Low-scoring groups on the HS scale included Nursing students ($\bar{X}=45$) and graduate students faking good ($\bar{X}=40$).

Williams et al. (1984), in discussing the TSDF reported that effective self-managers ($N=223$) obtained mean scores of 7.54, 9.61, 8.53, and 10.14 on work, social, health, and leisure respectively. Ineffective self-managers ($N=237$) obtained mean scores of -.62 on work, 3.86 on social, -.85 on health, and 6.46 on leisure. The normative sample ($N=1512$) means were 3.77 on work, 6.39 on social, 4.04 on health, and 8.18 on leisure. The scores of Self-Management for the subjects in this study were more like ineffective self-managers on all scales, as their mean scores were work (2.86), social (5.01), health (0.42), and leisure (4.95).

Tests of Hypotheses

Hypotheses One and Two

The first hypothesis stated that self-reported aggressiveness would diminish more for Vietnam in-country veterans who currently participate in rap groups sessions than for Vietnam era veterans who have never participated in rap group sessions. Additionally, hypothesis two stated that self-reported aggressiveness would be less for Vietnam in-country veterans who had previously participated in rap groups than for Vietnam in-country veterans who had never participated in rap group sessions. An analysis of covariance with pretest scores on the IBS as covariates was used. The F ratio on the General Aggressiveness Rational score was not significant (group 1, $\bar{X}=52.22$; group 2, $\bar{X}=52.00$; group 3, $\bar{X}=54.25$); thus, the two hypotheses were not supported. However, on the scale of Expression of Anger the difference between the groups was significant ($F=3.68$, $p<.031$). A Newman-Keuls test for post hoc comparisons was used to locate significant differences. When no differences were found, an analysis of covariance contrasting the combined groups one (previous rap group) and two (current rap group) with group three (no rap group) was done. Results indicated that the combined treatment groups obtained significantly lower Expression of Anger scores than the non-treatment group ($F=7.43$, $p<.008$). Table 4 and 5 provide the F tables for these analyses.

Table 6 contains the means and standard deviations of the IBS for all treatment groups. All groups had high mean scores for the Expression of Anger scale. Group three (pretest $\bar{X}=53.53$; posttest $\bar{X}=55.30$) showed

an increase between their pretest and posttest scores. Group one (pretest $\bar{X}=54.07$; posttest $\bar{X}=52.55$) and group two (pretest $\bar{X}=57.15$; posttest $\bar{X}=55.21$) showed a decrease from pretest to posttest scores.

According to the authors of the IBS, the Expression of Anger scale is a measure of a person's proneness toward temper outbursts. This expression of anger is different from what Lazarus (1971) has described as the freedom of emotional expression. A high score on the Expression of Anger Scale shows an enslavement to anger (Mauger et al., 1980). Thus, the expression is not positive or a growth-producing experience, it is more a lack of ability to control the anger and express it in constructive and positive ways. This finding lends support to the research by Scurfield et al. (in press) which found the predominant themes of three therapy groups (81 sessions, 1 year length) of help-seeking, Vietnam in-country veterans were anger and impulse control. Based on the present results, it would seem that the Vietnam in-country veterans are having problems with their aggressiveness and its expression. Results indicate that the rap group format used in this study allows for positive change regarding their attempts to express this anger constructively.

Hypothesis Three

The third hypothesis stated that there would be a negative relationship between self-management and self-reported aggressiveness. Table 7 shows the pre and post correlations between the IBS, General Aggressiveness score and the TSDF total score for all subjects and for each group. Examination of pretest scores on the IBS and TSDF for the total sample

revealed a negative correlation of $r = -.39$ ($p < .001$). Posttest scores showed a negative correlation of $r = -.42$ ($p < .0001$). Group 1 (previous rap group) showed a pretest correlation of $r = -.43$ ($p < .01$) and a posttest correlation of $r = -.48$ ($p < .005$). Group 2 (current rap group) showed a pretest correlation of $r = -.26$ ($p < .13$) and a posttest correlation of $r = -.42$ ($p < .03$). Group 3 (no rap group) showed a pretest correlation of $r = -.39$ ($p < .04$) and a posttest correlation of $r = -.34$ ($p < .06$). These results suggest that as aggressiveness decreases, self-management effectiveness tends to increase.

Pretest and posttest correlations of self-management subscale scores with aggressiveness variables are presented in Tables 8 and 9. All self-management variables were negatively correlated with all aggressiveness variables, with the strongest correlations between the Social Self-Management sub-scale and all aggressiveness variables. In particular, the Social Self-Management subscale correlated most strongly with the Hostile Stance scale ($r = -.44$, $p < .001$) and the Expression of Anger scale ($r = -.38$, $p < .003$). On the Health Self-Management subscale the strongest correlations with the aggressiveness scales were Physical Aggressiveness ($r = -.33$, $p < .004$) and Disregard for Rights ($r = -.29$, $p < .009$).

In general the Work and Leisure Self-Management subscales were not as strongly correlated with the aggressiveness scales. The strongest correlations were found between Leisure Self-Management and Physical Aggressiveness ($r = -.30$, $p < .007$) and Work Self-Management and Passive Aggressiveness ($r = -.33$, $p < .003$).

Recent media articles have noted that Vietnam combat veterans are likely to seek isolation from those around them and the world in general

(Davidson & Lang, 1984; Stammer, 1984). Lipkin, Blank, Parson, and Smith (1982) state that many veterans display "general alienation and detachment to some degree from life pressures such as marriage, career, and social and political institutions, leading to a loss of social and vocational effectiveness. Some veterans with such characteristics seem frozen at age 20, have not learned skills for living, and are unsophisticated in dealing with traditional institutions" (p. 911). Also, one of the diagnostic criteria for PTSD is a reduced involvement with the external world demonstrated partly by feelings of detachment or estrangement from others. It may be that the aggressiveness in the Vietnam veterans studied here serves to isolate or alienate them from social interactions. An example of this behavior can be demonstrated by examining positive items taken from the Social Self-Management subscale. One item asks how often the person shows affection toward others, while another asks how often the person initiates conversation. If the veteran does not engage in these behaviors frequently or he/she engages in aggressive social behaviors (e.g., reprimanding others, interrupting others during conversation), his/her social relationships are likely to be severely thwarted.

Hypothesis Four

The fourth hypothesis stated that as the level of support for the returning Vietnam in-country veterans increased, they would report lower aggressiveness. An Eta correlation of $-.24$ ($p < .05$) between the pretest level of General Aggressiveness (dependent variable) and level of support (independent variable) provides moderate support for this hypothesis.

Table 10 shows the results of the Support Unit Survey (SUS). Most veterans (71.2%) reported having a support unit upon return from Vietnam. However, 15.1% considered the support unit of no help to them when they returned from Vietnam. When this percentage is combined with the 28.8% who reported their support unit as neutral and the 28.8% who reported no support unit upon return, the result is that 72.8% of the subjects had either no, neutral, or negative support upon return.

In Frye and Stockton's (1982) comparison of Vietnam veterans experiencing PTSD and those who were not, of the five variables found to distinguish between these groups, a negative perception of their family's helpfulness upon return home accounted for 44% of the discriminant function. Kadushin et al. (1981) found a lower incidence of PTSD among Vietnam veterans who had a supportive spouse. They also reported that having Vietnam-veteran friends in large cities and a community of Vietnam veteran friends in small towns helped to reduce combat-induced stress. Card (1983) concluded that even though the data are correlational, a consistent pattern suggests that social support given to the returning veteran aids in eliminating long term stress.

Correlation of Level of Combat and General Aggressiveness

Table 11 lists the percentages of levels of combat for the subjects. The present percentages approximated those reported in other studies; however, various methods of defining combat experience has led to some ambiguity in research as to what constitutes different levels of combat. In this study an Eta correlation was computed for self-reported levels of combat and pre- and post-test scores on levels

of aggressiveness. A correlation of .48 ($p < .001$) was found for the pretest variables, while a correlation of .41 ($p < .001$) was found on the posttest variables. Figley (1979) and Card (1983) have commented extensively on how the level of intensity of combat has impacted negatively on Vietnam veterans. Their research shows that as combat levels increase, Vietnam veterans are more likely to experience readjustment problems or PTSD. Other researchers (Barret-Ruger & Lammers, 1981; Kadushin et al., 1981; Laufer et al., 1981; Stampler & Sippaelle, 1981; Strayer & Ellenhorn, 1975) also have reported that the level of combat experienced in Vietnam is a critical factor in the triggering of PTSD and related problems.

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

Introduction

The following incident occurred to Frederick Downs, who is presently the Director of Prosthetics of the Veterans Administration:

"In the Fall of 1968, as I stopped at a traffic light on my walk to class across the campus of the University of Denver, a man stepped up to me and said, 'Hi'. Without waiting for my reply to his greeting, he pointed to the hook sticking out of my left sleeve. 'Get that in Vietnam?'

I said, 'Yeah, up near Tam Ky in I Corps.'

'Serves you right.'

As the man walked away, I stood rooted, too confused with hurt, shame, and anger to react" (Downs, 1978, preface).

While incidents as overt as this did not occur to all of those men and women who served during the Vietnam War, researchers and clinicians have observed and documented a phenomenon existing in the lives of many of these men and women that may have begun in more subtle ways. Smith (1980) identified a normal psychological process in recovering from traumatic, catastrophic events. This process involves several sequential stages. Among the last of these stages are sanctioning, sealing over, integration, and atonement. These stages are seen as the "working through process." They are what occur when the veteran begins to directly address his/her reactions to past traumatic events. This "working through process" had been denied historically and officially to Vietnam era veterans until the recognition of PTSD by the mental health community and the opening of Vet Centers around the U.S. Vietnam-era veterans, particularly those exposed to heavy combat and/or

daily doses of death and destruction, e.g., medical personnel, have had a part of their lives, in this researcher's terms, "frozen." Unthawing that part of their lives becomes a part of the "working through process." With the opening of Vet Centers across the U.S., many Vietnam-era veterans began that "unthawing."

Rap Group Outcomes on Aggressiveness in Vietnam In-Country Veterans

Shatan (1973), Smith (1980), and Williams (1979) reported that rap groups made up primarily of Vietnam-era veterans, and if possible led by a Vietnam era veteran therapist, are the preferred therapeutic interventions for the problems faced by this population. As noted earlier in this research, Vietnam era veterans during the late 1960's and all of the 1970's had, for the most part, formed their own self-help groups. This study is, to the researcher's knowledge, the first to examine possible outcomes of professionally organized, structured rap groups. The study found that when aggressiveness in these subjects was broken into several specific types, the area of expression of anger stood out as most amenable to treatment changes. Several clinicians and researchers over the past ten years have noted that during therapy Vietnam veterans again and again raise the concern about their inability to control their anger or their fear of losing control of their anger. Perhaps what occurs in the rap groups is that the veterans are able to vent their anger in a safe environment, thus they realize they can release it without harming themselves or others. Also in rap groups, veterans are able to learn from the therapist(s) and from other

veterans new behaviors to dissipate their anger. Some examples of these are as follows: a) engaging in physical activities such as jogging, swimming, weightlifting, tennis, etc.; b) counting to some number before reacting to a anger-provoking situation; c) involving themselves in group activities such as going to church, playing cards with friends, or joining an interesting club; and d) engaging in some civic activity or philanthropic cause. While involved in activities such as these, there are many instances where the veteran is forced to interact with others, form relationships, and receive feedback on his/her actions. Similar feedback is given during the rap groups; thus the veteran has the information needed to understand how he/she is perceived and how he/she can change. If and when the veteran begins to express anger properly, the rap group serves to reinforce immediately this change and thus add to the veteran's feelings of self-worth.

Level of Combat

The present study noted a strong correlation between level of combat and aggressiveness in the veterans surveyed. This finding would support the results of many studies in which the combat levels reported by Vietnam veterans are found to play important roles in the types and severity of their problems. Wilmer (1982) notes that psychiatric casualties are greater after high combat exposure and implores therapists to ask questions of their Vietnam veteran clients about combat experiences so they can better understand their client's symptomology.

Self-Management in Vietnam In-Country Veterans

It could be hypothesized that the veterans' unresolved anger was interfering with the specific day to day management of their lives. This study revealed a particularly strong negative correlation between aggressiveness in Vietnam veterans and the social self-management area of their lives. These results suggest that the subjects could be using their aggressiveness to insure their continued alienation and isolation from others. Researchers and clinicians have noted that Vietnam veterans continually talk of not being close to anyone, or if they find themselves "getting close" they somehow pull away or alienate that person(s). This possibly relates to their experiences in combat where their friends were killed or maimed; thus they do not seek closeness with anyone for fear of losing them.

Perhaps part of therapy for these veterans could be directed towards reinforcing any positive social interactions in which they become involved. For many veterans the rap group itself is the first and only "social gathering" they attend. Expansion of this setting by involving the rap group in a larger social gathering may be beneficial also. Some Vet Centers have reported positive reactions when their rap groups formed softball teams, directed traffic at a July 4th celebration, or raised money for specific community needs. In engaging in these activities, veterans have the opportunity to learn to manage their social interactions in a facilitating rather than alienating fashion.

Future Research

Blum, Kelly, Meyer, Carlson, and Hodson (1984) conducted a needs assessment on World War II/Korean veterans (N=244) and Vietnam era veterans (N=210) living within the catchment area of Northport VAMC, Northport, New York. Among their findings was a reported immediate need by the Vietnam era veterans for anger-control therapy. Also the Vietnam era veterans who had experienced moderate to heavy combat felt strongly that they be treated separately from all other veterans as well as from non-combat veterans. The Vietnam era veterans (52%) reported dissatisfaction with the treatment they had received at a VA hospital. Only 11% of the World War II and Korean veterans reported dissatisfaction. Commenting on their findings, the researchers state:

"Vietnam era veterans believe that it is very important for them to discuss their problems in the presence of other Vietnam era veterans who have had similar experiences. This tendency has also been reported by other health care professionals... It is not known if this approach is therapeutically beneficial" (p. 696).

Perhaps the present study is a start in answering the questions surrounding this therapeutic intervention with Vietnam era veterans. Research is needed to understand the processes occurring in rap groups. Using Smith's model of stress recovery, researchers need to develop instruments to assess the stage at which a Vietnam era veteran is functioning before, during, and after rap group participation. Studies

comparing "closed" vs. "open" groups as modes of therapy might be fruitful.

Also the present study points to the need for further research on the relationship between self-management and aggressive behavior in Vietnam era veterans. Studies involving the teaching of self-management and assertiveness skills to those veterans could lead to very practical interventions for ameliorating their aggression.

Finally, emphasis needs to be placed on the training and sensitizing of current and future mental health professionals to the unique needs of Vietnam era veterans and their significant others. As this population moves through midlife, it has been hypothesized that because of the sometimes traumatic changes associated with that period, i.e., death of parents and friends, divorce, job change, and children leaving home, mental health professionals will see an increase in psychological problems in Vietnam era veterans. Should this occur, it is imperative the mental health community have the knowledge and skills needed to treat these veterans.

LIST OF REFERENCES

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APPENDIXES

APPENDIX A

Tables 1-11

Table 1. Percentage Distribution of Sociodemographic Variables
for All Subjects

Variable	%
Age	
29-34	10.6
35-40	72.7
41-46	10.6
47-52	6.1
52+	0.0
Marital Status	
Never Married	3.0
Married	51.5
Divorced	21.2
Seperated	4.5
Remarried	19.7
Widowed	0.0
Parenthood	
Yes	81.8
No	18.2
Educational Level	
Less Than High School	1.5
High School	48.5
Technical/Vocational School	18.5
BS/BA Degree	24.2
MS/MA Degree	6.1
Ed.D., Ph.D., MD, JD Degree	1.5
Employment Status	
Not Employed	21.2
Employed Full-Time	75.8
Employed Part-Time	3.0
Occupation	
Unskilled Labor	12.1
Skilled Labor or Trade	31.8
Supervisory	9.1
Managerial	9.1
Professional	24.2
Clerical	0.0
Military	3.0
Sales	4.5
Other	6.1

Table 1 (Continued)

Variable	%
Income	
Less than \$5,000/year	10.6
\$5,000-\$9,999	7.6
\$10,000-\$14,999	22.7
\$15,000-\$24,999	28.8
\$25,000 +	28.8
No Response	1.5
Family Background	
Lower Class	9.1
Lower-Middle Class	27.3
Middle Class	59.1
Upper-Middle Class	4.5
Upper Class	0.0
Living Arrangement	
Alone	12.1
With Spouse	69.7
With Parents	6.1
With Roommate	9.1
With Children	3.0
Religion	
None, No Belief in Higher Power	4.5
Belief, No Church/Synagogue	43.9
Belief, Some Church/Synagogue	33.3
Belief, Regular Church/Synagogue	18.2
Health Status	
Excellent	22.7
Good	47.0
Fair	27.3
Poor	3.0
Significant Physical/Psychological Handicap	
No	56.1
Yes	43.9
Number Hospitalizations Past 5 Years	
0	53.0
1-4	39.4
5-10	6.1
10+	1.5
Prescription Medications Used Regularly	
Yes	37.9
No	62.1

Table 2. Testing and Treatment Interventions for All Groups

	Pretest (All Instruments)	Current Treatment (Rap Groups)	Posttest (IBS & TSDF)
Group 1 (Previous Rap Group)	X		X
Group 2 (Current Rap Group)	X	X	X
Group 3 (No Rap Group)	X		X

Table 3. Means and Standard Deviations for the IBS for All Subjects

Variable	Pre			Post		
	<u>N</u>	<u>X</u>	<u>SD</u>	<u>N</u>	<u>X</u>	<u>SD</u>
(IBS)						
General Aggressivess, Rational	66	54.40	13.05	66	52.77	13.09
Hostile Stance	66	53.30	12.80	66	51.33	13.19
Expression of Anger	66	54.80	12.30	66	54.15	12.67
Disregard for Rights	66	51.65	11.34	66	50.90	10.15
Verbal Aggressiveness	66	48.19	11.47	66	48.00	11.26
Physical Aggressiveness	66	55.86	10.66	66	54.83	10.37
Passive Aggressiveness	66	56.66	11.98	66	55.89	11.17
(TSDF)						
Work	66	2.86	4.77	66	3.98	4.34
Social	66	5.01	4.70	66	5.77	4.55
Health	66	0.42	5.91	66	0.66	5.31
Leisure	66	4.95	2.27	66	5.62	2.27
Total	66	13.62	11.42	66	16.19	11.02

Table 4. Analysis of Covariance: Comparison of Groups on Expression of Anger

Source Of Variation	Sum of Squares	DF	Mean Square	F	Significance Of F
Covariates (Pretest scores on Expression of Anger)	8985.746	1	8985.746	415.696	0.000
	8985.746	1	8985.746	415.696	0.000
Main Effects (Groups)	159.348	2	79.674	3.686	0.031
	159.348	2	79.674	3.686	0.031
Explained	9102.207	3	3034.069	140.361	0.000
Residual	1340.203	62	21.616		
Total	10442.410	65	160.652		

Table 5. Analysis of Covariance: Comparison of Groups One and Two (Combined) With Group Three on Expression of Anger

Source Of Variation	Sum of Squares	DF	Mean Square	F	Significance Of F
Covariates	8942.859	1	8942.859	420.041	0.000
(Pretest scores on Expression of Anger)	8942.859	1	8942.859	420.041	0.000
Main Effects	158.254	1	158.254	7.433	0.008
(Groups)	158.254	1	158.254	7.433	0.008
Explained	9101.113	2	4550.555	213.737	0.000
Residual	1341.297	63	21.290		
Total	10442.410	65	160.652		

Table 6. Means and Standard Deviations for the IBS for All Treatment Groups

Variable	Pre			Post		
	<u>N</u>	<u>X</u>	<u>SD</u>	<u>N</u>	<u>X</u>	<u>SD</u>
Group 1 (Previous Rap Group)						
General Aggressiveness	27	53.92	13.21	27	52.22	13.57
Rational						
Hostile Stance	27	52.59	13.11	27	51.11	13.57
Expression of Anger	27	54.07	12.35	27	52.55	13.15
Disregard for Rights	27	52.55	12.51	27	50.88	10.19
Verbal Aggressiveness	27	47.55	10.58	27	47.11	11.74
Physical Aggressiveness	27	56.37	11.20	27	54.74	11.15
Passive Aggressiveness	27	56.70	12.05	27	56.18	12.40
Group 2 (Current Rap Group)						
General Aggressiveness	19	54.42	11.12	19	52.00	9.73
Rational						
Hostile Stance	19	52.94	11.06	19	50.68	11.47
Expression of Anger	19	57.15	13.16	19	55.21	13.15
Disregard for Rights	19	49.15	8.82	19	49.63	8.66
Verbal Aggressiveness	19	48.36	10.37	19	48.57	9.23
Physical Aggressiveness	19	53.21	11.19	19	53.43	10.21
Passive Aggressiveness	19	57.57	12.11	19	54.63	9.68
Group 3 (No Rap Group)						
General Aggressiveness	20	53.05	15.01	20	54.25	15.53
Rational						
Hostile Stance	20	54.60	14.39	20	52.25	14.75
Expression of Anger	20	53.55	11.70	20	55.30	11.95
Disregard for Rights	20	52.80	11.96	20	52.15	11.65
Verbal Aggressiveness	20	48.90	13.91	20	48.65	12.75
Physical Aggressiveness	20	55.80	9.88	20	56.30	9.75
Passive Aggressiveness	20	55.75	12.31	20	56.70	11.18

Table 7. Correlations of the IBS, General Aggressiveness with the TSDF Total Score for All Subjects and All Groups

Variables	Pre-TSDF	Post-TSDF
Pre IBS	$r = -.39 (N = 66)^a$ $p = <.001$ $r = -.43 (N = 27)^b$ $p = <.01$ $r = -.26 (N = 20)^c$ $p = <.13$ $r = -.39 (N = 19)^d$ $p = <.04$	
Post IBS		$r = -.42 (N = 66)^a$ $p = <.001$ $r = -.48 (N = 29)^b$ $p = <.005$ $r = -.42 (N = 20)^c$ $p = <.03$ $r = -.34 (N = 19)^d$ $p = <.06$

a = all subjects; b = previous rap group; c = current rap group; and d = no rap groups

Table 8. Pretest Correlations of Self-Management Variables with Aggressiveness Variables (N = 66)

Variables	Total Self-Management	Work Self-Management	Social Self-Management	Health Self-Management	Leisure Self-Management
General Aggressiveness Rational	-.39 .001	-.15 .117	-.42 .001	-.28 .012	-.17 .081
Hostile Stance	-.31 .006	-.15 .116	-.44 .001	-.15 .110	-.02 .438
Expression of Anger	-.30 .008	-.07 .280	-.38 .003	-.24 .025	-.15 .105
Disregard for Rights	-.35 .002	-.19 .006	-.34 .003	-.29 .009	-.12 .164
Verbal Aggressiveness	-.36 .002	-.14 .132	-.41 .001	-.22 .041	-.17 .083
Physical Aggressiveness	-.40 .001	-.18 .069	-.28 .011	-.33 .004	-.30 .007
Passive Aggressiveness	-.41 .001	-.33 .003	-.29 .009	-.27 .014	-.17 .091

Note: The first number in each entry is r and the second is p .

Table 9. Posttest Correlations of Self-Management Variables with Aggressiveness Variables (N = 66)

Variables	Total Self-Management	Work Self-Management	Social Self-Management	Health Self-Management	Leisure, Self-Management
General Aggressiveness Rational	-.42 .001	-.30 .007	-.45 .001	-.24 .026	-.16 .095
Hostile Stance	-.36 .001	-.17 .087	-.42 .001	-.24 .025	-.08 .269
Expression of Anger	-.36 .002	-.17 .080	-.38 .001	-.22 .037	-.17 .088
Disregard for Rights	-.42 .001	-.25 .020	-.24 .003	-.26 .019	-.29 .010
Verbal Aggressiveness	-.34 .002	-.26 .016	-.46 .001	-.08 .26	-.17 .176
Physical Aggressiveness	-.39 .001	-.16 .100	-.33 .003	-.32 .005	-.22 .039
Passive Aggressiveness	-.34 .002	-.24 .026	-.27 .015	-.25 .020	-.18 .078

Note: The first number in each entry is r and the second is p .

Table 10. Percentage Distribution of Support Unit Survey (N = 66)

Category	%
No Support Unit	28.8
Extremely Helpful Support Unit	4.5
Helpful Support Unit	22.7
Neutral Support Unit	28.8
Not Helpful Support Unit	10.6
Definitely Not Helpful Support Unit	4.5

Table 11. Percentage Distribution of Level of Combat (N = 66)

Level of Combat	%
Low	22.7
Medium	37.9
High	39.4

APPENDIX B

TENNESSEE SELF DESCRIPTION FORM

TENNESSEE SELF-DESCRIPTION FORM

This form lists many different personal and professional behaviors of adults. For each item, first identify how often you engage in that behavior. Then indicate your choice by putting the appropriate number for that item on the answer sheet. For example, if you drink coffee a few times a month, you would put a 2 for item 1. There are no right or wrong answers, so try to be objective in reporting your own behaviors. Be sure to put your ID Number on the answer sheet before you begin answering the items.

BEHAVIORS	FREQUENCY OF BEHAVIORS				
	Never	Few times a year	Few Times a month	Several times a week	Several times a day
1. Drinking coffee	0	1	2	3	4
2. Putting away work materials	0	1	2	3	4
3. Rambling in conversation	0	1	2	3	4
4. Flossing my teeth	0	1	2	3	4
5. Creating art objects	0	1	2	3	4
6. Overextending myself in work commitments	0	1	2	3	4
7. Keeping my word	0	1	2	3	4
8. Using hard drugs	0	1	2	3	4
9. Attending art and cultural exhibits	0	1	2	3	4
10. Donating to worthy causes	0	1	2	3	4
11. Reaching work goals	0	1	2	3	4
12. Criticizing others behind their back	0	1	2	3	4
13. Getting adequate rest at night	0	1	2	3	4
14. Playing a musical instrument	0	1	2	3	4
15. Aiding stranded motorists on the interstate	0	1	2	3	4

BEHAVIORS	FREQUENCY OF BEHAVIORS				
	Never	Few times a year	Few Times a month	Several times a week	Several times a day
16. Jumping from one task to another	0	1	2	3	4
17. Starting a conversation	0	1	2	3	4
18. Eating excessively	0	1	2	3	4
19. Attending concerts	0	1	2	3	4
20. Completing work assignments on time	0	1	2	3	4
21. Interrupting others during conversation	0	1	2	3	4
22. Participating in vigorous physical activity	0	1	2	3	4
23. Writing creatively (e.g., poetry, short stories)	0	1	2	3	4
24. Eating only nutritious food	0	1	2	3	4
25. Putting off unpleasant, but necessary, tasks	0	1	2	3	4
26. Listening closely to others' comments	0	1	2	3	4
27. Smoking cigarettes	0	1	2	3	4
28. Reading leisurely (e.g., poems, fiction magazines)	0	1	2	3	4
29. Helping anyone asking for help	0	1	2	3	4
30. Setting work goals	0	1	2	3	4
31. Dominating conversation	0	1	2	3	4
32. Drinking water	0	1	2	3	4

BEHAVIORS	FREQUENCY OF BEHAVIORS				
	Never	Few times a year	Few Times a month	Several times a week	Several times a day
33. Gardening/working in the yard	0	1	2	3	4
34. Losing work related materials	0	1	2	3	4
35. Encouraging others	0	1	2	3	4
36. Eating junk food	0	1	2	3	4
37. Engaging in outdoor nature activities	0	1	2	3	4
38. Doing more than two types of exercise	0	1	2	3	4
39. Reading course/ professionally related materials	0	1	2	3	4
40. Reprimanding/scolding others	0	1	2	3	4
41. Doing stretching exercises	0	1	2	3	4
42. Engaging in a hobby not listed in this form	0	1	2	3	4
43. Stopping a mugging	0	1	2	3	4
44. Failing to meet deadlines	0	1	2	3	4
45. Showing affection toward others	0	1	2	3	4
46. Gulping meals	0	1	2	3	4
47. Dancing	0	1	2	3	4

APPENDIX C

SUPPORT UNIT SURVEY

1. After returning from Vietnam I had a support unit available.
Example: family, mom, dad, wife, friend(s), military buddies,
etc. (circle appropriate number)
 1. Yes
 2. No
2. Using the example in the preceding question please list the
support unit available if you had one. _____
3. If the answer to #1 was yes, to what extent do you believe your
support unit was helpful to you after your return from Vietnam?
(circle the appropriate number)
 1. Extremely helpful
 2. Helpful
 3. Neutral
 4. Not helpful
 5. Definitely not helpful
4. How soon after your return from Vietnam did you talk about your
Vietnam experiences and your feelings about Vietnam with your
support unit? (circle the appropriate number)
 1. 0 - 6 months
 2. 6 - 12 months
 3. 1 year - 2 years
 4. 2 years - 5 years
 5. 5 years - 10 years
 6. 10 years - 15 years
 7. 15 years - 20 years
 8. Never

APPENDIX D

COMBAT EXPOSURE SCALE

The following questions directly relate to your experiences while in Vietnam. Please answer them by circling the appropriate number.

While in Vietnam, how often (if ever) did you:

	<u>Never</u>	<u>Rarely</u> (few times a year)	<u>Occasionally</u> (few times a month)	<u>Often</u> (several times a month)	<u>Very Often</u> (several times a week)
Receive fire from the enemy?	1	2	3	4	5
Fire your weapon at the enemy?	1	2	3	4	5
Kill the enemy?	1	2	3	4	5
See someone get killed?	1	2	3	4	5
See enemy wounded?	1	2	3	4	5
See American wounded?	1	2	3	4	5
See American dead?	1	2	3	4	5
Find yourself in a combat situation where you thought you might not survive?	1	2	3	4	5

APPENDIX E

DEMOGRAPHIC SURVEY

Demographic Survey

The following questions are designed to give me some basic life situation information on persons taking my surveys. Please circle the number corresponding to the answer most descriptive of you under each question, and please answer all questions. Thank you.

- | | |
|---|---|
| <p>A) Your sex?</p> <ol style="list-style-type: none"> 1. Female 2. Male | <p>G) Occupational status?</p> <ol style="list-style-type: none"> 1. unskilled labor 2. skilled labor or trade 3. supervisory 4. managerial 5. professional 6. clerical 7. military 8. sales 9. other |
| <p>B) Your age?</p> <ol style="list-style-type: none"> 1. 29-34 2. 35-40 3. 41-46 4. 47-52 5. 52+ | <p>H) Personal income level?</p> <ol style="list-style-type: none"> 1. lower class 2. lower-middle class 3. middle class 4. upper middle class 5. upper class |
| <p>C) Marital status?</p> <ol style="list-style-type: none"> 1. never married 2. married 3. divorced 4. widowed 5. separated 6. remarried | <p>J) Living arrangement?</p> <ol style="list-style-type: none"> 1. alone 2. with spouse 3. with parents 4. with roommate 5. with children |
| <p>D) Parenthood?</p> <ol style="list-style-type: none"> 1. yes, give number of children ____ 2. No | <p>K) Religious involvement?</p> <ol style="list-style-type: none"> 1. none, no belief in a higher power 2. belief in higher power 3. belief in higher power, some church/synagogue involvement 4. belief in higher power, regular church/synagogue involvement |
| <p>E) Educational level attained?</p> <ol style="list-style-type: none"> 1. less than high school 2. high school graduate or GED 3. technical/vocational school certificate or equivalent 4. BS/BA college graduate 5. MS/MA degree 6. EdD/PhD/Md/JD degree | <p>L) Health status?</p> <ol style="list-style-type: none"> 1. excellent 2. good 3. fair 4. poor |
| <p>F) Employment status?</p> <ol style="list-style-type: none"> 1. not currently employed 2. employed full-time 3. employed part-time | |

M) Significant physical/psychological handicap?

1. no

2. yes, describe_____

N) Number of hospitalizations past 5 years

1. 0

2. 1-4

3. 5-10

4. 10+

give number of above that
involved surgery_____

O) Number of visits to physician

1. 0

2. 1-2

3. 3-5

4. 5+

P) Prescribed medications used regularly?

1. yes, describe_____

2. no

APPENDIX F

GENERAL INFORMATION LETTER

Dear Fellow Vietnam Veteran:

I am engaged in research about Vietnam veterans. This research is a part of my doctoral program in Educational and Counseling Psychology at The University of Tennessee at Knoxville. I, too, am a Vietnam veteran having served in Vietnam with the 3rd Brigade, 82nd Airborne Division and the 4th Training Detachment, 4th Infantry Division during 1969 and 1970. Presently I am the Team Leader of the Knoxville Vietnam Era Veterans Outreach Center. Having worked officially with Vietnam veterans over the past three years and unofficially for a number of years beforehand, I have seen and personally felt the positive and negative effects the Vietnam war has had on its participants and on this country as a whole.

It is my desire to add solid, unbiased facts about certain characteristics found in Vietnam veterans, and thus I am asking your help in doing this. Your responses to my inquiries will be held in the strictest of confidence and treated with the respect and dignity they deserve. When my research is complete (spring 1985) I will be glad to share with you the overall findings of my study. Also, should you decide to participate, approximately 8- 10 weeks after you have filled out these inventories, you will be asked to complete two inventories again. At this time no further requests for information will be undertaken.

The materials enclosed will request you to give information about personal characteristics (e.g., behaviors, mood states, health factors, etc.) and your Vietnam experiences. You need not sign your name to any of these inventories. Any letters or numbers on the inventories are being used by me to identify particular groups of Vietnam veterans and also to identify how many inventories are being used. It is very important that you fill out the inventories within one week of receiving them.

Thank you for your help and cooperation. Whether or not you decide to participate I want to thank you for your time and most of all thank you for your service in Vietnam. To all my Vietnam brothers and sisters - Welcome Home!

Sincerely,

CRAIG W. BURNETTE

P.S. If you choose not to participate, please place all the materials in the enclosed stamped envelope and return them. It is very important that I receive all materials back. Thank you.

APPENDIX G

INFORMED CONSENT STATEMENT

INFORMED CONSENT STATEMENT

I understand that the purpose of this study is to develop a more comprehensive picture of certain characteristics of Vietnam veterans. I have been informed that I will take a series of paper and pencil inventories dealing with my personal characteristics (e.g., behaviors, mood states, health factors) and my Vietnam experiences. However, I have been informed that I need not sign my name to any of the inventories and that my responses will be held in the strictest confidence. I also understand that my participation is totally voluntary and that I can withdraw from participation at any point without penalty. If I have any further questions regarding my participation in the study, I will have the option of contacting the experimenter at the address and phone number listed below.

Name _____

Address _____

Date _____

Craig Burnette
Vietnam Veterans Outreach Center
Knoxville, Tennessee 37917

(615) 971-5866

APPENDIX H

INSTRUCTIONS

INSTRUCTIONS

Assuming you have decided to participate in this study, please do the following things:

1. Read, sign, and date the Informed Consent Statement.
2. Using a #2 pencil fill out the enclosed inventories. Each inventory is self-explanatory. You need not do them in any particular order.
3. Upon completion of all the inventories, place all materials in the enclosed stamped envelope and return them to me.
4. It is very critical to my research that you take the inventories within one week of receiving them and then return them to me promptly. Thank you!

APPENDIX I

FOLLOW-UP INFORMATION LETTER

1515 E. Magnolia Avenue
Suite 201
Knoxville, TN 37917

Dear

First I want to thank you for your participation in my research on Vietnam veterans. It really means a lot to me to know you have taken the time to help me and other veterans learn more about our Vietnam experiences.

I told you in my first letter that I would be asking you fill out two final surveys at a later date. Well that time has arrived and enclosed you will find two very similar surveys to the ones I sent you initially. I would like for you to complete and return them to me as soon as possible in the enclosed envelope. This is the last time I will ask you for assistance in my research. As before your assistance is voluntary.

Again I cannot thank you enough for responding to me. Do not hesitate to call me if you have any questions.

Sincerely,

CRAIG W. BURNETTE
Vietnam Veterans Outreach Center
Knoxville, Tennessee 37917

(615) 971-5866

Craig Wilburn Burnette was born in Rock Hill, South Carolina and received his early education in public schools in Spartanburg County, South Carolina. He graduated with a B.S. in Psychology from Wofford College, Spartanburg, South Carolina in 1968. He immediately entered the U.S. Army and served until early 1971. His duty stations included Ft. Bragg, Ft. Knox, Ft. Jackson, Panama Canal Zone, and Vietnam where he was a platoon leader, company commander, and military advisor. His combat units were the 82nd Airborne and 4th Infantry Division. He was decorated several times for both bravery and meritorious service.

He obtained a M.Ed. in counseling from the University of South Carolina, Columbia in 1972. For several years he taught, counseled, and coached in schools in Frederick, Maryland and Oak Ridge, Tennessee. After admission to the doctoral program in the Department of Educational and Counseling Psychology, The University of Tennessee, Knoxville (UTK), he taught several courses there. He also was the student graduate assistant in the Orientation Department, UTK for two years.

He became a regional director for the Southeast Sex Desegregation Center in 1980 and from there became the Team Leader, Knoxville Vietnam Era Veterans Outreach Center. While in this position, Craig helped to provide crises counseling for participants in the dedication of the Vietnam Veterans Memorial in Washington, D.C., during November, 1982. During the anniversary observance, the following year, he co-coordinated the efforts to provide these services. For his work he has been recognized with commendations and awards given by the VA Administrator. He also was selected to testify before a Congressional

Subcommittee on the present performance of Vet Centers and on the future needs of Vietnam era veterans. He serves on a Veterans Administration planning committee that is charged with designing and recommending to the VA Administrator the future organization and goals of Vet Centers. Recently he was appointed by the Governor of Tennessee to an advisory committee on employment of the handicapped.

In his work with Vietnam era veterans, he has delivered over 350 speeches, lectures, and workshops to lay persons and professional mental health personnel. He currently is the Deputy Regional Manager of Region III, Readjustment Counseling Services, and has responsibility for 28 Vet Centers in the nine state Southeast region.

He is married to Karen Louise Johnson, R.N. She is also a Vietnam in-country veteran and serves on the VA Advisory Committee on Women Veterans. They have two children, Joshua, 10, and Erica, 7.